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Proposed Regulation Agency Background Document

Agency name	Virginia Workers' Compensation Commission
Virginia Administrative Code (VAC) citation	16 VAC 30 - 110
Regulation title	Procedures for Processing Awards
Action title	Awards Processing in Non-Disputed Cases
Date this document prepared	May 15, 2008

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual*.

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

This is a promulgation of new regulations. It is designed to mirror the current systems of processing agreement forms relating to workers' compensation cases, but utilizing information systems technologies to allow this to be done in an automated and efficient manner computer-to-computer. The ultimate goal is to eliminate much of the confusing and burdensome paperwork currently required by the Commission, while retaining the outcomes being accomplished by those forms.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The Commission is an independent, non-executive branch agency, governed by three Commissioners elected by the General Assembly. Code § 65.2-200. The Commission is charged with carrying out the provisions of the Virginia Workers' Compensation Act, Code § 65.2-100 et seq. The Commission is authorized to promulgate rules and regulations. Code § 65.2-201. The Commission is authorized to collect specific accident data, as well as "such other information as may be required by the Commission" concerning injuries, and to regulate this activity. Code § 65.2-900. Any voluntary agreements as to compensation, falling outside the dispute resolution authority of the Commission, must be filed with the Commission, "in the form prescribed by the Commission." Code § 65.2-701.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal, the environmental benefits, and the problems the proposal is intended to solve.

In Virginia, workers' compensation claims are processed largely in the same manner as any other jurisdiction: an employer acquires coverage, either through traditional insurance, through a group insurer or through self-insurance; an employee suffers an injury and reports the injury to his or her employer and carrier; the carrier, or an organization managing these losses on behalf of the carrier (often known as a "third party administrator"), investigates the claim; the claim is either denied or, if accepted, payments are made and treatment offered.

The Virginia Workers' Compensation Commission (the "Commission") has two primary functions in this process: (1) the Commission monitors coverage; and (2) the Commission monitors specific claims against that coverage. "Reporting" forms the basis of how the Commission performs these functions. Employers and their carriers report acquisition of and changes in coverage. Carriers report accident data and payment activity. These reports are then compared to what the law requires and processed accordingly. Disputes arise when parties disagree with each other, or with the results of the Commission's administrative operations, about what the law requires. The Commission then acts in its judicial capacity to resolve the dispute.

Approximately 200,000 workplace accidents occur in Virginia each year. Most of these do not result in more than limited medical treatment or in more than a day or so of time lost from work. Approximately 50,000 each year, however, result in more than \$1000 in treatment or more than 7 days of time lost from work, or both. Among these 50,000, it is estimated that in approximately 40,000 of the cases the employee has returned to work without residual medical impact from the injury within 4 to 6 weeks. The remaining 10,000 cases are scheduled for a more formal dispute resolution process; 5,000 of those scheduled result in a formal judicial opinion.

Under the Act any "agreement in regard to compensation or in compromise of a claim for compensation" must be submitted to the Commission for approval. Traditionally, the Commission has supplied

“agreement forms” to insurance adjusters, who undertake to reduce payment activity to these forms and collect signatures reflecting “agreement.” After execution, the forms are filed with the Commission, which enters “awards” reflecting the payment activity. If the activity has occurred in the past, an “award for record purposes” is entered; if the form reflects ongoing disability, and award for temporary disability benefits “until circumstances justify modification thereof” is entered.

Although difficult to measure with precision, research and analysis shows that a large percentage of “agreed upon” payment activity takes place prior to any forms being completed and executed. The evidence for this is somewhat anecdotal. First, the Commission’s awards processing unit frequently receives several forms, all at one time, on individual cases that reflect “agreement” to start, modify, and stop payments. Thus, although there might have been “agreement” for some time to make and accept payment, the Commission’s forms are not completed until all of the “agreeing” that has to occur has occurred. It is believed that this occurs largely to minimize processing headaches.

Another reason why agreement forms might be late in coming to the Commission is that employees simply resist executing forms submitted by insurance adjusters. Although the payments are indeed welcome, there are varying degrees of misunderstanding, mistrust, or both that operate to discourage compliance with the Commission’s requirements. Finally, agreement forms are delayed because the parties simply do not want them submitted. Although there is “agreement” to make and accept payment, the “consequences” of an award of ongoing benefits being entered are such that the process is delayed. There is little, if any, downside to an employee in having an award of ongoing benefits entered. There is potential downside to an insurance adjuster, however, in that suspension of the award in several types of cases has to be approved by the Commission to be effective.

The purpose of these regulations is to eliminate as much as possible the “paper” aspect of this agreed-upon payment activity. This activity is being reported to the Commission in an automated way; the regulations are intended to use these automated reports to generate awards, based upon the assumption that the vast majority of these result from agreement among the parties. If this assumption is incorrect in any particular case, these regulations would not apply and the Commission would provide as always dispute resolution services to its customers.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the “Detail of changes” section.)

These regulations will set forth the manner in which information received through EDI may form the basis of a memorandum of agreement under §65.2-701 of the Code of Virginia, the manner in which parties may be deemed to have evidenced their consent to such agreement, and the manner in which the commission may enter, modify, or terminate awards based upon such agreements.

Issues

- Please identify the issues associated with the proposed regulatory action, including:*
- 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;*
 - 2) the primary advantages and disadvantages to the agency or the Commonwealth; and*
 - 3) other pertinent matters of interest to the regulated community, government officials, and the public.*

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The primary advantages are reduced paper filings. The primary beneficiaries of these advantages are employers, or if insured their insurance carriers, which are required to produce such filings in workers' compensation cases. As an employer, the Commonwealth would also benefit from these changes. The action poses no disadvantages to the public or the Commonwealth.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which are more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

No applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities particularly affected.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the board/agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so by mail, email or fax to Matthew Bryant, Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220, phone 804-367-2253, fax 877-366-5495, and email matthew.bryant@vwc.state.va.us. Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last date of the public comment period.

A public hearing will be held and notice of the public hearing may appear on the Virginia Regulatory Town Hall website (www.townhall.virginia.gov) and can be found in the Calendar of Events section of the Virginia Register of Regulations. Both oral and written comments may be submitted at that time.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

<p>Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures</p>	<p>Projected cost to the Commission to implement and enforce: \$3,537,772 (from Commission’s administrative fund) (this is within the cost to implement new EDI reporting procedures) Projected ongoing annual costs: no additional cost (the Commission’s administrative fund is funded by a workers’ compensation premium tax levied annually by the Commission on insurance carriers)</p>
<p>Projected cost of the regulation on localities</p>	<p>None perceived</p>
<p>Description of the individuals, businesses or other entities likely to be affected by the regulation</p>	<p>Employers, injured workers, insurance carriers, and individuals and businesses providing specialized services to these individuals and organizations relating to workers’ compensation, such as attorneys and third-party administrators</p>
<p>Agency’s best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million.</p>	<p>Approximately 200,000 accidents each year, with the same number of injured workers, a somewhat smaller number of employers, and approximately 400 insurance related organizations handle these accident. Many of these are small businesses.</p>
<p>All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.</p>	<p>None perceived</p>

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

Virginia considered continuing to collect agreement forms on paper, and then scanning the paper and indexing the content. Doing so would allow reporters to continue to send paper reports. This is burdensome to the Commission, difficult to perform with accuracy because of the volume of data elements collected, and it is not aligned with the industry EDI reporting methods. It also makes retains the burden of collecting physical signatures. It was determined that a system utilizing the data already being collected through electronic means would result in the least burdensome action, especially on small business.

Regulatory flexibility analysis

Please describe the agency’s analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

Compliance will result in a less-burdensome process for submitting forms; thus, delaying promulgation would prolong having to comply with paper-form submission procedures. The action simplifies reporting requirements at minimal impact on operations. The Act requires such reporting, without exception.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

Commenter	Comment	Agency response
Third-Party Administrator Compliance Representative	What are awards?	<p>Changes to the Awards Process for VWC Carriers</p> <p>The VWC Commissioners approved regulations to be proposed that represent a major change to the Commission’s Awards Process. These anticipated changes will result in significant improvements, especially reducing the need to capture and manage paper signatures.</p> <p>What This Means for VWC’s Carriers</p> <p>Because the new EDI system will automate major portions of the approval process, in the majority of cases Carriers will no longer be required to capture or manage paper signatures for Non-Disputed claims. See the next section for an overview of these changes.</p> <p>Summary of Changes</p> <ul style="list-style-type: none"> • For Non-Disputed Claims where a claimant’s payment is suspended within the same quarter the claim is opened, Carriers are no

		<p>longer required to capture or manage paper signatures. Awards for “record purposes” will be entered, and they will be required to object if they disagree with the record award.</p> <ul style="list-style-type: none"> • For Non-Disputed Claims which span beyond the quarter when they were filed, Carriers are no longer required to capture employee signatures; however, they will be required to provide their own assent to awards for continuing benefits. • For Disputed Claims, Carrier responsibilities for capturing and managing signatures are largely reduced. <p>How to Learn More About These Changes</p> <p>In late April, VWC will host a conference call to share details about changes to the Awards Process, and to answer Carrier questions. Look for information in next week’s communication about the date and time for the conference call, and for how to register.</p> <p>While the conference call will serve as the forum for you to pose specific questions, should you have general questions or comments in the meantime, please submit those via the TAP Feedback e-mail box. tapfeedback@vwc.state.va.us</p>
Attorney practicing before Commission	Is there a plan to hold public hearings?	Yes
Attorney practicing before Commission	Will the proposed regulations be available for review?	Yes—link provided to working draft posted on website
Third-Party Administrator Claims Representative	Will I be able to provide comment after the text of regulations is proposed?	Yes
Attorney practicing before Commission	I understand we are to direct to you any comments regarding the proposed workers’ compensation regulations. As our firm generally represents employers and carriers, we have concerns about the regulations as proposed.	Thank you for your comments received yesterday. As you know the Commission is intending to propose regulations concerning processing awards in non-disputed cases, and has posted draft regulations to allow ample time for review and comment. Your comments are appreciated.

	<p>The biggest concern is with regard to the entry of awards unless an adjuster timely objects (provided either indemnity or medical payments have been made to or on behalf of the claimant). Considering our clients routinely pay emergency room bills (and possibly other panel physicians), medical payments will be made on behalf of a claimant in almost every situation. This is not indicative of whether the claim is compensable under the Act, but is solely representative of our client’s generosity towards the initial visits. It seems the only recourse our clients will have, should these regulations be adopted, is to ensure that these gratuitous payments are never made. It seems the logical course for our clients to adopt is one that prohibits the payment of indemnity and medical benefits until a full investigation is concluded. In the event the case is not compensable, the claimant will have even more medical bills to pay (as our clients will not have made the initial payments).</p> <p>Also, with respect to the procedure concerning the claimant’s release to pre-injury work, we do not believe there is either a likelihood our client will be aware of the release within two business days (of the actual release) or that any claimant will “agree” that they can return to their pre-injury job. Our clients routinely do not receive medical</p>	<p>Your first concern is that a record award will be entered “unless an adjuster timely objects.” You mention the situation where an adjuster might routinely pay for an emergency room bill or other medical bill without regard to compensability, and you do not want our new system to discourage these gratuitous payments. We agree that we do not want to discourage such gratuitous payments, and your belief that record awards will be entered in such cases unless an adjuster timely objects is not accurate. There are several ways for an adjuster to signal that he or she does not want to accept a claim despite payments being made.</p> <p>First, a denial report (an available EDI report) can be filed with the initial accident report (FROI). Second, a denial can be filed when a medical payment is made. Third, a denial can be filed after a medical payment is made. Indeed, a denial report can be filed at ANY time. If a denial report is filed, no record award will be offered to the adjuster. Further, in those cases where a record award is proposed to the carrier, the carrier can object both during the 15 days before the Award is entered and during the 20 day appeal period. So, as you can see, there are ample opportunities for an adjuster to indicate a rejection or denial.</p> <p>Another important point is that “minor” injuries—which includes medical treatment less than \$1,000—will not trigger the proposed award process. Thus, small medical only payments like you mention are excluded from this process.</p> <p>Your second concern is based upon the mistaken belief that an adjuster must file supporting documentation within two days of a medical release to pre-injury work. In fact, the adjuster must file the</p>
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	<p>reports until well after an office visit, and claimants almost never simply agree that they can return to their pre-injury job. This procedure might be better if the award was automatically terminated if the office note was from a recognized treating physician and clearly indicated the claimant could return to pre-injury work, unless the claimant filed documentation to the contrary within a reasonable period of time.</p> <p>I hope this information is helpful and we thank you very much for your time in analyzing the current Commission regulations. We know it is a very difficult task.</p>	<p>documentation within two days of the SUSPENSION of payments. This process tracks the current Form 46, Option 2, which the Commission now processes.</p> <p>Your suggestion about automated termination “if the office note was from a recognized treating physician and clearly indicated the claimant could return to pre-injury work” is well made and will be duly considered in the regulatory process.</p> <p>Please contact me directly with any questions. Also, please “sign up” for EDI information at http://www.vwc.state.va.us/EDI/signup.html and refer to our website and to the Regulatory Town Hall for information about public hearings on these changes.</p>
<p>Attorney practicing before commission</p>	<p>The information put forward clearly makes it easier for an employee to obtain a lifetime medical benefits Award without having to do anything. The current system of having the \$1000 payment threshold trigger additional information be sent to the injured employee advising them of their rights and HOW to go about seeking an Award that would provide medical benefits beyond the current two year limit is how the rules were written. This provides at least a minimum level of responsibility for the employee seeking extended medical benefits.</p> <p>As I understand it, the process proposed will allow the insurer/employer/TPA to 'dispute' the automatic entry of a lifetime medical Award and disputed, the employee will be made aware by the VWCC and provided with information as to how to apply for a lifetime medical Award. This will then generate another inquiry to the insurer/employer/TPA that will require a response. If a second objection is raised, then the matter would head to dispute resolution.</p>	<p>Thanks for your message—our response follows in blue. Please sign up at http://www.vwc.state.va.us/EDI/signup.html to receive updates. There will be a public hearing in the summer. Notification of rights are sent to the injured employee regardless of severity. 65.2-201(D).</p> <p>There is no “automatic entry” of awards, including medical only awards which you mention. To the contrary, there are numerous communications to try to ascertain if the parties are in agreement that the injury and treatment should be covered under the Act. There are several ways for an adjuster to assert that an award should not be entered. First, a denial report (an available EDI report) can be filed with the initial accident report (FROI). Second, a denial can be filed when a medical payment is made. Third, a denial can be filed after a medical payment is made. Indeed, a denial report can be filed at ANY time. If a denial report is filed, no record award will be offered to the adjuster. Further, in those cases where a record award is proposed to the carrier, the adjuster can object both during the 15 days before the Award is entered and during the 20 day appeal period. This process equally applies in medical only cases, to prevent awards on denied claims. Similarly, if the</p>

	<p>This process will basically make the insurer/employer/TPA look like the 'bad guy' because we objected to an automatic entry of an Award. Due diligence will require that we not voluntarily accept automatic entrance of Medical Awards. This will require more touches on minor claims than both sides have today, therefore being counterproductive to streamlining the process.</p> <p>Has consideration been made to eliminating the 'assent' process altogether for Medical Only claims that exceed \$1000? Instead of asking the insurer/employer/TPA whether it is acceptable to enter a lifetime medical award, have the \$1000 threshold trigger the sending of additional information to the employee -- as it does now. Then the insurer/employer/TPA would only need to provide assent or disagreement with an actual request generated by the employee. This would make the default minor medical claim a 2 year eligibility to medical benefits unless the employee seeks an extension -- just as it exists today.</p> <p>If this is not being considered as a change, will it be possible for insurers/employers/TPA's to go ahead and enter in a blanket response, applicable to ALL claims, that we do NOT agree with the automatic entry of a lifetime medical award?</p>	<p>\$1000 medical payment threshold is not reached, this process will not begin. So, as you can see, there are ample opportunities for an adjuster to indicate a rejection or denial, which will tell us not to begin any award process, and will allow adjusters to prevent awards.</p> <p>“Minor” claims do not trigger the proposed process, so should not change your current processes other than the minor injury report comes in electronically instead of on paper. Also, the due diligence you mention is presumably the investigation process. In the medical only case with benefits exceeding \$1000, there will be at least 13 weeks for investigation, and several ways to note after investigation, as mentioned above, that the claim is not accepted.</p> <p>This is not how our operations or the Act work today. Compensable injuries receive benefits under 65.2-603, not the “2 year eligibility” you describe. You mention a “minor medical claim”—if benefits do not exceed \$1000, the proposed process is not triggered. Your suggestion that medical only claims not trigger the proposed process, in the case where benefits exceed \$1000, will be duly considered by the Commission in proposing the regulatory changes.</p> <p>Each case that is in dispute is handled on a case-by-case basis.</p>
<p>Attorney practicing before commission</p>	<p>Section D of the proposed Rule states, “The award shall constitute the filing of a claim with the commission under §65.2-601 of the Code of Virginia for those indemnity and medical benefits paid by the employer prior to entry of the award, and the claim specifically includes injuries causally related to the accident that are treated and that are paid by the</p>	<p>The Commission is planning on including such notifications in its communications in the scenario you described. Thank you for your proposed wording—in creating these notices, this will certainly prove helpful. As the wording of such notices can change, please continue to communicate suggestions, especially when a specific case alerts you to a particular item that would be beneficial, that help us provide clearer and more useful information. Your comment is well taken with regard to</p>

	<p>employer.”</p> <p>As a Claimant's attorney, I believe the automated entry of an award for a closed period of disability should also require the Commission to provide the Claimant a specific written Notice that the Award being entered is for a closed period of disability and that it is the obligation of the Claimant to file a separate claim if additional wage benefits have been paid or if the Claimant seeks wage benefits for temporary total disability, temporary partial disability, or permanent partial disability. The Commission's notice should include reference to the time requirements of Rule 1.2, which allows the filing of a claim to relate back only ninety (90) days prior to the date of filing. The Commission's notice also should include reference to the statute of limitations set forth in <u>Va. Code</u> §65.2-708 for filing a change in condition for temporary disability and permanent partial disability benefits. A proposed Notice Would state [text of proposed notice].</p> <p>The proposed Notice requirement would ensure fundamental fairness to Claimants who became subject to the entry of an automated award. While entry of automated awards will promote the goal of promptly finalizing awards of the Commission, in order to obtain a prompt recovery backed by the Commission's authority and enforcement mechanisms, the entry of closed awards in conjunction with the Commission's complicated time limitations will likely result in "timing traps," for unwitting</p>	<p>“automated termination of a wage benefit award” in the “actual” return to work case. Positive agreement must be received before termination in the “release to” return to work case. As mentioned above, information such as you suggest is being included on award notifications.</p> <p>This proposal applies only in the “changes in actual earnings” case. In this case as currently in operation, adjusters are effectively free to “self adjust” because an employer's application based upon return to work can always be filed (within two years at least) going back to the date of the return. If a claimant is not being paid correctly, the Commission will as always make every effort to assist. In any other case where an adjustment is made, the current procedures continue.</p> <p>The Commission agrees that clear, effective communications on the notices, as you suggest, are required to help all parties, especially unrepresented ones who are unfamiliar with the law, will understand what their respective positions are, and how to respond if they need assistance, and to avoid problems. Thank you for your suggestions.</p>
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	<p>Claimants. The proposed notice would ensure a reasonable amount of information for Claimants to be able to determine their unknown legal obligations in the event of a closed award. The Notice requirement would discourage Employers and Insurers from engaging in a practice of agreeing to entry of wage awards for closed periods in order to leave Claimants in a position where they were estopped from pursuing lawful remedies due to the imposition of time limitations.</p> <p>This Rule permits the suspension of wage benefits pursuant to an award when the employee returns to work at a post-injury weekly wage that is equal to or greater than the pre-injury average weekly wage or when the employee is able to return to his or her pre-injury work. If the employee returns to work at a wage equal to or greater than the pre-injury wage and no objection is filed within an allotted time, the Commission will deem the notification and lack of objection as a memorandum of agreement and may terminate the award and shall notify the parties and their representatives. If indemnity payments are stopped because the employee is able to return to pre-injury work, the commission shall notify the parties and their representatives that the open award will be terminated if the employee agrees within the time allotted in the notice. If the employee agrees, the Commission may approve the agreement and terminate the award and shall notify the parties and their representatives.</p>	
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	<p>As a Claimant's attorney, I believe the automated termination of a wage benefit award should also require the Commission to provide the Claimant a specific written Notice that the Award is terminated and that it is the obligation of the Claimant to file a separate claim if additional wage benefits have been paid or if the Claimant seeks wage benefits for temporary total disability, temporary partial disability, or permanent partial disability. The Commission's notice should include reference to the time requirements of Rule 1.2, which allows the filing of a claim to relate back only ninety (90) days prior to the date of filing. The Commission's notice also should include reference to the statute of limitations set forth in <u>Va. Code</u> §65.2-708 for filing a change in condition for temporary disability and permanent partial disability benefits. A proposed Notice Would state: [text of proposed notice]</p> <p>The proposed Notice requirement would ensure fundamental fairness to Claimants who became subject to the automated termination of a wage benefit award. While entry of automated awards will promote the goal of promptly finalizing awards of the Commission, in order to obtain a prompt recovery backed by the Commission's authority and enforcement mechanisms, termination of wage benefit awards in conjunction with the Commission's complicated time limitations will likely result in "timing traps," for unwitting</p>	
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	<p>Claimants. The proposed notice would ensure a reasonable amount of information for Claimants to be able to determine their unknown legal obligations in the event a wage benefit award is terminated. The Notice requirement would avoid Claimants being left in a position where they were estopped from pursuing lawful remedies due to the imposition of time limitations.</p> <p>This Rule permits the adjustment of wage benefits based upon return to work or changes in earnings. These adjustments, pursuant to Section B, may be affected by an Employer or Insurer without prior approval of the Commission. .</p> <p>As a Claimant's attorney, I believe that permitting Employers and Insurers to exercise a "self-executing," mechanism to adjust indemnity payments, subject to the Commission's after the fact review, will encourage Employers and Insurers to overreach and to unreasonably fail to pay benefits at the correct rate in order to produce an economic hardship upon Claimants entitled to temporary partial disability benefits. The Rule gives Claimants no remedy to address promptly a financial hardship which may result from the incorrect underpayment of wage benefits. The proposed rule shifts the burden of ensuring proper modification of an award based upon changed earnings from Employers and Insurers, who are in the best economic and informational position to determine the need for this, to Claimants, who are</p>	
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	<p>not in a position to ascertain this. The Commission's proposed "after-the-fact" adjustment procedure in section "E" will not ensure a prompt financial recovery for Claimants who face hardship as a result of reduced earnings and will prolong, rather than shorten, the time necessary to correct wage benefit awards.</p> <p>In the event the Commission determines this Rule is necessary, it should require Notice to Claimants in the even of modification of awards as set forth in sections 1 and 2 above. A proposed Notice Would state [text of proposed notice]</p> <p>The proposed Notice requirement would ensure fundamental fairness to Claimants who became subject to the entry of an automated award. While entry of automated awards will promote the goal of promptly finalizing awards of the Commission, in order to obtain a prompt recovery backed by the Commission's authority and enforcement mechanisms, the entry of closed awards in conjunction with the Commission's complicated time limitations will likely result in "timing traps," for unwitting Claimants. The proposed notice would ensure a reasonable amount of information for Claimants to be able to determine their unknown legal obligations in the event of a closed award. The Notice requirement would discourage Employers and Insurers from engaging in a practice of agreeing to entry of wage awards for closed periods in</p>	
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	<p>order to leave Claimants in a position where they were estopped from pursuing lawful remedies due to the imposition of time limitations.</p>	
<p>Attorney practicing before commission</p>	<p>As an attorney who has represented employers and insurers before the Commission for over 25 years, I would appreciate your reconsideration of the entry of awards unless an adjuster timely objects. That procedure simply will not work and will create many more litigated cases. There are many reasons why an employer may not want an Award entered after certain benefits are paid voluntarily. Adjusters must not be held to Awards entered due to an act of omission, but rather awards should only be entered if the adjuster affirmatively indicates agreement for the entry of the Award. Moreover, the entry of Medical Only Awards under the proposed regulations will discourage the voluntary payment of medical bills in many claims. Employers often will pay medical bills in claims that should not be accepted under the Act. If such voluntary payments will now expose the employer to inappropriate Awards, then employers need to be advised to never make such payments. Thank you for considering these concerns.</p>	<p>Thanks for your comment. Your comment that “inappropriate Awards” will be entered unless an adjuster timely objects is not accurate—the intent is to enter awards only in those cases where the parties are in agreement that one should enter. There are ample opportunities for an adjuster to object-- First, a denial report (an available EDI report) can be filed with the initial accident report (FROI). Second, a denial can be filed when a medical payment is made. Third, a denial can be filed after a medical payment is made. Indeed, a denial report can be filed at ANY time. If a denial report is filed, no record award will be offered to the adjuster. Further, in those cases where a record award is proposed to the carrier, the adjuster can object both during the 15 days before the Award is entered and during the 20 day appeal period. This process equally applies in medical only cases, to prevent awards on denied claims. So, as you can see, there are ample opportunities for an adjuster to indicate a rejection or denial, which will tell us not to begin any award process, and will allow adjusters to prevent inappropriate awards.</p> <p>I hope this helps clarify. We will have public hearings this summer on these changes, and will of course address these comments, and also please sign up at http://www.vwc.state.va.us/EDI/signup.html to receive updates.</p>
<p>Attorney</p>	<p>I was at the VADA meeting last</p>	<p>To be clear, notification of payments is not</p>

<p>practicing before Commission</p>	<p>Friday. As you know, many of us raised concerns about the new regulations, specifically entry of a record award after notification that payments have been made. It does not appear to be specified in the regulations, but you indicated that adjusters would be notified by e mail and that if a response was not received within the time specified, an award would be entered. Many of my adjusters are overwhelmed with e mails already, and the possibility that yet another could be overlooked is significant. The regulations also do not specify how the parties will be notified that an award has been entered. Will a paper award be sent out to all parties, or will this notification be by e mail also? Having both notifications by e mail is a concern again due to the volume of e mails that most adjusters I deal with currently receive. One suggestion could be to send out a paper award with the standard 20 day appeal period, and that if an appeal is noted, then the claim gets referred to the hearing docket. However, I am also concerned about the injuries covered by any such award. Simply referring to the injuries that are "treated and that are paid by the employer" seems vague and leaves open the potential for disputes, which disputes currently can defeat a <i>de facto</i> award.</p> <p>I hope that there will be additional opportunity for attorneys to comment on these proposed regulations. If you have any questions or wish to discuss further, please do not hesitate to contact me.</p>	<p>sufficient to enter a record award. There are several steps along the way where denial can be noted, and the proposed award process will not start in such situations. First, a denial report (an available EDI report) can be filed with the initial accident report (FROI). Second, a denial can be filed when a medical payment is made. Third, a denial can be filed after a medical payment is made. Indeed, a denial report can be filed at ANY time. If a denial report is filed, no record award will be offered to the adjuster. Further, in those cases where a record award is proposed to the adjuster, the adjuster can object both during the 15 days before the Award is entered and during the 20 day appeal period. This process equally applies in medical only cases, to prevent awards on denied claims. It is also important to note that in "minor" cases (in general, indemnity less than 7 days or meds less than \$1000) this process does not start. So, as you can see, there are ample opportunities for an adjuster to indicate a rejection or denial, which will tell us not to begin any award process, and will allow adjusters to prevent inappropriate awards.</p> <p>E-mail will be available (mid 2009) to people who prefer and ask for that; otherwise, it's paper.</p> <p>What is currently planned is if the "notice that award will be entered" is objected to, or if the "award" that follows if not objected to is appealed, we will attempt to informally resolve that, and then wait for a claim before referring to the docket.</p> <p>The injuries also must be causally related, in addition to being treated and paid for. The intent is that treatment paid for (greater than \$1000) is more than likely agreed to as compensable. Of course some payments are gratuitous, or made by mistake. The thought is that, for the most part, adjusters make only those payments they feel obligated to make (no such thing as a free lunch!), and that these would end up on an award. In murkier cases like you mention, attention is needed in paying for treatment that is not causally related—however, causation is always a defense. There definitely will be! Please sign up at http://www.vwc.state.va.us/EDI/signup.html to receive updates. There will be a hearing sometime this summer. Also—call anytime.</p>
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Note: The Commission has conducted a webcast for claims adjusters, and received questions during the webcast. These are posted as FAQ’s on the Commission’s website, <http://www.vwc.state.va.us/EDI/FAQs.html>. Additionally, the Commission has posted a draft of regulations it is considering proposing. The posted draft is the same text as that attached to the townhall submission. There were four comments to the posted draft, which are listed above with response.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one’s spouse, and one’s children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

None.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

For changes to existing regulations, use this chart:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
NA	30-110-10	Current practice is for awards information to be collected by parties on paper forms provided by the Commission and filed with the Commission. The Commission then processes the paper forms and returns a paper “award” to the parties setting forth the information provided on the forms.	Proposed change would use data, already collected via electronic methods, to populate the fields currently provided to the parties on paper and provide opportunities to accept or reject the data so populated. The primary rationale is that the parties’ signatures is not collected via electronic methods, and thus the regulatory action is necessary to inform and educate parties how their signature is “collected.”
NA	30-110-20	NA	Proposed section provides definitions application to proposed regulations
NA	30-110-30	Current practice is for	Proposed section provides that payments

		parties to complete paper forms indicating their agreement to pay and accept benefits, and file with the Commission. This typically results in an award of ongoing benefits being entered.	can be freely made and stopped within the first quarterly period after a workers' compensation accident, and that the Commission will interpret that payment activity, already reported to the Commission, to form the basis of an agreement to pay and accept the benefits paid and accepted. The rationale is that the vast majority of payments are not the subject of litigation or dispute, and that the Commission should provide simple, easy mechanisms for the "paperwork" currently required.
NA	30-110-40	Current practice is for parties to either agree, and complete paperwork, or if agreement not reached for the employer to file a pleading requesting termination of an award of ongoing benefits.	Proposed section would allow a payment activity report, already filed electronically with the Commission, to serve as the pleading to be filed with the Commission, in "return to work" cases. The Commission would solicit agreement from the worker before processing a dispute. The rationale is that most return-to-work cases are the result of agreement, and that the Commission should provide simple, easy mechanisms for the "paperwork" currently required.
NA	30-110-50	Current practice is for parties to complete paper forms and file with the Commission. The Commission then enters an award for ongoing benefits, which can only be terminated after approval by the Commission. These forms are due upon reaching the agreement to pay benefits.	Proposed section would interpret payment activity spanning beyond a quarterly period as indicative that an agreement to ongoing benefits has been reached, and the Commission (and not the parties) would solicit accepted via signature as to this fact. The rationale is that most payments on claims fall well within thirteen weeks, and only those falling beyond thirteen weeks represent agreement to ongoing benefits, and thus provides a streamlined method of processing the signatures.
NA	30-110-60	Current practice is for minor injuries to receive awards only on request by the parties	No proposed change to current practice.

The new provisions are based upon the receipt of injury and payment data through EDI. This is required on all workplace injuries. It is also required by law that for all voluntary agreements, the agreement be reduced to writing according to the form prescribed by the Commission and filed.

Through EDI, the Commission will learn of accidents, and of payments being made to an injured worker because of the accident. The Commission will take the information, and notify the parties that an award will be entered, based on the information, if not objected to within a specified time. The result of the award is the same as if the parties had submitted agreement forms required by law.

If the award is for an ongoing flow of benefits, the Commission will request that each party positively respond that the award should be entered. This is the most precise mirroring of current paper-form processing.

If an award of ongoing benefits is agreed to be suspended, for example because of a return to work, the provisions allow the EDI report to serve as the basis of a notice from the Commission that the benefits should be suspended.

These regulations apply to non-disputed cases only, where the basic compensability of an injury and agreement to pay benefits are not at issue. It encourages voluntary payment, with minimal intervention by the Commission. The Commission continues to provide formal and informal dispute resolution services.