

The Virginia Workers' Compensation Commission: Claims and Adjudication Processes

The Commission has two primary functions with respect to administering benefits under the Virginia Workers' Compensation Act. The first function is establishing and monitoring claims seeking benefits under the Act. The second function is the adjudication of specific disputes as they arise during the claim. This article will provide a brief summary of each of these functions. We will start with an overview of the claim process.

The Commission creates a claim file when it receives notification from either the claimant or the employer that there has been a work-related accident or diagnosis of an occupational disease.¹ The employer is required to report the accident within 10 days using the Commission's Employer's Accident Report Form ("EAR").² The Commission will create a claim file when it receives an EAR. However, if the accident involves no lost time from work and less than \$1,000 in medical bills, the employer reports the incident as a "minor" accident using a different form. The Commission does not create a claim file for minor accidents unless the claimant files a claim.

The Commission will also initiate a claim file when it receives a claim for benefits. Generally, the claimant files the initial claim for benefits. The claimant must file the claim within two years of the date of the accident or risk losing all benefits under

¹ As was true of the first article, the focus here will be on workplace injuries.

² See Code Section 65.2-900.

the Act.³ A claim form may also be filed with the Commission at any time during the life of the claim when a dispute arises between the parties.

Health care providers may also file claims with the Commission. Provider claims arise generally in two situations: (1) when an insurance company fails to pay a bill, and (2) where the carrier has made payment after repricing the bill, and the provider does not agree with the reimbursed amount.⁴ In either case, the provider's claim triggers the Commission's adjudication process which results in a Commission decision. The provider may file the initial claim where the injured worker has not; however, in such cases, the provider may be required to prove initial compensability of the claim.⁵

The majority of claims are accepted by insurance carriers as compensable. In these cases, the carrier begins paying medical and wage loss benefits as appropriate. Once the claim file is established and the carrier indicates acceptance, the Commission retains jurisdiction to monitor activity throughout the claim's lifetime. However, if a dispute arises between the parties, the Commission may be called upon to resolve the matter through its adjudication process.

Matters are referred for adjudication when either party files an appropriate claim or application describing a contested issue. This filing may take the form of an initial

³ See Code Section 65.2-601. This is generally referred to as the "statute of limitations." There are statutes of limitations relating to occupational disease claims. However, because the majority of claims involve accidents, that will be the focus of this discussion.

⁴ When the dispute involves the amount of reimbursement the provider may elect the Commission's peer review process. In peer review, the appropriate amount of reimbursement is determined by a panel of physicians in the locality where the treatment was rendered. Peer review is an alternative to adjudication and cannot be elected if the provider has already filed a claim for adjudication. These remedies will be discussed in more detail in the next article in this series which will discuss the Commission's dispute resolution processes.

⁵ The compensability determination may require resolution of a number of complex issues. Generally, for a work-related injury to be compensable under the Act, it must be shown to have been caused by an "accident arising out of and in the course of the employment." Code Section 65.2-101. Occupational diseases are also covered under the Act; however, because of their statistical prevalence, injuries by accident are the focus of this discussion.

claim where the carrier indicates it is contesting coverage, or a document filed later advising the Commission that there is a disputed issue. Once the issue is identified, the Commission's claims personnel determine whether the matter should be referred to either the On the Record ("OTR") or evidentiary hearing docket.

In both OTR and evidentiary proceedings, a deputy commissioner makes the initial determination as to the contested issue. In an OTR proceeding, the deputy commissioner renders a decision based solely upon review of the Commission's file. The parties may submit position statements for the deputy's consideration. In an evidentiary proceeding, the deputy commissioner makes the decision after holding a trial-type hearing where the parties have an opportunity to testify under oath and to cross-examine the other party's witnesses. Both processes culminate in a written opinion and, if appropriate, an award of benefits, sent to all the parties.

Any party who is dissatisfied with the deputy commissioner's decision may file a written request for review. Review is the Commission's internal appeal process and constitutes the first appellate level. The Commission issues a review opinion affirming, reversing, modifying or vacating the deputy commissioner's opinion. Parties have a right to appeal review decisions to the Virginia Court of Appeals. A party aggrieved by a decision of the Court of Appeals may request an appeal to the Virginia Supreme Court. Review by the Supreme Court is discretionary.

The focus of this article has been the Commission's claims and adjudication processes. The adjudication process constitutes the Commission's formal dispute resolution procedures. The next article in this series will acquaint the reader with the Commission's highly effective alternate informal dispute resolution systems.

