RECENT LEGISLATIVE DEVELOPMENTS OF INTEREST TO VA WORKERS' COMPENSATION CLAIMANTS' LAWYERS

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Virginia Legislative Session in 2012

A. 714 bill

Several months before the 2012 Legislative Session, the Virginia Court of Appeals issued an opinion in the case of Budnick v. Murphy-Brown, LLC , Record No. 2025-10-2 (Va. Court of Appeals, May 10, 2011) (See attachment 1) in which it was held that so long as all of the medical bills for a provider were fully paid and no unpaid amounts were due and owing by the injured worker, that neither the injured worker or claimant's counsel would have standing to pursue a 714 claim. Also, the commission would not have jurisdiction to entertain a claim against the workers' compensation insurance company or force that carrier to pay charges which it would normally be required to pay. That case involved Medicaid payment of the medical bills, but would appear to have equal application to defeating claims on behalf of claimants or their counsel in regards to any bills or amounts whenever there was no balance owed on the bills in question.

In the 2012 session, Va. Code 65.2-714 was amended to overturn Budnick and clarify that even though the bills may be entirely paid, the commission retained jurisdiction and the claimant and counsel would have standing to pursue a 714 claim to make sure that the correct party paid the medical bills related to the otherwise compensable claim (See attachment 2).

B. Longshore bill

Also in the 2012 session, the Virginia Legislature passed legislation which provides that when an injured worker might qualify for both longshore benefits and workers' compensation benefits that Virginia workers' compensation benefits would not apply and the commission would not have jurisdiction over that claim. That claimant would be limited to a longshore claim hereafter (See attachment 3).

C. Quorum bill

In the 2012 session, legislation was passed overruling the case of Hitt v. Pratt, Record No. 0723-08-4 (Va. Court of Appeals, Feb. 17, 2009) on the question of whether any two full commissioners could render an opinion in the absence of the third full commissioner with the assistance of a deputy commissioner on a full commission appeal. The statute in question not only overruled Hitt, but also provides that any two full commissioners have authority to make administrative decisions and exercise their legislative duties without the involvement of the third commissioner even in instances where said third full commissioner is not absent (See attachment 5).

Virginia Legislative Session in 2013

A. Brain Injury bill

In the 2013 session, the House and Senate approved and the governor will be asked to sign an amendment to what is commonly referred to as the Brain Injury Bill. That statute specifically provides that in certain cases of inability to testify that the claimant would have a lesser burden of proof and/or there would be a presumption that might assist injured workers in proving their case. The statue as originally drafted has met with little success to date and it is hoped that this modification will go some way towards improving the usefulness of this statute (See attachment 6).

B. 708 bill

Also in the 2013 session, the House and Senate approved and the governor will be asked to sign legislation amending 65.2-708 of the Virginia Code. The amendment provides that while it may be that periods of light duty return to work by claimant with the regular employer shall be considered compensation under an award that said periods are not an offset or reduction in the total number of weeks of indemnity that the claimant may otherwise be entitled to under the Workers Compensation Act. This change, albeit an apparent codification of the current case law, would appear to foreclose this issue (See attachment 7).

C. Officer Presumption bill

Since it has been long recognized that certain public employees are more inclined to be in dangerous situations, there was an attempt by the sponsor of this bill to remove the "act of God" defense regarding certain accidents. However, the ultimate modification as drafted would appear to be no more than a codification of the current Virginia case law (See attachment 8).

D. Peer Review Opt-out bill

Many healthcare providers have sometimes seen medical charges challenged through the peer review process, but have also found that the peer review process is slow and ineffective in resolving medical charge disputes. If this bill is signed into law, healthcare providers are now given an opt-out in order to proceed with the normal commission adjudication process pursuant to a new statute enacted in this session (See attachment 9).

Virginia Legislative Session 2014

In the 2014 session, we expect a reoccurrence of several bills which were before the legislature in the 2013 session, but which were referred to a subcommittee and then tabled until next year.

A. Medical bill SOL

Up until the present, there is no statute of limitations applicable for medical bills relating to compensable workers' compensation claims. In the 2013 session, there was proposed legislation to modify this imposing a one year SOL (See attachment 10). In response, another proposal is pending requiring notice before a SOL can be applied (See attachment 11).

B. Prompt Payment bill

Related to the statute of limitations issues, a Prompt Payment bill was introduced. Up until this time there has been no penalty for late payment of medical bills. This bill is patterned after the prompt payment provisions present in health insurance law (See also attachment 11).

C. 714 Amendment

We also saw a proposed modification of 65.2-714 of the Va. Code which would provide that in the event bills are unpaid and/or paid by the wrong party and through the work of counsel for the claimant the medical bills are found compensable and finally paid by the workers' compensation insurance company, that while 714 attorney fees may be awarded, the fee would not be awarded against healthcare providers. Rather the claimant counsel's attorney fees would be paid by the workers compensation carrier pursuant to this recent proposal (See also attachment 11).

D. Medical Fee Schedules

Also in the 2013 session and carried over into the 2014 session is a proposal by the workers' compensation carriers to modify Virginia law in regards to what are considered appropriate charges for medical care and treatment in Virginia Workers' Compensation cases. The current law of course allows for reasonable and customary charges. Some would like to see a medical fees schedule based upon "Medicare plus." They submitted language in favor of same (See attachment 12). In response to that, there was a proposal which is closer to the current standard (See attachment 11).

National Legislation of Interest

While all of the above has been taking place in the Virginia legislature, there have been important changes of note in Washington, DC. More specifically there are two pieces of legislation; one that passed and one that is pending which workers compensation claimants' attorneys should be aware of. The first is referred to as the SMART Bill, which provides new rules in regards to Medicare conditional payments for either workers compensation or personal injury cases (See attachment 13). The American Association for Justice Summary of said bill is attached (See attachment 14).

In a similar vein, but only limited to workers' compensation cases, legislation that has been pending in a variety of forms for a number of years to the unclear, unfair, and unworkable guidelines promulgated by CMS having to do with when or if Medicare set asides might be appropriate or how claimants settling workers compensation cases should properly "consider Medicare's interest."

The bill in question includes deadlines for CMS to respond to Medicare set aside requests, appeal procedures, the institution of proportionality rules and also allow an option for a onetime payment to CMS in lieu of a Medicare set aside (See attachment 15). An executive summary of these two bills are also attached (See attachment 16). [1]

[1] Courtesy of Rich Swanson, Esq., Workers' Injury law and Advocacy Group, Federal Legislature Chair. Rich's practice in Indianapolis, Indiana includes employment and workers' compensation claims.

INDEX OF ATTACHMENTS

1. **Budnick v. Murphy-Brown, LLC** (Va. Ct. of Appeals 2012)

2. **HB 1169,** amending §65.2-714 of the Va. Code

3. **HB 153,** amending §65.2-101 of the Va. Code

4. **Hitt v. Pratt,** Record No. 0723-08-4 (Va. Ct. of Appeals 2009)

5. **SB 577,** amending §§65.2-201, 704 and 705 of the Va. Code

6. **HB 1305,** amending §65.2-105 of the Va. Code

7. **HB 2174,** amending §65.2-708 of the Va. Code

8. **HB 896,** amending §65.2-301.1 of the Va. Code

9. **HB 1733,** amending §65.2-1306 of the Va. Code

10. **HB 2160,** amending §§65.2-605 and 714 of the Va. Code

11. **HB 2206,** amending §§65.2-605 and 714 of the Va. Code

12. **HB 1612,** amending §65.2-605 of the Va. Code

13. **HR 1845,** 112th Congress of the United States

14. AAJ Summary of **HR 1845**

15. **HR 5284,** 112 Congress of the United States

16. Summary of **HR 5284** of 1845

COURT OF APPEALS OF VIRGINIA

Present: Judges Frank, Beales and Powell
Argued by teleconference

STEVE BUDNICK

v. Record No. 2025-10-2

MURPHY-BROWN, LLC &
ACE AMERICAN INSURANCE CO., INC.

MEMORANDUM OPINION* BY
JUDGE RANDOLPH A. BEALES
MAY 10, 2011

FROM THE VIRGINIA WORKERS' COMPENSATION COMMISSION

Thomas J. Schilling (Schilling & Esposito, PLLC, on brief), for appellant.

William W. Nexsen (Jeffrey P. Partington; Stackhouse, Nexsen & Turrietta, PLLC, on brief), for appellees.

Steve Budnick (claimant) appeals from a decision of the Workers' Compensation Commission (the commission) denying his request for an order that would require Murphy-Brown, LLC, or its insurer (collectively, "employer") to pay $308,525.45 to MCV Hospitals (MCV). For the following reason, we affirm the commission's decision.

I. BACKGROUND

Claimant was severely injured in an automobile accident in 2005 while working for employer. He initially received medical care from MCV. By July 20, 2006, claimant's medical bills at MCV had reached a total of $308,525.45. On August 28, 2006, the Department of Medical Assistance Services[1] (DMAS), the Virginia agency that regulates the Commonwealth's

* Pursuant to Code § 17.1-413, this opinion is not designated for publication.

[1] The Department of Medical Assistance Services was established under Chapter 10 of Title 32.1 of the Code, to oversee the administration of federal and state Medicaid funds in the Commonwealth.

Medicaid program, paid $145,764.17 to MCV in settlement of claimant's bills. MCV then made "adjustments" of $162,761.28 to its total bill, leaving a balance due of zero.

Claimant filed a worker's compensation claim with the commission, and employer objected that the injury was not compensable. The commission entered an award of benefits to claimant on October 24, 2008. On appeal, this Court approved that award. Murphy-Brown, LLC v. Budnick, Rec. No. 2752-08-2 (Va. Ct. App. Apr. 14, 2009).

After this Court affirmed the award of benefits, claimant filed a "Claim for Benefits" with the commission. He asked that the commission order employer to pay the original MCV bill of $308,525.45, and he submitted as supporting documentation a statement from 2006 that showed the entire original balance of the MCV bill as still outstanding. MCV and DMAS were not given notice of this filing, and neither entity has ever been made a party or put in an appearance in these proceedings.

A deputy commissioner ordered that employer pay $162,761.28 to MCV, the amount "adjusted" off the original bill. Employer then appealed to the full commission. The full commission found that employer, while responsible for claimant's medical bills, could "not [be] required to make any payments to MCV." Claimant now appeals to this Court, arguing that the commission should have ordered employer to pay to MCV the original balance of $308,525.45, so that MCV could then reimburse $145,764.17 to DMAS.

II. ANALYSIS

Claimant argues on appeal, as it did before the commission, that the commission has the authority to order that employer pay $308,525.45 to MCV, even though claimant's bill from MCV shows a balance due of zero. Under these circumstances, we find that the commission did not have authority to exercise its jurisdiction here.

The Supreme Court considered a similar issue in Bogle Dev. Co. v. Buie, 250 Va. 431, 463 S.E.2d 467 (1995). In that case, Bogle Development, through an insurance company named Guaranty Fund Management Services (the Fund), reimbursed Buie for his out-of-pocket medical expenses related to his workplace accident, but refused to reimburse Blue Cross/Blue Shield, Buie's personal insurer, for its coverage of his medical expenses related to the accident. Id. at 433, 463 S.E.2d at 467-68. The "dispositive issue" in the case was "whether the Commission's jurisdiction over this controversy ceased when the Fund reimbursed Buie." Id. at 433, 463 S.E.2d at 468. The Supreme Court found that the commission had jurisdiction over "all questions 'arising under'" the Workers' Compensation Act, but that this authority was limited to questions involving a "right of the claimant." Id. at 434, 463 S.E.2d at 468 (citing Hartford Fire Ins. Co. v. Tucker, 3 Va. App. 116, 348 S.E.2d 416 (1986)). The Supreme Court concluded that the commission did not have authority to exercise its jurisdiction over the disagreement between the Fund and Blue Cross/Blue Shield "once Buie was reimbursed for his out-of-pocket expenses." Id.

Claimant here raises essentially the same issue that was raised in Bogle Dev. Co. He does not contend that the employer owes him any reimbursement for his out-of-pocket medical expenses. He does not contend that he has any liability for any outstanding medical expenses. Claimant does not contend that he is in danger of being held responsible for this medical bill because he has no outstanding medical bill at MCV. Instead, claimant contends that the commission should order employer to pay the original medical bill of $308,525.45, even though MCV shows a balance owing of zero.

DMAS paid $145,764.17 of this original bill under the Commonwealth's provisions for Medicaid coverage. Claimant is not in danger of being charged for the amount adjusted off his bill by MCV. Under Code § 32.1-346(D), one of the statutes regulating DMAS, MCV cannot

charge claimant for the $162,761.28 that was adjusted off the original bill. This statute states, "Acceptance of payment for services by a provider under this Program [DMAS/Medicaid] shall constitute payment in full." Therefore, when MCV accepted payment from DMAS, it accepted the $145,764.17 in full satisfaction of its bill. Federal law also requires that state Medicaid programs limit medical providers such that, once a provider accepts Medicaid funds for a patient's medical bills, the provider cannot then attempt to collect any additional funds from the patient. See 42 U.S.C. § 1396a(a)(25)(C).

Pursuant to Bogle, therefore, the commission here did not have jurisdiction to order that employer "pay" a bill that has been paid in full because "no right of the claimant" is involved. He is not at risk of being pursued by MCV to recover any costs from this medical care, so his "right" to have employer pay his medical expenses is not directly involved here. If MCV and/or DMAS want employer to cover a part (or all) of the bill, then they can sue employer in circuit court. See Bogle, 250 Va. at 434, 463 S.E.2d at 468; see also Code § 32.1-325.2. As this Court explained in Hartford Fire Ins. Co. v. Tucker, 3 Va. App. 116, 120, 348 S.E.2d 416, 418-19 (1986):

> The purpose and effect of the Workers' Compensation Act (Act) are to control and regulate the relations between the employer and the employee. . . . [I]ts jurisdiction does not extend to the litigation and resolution of issues between two insurance carriers which do not affect an award of the Commission. Generally, the Commission's jurisdiction is limited to those issues which are directly or necessarily related to the right of an employee to compensation for a work-related injury.
>
> In many states, including Virginia, when the rights of the employee in a pending claim are not at stake, the commissions disavow jurisdiction and send the parties to the courts for relief.

(Citations omitted). Under Bogle and Hartford Fire, the commission here correctly refused to order that employer pay $308,525.45 to MCV for an account that MCV considers paid in full.

Claimant argues that Bogle did not involve a medical provider, but instead involved only third-party health insurance companies, so its analysis does not apply here. However, the Supreme Court in Bogle limited the commission's ability to exercise its jurisdiction to questions involving a "right of the claimant," not to rights of a claimant *or* his medical providers. 250 Va. at 434, 463 S.E.2d at 468. Here, no right of the claimant is affected – just as no right of the claimant in Bogle was affected. Therefore, Bogle is controlling case law here.

Claimant also contends that Combustion Eng'g, Inc. v. Lafon, 22 Va. App. 235, 468 S.E.2d 698 (1996), is more relevant to the facts presented by his case. However, in Lafon, *the medical provider* brought the action to the commission, asking for payment of outstanding medical bills from its treatment of Lafon. Id. at 237, 468 S.E.2d at 698-99. This Court held, "In this case, unlike Bogle, the employee's rights were at stake. If Lafon's reasonable and necessary medical bills were not paid by the employer, he would be personally liable for them." Id. at 238, 468 S.E.2d at 699. Thus, Lafon involved a situation where a claimant was actually liable for the bills if they went unpaid – whereas claimant here is not liable for any bill from MCV because the account is paid in full.[2]

Claimant also argues that his relationship with his medical provider will be weakened if employer does not pay the original amount of the medical bill to MCV. We do not find this argument persuasive given MCV has not asked anyone to pay the $162,761.28 that was adjusted off claimant's bill.[3]

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[2] Very few other states have considered this question. However, a Nebraska court overturned their commission's order that an employer reimburse the Veterans' Administration and Medicare for a claimant's medical care in Spiker v. John Day Co., 270 N.W.2d 300, 305 (Neb. 1978). That court based its decision on the fact that neither agency was a party to the action and the fact that the claimant had not "incurred any liability for services furnished" by either agency. Id.

[3] The commission noted that MCV, under federal regulations, may lose its standing as a Medicaid/DMAS provider if it attempts to collect the amount that was adjusted off of claimant's

Two states have considered this argument. The North Carolina Court of Appeals rejected it, holding instead that a claimant had no standing to bring such a claim because he had no injury. Estate of Apple v. Commerical Courier Express, Inc., 607 S.E.2d 14, 17 (N.C. Ct. App. 2005).[4] A Montana court, in a case involving payments to insurance companies, found this argument was not "reasonable" and added that the claimant could petition the commission if there was an *unpaid* balance and he was sued for those bills. Shepard v. Midland Foods, Inc., 710 P.2d 1355, 1358 (Mont. 1985) (noting that this solution was "logical" and "equitable").

We agree with these courts. MCV decided to accept payment from DMAS,[5] rather than wait for the commission to determine if employer was liable under the Workers' Compensation

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original bill. See Rehab. Ass'n v. Kozlowski, 42 F.3d 1444, 1447 (4th Cir. 1994) ("Service providers who participate in the Medicaid program are required to accept payment of the state-denoted Medicaid fee as payment in full for their services, i.e., they are required to take assignment, and may not attempt to recover any additional amounts elsewhere."). See also Miller v. Wladyslaw Estate, 547 F.3d 273, 284-85 (5th Cir. 2008); Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust, 410 F.3d 304, 314 (6th Cir. 2005); Lizer v. Eagle Air Med Corp., 308 F. Supp. 2d 1006, 1010 (D. Ariz. 2004) (noting the holdings of the First and Seventh Circuits). We need not consider this argument here, especially as MCV is not a party to this case and has not asked for reimbursement through the commission.

[4] Claimant refers this Court to another opinion of the North Carolina appellate courts, Pearson v. C.P. Buckner Steel Erection Co., 498 S.E.2d 818 (N.C. 1998), as supporting portions of his argument here. However, as was noted in Estate of Apple, the court in Pearson "did not discuss standing, compromise and settlement agreements, or the issue presented by this case." 607 S.E.2d at 18. In Pearson, the claimant's medical provider, Cary Health, intervened in the case and asked the commission to order the payments. 498 S.E.2d at 819. The North Carolina Supreme Court found that the commission had jurisdiction and that Medicaid law did not preclude the commission from ordering that Cary Health be paid the remainder of its bill. Id. at 820, 822.

We find Pearson distinguishable from the situation presented here. Cary Health itself intervened in Pearson, so that case did not present a question about jurisdiction where the medical provider does not ask for additional payments from the employer – the situation that is currently before this Court. Most importantly, Bogle Dev. Co. is a decision of the Supreme Court of Virginia, and Hartford Fire Ins. is a decision of this Court. Therefore, they are, of course, binding precedent on us.

[5] If DMAS wants to be reimbursed by employer, it can sue employer pursuant to the Code and its own regulations. See Code § 32.1-325.2 (DMAS may recover its payments from third parties through an action at law); 12 VAC 30-10-610 (Third party liability); 12 VAC

Act. See Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust, 410 F.3d 304, 315-16 (6th Cir. 2005) ("Moreover, Spectrum also used Medicaid as an insurance policy against an adverse outcome of the malpractice litigation."). As a result of that decision, MCV received approximately half of its original bill and wrote off the other half. The commission cannot now order employer to pay MCV the entire amount of the original bill. If MCV wants to collect additional amounts from employer, it can bring suit in a circuit court.

III. CONCLUSION

For the foregoing reasons, we hold that the commission did not err in refusing to order that employer pay $308,525.45 to MCV. Because no right of claimant was involved in this case, the commission correctly declined to exercise its jurisdiction here. Therefore, we affirm the commission's decision.

Affirmed.

30-20-190 (Requirements for third party liability, identifying liable resources); 12 VAC 30-20-200 (Requirements for third party liability, payment of claims).

VIRGINIA ACTS OF ASSEMBLY -- 2012 SESSION

CHAPTER 543

An Act to amend and reenact § 65.2-714 of the Code of Virginia, relating to the Workers' Compensation Commission; charges for medical services.

[H 1169]

Approved April 4, 2012

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-714 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-714. Fees of attorneys and physicians and hospital charges.

A. Fees of attorneys and physicians and charges of hospitals for services, whether employed by employer, employee or insurance carrier under this title, shall be subject to the approval and award of the Commission. In addition to the provisions of Chapter 13 (§ 65.2-1300 et seq.) ~~of this title~~, the Commission shall have exclusive jurisdiction over all disputes concerning such fees or charges and may order the repayment of the amount of any fee which has already been paid that it determines to be excessive; appeals from any Commission determinations thereon shall be taken as provided in § 65.2-706. *The Commission shall also retain jurisdiction for employees to pursue payment of charges for medical services notwithstanding that bills or parts of bills for health care services may have been paid by a source other than an employer, workers' compensation carrier, guaranty fund or uninsured employer's fund.* No physician shall be entitled to collect fees from an employer or insurance carrier until he has made the reports required by the Commission in connection with the case.

B. If a contested claim is held to be compensable under this title and, after a hearing on the claim on its merits or after abandonment of a defense by the employer or insurance carrier, benefits for medical services are awarded and inure to the benefit of a third party insurance carrier or health care provider, the Commission shall award to the employee's attorney a reasonable fee and other reasonable pro rata costs as are appropriate from the sum which benefits the third party insurance carrier or health care provider. Such fees shall be based on the amount paid by the employer or insurance carrier to the third party insurance carrier or health care provider for medical, surgical and hospital service rendered to the employee through the date on which the contested claim is heard before the Deputy Commissioner. For the purpose of this subsection, a "contested claim" is an initial contested claim for benefits and claims for medical, surgical and hospital services that are subsequently contested and litigated or after abandonment of a defense by the employer or insurance carrier.

C. Payment of any obligation pursuant to this section to any third party insurance carrier or health care provider shall discharge the obligation in full. The Commission shall not reduce the amount of medical bills owed to the Commonwealth or its agencies without the written consent of the Office of the Attorney General.

D. No physician, hospital, or other health care provider as defined in § 8.01-581.1 shall balance bill an employee in connection with any medical treatment, services, appliances or supplies furnished to the employee in connection with an injury for which an award of compensation is made pursuant to § 65.2-704. For the purpose of this subsection, a health care provider "balance bills" whenever (i) an employer or the employer's insurance carrier declines to pay all of the health care provider's charge or fee and (ii) the health care provider seeks payment of the balance from the employee.

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VIRGINIA ACTS OF ASSEMBLY -- 2012 SESSION

CHAPTER 654

An Act to amend and reenact § 65.2-101 of the Code of Virginia, relating to workers' compensation; exclusion of certain employees.

[H 153]

Approved April 6, 2012

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-101 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-101. Definitions.

As used in this title:

"Average weekly wage" means:

1. a. The earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, divided by 52; but if the injured employee lost more than seven consecutive calendar days during such period, although not in the same week, then the earnings for the remainder of the 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. When the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed, provided that results fair and just to both parties will be thereby obtained. When, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

b. When for exceptional reasons the foregoing would be unfair either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

2. Whenever allowances of any character made to an employee in lieu of wages are a specified part of the wage contract, they shall be deemed a part of his earnings. For the purpose of this title, the average weekly wage of the members of the Virginia National Guard, the Virginia Naval Militia and the Virginia Defense Force, registered members on duty or in training of the United States Civil Defense Corps of this Commonwealth, volunteer firefighters engaged in firefighting activities under the supervision and control of the Department of Forestry, and forest wardens shall be deemed to be such amount as will entitle them to the maximum compensation payable under this title; however, any award entered under the provisions of this title on behalf of members of the National Guard, the Virginia Naval Militia or their dependents, or registered members on duty or in training of the United States Civil Defense Corps of this Commonwealth or their dependents, shall be subject to credit for benefits paid them under existing or future federal law on account of injury or occupational disease covered by the provisions of this title.

3. Whenever volunteer firefighters, volunteer lifesaving or volunteer rescue squad members, volunteer law-enforcement chaplains, auxiliary or reserve police, auxiliary or reserve deputy sheriffs, volunteer emergency medical technicians, members of volunteer search and rescue organizations, volunteer members of community emergency response teams, and volunteer members of medical reserve corps are deemed employees under this title, their average weekly wage shall be deemed sufficient to produce the minimum compensation provided by this title for injured workers or their dependents. For the purposes of workers' compensation insurance premium calculations, the monthly payroll for each volunteer firefighter or volunteer lifesaving or volunteer rescue squad member shall be deemed to be $300.

4. The average weekly wage of persons, other than those covered in subdivision 3 of this definition, who respond to a hazardous materials incident at the request of the Department of Emergency Management shall be based upon the earnings of such persons from their primary employers.

"Award" means the grant or denial of benefits or other relief under this title or any rule adopted pursuant thereto.

"Change in condition" means a change in physical condition of the employee as well as any change in the conditions under which compensation was awarded, suspended, or terminated which would affect the right to, amount of, or duration of compensation.

"Client company" means any person that enters into an agreement for professional employer services with a professional employer organization.

"Coemployee" means an employee performing services pursuant to an agreement for professional employer services between a client company and a professional employer organization.

"Commission" means the Virginia Workers' Compensation Commission as well as its former designation as the Virginia Industrial Commission.

"Employee" means:

1. a. Every person, including aliens and minors, in the service of another under any contract of hire or apprenticeship, written or implied, whether lawfully or unlawfully employed, except (i) one whose employment is not in the usual course of the trade, business, occupation or profession of the employer or (ii) as otherwise provided in subdivision 2 of this definition.

b. Any apprentice, trainee, or retrainee who is regularly employed while receiving training or instruction outside of regular working hours and off the job, so long as the training or instruction is related to his employment and is authorized by his employer.

c. Members of the Virginia National Guard and the Virginia Naval Militia, whether on duty in a paid or unpaid status or when performing voluntary service to their unit in a nonduty status at the request of their commander.

Income benefits for members of the National Guard or Naval Militia shall be terminated when they are able to return to their customary civilian employment or self-employment. If they are neither employed nor self-employed, those benefits shall terminate when they are able to return to their military duties. If a member of the National Guard or Naval Militia who is fit to return to his customary civilian employment or self-employment remains unable to perform his military duties and thereby suffers loss of military pay which he would otherwise have earned, he shall be entitled to one day of income benefits for each unit training assembly or day of paid training which he is unable to attend.

d. Members of the Virginia Defense Force.

e. Registered members of the United States Civil Defense Corps of this Commonwealth, whether on duty or in training.

f. Except as provided in subdivision 2 of this definition, all officers and employees of the Commonwealth, including (i) forest wardens; (ii) judges, clerks, deputy clerks and employees of juvenile and domestic relations district courts and general district courts; and (iii) secretaries and administrative assistants for officers and members of the General Assembly employed pursuant to § 30-19.4 and compensated as provided in the general appropriation act, who shall be deemed employees of the Commonwealth.

g. Except as provided in subdivision 2 of this definition, all officers and employees of a municipal corporation or political subdivision of the Commonwealth.

h. Except as provided in subdivision 2 of this definition, (i) every executive officer, including president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the charter and bylaws of a corporation, municipal or otherwise and (ii) every manager of a limited liability company elected or appointed in accordance with the articles of organization or operating agreement of the limited liability company.

i. Policemen and firefighters, sheriffs and their deputies, town sergeants and their deputies, county and city commissioners of the revenue, county and city treasurers, attorneys for the Commonwealth, clerks of circuit courts and their deputies, officers and employees, and electoral board members appointed in accordance with § 24.2-106, who shall be deemed employees of the respective cities, counties and towns in which their services are employed and by whom their salaries are paid or in which their compensation is earnable. However, notwithstanding the foregoing provision of this subdivision, such individuals who would otherwise be deemed to be employees of the city, county, or town in which their services are employed and by whom their salaries are paid or in which their compensation is earnable shall be deemed to be employees of the Commonwealth while rendering aid outside of the Commonwealth pursuant to a request, approved by the Commonwealth, under the Emergency Management Assistance Compact enacted pursuant to § 44-146.28:1.

j. Members of the governing body of any county, city or town in the Commonwealth, whenever coverage under this title is extended to such members by resolution or ordinance duly adopted.

k. Volunteers, officers and employees of any commission or board of any authority created or controlled by a local governing body, or any local agency or public service corporation owned, operated or controlled by such local governing body, whenever coverage under this title is authorized by resolution or ordinance duly adopted by the governing board of any county, city, town, or any political subdivision thereof.

l. Except as provided in subdivision 2 of this definition, volunteer firefighters, volunteer lifesaving or rescue squad members, volunteer law-enforcement chaplains, auxiliary or reserve police, auxiliary or reserve deputy sheriffs, volunteer emergency medical technicians, members of volunteer search and rescue organizations, volunteer members of regional hazardous materials emergency response teams, volunteer members of community emergency response teams, and volunteer members of medical reserve corps, who shall be deemed employees of (i) the political subdivision or state institution of higher education in which the principal office of such volunteer fire company, volunteer lifesaving or rescue squad, volunteer law-enforcement chaplains, auxiliary or reserve police force, auxiliary or reserve deputy sheriff force, volunteer emergency medical technicians, volunteer search and rescue organization, regional hazardous materials emergency response team, community emergency response team, or medical

reserve corps is located if the governing body of such political subdivision or state institution of higher education has adopted a resolution acknowledging those persons as employees for the purposes of this title or (ii) in the case of volunteer firefighters or volunteer lifesaving or rescue squad members, the companies or squads for which volunteer services are provided whenever such companies or squads elect to be included as an employer under this title.

m. (1) Volunteer firefighters, volunteer lifesaving or rescue squad members, volunteer law-enforcement chaplains, auxiliary or reserve police, auxiliary or reserve deputy sheriffs, volunteer emergency medical technicians, members of volunteer search and rescue organizations and any other persons who respond to an incident upon request of the Department of Emergency Management, who shall be deemed employees of the Department of Emergency Management for the purposes of this title.

(2) Volunteer firefighters when engaged in firefighting activities under the supervision and control of the Department of Forestry, who shall be deemed employees of the Department of Forestry for the purposes of this title.

n. Any sole proprietor, shareholder of a stock corporation having only one shareholder, member of a limited liability company having only one member, or all partners of a business electing to be included as an employee under the workers' compensation coverage of such business if the insurer is notified of this election. Any sole proprietor, shareholder or member or the partners shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this title.

When any partner or sole shareholder, member or proprietor is entitled to receive coverage under this title, such person shall be subject to all provisions of this title as if he were an employee; however, the notices required under §§ 65.2-405 and 65.2-600 of this title shall be given to the insurance carrier, and the panel of physicians required under § 65.2-603 shall be selected by the insurance carrier.

o. The independent contractor of any employer subject to this title at the election of such employer provided (i) the independent contractor agrees to such inclusion and (ii) unless the employer is self-insured, the employer's insurer agrees in writing to such inclusion. All or part of the cost of the insurance coverage of the independent contractor may be borne by the independent contractor.

When any independent contractor is entitled to receive coverage under this section, such person shall be subject to all provisions of this title as if he were an employee, provided that the notices required under §§ 65.2-405 and 65.2-600 are given either to the employer or its insurance carrier.

However, nothing in this title shall be construed to make the employees of any independent contractor the employees of the person or corporation employing or contracting with such independent contractor.

p. The legal representative, dependents and any other persons to whom compensation may be payable when any person covered as an employee under this title shall be deceased.

q. Jail officers and jail superintendents employed by regional jails or jail farm boards or authorities, whether created pursuant to Article 3.1 (§ 53.1-95.2 et seq.) or Article 5 (§ 53.1-105 et seq.) of Chapter 3 of Title 53.1, or an act of assembly.

r. AmeriCorps members who receive stipends in return for volunteering in local, state and nonprofit agencies in the Commonwealth, who shall be deemed employees of the Commonwealth for the purposes of this title.

s. Food Stamp recipients participating in the work experience component of the Food Stamp Employment and Training Program, who shall be deemed employees of the Commonwealth for the purposes of this title.

t. Temporary Assistance for Needy Families recipients not eligible for Medicaid participating in the work experience component of the Virginia Initiative for Employment Not Welfare Program, who shall be deemed employees of the Commonwealth for the purposes of this title.

2. "Employee" shall not mean:

a. Officers and employees of the Commonwealth who are elected by the General Assembly, or appointed by the Governor, either with or without the confirmation of the Senate. This exception shall not apply to any "state employee" as defined in § 51.1-124.3 nor to Supreme Court Justices, judges of the Court of Appeals, judges of the circuit or district courts, members of the Workers' Compensation Commission and the State Corporation Commission, or the Superintendent of State Police.

b. Officers and employees of municipal corporations and political subdivisions of the Commonwealth who are elected by the people or by the governing bodies, and who act in purely administrative capacities and are to serve for a definite term of office.

c. Any person who is a licensed real estate salesperson, or a licensed real estate broker associated with a real estate broker, if (i) substantially all of the salesperson's or associated broker's remuneration is derived from real estate commissions, (ii) the services of the salesperson or associated broker are performed under a written contract specifying that the salesperson is an independent contractor, and (iii) such contract includes a provision that the salesperson or associated broker will not be treated as an employee for federal income tax purposes.

d. Any taxicab or executive sedan driver, provided the Commission is furnished evidence that such individual is excluded from taxation by the Federal Unemployment Tax Act.

e. Casual employees.

f. Domestic servants.

g. Farm and horticultural laborers, unless the employer regularly has in service more than three full-time employees.

h. Employees of any person, firm or private corporation, including any public service corporation, that has regularly in service less than three employees in the same business within this Commonwealth, unless such employees and their employers voluntarily elect to be bound by this title. However, this exemption shall not apply to the operators of underground coal mines or their employees. An executive officer who is not paid salary or wages on a regular basis at an agreed upon amount and who rejects coverage under this title pursuant to § 65.2-300 shall not be included as an employee for purposes of this subdivision.

i. Employees of any common carrier by railroad engaging in commerce between any of the several states or territories or between the District of Columbia and any of the states or territories and any foreign nation or nations, and any person suffering injury or death while he is employed by such carrier in such commerce. This title shall not be construed to lessen the liability of any such common carrier or to diminish or take away in any respect any right that any person so employed, or the personal representative, kindred or relation, or dependent of such person, may have under the act of Congress relating to the liability of common carriers by railroad to their employees in certain cases, approved April 22, 1908, or under §§ 8.01-57 through 8.01-62 or § 56-441.

j. Employees of common carriers by railroad who are engaged in intrastate trade or commerce. However, this title shall not be construed to lessen the liability of such common carriers or take away or diminish any right that any employee or, in case of his death, the personal representative of such employee of such common carrier may have under §§ 8.01-57 through 8.01-61 or § 56-441.

k. Except as provided in subdivision 1 of this definition, a member of a volunteer fire-fighting, lifesaving or rescue squad when engaged in activities related principally to participation as a member of such squad whether or not the volunteer continues to receive compensation from his employer for time away from the job.

l. Except as otherwise provided in this title, noncompensated employees and noncompensated directors of corporations exempt from taxation pursuant to § 501 (c) (3) of Title 26 of the United States Code (Internal Revenue Code of 1954).

m. Any person performing services as a sports official for an entity sponsoring an interscholastic or intercollegiate sports event or any person performing services as a sports official for a public entity or a private, nonprofit organization which sponsors an amateur sports event. For the purposes of this subdivision, "sports official" includes an umpire, referee, judge, scorekeeper, timekeeper or other person who is a neutral participant in a sports event. This shall not include any person, otherwise employed by an organization or entity sponsoring a sports event, who performs services as a sports official as part of his regular employment.

n. Any person who suffers an injury on or after July 1, 2012, for which there is jurisdiction under either the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 et seq., and its extensions, or the Merchant Marine Act of 1920, 46 U.S.C. § 30104 et seq. However, this title shall not be construed to eliminate or diminish any right that any person or, in the case of the person's death, his personal representative, may have under either the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 et seq., and its extensions, or the Merchant Marine Act of 1920, 46 U.S.C. § 30104 et seq.

"Employer" includes (i) any person, the Commonwealth or any political subdivision thereof and any individual, firm, association or corporation, or the receiver or trustee of the same, or the legal representative of a deceased employer, using the service of another for pay and (ii) any volunteer fire company or volunteer lifesaving or rescue squad electing to be included and maintaining coverage as an employer under this title. If the employer is insured, it includes his insurer so far as applicable.

"Executive officer" means (i) the president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the charter and bylaws of a corporation and (ii) the managers elected or appointed in accordance with the articles of organization or operating agreement of a limited liability company. However, such term does not include noncompensated officers of corporations exempt from taxation pursuant to § 501 (c) (3) of Title 26 of the United States Code (Internal Revenue Code of 1954).

"Filed" means hand delivered to the Commission's office in Richmond or any regional office maintained by the Commission; sent by telegraph, electronic mail or other means of electronic transmission approved by the Commission or facsimile transmission; or posted at any post office of the United States Postal Service by certified or registered mail. Filing by first-class mail, telegraph, electronic mail or other means of electronic transmission or facsimile transmission shall be deemed completed only when the document or other material transmitted reaches the Commission or its designated agent.

"Injury" means only injury by accident arising out of and in the course of the employment or occupational disease as defined in Chapter 4 (§ 65.2-400 et seq.) of this title and does not include a disease in any form, except when it results naturally and unavoidably from either of the foregoing

causes. Such term shall not include any injury, disease or condition resulting from an employee's voluntary:

1. Participation in employer-sponsored off-duty recreational activities which are not part of the employee's duties; or

2. Use of a motor vehicle that was provided to the employee by a motor vehicle dealer as defined by § 46.2-1500 and bears a dealer's license plate as defined by § 46.2-1550 for (i) commuting to or from work or (ii) any other nonwork activity.

Such term shall include any injury, disease or condition:

1. Arising out of and in the course of the employment of (a) an employee of a hospital as defined in § 32.1-123; (b) an employee of a health care provider as defined in § 8.01-581.1; (c) an employee of the Department of Health or a local department of health; (d) a member of a search and rescue organization; or (e) any person described in clauses (i) through (iv), (vi), and (ix) of subsection A of § 65.2-402.1 otherwise subject to the provisions of this title; and

2. Resulting from (a) the administration of vaccinia (smallpox) vaccine, Cidofivir and derivatives thereof, or Vaccinia Immune Globulin as part of federally initiated smallpox countermeasures, or (b) transmission of vaccinia in the course of employment from an employee participating in such countermeasures to a coemployee of the same employer.

"Professional employer organization" means any person that enters into a written agreement with a client company to provide professional employer services.

"Professional employer services" means services provided to a client company pursuant to a written agreement with a professional employer organization whereby the professional employer organization initially employs all or a majority of a client company's workforce and assumes responsibilities as an employer for all coemployees that are assigned, allocated, or shared by the agreement between the professional employer organization and the client company.

"Staffing service" means any person, other than a professional employer organization, that hires its own employees and assigns them to a client to support or supplement the client's workforce. It includes temporary staffing services that supply employees to clients in special work situations such as employee absences, temporary skill shortages, seasonal workloads, and special assignments and projects.

COURT OF APPEALS OF VIRGINIA

Present: Judges Humphreys, Haley and Beales
Argued at Alexandria, Virginia

HITT CONSTRUCTION AND ZURICH
AMERICAN INSURANCE COMPANY

v. Record No. 0723-08-4

RICHARD J.E. PRATT, JR.

OPINION BY
JUDGE JAMES W. HALEY, JR.
FEBRUARY 17, 2009

FROM THE VIRGINIA WORKERS' COMPENSATION COMMISSION

John H. Carstens (Virginia M. Sadler; Jordan, Coyne & Savits, LLP, on briefs), for appellants.

M. Thomas McWeeny (Koonz, McKenney, Johnson, DePaolis & Lightfoot, L.L.P., on brief), for appellee.

I. INTRODUCTION

Hitt Construction and Zurich American Insurance Company (collectively "Hitt") maintain the Workers' Compensation Commission: (1) lacked authority to review its appeal from a deputy commissioner's decision, because at the time of that review the commission was composed of only two statutorily authorized commissioners and (2) erred in that review in concluding claimant suffered permanent impairment causally related to his industrial accident. We hold that for the commission to exercise its review authority, under the Workers' Compensation Act, when that authority is timely challenged, it must be composed of three statutorily authorized members. This conclusion being dispositive, we do not address Hitt's second assignment of error. We remand the case for review by a now properly constituted commission.

II. FACTS

Pratt filed a claim for compensation on February 22, 2007. Deputy Commissioner Link awarded Pratt permanent partial disability benefits on July 20, 2007. Hitt requested review by the full commission.

Commissioner Tarr had retired effective February 1, 2008, leaving a vacancy. The General Assembly, which had gone into session on January 9, 2008, elected his successor, Commissioner Williams, on April 23, 2008, for a term beginning May 1, 2008. Due to the vacancy, the commission's review membership in the instant case consisted of the remaining two full commissioners — Commissioner Diamond and Commissioner Dudley — and Deputy Commissioner Szablewicz. The review decision was rendered on February 21, 2008.

In light of the vacancy on the commission, and of specific import to our decision, Hitt filed a motion to reconsider and vacate award, alleging in part that "the Commission is currently comprised of only two members and lacks *jurisdiction* to act under Va. Code § 65.2-200." (Emphasis added) (see part III of this opinion). Responding, Commissioner Dudley and Commissioner Diamond (and no one else) denied the motion by order entered March 6, 2008. The order included the following: "Chairman Diamond will appoint Deputy Commissioners to sit with the Commission in consideration of matters on Review, until the Virginia General Assembly has appointed someone to fill the *vacant* Commission seat." (Emphasis added). That order relied upon Code § 65.2-704(B) and this Court's decision in Clinch Valley Medical Center v. Hayes, 34 Va. App. 183, 538 S.E.2d 369 (2000), in support of the denial.

III. THE NATURE OF JURISDICTION

As quoted above, Hitt's motion to reconsider challenged the "jurisdiction" of the commission to review its appeal.

"'Jurisdiction' is a word of many, too many meanings." United States v. Vanness, 85 F.3d 661, 663 n.2 (D.C. Cir. 1996), quoted with approval in Steel Co. v. Citizens for a Better Env't, 523 U.S. 83, 90 (1998).

"Clarity would be facilitated if courts and litigants used the label 'jurisdictional,' not for claim-processing rules, but only for prescriptions delineating the classes of cases (subject-matter jurisdiction) and the persons (personal jurisdiction) falling within a court's adjudicatory authority." Kontrick v. Ryan, 540 U.S. 443, 455 (2004).

To provide clarity and guidance in matters of jurisdiction, in Porter v. Commonwealth, 276 Va. 203, 228, 661 S.E.2d 415, 426 (2008), our Supreme Court quoted from Morrison v. Bestler, 239 Va. 166, 169, 387 S.E.2d 753, 755 (1990):

> "A court may lack the requisite 'jurisdiction' to proceed to an adjudication on the merits for a variety of reasons.
>
> The term jurisdiction embraces several concepts including subject matter jurisdiction, which is the authority granted through constitution or statute to adjudicate a class of cases or controversies; *territorial jurisdiction, that is, authority over persons*, things, or occurrences located in a defined geographic area; notice jurisdiction, or effective notice to a party or if the proceeding is *in rem* seizure of a *res*; and 'the other conditions of fact must exist which are demanded by the unwritten or statute law as the prerequisites of the authority of the court to proceed to judgment or decree.' Farant Inv. Corp. v. Francis, 138 Va. 417, 427-28, 122 S.E. 141, 144 (1924)."

(Emphasis added).

The Porter Court continued:

> Our recitation in Morrison reflects the long-standing distinction between subject matter jurisdiction, which cannot be granted or waived by the parties and the lack of which renders an act of the court void, and territorial jurisdiction or venue. *The latter goes to the authority of the court to act in particular circumstances or places and is waived if not properly and timely raised.*

276 Va. at 229, 661 S.E.2d at 427 (emphasis added).

In Miller v. Potomac Hospital Foundation, 50 Va. App. 674, 683, 653 S.E.2d 592, 596 (2007), the claimant maintained the commission erred in determining a deputy commissioner "did not have jurisdiction to order the employer to pay medical expenses to the health care provider in a dispute between an employer, an employee, and a health care provider."

Citing Nelson v. Warden, 262 Va. 276, 281, 552 S.E.2d 73, 75 (2001), we noted the distinction between subject matter jurisdiction and the authority of the commission to exercise its subject matter jurisdiction when that jurisdiction may be compromised by failure to comply with mandatory statutory requirements. Miller, 50 Va. App. at 684, 653 S.E.2d at 597. We noted that a challenge to subject matter jurisdiction cannot be waived by a litigant, may be raised at any time, and, if successful, renders any decision by a court or commission void. Id. By contrast, "[f]ailure to timely and properly object to a lack of authority waives any later challenge; any actions taken without authority are merely '*voidable* and not void.'" Id. at 684-85, 653 S.E.2d at 597 (quoting Nelson, 262 Va. at 284-85, 552 S.E.2d at 77).

After noting that the commission had subject matter jurisdiction over the controversy, we held that because the insurer did not timely raise the question of the authority of the deputy commissioner to order the payment in its direct appeal to the full commission, the challenge was waived and precluded from consideration by the commission.

With this preface as to jurisdiction, we turn to an analysis of the instant case.

IV. ANALYSIS

Code § 65.2-700 states in relevant part: "All questions arising under this title . . . shall be determined by the Commission . . . ." The substantive dispute in this case involved whether or not the claimant suffered permanent impairment causally related to his industrial accident. It is clear that the commission has original and exclusive subject matter jurisdiction to consider that issue.

As noted above, the commission, in responding to Hitt's challenge to its "jurisdiction," in its order of March 6, 2008, maintained it had jurisdiction—that is, the authority—to render its decision. We find the commission's reliance on the statute and case it cites in its order misplaced.

Code § 65.2-704(B) states in relevant part: "When a member [of the commission] *is absent or is prohibited* . . . from sitting with the full Commission to hear a review, the Chairman shall appoint one of the deputies to sit with the other Commission members." (Emphasis added). Here, no member of the commission was absent or prohibited from sitting. No third member of the commission existed, there being a vacancy on the commission. The commission's analysis of Clinch Valley Medical Center is equally faulty. There, the requisite three commissioners existed. "The employer contends a deputy commissioner may not sit when the review is a review of the record without an appearance by the parties, representatives, and witnesses." Clinch Valley Med. Ctr., 34 Va. App. at 188, 538 S.E.2d at 371. In short, the employer sought to distinguish between an "on the record" review and an "*ore tenus*" review, arguing a deputy could only sit in the latter. Addressing Code § 65.2-704(B), this Court rejected that argument. "The chairman can appoint a deputy for either type of review when absence creates the need." Id. at 191, 538 S.E.2d at 372. We did not address the issue raised in this appeal, i.e., can the chairman appoint a deputy to sit on a review when a commissioner is not merely absent and unavailable to serve, but does not, in fact, exist because of a vacancy on the commission.

Turning to the statutory provisions dealing with the structure of the commission, Code § 65.2-200 states in relevant part:

> B. The Commission shall consist of three members . . . .
>
> C. Whenever a vacancy in the Commission occurs or exists when the General Assembly is in session, the General Assembly shall elect a successor for the unexpired term. If the General Assembly is not in session, the Governor shall forthwith

> appoint pro tempore a qualified person to fill the vacancy for a term ending thirty days after the commencement of the next session of the General Assembly, and the General Assembly shall elect a successor for the unexpired term.

Furthermore, Code § 65.2-705(A) states that "[i]f an application for review is made to the Commission . . . *the full Commission*, except as provided in subsection B of § 65.2-704 and if the first hearing was not held before the full Commission, shall review the evidence." (Emphasis added).

The commission by statute is composed of three, not two, members. That being said, the question arises: if the Governor cannot fill a vacancy in the commission when the General Assembly is in session, by what authority does the chairman appoint a deputy to fill that vacancy?

On brief and in oral argument, Pratt relies on Code § 65.2-201(B) and Code § 65.2-203(A) for that authority. The former reads: "The Commission may appoint deputies, bailiffs, and such other personnel as it may deem necessary for the purpose of carrying out the provisions of this title." The latter reads in relevant part: "Deputies may exercise other powers and perform any duties of the Commission delegated to them by the Commission."

In short, Pratt argues that *a majority* of the commissioners may act as the commission and that, therefore, a majority of the commissioners may appoint a deputy to fill a vacancy on the commission, or to act as a commissioner, even though for review purposes no commissioner is absent or prohibited from hearing a review. No statute dealing with the Workers' Compensation Commission grants that authority.

When construing statutes, it is presumed that the absence of language, or a provision, in a body of legislation is purposeful, if potentially equally relevant language is included in a similar body of legislation. "Interpretation of the statute by comparison to other, similar statutes supports this result . . . showing that the General Assembly clearly knew how to limit a privilege

. . . when it so desired." Schwartz v. Schwartz, 46 Va. App. 145, 157-58, 616 S.E.2d 59, 66 (2005).

In Hechler Chevrolet v. General Motors Corp., 230 Va. 396, 401, 337 S.E.2d 744, 747 (1985), our Supreme Court wrote: "The General Assembly was fully aware of the distinction . . . . Thus, it is clear that if the General Assembly . . . had desired to regulate a manufacturer's right to discontinue a product line, it knew how to do so."[1]

To quote another relevant Virginia Supreme Court opinion:

> Had the General Assembly intended to impose upon a petitioner the burden of showing good cause that a tissue sample could be retrieved that would be sufficient to establish parentage, it would have so provided. It did not do so. Certainly, the General Assembly knew how to do so, as is evidenced by the "good cause" required in subsection C regarding costs of exhumation and the "sufficient cause" required for exhumation pursuant to subsection B.

Martin v. Howard, 273 Va. 722, 726, 643 S.E.2d 229, 231-32 (2007). Succinctly stated: "The Legislature is presumed to know what it intends to do and can do." Miller v. Commonwealth, 172 Va. 639, 649, 2 S.E.2d 343, 348 (1939).[2]

The language in Code § 12.1-6 establishes the procedure for filling a vacancy on the State Corporation Commission, composed of three members. That language is essentially the verbatim language set forth in Code § 65.2-200(B), quoted above.[3] But, the General Assembly

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[1] For federal cases demonstrating this rule of statutory construction, see George Costello, Cong. Research Serv., Statutory Interpretation: General Principles and Recent Trends 15 (2006).

[2] For example, Code § 17.1-300 reads in part: "The Supreme Court shall consist of seven justices, any four of whom convened shall constitute a quorum." Code § 17.1-302(B) authorizes the Chief Justice to designate and assign a senior justice "to perform the duties of a justice of the Court."

[3] A gubernatorial appointee to the State Corporation Commission must be elected by the General Assembly, not merely confirmed in that appointment, and must receive a majority of the votes in both the Senate and the House. Thomson v. Robb, 229 Va. 233, 236, 243, 328 S.E.2d 136, 137-38, 142 (1985).

included the following statute in the legislation concerning the State Corporation Commission: "A majority of the commissioners shall constitute a quorum for the exercise of judicial, legislative, and discretionary functions of the Commission, whether there be a vacancy in the Commission or not, but a quorum shall not be necessary for the exercise of its administrative functions." Code § 12.1-8.

No remotely similar language may be found in the body of legislation concerning the Workers' Compensation Commission. If the General Assembly had desired to grant a majority of the commissioners of the Workers' Compensation Commission the ability to act in a judicial capacity, whether there was a vacancy or not, the General Assembly knew how to do so — as evidenced by Code § 12.1-8 granting that authority to a majority of the State Corporation Commission. But the General Assembly did not.

Pratt attempts to insert language similar to Code § 12.1-8 into the legislation concerning the Workers' Compensation Commission by relying on the well-recognized principle that the Act is "highly remedial" and to be "liberally construed." That principle is appropriate when dealing with the goals of the Workers' Compensation Commission. It is not appropriate when dealing with the structure of the commission itself.

As we held in another case: "That liberality, however, has its limits. We cannot 'permit a liberal construction to change the meaning of the statutory language or the purpose of the Act.'" Clinchfield Coal Co. v. Reed, 40 Va. App. 69, 73, 577 S.E.2d 538, 540 (2003) (quoting Am. Furniture Co. v. Doane, 230 Va. 39, 42, 334 S.E.2d 548, 550 (1985)). Likewise, "we will withhold the deference we normally accord the commission's statutory interpretation of the Workers' Compensation Act when the commission's interpretation conflicts with the plain language of the statute." Peacock v. Browning Ferris, Inc., 38 Va. App. 241, 248, 563 S.E.2d 368, 372 (2002).

In direct contrast with the proposition that the General Assembly intended to grant the commission this authority, but did not see the need to expressly state it, is another proposition that we must consider — the concept of *casus omissus*. Simply stated, the Latin phrase means that a legislature simply omitted to consider the matter. That phrase may be well applicable to the Workers' Compensation Act.

Thus, the Virginia Supreme Court decision in Jordan v. Town of South Boston, 138 Va. 838, 122 S.E. 265 (1924), becomes relevant.

> We do not question the power of the legislature to grant to towns police powers to the three mile limit, but are concerned only with the question, whether or not it has done so by the act under consideration. There may be good reasons why it should have done so, and no good reasons why it should not have done so. It may be a mere *casus omissus*, but if so, this court cannot supply the omission.

Id. at 843, 122 S.E. at 266-67.

In Chandler v. Peninsula Light & Power Co., 152 Va. 903, 908, 147 S.E. 249, 251 (1929), that Court expanded upon the concept of *casus omissus* by quoting at length from 25 R.C.L., page 974,[4] as follows:

> "The courts cannot by construction supply a *casus omissus* by giving force and effect to the language of the statute when applied to a subject about which nothing whatever is said, and which to all appearances was not in the minds of the legislature at the time of the enactment of the law. No mere omission, no mere failure to provide for contingencies, which it may seem wise to have provided for specifically, justify any judicial addition to the language of the statute. It is not for the court to say, where the language of the statute is clear, that it shall be so construed as to embrace cases because no good reason can be assigned why they were excluded from its provisions."

[4] R.C.L. is the citation for Ruling Case Law, a 1919 treatise edited by William M. McKinney and Burdett A. Rich. The quotation is in § 225 from volume 25, page 974, "Changing, Supplying and Eliminating Words and Phrases."

Thus, even if the General Assembly simply forgot to include in the Workers' Compensation Act a provision for a majority of commissioners to exercise the authority of the full commission, this Court may not add such language. It is for the General Assembly to write the statute; this Court merely interprets it.

Aside from these principles of statutory construction, our Supreme Court addressed a situation similar to this case in Dillon v. Davis, 201 Va. 514, 112 S.E.2d 137 (1960). A statute there stated a panel "shall" consist of five persons, but only four served. Id. at 519-20, 112 S.E.2d at 141. Although those four persons reached a unanimous decision, our Supreme Court held "a commission of five" to be "expressly required." Id. at 520, 112 S.E.2d at 141-42. The Court remanded the cases for consideration by a fully constituted panel. Id. at 521, 112 S.E.2d at 142. Likewise, here the Code states the commission "shall consist of three members." Code § 65.2-200(B). Without those three members, the commission was subject to a challenge to its authority to decide the cases before it.

Finally, the mandatory nature of a fully constituted commission becomes clear in light of the case law interpreting Code § 1-222. Code § 1-222 states: "Whenever authority is conferred by law to three or more persons, a majority of such persons shall have the power to exercise such authority, unless otherwise provided." Our Supreme Court has held a substantially identical predecessor to this statute simply authorizes a majority *of a fully constituted body* to exercise authority, unless otherwise provided. See Dillon, 201 Va. at 520, 112 S.E.2d at 142; Norfolk & W. Ry. Co. v. Virginian Ry. Co., 110 Va. 631, 645-46, 66 S.E. 863, 868 (1910).

In summary, whether the General Assembly purposefully, or inadvertently, failed to grant a majority of the commission the authority to decide cases on review, or to fill a vacancy on the commission for that purpose, is of no consequence. The result here is the same. The

commission lacked authority to hear the review requested by Hitt and, accordingly, any decision by that thus constituted reviewing body is voidable.

We emphasize that the commission's decision in this case was voidable, not void. The authority of the commission to exercise its subject matter jurisdiction was here compromised by its composition—a composition not authorized by statute.

Nonetheless, the commission is a "hybrid" governmental entity that possesses both policy-making and judicial responsibilities. See § Code 65.2-201(A); Williams v. Va. Elec. & Power Co., 18 Va. App. 569, 574, 445 S.E.2d 693, 696 (1994). We have referred to the commission as "like any other judicial or quasi-judicial entity." Cura Group, Inc. v. Workers' Comp. Comm'n, 45 Va. App. 559, 566, 612 S.E.2d 735, 738 (2005). We have also noted: "'The Commission, as a quasi-judicial body within the area of its jurisdiction, has the power of contempt . . . .'" Jeff Coal, Inc. v. Phillips, 16 Va. App. 271, 277, 430 S.E.2d 712, 716 (1993) (quoting Hudock v. Indus. Comm'n, 1 Va. App. 474, 481, 340 S.E.2d 168, 172 (1986)).

To the extent that the commission acts in its judicial capacity, we conclude that those precedents cited above—Porter, Morrison, Nelson, and Miller—are likewise applicable in this case.

Accordingly, while a challenge to the authority of the commission was subject to being waived, that challenge was not here waived. Rather, it was specifically raised to the commission by Hitt's motion to reconsider and vacate award. We have found that challenge well-founded. Thus, the case is reversed and remanded to the now properly constituted commission.

Reversed and remanded.

VIRGINIA ACTS OF ASSEMBLY -- 2012 SESSION

CHAPTER 588

An Act to amend and reenact §§ 65.2-201, 65.2-704, and 65.2-705 of the Code of Virginia, relating to vacancies on the Workers' Compensation Commission.

[S 577]

Approved April 4, 2012

Be it enacted by the General Assembly of Virginia:

1. That §§ 65.2-201, 65.2-704, and 65.2-705 of the Code of Virginia are amended and reenacted as follows:

§ 65.2-201. General duties and powers of the Commission.

A. It shall be the duty of the Commission to administer this title and adjudicate issues and controversies relating thereto. In all matters within the jurisdiction of the Commission, it shall have the power of a court of record to administer oath, to compel the attendance of witnesses and the production of documents, to punish for contempt, to appoint guardians pursuant to Title 31, and to enforce compliance with its lawful orders and awards. The Commission shall make rules and regulations for carrying out the provisions of this title.

B. The Commission may appoint deputies, bailiffs, and such other personnel as it may deem necessary for the purpose of carrying out the provisions of this title.

C. The Commission or any member thereof or any person deputized by it may for the purposes of this title subpoena witnesses, administer or cause to be administered oaths, and examine or cause to be examined such parts of the books and records of the parties to a proceeding as relate to questions in dispute arising in instances in which the Commission has power to award compensation. This authority shall extend to requests from like agencies of other states who honor similar requests from the Commission.

D. The Commission shall publish and, upon request, furnish free of charge, such blank forms and literature as it shall deem requisite to facilitate or promote the efficient administration of this title. The Commission shall publish a workers' compensation guide for employees which informs an injured employee of his rights under this title. If the Commission receives notice of an accident, it shall provide a workers' compensation guide to the employee.

E. *A majority of the commissioners shall constitute a quorum for the exercise of judicial, legislative, and discretionary functions of the Commission, whether there is a vacancy in the Commission or not, but a quorum shall not be necessary for the exercise of its administrative functions.*

F. The Commission shall tabulate the accident reports received from employers in accordance with § 65.2-900 and shall publish the same in the annual report of the Commission and as often as it may deem advisable, in such detailed or aggregate form as it may deem best. The name of the employer or employee shall not appear in such publications, and the employers' reports shall be private records of the Commission and shall not be open for public inspection except for the inspection by the parties directly involved, and only to the extent of such interest. These reports shall not be used as evidence against any employer in any suit at law brought by any employee for the recovery of damages.

§ 65.2-704. Hearing; award or opinion by Commission.

A. The Commission or any of its members or deputies shall hear the parties at issue, their representatives, and witnesses; shall decide the issues in a summary manner; and shall make an award or opinion carrying out the decision.

B. Any member of the Commission who hears the parties at issue and makes an award under the provisions of subsection A ~~of this section~~ shall not participate in a rehearing and review of such award provided under § 65.2-705. ~~When a member is absent or is prohibited by the provisions of this subsection from sitting with the full Commission to hear a review, the Chairman shall appoint one of the deputies to sit with the other Commission members.~~

C. Hearings convened by the Commission shall be public proceedings and, upon proper request to the Commission, may, in the discretion of the Commission, be video recorded for public broadcast at the expense of the requesting party, subject only to the same limitations and conditions as apply to court proceedings in the Commonwealth.

§ 65.2-705. Review of award; rehearing.

A. If an application for review is made to the Commission within 30 days after issuance of an award, the full Commission, except as provided in subsection B of § 65.2-704 and if the first hearing was not held before the full Commission, shall review the evidence or, if deemed advisable, as soon as practicable, hear the parties at issue, their representatives, and witnesses. The Commission shall make an award which, together with a statement of the findings of fact, rulings of law, and other matters pertinent to the questions at issue, shall be filed with the record of the proceedings.

B. A rehearing convened under this section shall be a public proceeding and, upon proper request, may, in the discretion of the Commission, be video recorded for public broadcast at the expense of the requesting party, subject only to the same limitations and conditions as apply to court proceedings in the Commonwealth.

C. Upon an application for review made pursuant to subsection A ~~of this section~~, the opposing party at issue shall have 14 days thereafter to make an independent application for review.

D. When a vacancy on the Commission exists, or when a member of the Commission is absent or is prohibited from sitting with the full Commission to hear a review, the Chairman may appoint a deputy commissioner to participate in the review.

13104004D

HOUSE BILL NO. 1305

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Labor on January 17, 2013)

(Patron Prior to Substitute—Delegate Habeeb)

A BILL to amend and reenact § 65.2-105 of the Code of Virginia, relating to workers' compensation; presumption; injuries in course of employment.

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-105 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-105. Presumption that certain injuries arose out of and in the course of employment.

In any claim for compensation, where the employee is physically or mentally unable to testify as confirmed by competent medical evidence and where ~~there is unrebutted prima facie evidence that indicates that the injury~~ *the factual circumstances are of sufficient strength from which the only rational inference to be drawn is that the accident* arose out of and ~~was~~ in the course of employment, it shall be presumed~~, in the absence of~~ *the accident arose out of and in the course of employment, unless such presumption is overcome by* a preponderance of *competent* evidence to the contrary~~, that the injury arose out of and was in the course of employment~~.

INTRODUCED

13103682D

HOUSE BILL NO. 2174

Offered January 9, 2013

A BILL to amend and reenact § 65.2-708 of the Code of Virginia, relating to workers' compensation; review of award on change in condition.

Patron—Lewis

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-708 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-708. Review of award on change in condition.

A. Upon its own motion or upon the application of any party in interest, on the ground of a change in condition, the Commission may review any award *of compensation* and on such review may make an award ending, diminishing or increasing the compensation previously awarded, subject to the maximum or minimum provided in this title, and shall immediately send to the parties a copy of the award. No application filed by a party alleging a change in condition shall be docketed for hearing by the Commission unless any medical reports upon which the party is relying are submitted to the Commission. No such review shall affect such award as regards any moneys paid except pursuant to §§ 65.2-712, 65.2-1105, and 65.2-1205. No such review shall be made after ~~twenty-four~~ *24* months from the last day for which compensation was paid, pursuant to an award under this title, except: (i) ~~thirty-six~~ *36* months from the last day for which compensation was paid shall be allowed for the filing of claims payable under § 65.2-503 and certain claims under subsection B of § 65.2-406 or (ii) ~~twenty-four~~ *24* months from the day that the claimant undergoes any surgical procedure compensable under § 65.2-603 to repair or replace a prosthesis or orthosis.

B. In those cases where no compensation has been paid, the Commission may make an award under § 65.2-503 within ~~thirty-six~~ *36* months from the date of the accident.

C. All wages paid, for a period not exceeding ~~twenty-four~~ *24* consecutive months, to an employee (i) who is physically unable to return to his pre-injury work due to a compensable injury and (ii) who is provided work within his capacity at a wage equal to or greater than his pre-injury wage~~,~~ shall be considered compensation *paid pursuant to an award for compensation.*

7 - See ALSO Page 2

(HB2174)

AMENDMENT(S) PROPOSED BY THE SENATE

COMMERCE AND LABOR

1. Line 30, engrossed, after *award for compensation*

insert

but shall not result in a reduction of the maximum number of weeks of compensation benefits as described in §§ 65.2-500 and 65.2-518

Legislative Information System

SENATE SUBSTITUTE

13104357D

SENATE BILL NO. 896

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on January 28, 2013)

(Patrons Prior to Substitute—Senators Reeves, Norment [SB 1126], Ruff [SB 915], and Saslaw [SB 1199])

A BILL to amend the Code of Virginia by adding a section numbered 65.2-301.1 relating to workers' compensation; weather as a risk of a public safety officer's employment.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 65.2-301.1 as follows:

§ 65.2-301.1. Public safety officers.

In situations where weather constitutes a particular risk of a public safety officer's employment and where the public safety officer's injury arose out of and in the course of his employment, absent a misconduct defense asserted pursuant to § 65.2-306, such injury shall be compensable under this title. As used in this section, "public safety officer" shall have the meaning ascribed to it in § 9.1-801.

2/7/13 10:25

SENATE SUBSTITUTE

SB896S1

8

13103396D

HOUSE BILL NO. 1733

Offered January 9, 2013
Prefiled January 8, 2013

A BILL to amend and reenact § 65.2-1306 of the Code of Virginia, relating to workers' compensation; peer review of medical costs; referral to committee.

Patron—Loupassi

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-1306 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-1306. Corrective action.

A. If it is determined that a physician improperly overutilized or otherwise rendered or ordered inappropriate medical treatment or services, or that the cost or duration of such treatment or services was inappropriate, the regional peer review committee shall, in accordance with the standard set forth in § 65.2-605, adjust the amount of reimbursement to which the physician is entitled pursuant to this title and, if the physician already has been paid, shall require such physician to repay any excess amount that was paid to him for rendering or ordering such treatment or services.

B. Any such determination by any regional peer review committee shall be reviewable by the Commission, which shall have exclusive jurisdiction to effect any such review. Any review by the Commission shall be pursuant to § 65.2-714. To be entitled to review by the Commission, the physician must deliver to the Commission written notice of his request for review, which notice must be received within thirty days after notice of the decision of the regional peer review committee is received by the physician.

C. By accepting payment pursuant to this title, (i) any physician, any hospital and any employee shall be deemed to have consented to the submitting of all records concerning treatment of the employee to the Commission, to the Statewide Coordinating Committee, to any regional peer review committee, or to any agent of any such committee and (ii) any physician shall be deemed to agree to comply with any decision of the regional peer review committee, subject to his right to have the decision reviewed by the Commission.

D. If any matter referred to any particular peer review committee shall not be resolved by a determination from the committee within six months of referral, then any party to the dispute previously referred may request that the matter be remanded to the Commission for handling pursuant to § 65.2-714, and upon verification of a failure of the committee to issue a determination within the requisite six-month period, such remand shall be granted as a matter of right. Once so remanded, a case shall not be re-referred to a peer review committee.

9

13102231D

HOUSE BILL NO. 2160

Offered January 9, 2013
Prefiled January 9, 2013

A BILL to amend and reenact §§ 65.2-605 and 65.2-714 of the Code of Virginia, relating to the Virginia Workers' Compensation Act; limitations period and balance billing.

Patron—Kilgore

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 65.2-605 and 65.2-714 of the Code of Virginia are amended and reenacted as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice; limitations period.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

B. No claim for payment of charges for services rendered under this title by a health care provider shall be brought more than one year from the later of (i) the date of service for which payment is sought or (ii) the date a medical award covering such service becomes final.

§ 65.2-714. Fees of attorneys and physicians and hospital charges.

A. Fees of attorneys and physicians and charges of hospitals for services, whether employed by employer, employee or insurance carrier under this title, shall be subject to the approval and award of the Commission. In addition to the provisions of Chapter 13 (§ 65.2-1300 et seq.), the Commission shall have exclusive jurisdiction over all disputes concerning such fees or charges and may order the repayment of the amount of any fee which has already been paid that it determines to be excessive; appeals from any Commission determinations thereon shall be taken as provided in § 65.2-706. The Commission shall also retain jurisdiction for employees to pursue payment of charges for medical services notwithstanding that bills or parts of bills for health care services may have been paid by a source other than an employer, workers' compensation carrier, guaranty fund or uninsured employer's fund. No physician shall be entitled to collect fees from an employer or insurance carrier until he has made the reports required by the Commission in connection with the case.

B. If a contested claim is held to be compensable under this title and, after a hearing on the claim on its merits or after abandonment of a defense by the employer or insurance carrier, benefits for medical services are awarded and inure to the benefit of a third party insurance carrier or health care provider, the Commission shall award to the employee's attorney a reasonable fee and other reasonable pro rata costs as are appropriate from the sum which benefits the third party insurance carrier or health care provider. Such fees shall be based on the amount paid by the employer or insurance carrier to the third party insurance carrier or health care provider for medical, surgical and hospital service rendered to the employee through the date on which the contested claim is heard before the Deputy Commissioner. For the purpose of this subsection, a "contested claim" is an initial contested claim for benefits and claims for medical, surgical and hospital services that are subsequently contested and litigated or after abandonment of a defense by the employer or insurance carrier.

C. Payment of any obligation pursuant to this section to any third party insurance carrier or health care provider shall discharge the obligation in full. The Commission shall not reduce the amount of medical bills owed to the Commonwealth or its agencies without the written consent of the Office of the Attorney General.

D. ~~No~~ *During the pendency of any claim filed under this title by an employee for workers' compensation benefits, or after an award of compensation is made pursuant to § 65.2-704, no* physician, hospital, or other health care provider as defined in § 8.01-581.1 shall balance bill an employee in connection with any medical treatment, services, appliances or supplies furnished to the employee in connection with an injury for which ~~an award of compensation is made pursuant to § 65.2-704~~ *compensation is sought under such claim or that is covered by such award when any portion of the bill at issue, for the date of service at issue, has been paid by the employer, carrier, or third-party administrator under this title.* For the purpose of this subsection, a health care provider "balance bills" whenever (i) an employer or the employer's insurance carrier declines to pay all of the health care

provider's charge or fee and (ii) the health care provider seeks payment of the balance from the employee.

INTRODUCED

13103623D

HOUSE BILL NO. 2206

Offered January 10, 2013

A BILL to amend and reenact §§ 65.2-605 and 65.2-714 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 65.2-605.1 and 65.2-605.2, relating to the Virginia Workers' Compensation Act; payment of charges for medical services; duties of insurance carriers; unfair claim settlement practices; fees.

Patrons—Ware, R.L. and O'Bannon

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 65.2-605 and 65.2-714 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 65.2-605.1 and 65.2-605.2 as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be ~~limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.~~ *established as follows:*

1. Providers desiring to treat injured workers' compensation employees shall attempt reasonable steps to enter into one or more agreements with any one or more employers, workers' compensation insurance carriers, third-party administrators, and preferred provider organizations for provision of treatment of any covered employee. Such agreements shall establish rates for payment for treatment. Rates shall be negotiated in any such agreement between (i) provider and employer, (ii) provider and insurance carrier, (iii) provider and third-party administrator, or (iv) provider and preferred provider organization. Insurance carriers and employers entering into such agreements shall not change rates established in agreements through repricing, recoding, subcontracting, or other means; or

2. If there is no such agreement, then the provider and the insurance carrier or employer may negotiate a reasonable rate for a single episode of care; or

3. If a negotiated rate is not agreed upon pursuant to subdivision 1 or 2, the provider, insurance carrier, or employer may have its case heard by the Commission. In such event, the Commission shall determine the payment rate, which shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person, and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such. For health care services or treatment rendered after July 1, 2013, to a claimant, a health care provider shall be allowed to adjust the charge for provider fees, excluding implants, devices, or technology, by an amount that is less than or equal to the medical care component of the Consumer Price Index as published by the Bureau of Labor Statistics of the U.S. Department of Labor for the 12-month period preceding the date of the adjustment. An employer or carrier shall have no pecuniary liability for that portion of the provider fee that exceeds the adjustment of charges permitted by this subdivision.

B. Employers and insurance carriers shall provide employee access to an adequate network of health care providers.

C. The prompt payment provisions of § 65.2-605.1 and terms and conditions of § 65.2-605.2 shall apply to the payment of claims.

D. For health care services rendered after July 1, 2013, if an insurance carrier or employer files notices of denial of payment with the Commission for any bill or part of a bill for health care services and sends a copy of such notice to (i) the claimant, (ii) the attorney representing the claimant, and (iii) the health care provider, which notice is substantially in the following format, then any action brought to recover such denied fees and charges shall be forever barred unless filed with the Commission within two years from the date of receipt of such notice of denial:

"Notice to employee and health care provider:

Be advised that the workers' compensation insurance carrier or employer has denied payment for health care services rendered by the health care provider for the date or dates of services listed below and that you will have two years from your receipt of this notice to contest that denial by filing a claim for payment of such charges or risk having that claim barred.

*Claimant*_____

*Attorney for Claimant*_____

Health Care Provider _____

Dates of Service _____"

Notwithstanding any other provision of this subsection, when partial payment or less than full payment has been made on a bill or part thereof pursuant to an award order relating to that specific bill or part thereof, any claim to contest the sufficiency of payment related to such bill or part thereof shall be unenforceable if not filed within two years from the date partial payment was received by the health care provider. The Commission shall hear such claims on the record.

§ 65.2-605.1. Prompt payment.

A. Employers and employers' insurance carriers shall:

1. Make available all billing and reimbursement requirements, together with applicable documentation, to health care providers or make the same available via the Internet in real time;

2. Enable health care providers to electronically verify if a claim has been reported by an employee or employer;

3. Accept reports from health care providers electronically; and

4. Accept claims from health care providers electronically.

For the purposes of this section, "employers and employers' insurance carriers" includes the uninsured employer's fund and any guaranty fund.

B. Except as provided in provider agreements with employers or employers' insurance carriers, payment for health care services shall be made to the health care provider within 40 days after receipt of each separate itemization of the health care services provided. If the itemization or a portion thereof is contested, denied, or considered incomplete, the employer or the employer's insurance carrier shall notify the health care provider within 30 days after receipt of the itemization that the itemization is contested, denied, or considered incomplete and shall include the following information:

1. The reasons for contesting or denying the itemization, or the reasons the itemization is considered incomplete;

2. If the itemization is considered incomplete, all additional information required to make a decision; and

3. The remedies available to the health care provider if the health care provider disagrees.

Payment due for any properly documented health care services that are neither contested within the 30-day period nor paid within the 40-day period, as required by this subsection, shall be increased by 15 percent, together with interest at the judgment rate of interest as provided in § 6.2-302 retroactive to the date of receipt of the itemization.

C. An employer's liability to a health care provider under this section shall not affect its liability to an employee.

D. If the employer is a governmental entity, payment for health care services provided shall be made within 60 days after receipt of each separate itemization, together with all required reports.

E. In the absence of a provider agreement, whenever an employer or insurance carrier conducts an audit of an itemization submitted by a health care provider, the employer or employer's insurance carrier shall make available to that individual or entity all documentation submitted together with that itemization by the health care provider. No audit shall include an onsite visit to the office of the health care provider unless such auditor or reviewer reimburses the health care provider the actual cost of having staff present to participate in the audit or review. When an audit determines that additional information or documentation is necessary, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the health care provider pursuant to subsection B.

F. In the absence of a provider agreement, an audit of service submitted by a health care provider shall not alter the procedure codes listed. If the auditor does not recommend payment for services as itemized by the health care provider, a specific explanation of review shall be provided to the health care provider. No claim shall be audited later than one year from the date of service or date of payment, whichever is later.

G. The Commission shall have jurisdiction over disputes arising out of this section.

§ 65.2-605.2. Terms of agreements between health care providers and employers' insurance carriers.

A. As used in this section:

"Claim" means any bill, claim, or proof of loss made by or on behalf of a provider to a carrier with which the provider has a provider agreement for payment for health care services; however, "claim" does not include a request for payment of a capitation or a withhold.

"Health care services" means medical, surgical, and hospital services that an employer is required to provide to an injured person pursuant to this title.

"Insurance carrier" or "carrier" means an insurer providing workers' compensation coverage for an

employer. The term includes a carrier's network, provider panel, intermediary, or representative.

"Provider agreement" means any agreement, as referenced in § 65.2-605, between a provider and an insurance carrier relating to the provision of health care services.

B. Every provider agreement entered into by a provider and an employer's insurance carrier shall comply with the following:

1. Every provider agreement shall include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and all policies applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider agreement; and

2. No amendment to any provider agreement or to any addenda, schedule, exhibit, or policy thereto, or new addenda, schedule, exhibit, or policy, applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider, shall be effective as to the provider unless the provider has been provided with the applicable portion of the proposed amendment or of the proposed new addenda, schedule, exhibit, or policy at least 60 calendar days before the effective date and the provider has not notified the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider agreement at the earliest date thereafter permitted under the provider agreement.

C. The Commission shall have jurisdiction over disputes arising out of this section.

§ 65.2-714. Fees of attorneys and physicians and hospital charges.

A. Fees of attorneys and physicians and charges of hospitals for services, whether employed by employer, employee or insurance carrier under this title, shall be subject to the approval and award of the Commission. In addition to the provisions of Chapter 13 (§ 65.2-1300 et seq.), the Commission shall have exclusive jurisdiction over all disputes concerning such fees or charges and may order the repayment of the amount of any fee which has already been paid that it determines to be excessive; appeals from any Commission determinations thereon shall be taken as provided in § 65.2-706. The Commission shall also retain jurisdiction for employees to pursue payment of charges for medical services notwithstanding that bills or parts of bills for health care services may have been paid by a source other than an employer, workers' compensation carrier, guaranty fund or uninsured employer's fund. No physician shall be entitled to collect fees from an employer or insurance carrier until he has made the reports required by the Commission in connection with the case.

B. If a contested claim is held to be compensable under this title and, after a hearing on the claim on its merits or after abandonment of a defense by the employer or insurance carrier, benefits for medical services are awarded and inure to the benefit of a third party insurance carrier or health care provider, the Commission shall award to the employee's attorney a reasonable fee and other reasonable pro rata costs as are appropriate ~~from the sum which benefits the third party insurance carrier or health care provider~~. Such fees shall be based on the amount paid by the employer or insurance carrier to the third party insurance carrier or health care provider for medical, surgical and hospital service rendered to the employee through the date on which the contested claim is heard before the Deputy Commissioner. For the purpose of this subsection, a "contested claim" is an initial contested claim for benefits and claims for medical, surgical and hospital services that are subsequently contested and litigated or after abandonment of a defense by the employer or insurance carrier. *The employee's attorney fees shall be the responsibility of the employer or insurance carrier that contested the compensability of the claim.*

C. Payment of any obligation pursuant to this section to any third party insurance carrier or health care provider shall discharge the obligation in full. The Commission shall not reduce the amount of medical bills owed to the Commonwealth or its agencies without the written consent of the Office of the Attorney General.

D. No physician, hospital, or other health care provider as defined in § 8.01-581.1 shall balance bill an employee in connection with any medical treatment, services, appliances or supplies furnished to the employee in connection with an injury for which an award of compensation is made pursuant to § 65.2-704 *or when an employer or the employer's insurance carrier voluntarily makes full payment for services provided to the injured employee under the terms of a valid provider agreement in advance of an award of compensation being made.* For the purpose of this subsection, a health care provider "balance bills" whenever (i) an employer or the employer's insurance carrier declines to pay all of the health care provider's charge or fee and (ii) the health care provider seeks payment of the balance from the employee.

INTRODUCED

13103135D

HOUSE BILL NO. 1612

Offered January 9, 2013
Prefiled January 6, 2013

A BILL to amend and reenact § 65.2-605 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 65.2-605.1, relating to workers' compensation; fee schedule for medical care services; payment of bills for medical care services.

Patrons—Hugo, Jones and Villanueva

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-605 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 65.2-605.1 as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice; medical care fee schedule regulations.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall, *absent a contract providing otherwise,* be limited to ~~such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person and~~ the *maximum amount that may be paid pursuant to the fee schedules established under subsection B. The* employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

B. The Commission shall promulgate regulations establishing medical care fee schedules governing all medical care services rendered pursuant to this title. The medical care fee schedule regulations shall be comprehensive in scope, be based on Medicare where applicable, utilize Medicare coding and reimbursement rules, and address fees of physicians and surgeons, hospitals, ancillary services provided by other health care facilities and providers, pharmacy and pharmaceutical services, and utilization review issues and procedures. The regulations implementing such medical care fee schedules shall become effective on October 1, 2014. The initial fee schedules shall utilize the Medicare fee schedules reimbursement rates for Virginia in effect on December 1, 2012. Beginning October 1, 2015, and on each October 1 thereafter, the reimbursement rates for Virginia in effect on the immediately prior December 1 shall be used to update the fee schedules. The physician fee schedule shall apply a uniform conversion factor of up to 150 percent of Medicare base reimbursement rates in determining reimbursement levels. The fee schedule applicable to inpatient and outpatient hospital services shall be based on Medicare's prospective payment system Diagnostic Related Groups (DRG) and ambulatory surgical center fee schedules, respectively, and shall provide a uniform conversion factor of up to 150 percent of Medicare base reimbursement rates in determining inpatient and outpatient hospital services reimbursement levels. The fee schedule applicable to ancillary services provided by other health care facilities and providers shall provide a uniform conversion factor of up to 150 percent of Medicare base reimbursement rates in determining reimbursement levels. Reimbursement for durable medical equipment shall be limited to that reimbursed under Medicare. No fee schedule developed under this section shall authorize separate reimbursement for implantable hardware or utilize multiple conversion factors. In determining the appropriate uniform conversion percentage to be utilized pursuant to this section for physicians and surgeons, hospitals, and ancillary services provided by other health care facilities and providers, or in determining the reimbursement level to be assigned for pharmacy and pharmaceutical services or for any medical care service not specifically addressed under Medicare, the Commission shall consider the maximum amounts payable for such pharmacy or medical care services that are contained in the fee schedules utilized by states that border on the Commonwealth, issues relating to access to care or medications, the need to control costs, and information contained in reports on Virginia's workers' compensation system and medical costs within such system that have been published since 2009. Pharmacy fee schedule reimbursement rates shall be based on the NDC number assigned by the original manufacturer. Except when emergency care is being provided, prescribing of Schedule II and Schedule III narcotics shall require the prior authorization of the employer.

C. The Commission shall review the fee schedules adopted pursuant to this section on an annual basis and when appropriate shall revise the fee schedules as necessary.

D. The Commission shall have a peer-reviewed study conducted every two years by a reputable independent, not-for-profit research organization to determine how Virginia's workers' compensation

system and workers' compensation medical costs compare with (i) those of other states' systems and (ii) previous workers' compensation medical benchmarks studies conducted in Virginia. Such studies shall also review the status of access to medical services under Virginia's workers' compensation system. The Commission is authorized to retain workers' compensation experts to assist in the development, review, and revision of the medical care fee schedule regulations required pursuant to this section and shall pay for such services and the aforementioned studies through revenues generated pursuant to the administrative tax assessed pursuant to Chapter 10 (§ 65.2-1000 et seq.) and deposited in the fund established pursuant to § 65.2-1007.

§ 65.2-605.1. Payment of medical expenses.

A. Within 60 days of receipt by the insurer or self-insured employer of (i) a medical bill that includes, at a minimum, the identity of the employee, the date of injury, the dates the medical services were provided, and the relevant ICD-9 and CPT codes required to identify the diagnosis of the injury and the nature of the services provided and (ii) supporting medical documentation demonstrating the bill for medical service involves reasonable and necessary treatment causally related to the employee's work-related injuries that are subject to § 65.2-603, the insurer or self-insured employer shall either pay the medical bill in accordance with § 65.2-605 or deny payment of the bill.

B. If the Commission finds that the self-insured employer or insurer unreasonably denied payment for medical services described in subsection A of § 65.2-603, the Commission shall order payment for such services and shall award interest to the employee, if the employee has previously paid such bill, on the amount that the self-insured employer or insurer should have paid for such medical attention at the judgment rate provided in § 6.2-302 from either (i) 60 days after the date of the bill and supporting medical documentation for such medical attention was received by the insurer or self-insured employer until the date paid or (ii) the date such bill was paid by the employee, whichever period is shorter.

2. That the provisions of this act amending subsection A of § 65.2-605 of the Code of Virginia and the provisions of § 65.2-605.1 as created by this act shall become effective on October 1, 2014.

I

Suspend the Rules And Pass the Bill, H. R. 1845, with Amendments

(The amendments strike all after the enacting clause and insert a new text and a new title)

112TH CONGRESS
1ST SESSION

H. R. 1845

To provide for a study on issues relating to access to intravenous immune globulin (IVIG) for Medicare beneficiaries in all care settings and a demonstration project to examine the benefits of providing coverage and payment for items and services necessary to administer IVIG in the home.

IN THE HOUSE OF REPRESENTATIVES

MAY 11, 2011

Mr. BRADY of Texas (for himself, Ms. MATSUI, Mr. BURGESS, Mr. SARBANES, Mr. PAUL, Mr. VAN HOLLEN, Mr. TIBERI, Mr. RUPPERSBERGER, Mrs. BLACKBURN, Mr. SCHIFF, Ms. JENKINS, Mr. KIND, Ms. FUDGE, Ms. RICHARDSON, and Mr. RUSH) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide for a study on issues relating to access to intravenous immune globulin (IVIG) for Medicare beneficiaries in all care settings and a demonstration project to examine the benefits of providing coverage and payment for items and services necessary to administer IVIG in the home.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012".

TITLE I—MEDICARE IVIG ACCESS

SEC. 101. MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary shall establish and implement a demonstration project under part B of title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globin for the treatment of primary immune deficiency diseases.

(b) DURATION AND SCOPE.—

(1) DURATION.—Beginning not later than one year after the date of enactment of this Act, the Secretary shall conduct the demonstration project for a period of 3 years.

(2) SCOPE.—The Secretary shall enroll not more than 4,000 Medicare beneficiaries who have been diagnosed with primary immunodeficiency dis-

ease for participation in the demonstration project. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time.

(c) COVERAGE.—Except as otherwise provided in this section, items and services for which payment may be made under the demonstration program shall be treated and covered under part B of title XVIII of the Social Security Act in the same manner as similar items and services covered under such part.

(d) PAYMENT.—The Secretary shall establish a per visit payment amount for items and services needed for the in-home administration of intravenous immune globin based on the national per visit low-utilization payment amount under the prospective payment system for home health services established under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary to carry out the demonstration project.

(f) STUDY AND REPORT TO CONGRESS.—

(1) INTERIM EVALUATION AND REPORT.—Not later than three years after the date of enactment of this Act, the Secretary shall submit to Congress a

report that contains an interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

(2) FINAL EVALUATION AND REPORT.—Not later than one year after the date of completion of the demonstration project, the Secretary shall submit to Congress a report that contains the following:

(A) A final evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k et seq.).

(C) An update to the report entitled "Analysis of Supply, Distribution, Demand, and Access Issues Associated with Immune Globulin Intravenous (IGIV)", issued in February 2007 by the Office of the Assistant Secretary for

Planning and Evaluation of the Department of Health and Human Services.

(g) FUNDING.—There shall be made available to the Secretary to carry out the demonstration project not more than $45,000,000 from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(h) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term "demonstration project" means the demonstration project conducted under this section.

(2) MEDICARE BENEFICIARY.—The term "Medicare beneficiary" means an individual who is enrolled for benefits under part B of title XVIII of the Social Security Act.

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

TITLE II—STRENGTHENING MEDICARE SECONDARY PAYER RULES

SEC. 201. DETERMINATION OF REIMBURSEMENT AMOUNT THROUGH CMS WEBSITE TO IMPROVE PROGRAM EFFICIENCY.

Section 1862(b)(2)(B) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

"(vii) USE OF WEBSITE TO DETERMINE FINAL CONDITIONAL REIMBURSEMENT AMOUNT.—

"(I) NOTICE TO SECRETARY OF EXPECTED DATE OF A SETTLEMENT, JUDGMENT, ETC.—In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a

payment is reasonably expected and the expected date of such payment.

"(II) SECRETARIAL PROVIDING ACCESS TO CLAIMS INFORMATION THROUGH A WEBSITE.—The Secretary shall maintain and make available to individuals to whom items and services are furnished under this title (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment . Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as pos-

sible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

"(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

"(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

"(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

"(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

"(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a 'statement of reimbursement amount') on payments for claims under this title relating to a potential settlement, judgment, award, or other payment.

"(III) USE OF TIMELY WEB DOWNLOAD AS BASIS FOR FINAL CONDITIONAL AMOUNT.—If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement,

judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

"(IV) RESOLUTION OF DISCREPANCIES.—If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether

there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a

statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

"(V) PROTECTED PERIOD.—In subclause (III), the term 'protected period' means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be ex-

tended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

"(VI) EFFECTIVE DATE.—The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after the date of the enactment of this clause.

"(VII) WEBSITE INCLUDING SUCCESSOR TECHNOLOGY.—In this clause, the term 'website' includes any successor technology.

"(viii) RIGHT OF APPEAL FOR SECONDARY PAYER DETERMINATIONS RELATING TO LIABILITY INSURANCE (INCLUDING

SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this title for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii), under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination".

SEC. 202. FISCAL EFFICIENCY AND REVENUE NEUTRALITY.

(a) IN GENERAL.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (2)(B)(ii), by striking "A primary plan" and inserting "Subject to paragraph (9), a primary plan"; and

(2) by adding at the end the following new paragraph:

"(9) EXCEPTION.—

"(A) IN GENERAL.—Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

"(B) ANNUAL COMPUTATION OF THRESHOLD.—

"(i) IN GENERAL.—Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding

alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for a year, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

"(ii) PUBLICATION.— The Secretary shall include, as part of such publication for a year—

"(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

"(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

"(C) EXCLUSION OF ONGOING EXPENSES.—For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this title.

"(D) REPORT TO CONGRESS.—Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

"(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

"(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this title achieved by the Secretary implementing each such threshold.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to years beginning with 2014.

SEC. 203. REPORTING REQUIREMENT.

Section 1862(b)(8) of the Social Security Act (42 U.S.C. 1395y(b)(8)) is amended—

(1) in the first sentence of subparagraph (E)(i), by striking "shall be subject" and all that follows through the end of the sentence and inserting the following: "may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant."; and

(2) by adding at the end the following new subparagraph:

"(I) REGULATIONS.—Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so sub-

mitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.".

SEC. 204. USE OF SOCIAL SECURITY NUMBERS AND OTHER IDENTIFYING INFORMATION IN REPORTING.

Section 1862(b)(8)(B) of the Social Security Act (42 U.S.C. 1395y(b)(8)(B)) is amended by adding at the end (after and below clause (ii)) the following:

"Not later than 18 months after the date of enactment of this sentence, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of juris-

diction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.".

SEC. 205. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Section 1862(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)(iii)) is amended by adding at the end the following new sentence: "An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to actions brought and penalties sought on or after 6 months after the date of the enactment of this Act.

Amend the title so as to read: "A bill to provide a demonstration project providing Medicare coverage for in-home administration of intravenous immune globulin

(IVIG) and to amend title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims.''.

President Signs Bipartisan Medicare Law

AAJ Response to the Passage of the SMART Act

Washington, DC— *The following is a statement from the American Association for Justice (AAJ) President Mary Alice McLarty in response to the President signing the Strengthening Medicare and Repaying Taxpayers (SMART) Act, which was introduced by Reps. Tim Murphy (R-PA) and Ron Kind (D-WI) in the House and Sens. Ron Wyden (D-OR), Rob Portman (R-OH), Ben Nelson (D-NE) and Richard Burr (R-NC) in the Senate:*

"This bipartisan legislation is a practical solution that will streamline the Medicare Secondary Payer system to ensure that seniors and persons with disabilities get timely assistance and taxpayers are repaid millions of dollars every year."

"This legislation is a big step forward and is the result of senior advocates, the legal community and the business community coming together to work out a common sense solution."

"There is still work to be done. To ensure this legislation has the most impact, [the Centers for Medicare and Medicaid Services] CMS must eliminate confusion and uncertainty by providing clear, efficient and definitive information to seniors."

Medicare Secondary Payer (MSP):

- The MSP process ensures Medicare is reimbursed for medical bills that are the responsibility of another party – such as an insurer or negligent party.
- A senior or person with disabilities who has been injured, and later obtains recourse through the legal system, often cannot access their settlement until Medicare is reimbursed for all medical costs.
- The current MSP system is inefficient and slow to return dollars to the Medicare Trust Fund, which is funded by tax payer money.
- It can take years for the Centers for Medicare and Medicaid Services (CMS) to report reimbursement amounts to beneficiaries and CMS can seek multiple reimbursement amounts over time, providing further delay and uncertainty.

The SMART Act will:

- **Require CMS to maintain a secure web portal to access claims and reimbursement amounts in a timely fashion.**
    - CMS must upload care payments they disperse within 15 days with the required information about the payment.
- **Streamline the process of obtaining reimbursement amounts.**
    - Medicare beneficiaries must notify CMS they are anticipating a settlement no more than 120 days beforehand.
    - CMS then has 65 days to ensure the web portal is up-to-date, but may request an additional 30 days, if needed.
    - Reimbursement amounts are reliable if downloaded from the web portal within three days of settlement.
- **Provide a process and timeline for discrepancies and appeals.**
    - Medicare beneficiaries can provide documentation for discrepancies on the web portal to CMS.

    - CMS has 11 days to respond to discrepancies.
    - If CMS does not respond in 11 days, the amount calculated by the beneficiary is the correct amount.
    - An additional appeal process must be established by CMS for reimbursements it attempts to collect from insurance plans.
- **Create a threshold** for collecting any payment amounts by CMS that are below the cost it incurs to collect an average claim.
- **Readjust the penalty for reporting errors** by insurers based on the violation.
- **Ensure greater privacy for beneficiaries** by no longer requiring use of full social security or health id claim numbers.
- **Create a three year limit** for CMS to seek any repayments beginning from when they were informed of an anticipated settlement.

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I

112TH CONGRESS
2D SESSION

H. R. 5284

To amend section 1862 of the Social Security Act with respect to the application of Medicare secondary payer rules to workers' compensation settlement agreements and Medicare set-asides under such agreements.

IN THE HOUSE OF REPRESENTATIVES

APRIL 27, 2012

Mr. REICHERT (for himself and Mr. THOMPSON of California) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend section 1862 of the Social Security Act with respect to the application of Medicare secondary payer rules to workers' compensation settlement agreements and Medicare set-asides under such agreements.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2012".

15

SEC. 2. APPLICATION OF MEDICARE SECONDARY PAYER RULES TO CERTAIN WORKERS' COMPENSATION SETTLEMENT AGREEMENTS AND QUALIFIED MEDICARE SET-ASIDE PROVISIONS.

(a) THRESHOLD FOR SECONDARY PAYER PROVISIONS FOR CERTAIN WORKERS' COMPENSATION SETTLEMENT AGREEMENTS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended—

(1) in subsection (b)(2)(A)(ii), by inserting "subject to subsection (p)," after "(ii)"; and

(2) by adding at the end the following new subsection:

"(p) THRESHOLD FOR SECONDARY PAYER PROVISIONS FOR CERTAIN WORKERS' COMPENSATION SETTLEMENT AGREEMENTS.—

"(1) IN GENERAL.—A workers' compensation law or plan shall not be treated as a primary plan for purposes of subsection (b) with respect to a workers' compensation settlement agreement if the agreement (or claimant under the agreement) is described in any of the following subparagraphs:

"(A) TOTAL SETTLEMENT AMOUNT NOT EXCEEDING $25,000.—The agreement has a total settlement amount (as determined under paragraph (2)) that does not exceed $25,000 or

such greater amount as the Secretary may specify in regulations.

"(B) LIKELY INELIGIBILITY OF WORKERS' COMPENSATION CLAIMANT FOR MEDICARE BENEFITS.—The claimant under the agreement—

"(i) is not eligible for benefits under this title as of the effective date of the agreement; and

"(ii) is unlikely to become so eligible, as determined under paragraph (3), within 30 months after such effective date.

"(C) NO FUTURE MEDICAL EXPENSES.—The claimant under the agreement is not eligible for payment of medical expenses, incurred after the effective date of the agreement, that are available under the workers' compensation law or plan of the jurisdiction in which such agreement will be effective.

"(D) NO LIMITATION ON FUTURE MEDICAL EXPENSES.—The agreement does not limit or extinguish the right of the claimant involved to payment of medical expenses, incurred after the effective date of such agreement, that are available under the workers' compensation law or

plan of the jurisdiction in which the agreement will be effective.

"(2) DETERMINATION OF TOTAL SETTLEMENT AMOUNT OF WORKERS' COMPENSATION SETTLEMENT AGREEMENT.—For purposes of paragraph (1)(A) and subsection (q) and with respect to a work-related injury or illness that is the subject of a workers' compensation settlement agreement, the total settlement amount of the agreement is the sum of monetary wage replacement benefits, attorney fees, all future medical expenses, repayment of Medicare conditional payments, payout totals for annuities to fund the expenses listed above, and any previously settled portion of the workers' compensation claim.

"(3) DETERMINATION OF LIKELY INELIGIBILITY OF CLAIMANT FOR MEDICARE BENEFITS.—For purposes of paragraph (1)(B)(ii), a workers' compensation claimant shall be deemed unlikely to become eligible for benefits under this title within 30 months after the effective date of the agreement unless, as of the effective date of the agreement, such claimant is insured, as determined under subsection (c)(1) of section 223, for disability insurance bene-

fits under such section and is described in any of the following subparagraphs:

"(A) AWARDED DISABILITY BENEFITS.—The individual has been awarded such disability insurance benefits.

"(B) APPLIED FOR DISABILITY.—The individual has applied for such disability insurance benefits.

"(C) ANTICIPATES APPEAL.—The individual has been denied such disability insurance benefits but anticipates appealing that decision.

"(D) APPEALING OR REFILING.—The individual is in the process of appealing or refiling for such disability insurance benefits.

"(E) MINIMUM AGE.—The individual is at least 62 years and 6 months of age.

"(F) END-STAGE RENAL DISEASE.—The individual has an end-stage renal disease condition but does not yet qualify for health benefits under section 226A based on such disease.

"(4) DEFINITIONS.—For purposes of this subsection and subsection (q):

"(A) COMPROMISE AGREEMENT.—The term 'compromise agreement' means a workers' compensation settlement agreement that—

"(i) applies to a workers' compensation claim that is denied or contested, in whole or in part, by a workers' compensation payer involved under the workers' compensation law or plan applicable to the jurisdiction in which the agreement has been settled; and

"(ii) does not provide for a payment of the full amount of benefits sought or that may be payable under the workers' compensation claim.

"(B) COMMUTATION AGREEMENT.—The term 'commutation agreement' means a workers' compensation settlement agreement to settle all or a portion of a workers' compensation claim, in which—

"(i) liability for past and future benefits is not disputed; and

"(ii) the parties to the agreement agree to include payment for future workers' compensation benefits payable after the date on which the agreement becomes effective.

"(C) WORKERS' COMPENSATION CLAIMANT.—The term 'workers' compensation claimant' means a worker who—

"(i) is or may be covered under a workers' compensation law or plan; and

"(ii) submits a claim or accepts benefits under such law or plan for a work-related injury or illness.

"(D) WORKERS' COMPENSATION LAW OR PLAN.—

"(i) IN GENERAL.—The term 'workers' compensation law or plan' means a law or program administered by a State or the United States to provide compensation to workers for a work-related injury or illness (or for disability or death caused by such an injury or illness), including the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901–944, 948–950), chapter 81 of title 5, United States Code (known as the Federal Employees Compensation Act), the Black Lung Benefits Act (30 U.S.C. 931 et seq.), and part C of title 4 of the Federal Coal Mine and Safety Act (30 U.S.C. 901 et seq.), but not

including the Act of April 22, 1908 (45 U.S.C. 51 et seq.) (popularly referred to as the Federal Employer's Liability Act).

"(ii) INCLUSION OF SIMILAR COMPENSATION PLAN.—Such term includes a similar compensation plan established by an employer that is funded by such employer or the insurance carrier of such employer to provide compensation to a worker of such employer for a work-related injury or illness.

"(E) WORKERS' COMPENSATION PAYER.—The term 'workers' compensation payer' means, with respect to a workers' compensation law or plan, a workers' compensation insurer, self-insurer, employer, individual, or any other entity that is or may be liable for the payment of benefits to a workers' compensation claimant pursuant to the workers' compensation law or plan.

"(F) WORKERS' COMPENSATION SETTLEMENT AGREEMENT.—The term 'workers' compensation settlement agreement' means an agreement, including a commutation agreement or compromise agreement, or any combination of both, between a workers' compensation

claimant and one or more workers' compensation payers which is intended—

"(i) to foreclose the possibility of future payment of some or all workers' compensation benefits involved; and

"(ii)(I) to compensate the claimant for a work-related injury or illness as provided for by a workers' compensation law or plan; or

"(II) to eliminate cause for litigation involving issues in dispute between the claimant and payer.".

(b) SATISFACTION OF SECONDARY PAYER REQUIREMENTS THROUGH USE OF QUALIFIED MEDICARE SET-ASIDES UNDER WORKERS' COMPENSATION SETTLEMENT AGREEMENTS.—Such section is further amended by adding at the end the following new subsection:

"(q) TREATMENT OF QUALIFIED MEDICARE SET-ASIDES UNDER WORKERS' COMPENSATION SETTLEMENT AGREEMENTS.—

"(1) SATISFACTION OF SECONDARY PAYER REQUIREMENTS THROUGH USE OF QUALIFIED MEDICARE SET-ASIDES.—

"(A) FULL SATISFACTION OF CLAIM OBLIGATIONS.—

"(i) IN GENERAL.—If a workers' compensation settlement agreement, related to a claim of a workers' compensation claimant, includes a qualified Medicare set-aside (as defined in paragraph (2)), such set-aside shall satisfy any obligation with respect to the present or future payment reimbursement under subsection (b)(2) with respect to such claim. The Secretary shall have no further recourse, directly or indirectly, under this title with respect to such agreement.

"(ii) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the submission of a Medicare set-aside to the Secretary.

"(B) MEDICARE SET-ASIDE AND MEDICARE SET-ASIDE AMOUNT DEFINED.—For purposes of this subsection:

"(i) MEDICARE SET-ASIDE.—The term 'Medicare set-aside' means, with respect to a workers' compensation settlement agreement, a provision in the agreement that provides for a payment of a lump sum, annuity, a combination of a

lump sum and an annuity, or other amount that is in full satisfaction of the obligation described in subparagraph (A) for items and services that the workers' compensation claimant under the agreement received or is likely to receive under the applicable workers' compensation law and for which payment would be made under this title, but for subsection (b)(2)(A).

"(ii) MEDICARE SET-ASIDE AMOUNT.—The term 'Medicare set-aside amount' means, with respect to a Medicare set-aside, the amount described in clause (i).

"(2) QUALIFIED MEDICARE SET-ASIDE.—

"(A) REQUIREMENTS OF QUALIFIED MEDICARE SET-ASIDE.—For purposes of this subsection, the term 'qualified Medicare set-aside' is a Medicare set-aside in which the Medicare set-aside amount reasonably takes into account the full payment obligation described in paragraph (1)(A), while meeting the requirements of subparagraphs (B) and (C) and giving due consideration to the following:

"(i) The illness or injury giving rise to the workers' compensation claim involved.

"(ii) The age and life expectancy of the claimant involved.

"(iii) The reasonableness of and necessity for future medical expenses for treatment of the illness or injury involved.

"(iv) The duration of and limitation on benefits payable under the workers' compensation law or plan involved.

"(v) The regulations and case law relevant to the State workers' compensation law or plan involved.

"(B) ITEMS AND SERVICES INCLUDED.—A qualified Medicare set-aside—

"(i) shall include payment for items and services that are authorized for payment under this title as of the effective date of the workers' compensation settlement agreement involved and that are covered by the workers' compensation law or plan involved; and

"(ii) is not required to provide for payment for items and services that are not described in clause (i).

"(C) PAYMENT REQUIREMENTS.—

"(i) REQUIRED USE OF WORKERS' COMPENSATION FEE SCHEDULE.—

"(I) IN GENERAL.—Except in the case of an optional direct payment of a Medicare set-aside made under paragraph (5)(A), the set-aside amount shall be based upon the payment amount for items and services under the workers' compensation fee schedule (effective as of the date of the agreement) applicable to the workers' compensation law or plan involved.

"(II) WORKERS' COMPENSATION FEE SCHEDULE DEFINED.—For purposes of this subsection, the term 'workers' compensation fee schedule' means, with respect to a workers' compensation law or plan of a State or a similar plan applicable in a State, the schedule of payment amounts the State has established to pay providers for items and services furnished to workers who incur a work-related in-

jury or illness as defined under such law or plan (or in the absence of such a schedule, the applicable medical reimbursement rate under such law or plan).

"(ii) OPTIONAL PROPORTIONAL ADJUSTMENT FOR COMPROMISE SETTLEMENT AGREEMENTS.—

"(I) IN GENERAL.—In the case of a compromise settlement agreement, a workers' compensation claimant or workers' compensation payer who is party to the agreement may elect (but is not required) to calculate the Medicare set-aside amount of the agreement by applying a percentage reduction to the Medicare set-aside amount for the total settlement amount that could have been payable under the applicable workers' compensation law or similar plan involved had the denied or contested portion of the claim not been subject to a compromise agreement. The percentage reduction shall be equal to the denied

or contested percentage of such total settlement. Such election may be made by a party to the agreement only with the written consent of the other party to the agreement.

"(II) APPLICATION.—If the workers' compensation claimant or workers' compensation payer elects to calculate the Medicare set-aside amount under this clause, the Medicare set-aside shall be deemed a qualified Medicare set-aside.

"(D) CERTAIN MEDICARE SET-ASIDES WITH SAFE HARBOR AMOUNT DEEMED QUALIFIED MEDICARE SET-ASIDES.—

"(i) IN GENERAL.—For purposes of this section and subject to clause (iv), a Medicare set-aside of a workers' compensation settlement agreement shall be deemed a qualified Medicare set-aside if the Medicare set-aside amount involved is the safe harbor amount for the agreement and the agreement does not exceed $250,000.

"(ii) WRITTEN CONSENT.—A safe harbor amount, with respect to a workers'

compensation agreement, shall be treated as the Medicare set-aside amount for such agreement for purposes of clause (i) only upon written consent of all parties to the agreement.

"(iii) SAFE HARBOR AMOUNT DEFINED.—For purposes of this subsection, the term 'safe harbor amount' means, with respect to a workers' compensation settlement agreement, 15 percent of the total settlement amount of the agreement (as determined under subsection (p)(2)), excluding repayment of conditional payments and previously settled portions of the claim involved. In applying the previous sentence for purposes of determining the safe harbor amount, with respect to a workers' compensation agreement, if the agreement includes an annuity, the cost (but not the payout of the annuity) shall be included in determining the total settlement amount of the agreement.

"(iv) MANDATORY DIRECT PAYMENT OF SAFE HARBOR AMOUNT.—A Medicare set-aside of a worker's compensation settle-

ment agreement may not be treated as a qualified set-aside under clause (i) unless an election is made under paragraph (5)(A) to transfer to the Secretary a direct payment of such set-aside.

"(E) SECRETARIAL AUTHORITY WITH RESPECT TO DEEMED QUALIFIED MEDICARE SET-ASIDES.—

"(i) DETERMINATION.—If the Secretary determines, based on the data described in clause (ii), that the provisions of subparagraph (D) have caused a significant negative financial impact (as specified by the Chief Actuary of the Centers for Medicare & Medicaid Services) on the Federal Hospital Insurance Trust Fund under section 1817 or the Federal Supplementary Medical Insurance Trust Fund under section 1841, then the Secretary shall adopt rules to reduce such impact by modifying the amount of the percent described in subparagraph (D)(iii).

"(ii) REQUIRED DATA.—The determination under clause (i) shall be based on data on—

"(I) the projected effect of the provisions described in such paragraph on the Federal Hospital Insurance Trust Fund under section 1817 or the Federal Supplementary Medical Insurance Trust Fund under section 1841 during the three-year period beginning on the date of the enactment of this subsection; as compared to

"(II) data on the effect on such trust funds of the provisions of subsection (b), as in effect during the three-year period prior to such date of enactment.

"(3) PROCESS FOR APPROVAL OF QUALIFIED MEDICARE SET-ASIDES.—

"(A) OPTIONAL PRIOR APPROVAL BY SECRETARY.—A party to a workers' compensation settlement agreement that includes a Medicare set-aside may submit to the Secretary the set-aside for approval of the set-aside as a qualified Medicare set-aside. The set-aside shall be submitted in accordance with a procedure specified by the Secretary.

"(B) NOTICE OF DETERMINATION OF APPROVAL OR DISAPPROVAL.—Not later than 60 days after the date on which the Secretary receives a submission under subparagraph (A), the Secretary shall notify in writing the parties to the workers' compensation settlement agreement of the determination of approval or disapproval. If the determination disapproves such submission the Secretary shall include with such notification the specific reasons for the disapproval. A determination that disapproves a submission is not valid if the determination does not include a specific explanation of each deficiency of the submission.

"(4) APPEALS.—

"(A) IN GENERAL.—A party to a workers' compensation settlement agreement that is dissatisfied with a determination under paragraph (3)(B), upon filing a request for reconsideration with the Secretary not later than 60 days after the date of notice of such determination, shall be entitled to—

"(i) reconsideration of the determination by the Secretary (with respect to such determination);

"(ii) a hearing before an administrative judge thereon; and

"(iii) judicial review of the Secretary's final determination after such hearing.

"(B) DEADLINES FOR DECISIONS.—

"(i) RECONSIDERATIONS.—

"(I) IN GENERAL.—The Secretary shall conduct and conclude a reconsideration of a determination under subparagraph (A)(i) and mail the notice of the decision of such reconsideration to the party involved by not later than the last day of the 30-day period beginning on the date that a request for such reconsideration has been timely filed.

"(II) APPEALS OF RECONSIDERATIONS.—If a party to the workers' compensation settlement involved is dissatisfied with the Secretary's decision under subclause (I) that party may file an appeal within the 30-day period after the date of receipt of the notice of the decision under such sub-

clause and request a hearing before an administrative law judge.

"(III) FAILURE BY SECRETARY TO PROVIDE NOTICE.—In the case of a failure by the Secretary to mail the notice of the decision under subclause (I) by the last day of the period described in such subclause, the Secretary shall be deemed to have approved the submission as submitted under paragraph (3)(A).

"(ii) HEARINGS.—

"(I) IN GENERAL.—An administrative law judge shall conduct and conclude a hearing on a decision of the Secretary under clause (i) and render a decision on such hearing by not later than the last day of the 90-day period beginning on the date that a request for such hearing has been timely filed.

"(II) JUDICIAL REVIEW.—A decision under subclause (I) by an administrative law judge constitutes a final

agency action and is subject to judicial review.

"(III) FAILURE BY ADMINISTRATIVE LAW JUDGE TO RENDER TIMELY DECISION.—In the case of a failure by an administrative law judge to render a decision under subclause (I) by the last day of the period described in such subclause, the party requesting the hearing may seek judicial review of the decision under clause (i), notwithstanding any requirements for a hearing for purposes of the party's right to such judicial review.

"(5) ADMINISTRATION OF MEDICARE SET-ASIDE PROVISIONS; PROTECTION FROM CERTAIN LIABILITY.—

"(A) OPTIONAL DIRECT PAYMENT OF MEDICARE SET-ASIDE AMOUNT.—

"(i) ELECTION FOR DIRECT PAYMENT OF MEDICARE SET-ASIDE.—With respect to a claim for which a workers' compensation settlement agreement is established, a workers' compensation claimant or workers' compensation payer who is party to

the agreement may elect, but is not required, to transfer to the Secretary a direct payment of the qualified Medicare set-aside. With respect to a qualified Medicare set-aside paid directly to the Secretary, the parties involved may calculate the Medicare set-aside amount of such set-aside using any of the following methods:

"(I) In the case of any Medicare set-aside of a compromise settlement agreement under paragraph (2)(C)(ii), the amount calculated in accordance with such paragraph.

"(II) In the case of any Medicare set-aside, the amount based upon the payment amount for items and services under the workers' compensation fee schedule (effective as of the date of the agreement) applicable to the workers' compensation law or plan involved, in accordance with paragraph (2)(C)(i)(I).

"(III) In the case of any Medicare set-aside, the payment amount applicable to the items and services

under this title as in effect on the effective date of the agreement.

Such transfer shall be in accordance with a procedure established by the Secretary and shall be made only upon written consent of the other party to the agreement.

"(ii) ELECTION SATISFYING LIABILITY.—An election made under clause (i), with respect to a qualified Medicare set-aside shall satisfy any payment, in relation to the underlying claim of the related workers' compensation settlement agreement, required under subsection (b)(2) to be made by the claimant or payer to the Secretary. The Secretary shall have no further recourse, directly or indirectly, under this title with respect to such agreement.

"(B) REQUIREMENT FOR TIMELY NOTICE OF MEDICARE REPAYMENTS OWED BY WORKERS' COMPENSATION CLAIMANT OR PAYER TO SECRETARY.—

"(i) IN GENERAL.—Not later than 90 days after the date on which the Secretary receives a request from a workers' compensation claimant or workers' compensa-

tion payer for documentation of any conditional payment made under subsection (b)(2)(B)(i) on behalf of the claimant, the Secretary shall provide to the claimant or payer such documentation. Such documentation shall be sufficient for the claimant or payer to make a reasonable determination whether such a payment was for an item or service furnished in connection with the claimant's work related injury or illness involved. The claimant or payer may rely on the documentation provided under this clause in making such determination. Payment of the amount of the conditional payment, after deducting from such amount any procurement costs involved and any costs for unrelated and inappropriate items or services, shall discharge further liability with respect to the conditional payment.

"(ii) LIABILITY FOR REIMBURSEMENTS RELATED TO REQUESTED INFORMATION.—If the Secretary fails to provide information in accordance with clause (i), then neither the claimant nor the payer de-

scribed in such clause shall be liable for any reimbursement under subsection (b)(2)(B) with respect to the conditional payment for which information was requested under such clause.

"(C) PROTECTION FROM CERTAIN LIABILITY.—

"(i) LIABILITY FOR MEDICARE SET-ASIDE PAYMENT GREATER THAN PAYMENT UNDER WORKERS' COMPENSATION LAW.—No workers' compensation claimant, workers' compensation payer, employer, administrator of the Medicare set-aside, legal representative of the claimant, payer, employer, or administrator, or any other party related to the claimant, payer, employer, or administrator shall be liable for any payment amount established under a Medicare set-aside for an item or service provided to the claimant that is greater than the payment amount for the item or service established under the workers' compensation fee schedule (or in the absence of such schedule, the medical reimbursement rate) under the compensation law or

plan of the jurisdiction where the agreement will be effective.

"(ii) LIABILITY FOR PROVIDER CHARGES GREATER THAN PAYMENT UNDER WORKERS' COMPENSATION AGREEMENT.—With respect to a workers' compensation settlement agreement, a provider may not bill (or collect any amount from) the workers' compensation claimant, workers' compensation payer, employer, administrator of the Medicare set-aside, legal representative of the claimant, payer, employer, or administrator, or any other party related to the claimant, payer, employer, or administrator an amount for items and services provided to the claimant that is greater than the payment rate for such items and services established under the Medicare set-aside of the agreement. No person is liable for payment of any amounts billed for an item or service in violation of the previous sentence. If a provider willfully bills (or collects an amount) for such an item or service in violation of such sentence, the Secretary may apply

sanctions against the provider in accordance with section 1842(j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of section 1842(j) shall apply under this clause in the same manner as such paragraph applies under such section.

"(6) TREATMENT OF STATE WORKERS' COMPENSATION LAW.—For purposes of this subsection and subsection (p), if a workers' compensation settlement agreement is accepted, reviewed, approved, or otherwise finalized in accordance with the workers' compensation law of the jurisdiction in which such agreement will be effective, such acceptance, review, approval, or other finalization shall be deemed conclusive as to any and all matters within the jurisdiction of the workers' compensation law, including the determination of reasonableness of the settlement value; any allocations of settlement funds; the projection of future indemnity or medical benefits that may be payable under the State workers' compensation law; and, in the case of a compromise agreement, the total amount that could have been payable for a claim which is the subject of such agreement in accordance with paragraph (2)(C)(ii).

A determination made by applicable authority for a jurisdiction that a workers' compensation settlement agreement is in accordance with the workers' compensation law of the jurisdiction shall not be subject to review by the Secretary.".

(c) CONFORMING AMENDMENTS.—Subsection (b) of such section is further amended—

(1) in paragraph (2)(B)(ii), by striking "A primary plan" and inserting "Subject to subsections (p) and (q), a primary plan";

(2) in paragraph (2)(B)(iii)—

(A) in the first sentence, by striking "In order to recover payment" and inserting "Subject to subsection (q), in order to recover payment"; and

(B) in the third sentence, by striking "In addition" and inserting "Subject to subsection (q), in addition"; and

(3) in paragraph (3)(A), by striking "There is established a private cause of action" and inserting "Subject to subsection (q), there is established a private cause of action".

(d) MODERNIZING TERMINOLOGY FOR PURPOSES OF MEDICARE SECONDARY PAYER PROVISIONS.—Subsection (b)(2)(A) of such section is amended by striking "work-

men's compensation law or plan" and inserting "workers' compensation law or plan" each place it appears.

SEC. 3. LIMITATION ON LIABILITY.

The parties to a workers' compensation settlement agreement which met the provisions of section 1862(b) of the Social Security Act (42 U.S.C. 1395y (b)) on the effective date of settlement shall be accepted as meeting the requirements of such section notwithstanding changes in law, regulations, or administrative interpretation of such provisions after the effective date of such settlement. Nothing in section 1862(b) of the Social Security Act (42 U.S.C. 1395y (b)) shall authorize the Secretary of Health and Human Services to impose liability that is additional to the liability in effect on the date of the enactment of this Act with respect to a workers' compensation settlement agreement the effective date of which is before such date of enactment, except in the case of fraud.

SEC. 4. EFFECTIVE DATE.

The amendments made by this Act shall apply to a workers' compensation settlement agreement with an effective date on or after the date of the enactment of this Act.

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Issue	HR 1845: Includes the Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act)	HR 5284: Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2012
Qualified Set-Asides	Does not address	Adds a new subsection (q) to the MSP Act governing "qualified" set-asides. A settlement which includes a "qualified" set-aside satisfies all obligations under the MSP Act, and Medicare has no further recourse against the claimant or payer.
Settlements Subject to Conditional Payments	Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards or other payments for conditional payment obligations arising from each of liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. Each such annual single threshold amount for a year shall be set such that the expected average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments for each of liability insurance (including self-insurance), workers' compensation laws or plans, and no fault insurance subject to this section shall equal the expected average cost of collection incurred by the United States (including payments made to contractors) for a conditional payment from each of liability insurance (including self-insurance) and alleged physical trauma-based incidents (excluding alleged ingestion, implantation or exposure cases) subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for a year, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount. The Secretary shall include, as part of such publication for a year— (I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for	Does not address

16

	such alleged incidents; and (II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.	
Settlement Subject to Set Aside	Does not address	Amends the Social Security Act by adding a new subsection (p) to the Medicare Secondary Payer (MSP) Act, which creates an exception to Medicare secondary payer requirements for certain workers' compensation settlement agreements. Settlements under threshold for consideration as primary plans subject to the MSP Act, such as: total settlement, including the sum of monetary wage replacement benefits, attorney fees, all future medical expenses, repayment of Medicare conditional payments, payout totals for annuities to fund the expenses listed above, and any previously settled portion of the workers' compensation claim, is $25,000 or less (includes both current and future Medicare beneficiaries); Claimant is not eligible for Medicare on the effective date of the agreement and is unlikely to become eligible within 30 months of the effective date of the agreement; claimant is not eligible for payment of medical expenses after the effective date of the agreement under the workers' compensation law of the jurisdiction; and/or the settlement does not extinguish the employer's responsibility for medical expenses after the effective date of the agreement.
Deadlines for List of Conditional Payments	Amends title XVIII (Medicare) of the Social Security Act with respect to any settlement, judgment, award, or other payment between a Medicare claimant and an applicable plan involving a payment made for items and services by the Secretary of Health and Human Services (HHS). Declares that, in the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement,	CMS has 90 days after receiving a request from a claimant or payer who is a party to the settlement, to provide documentation of conditional payments requiring repayment to the notifying party. The documentation must be sufficient for the claimant or payer to make a reasonable determination whether Medicare payments were for items or services provided in connection with the claimant's work related injury or illness. The claimant or payer may rely upon the provided documentation of this conditional payment amount. Payment of the conditional payment amount, after

	judgment, award, or other payment, notify the Secretary that a payment is reasonably expected, and the expected date of such payment. If the individual (or authorized representative) believes there is a discrepancy with the statement of re-imbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.	a deduction for procurement costs and removal of unrelated and inappropriate items or services, completely discharges further liability regarding any conditional payments. If CMS fails to provide information within 90 days, neither the claimant nor the payer shall be liable for reimbursement.
Appeals of Conditional Payments	The Secretary shall promulgate regulations establishing a right of appeal 4 and appeals process, with respect to any determination under this subsection for a payment made under this title for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan	Does not address

	under subsection (A)(ii), under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination.	
Appeals of Set Aside Determination	Does not address	The submitter may file a request for reconsideration within 60 days after the notice of determination. The steps are reconsideration by the Secretary, appeal to ALJ, and then appeal to federal district court. The Secretary must notify the parties to a reconsideration request of the Secretary's determination within 30 days of the request for reconsideration. The parties may appeal the determination on reconsideration within 30 days of receipt. If the Secretary fails to provide timely notice of the reconsideration determination the submission is deemed approved. An ALJ shall conduct and conclude a hearing on appeal and render a decision not later than 90 days after the request for hearing. A decision of an ALJ is appealable as a final administrative decision to federal court. If the ALJ fails to render a decision within the 90 days, the party requesting the hearing may seek judicial review.
Proportionality in Set Asides	Does not address	In the case of a compromise settlement agreement, a claimant or payer who is party to the agreement may elect (but is not required) to calculate the Medicare set-aside amount of the agreement by applying a percentage reduction to the Medicare set-aside amount for the total settlement amount that could have been payable under the applicable workers' compensation law or similar plan involved had the denied or contested portion of the claim not been subject to a compromise agreement. The percentage reduction would be equal to the denied or contested percentage of such total settlement. Such election may be made by a party to the agreement only with the written consent of the other party to the agreement. If the workers' compensation claimant or

		workers' compensation payer elects to calculate the Medicare set-aside amount under this clause, the Medicare set-aside shall be deemed a qualified Medicare set-aside.
Safe Harbor for Conditional Payments	Not later than 60 days after the date of the enactment of this Act, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under sub-paragraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.	Does not address
Safe Harbor for Set Asides	Does not address	A Medicare set-aside in the case of a compensation settlement agreement shall be deemed a qualified set-aside if the set-aside amount is a safe harbor amount of 15% of the total settlement amount and the agreed total settlement amount does not exceed $250,000. For purposes of the safe harbor provision, the total settlement amount shall exclude the repayment of conditional payments and previously settled portions of the claim. If such agreement includes an annuity, the cost (but not the payout of the annuity) shall be included in determining the total settlement amount. A Medicare set-aside under the safe harbor provision may not be treated as qualified unless the set aside amount is paid directly to the Secretary of HHS.
Civil Penalties for Conditional Payments	Makes discretionary rather than mandatory the current civil money penalty ($1,000) for an applicable plan's noncompliance with requirements to submit insurance information about a claimant.	Does not address

Statute of Limitations for Conditional Payments	Sets a three-year statute of limitations after notice of settlement or judgment on a Medicare secondary payer claim by the Secretary for reimbursement against an applicable plan that becomes a Medicare primary payer pursuant to a settlement, judgment, award, or other judicial action.	Does not address
Statute of Limitations for Set Asides	Does not address	The parties to a workers' compensation settlement agreement which met the provisions of section 1862(b) of the Social Security Act (42 U.S.C. 1395y (b)) on the effective date of settlement shall be accepted as meeting the requirements of such section notwithstanding changes in law, regulations, or administrative interpretation of such provisions after the effective date of such settlement. Nothing in section 1862(b) of the Social Security Act (42 U.S.C. 1395y (b)) shall authorize the Secretary of Health and Human Services to impose liability that is additional to the liability in effect on the date of the enactment of this Act with respect to a workers' compensation settlement agreement the effective date of which is before such date of enactment, except in the case of fraud.