AMERICAN INNS of COURT®

# AND YOU THOUGHT YOU KNEW EVERYTHING PRESENTATION

ON JUNE 9, 2022 AT 2:00 – 3:00 PM

BY

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# And You Thought You Knew Everything

06.09.2022


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1.) The filing of a claim shall create a lien, pursuant to Section 65.2-309

Most self-insured employers and carriers understand that the Virginia Workers' Compensation Act permits an injured worker the right to recover from a negligent third party full damages for injuries inflicted on him or her by such party; and, from the recovery, the employer is reimbursed its lien for compensation benefits paid, subject to its pro rata share of attorney's fees and costs. But often, a plaintiff's attorney will argue that the proceeds of that third-party settlement should be reduced or split in thirds, meaning a third for the plaintiff/injured worker, a third for the plaintiff's attorney, and a third for the workers' compensation carrier. In reality, the subrogation statutes in the Virginia Workers' Compensation Act (Section 65.2-309 and 310) that govern the subrogation rights of an employer provide for a more complex and equitable distribution of the proceeds of a third-party settlement.

The Act also penalizes an employee who settles their third-party action without the consent of the employer/carrier. The penalty for impairing the employer's right may be the loss of the employee's right to compensation benefits.

Often, a carrier may present the total amount they have paid out on a claim, to include costs from vendors and defense attorney's fees. However, the employer and carrier do not have a right of subrogation for certain expenses, including bill review fees, nurse case manager fees, and vocational rehabilitation counselors. Thus, those expenses need to be deducted from the total lien, before calculating the gross lien. Also, any portion of the employee's recovery that was received based upon the employee's own Underinsured Motorist coverage does not apply to the workers' compensation claim for an offset.

While an employer is entitled to recoupment of their lien, the employer must pay their share of the third-party attorney's costs and fees. As a result, there is a calculation of the employer's share of those costs and fees, in relation to the total recovery. The Commission requires approval of any third-party offset, and thus stipulations or settlement documents must be filed to approve the offset.

A simple example of the calculation of the offset demonstrates the method of calculation. Imagine if an employee receives $100,000.00 in a third-party settlement, and the employer has paid $50,000.00 in lost wage and medical expenses. The total amount of attorney's fees is $29,000.00, and costs are $1,000.00.

Step One: Calculate the sum of attorney's fees and costs and divide it by the gross recovery. This yields a percentage share of fees and costs owed by the insurance carrier at the time of the recovery. In our example, the calculation of the offset percentage is as follows:

| | | |
|---|---|---|
| | $29,000 | Attorney's Fees |
| + | $1,000 | Costs |
| = | $30,000 | Total Attorney's Fees and Costs |
| ÷ | 100,000 | Gross recovery |
| = | .30 | Percentage of Attorney's Fees and Costs |

Step two: The carrier's lien is then multiplied by the percentage of attorney's fees and costs, which yields the pro rata share. The carrier must deduct from the lien that pro rata share, as they are responsible for that portion of the attorney's fees and costs. The net amount is then received by the carrier in satisfaction of their present lien.

| | | |
|---|---|---|
| | $50,000 | Employer Lien |
| x | .30 | Percentage of Attorney's Fees and Costs |
| = | $15,000 | Total amount of Attorney's Fees and Costs that are the Employer's Share (at time of settlement) |

Step three: The employer then must reduce this amount of attorney's fees and costs from their lien amount, in satisfaction of its present lien.

| | | |
|---|---|---|
| | $50,000 | Employer Lien |
| - | $15,000 | Employer's Share of Attorney's Fees and Costs |
| = | $35,000 | Total recoupment of Employer's current Lien at time of settlement. |

| | | |
|---|---|---|
| | $10,000 | Medical Expenses, after the third-party action is settled |
| x | .30 | *pro rata* share |
| = | $3,000 | to be reimbursed to the Claimant |

Usually such reimbursement requests should be submitted to the carrier directly on a quarterly basis.

Just a few final thoughts on this topic—the filing of a claim creates a lien, so while it's best to put the plaintiff's attorney on notice, a lien is automatically created when a claim is filed. Secondly, Section 65.2-309.1 allows an employer and carrier to have a right of subrogation against the proceeds of the uninsured or underinsured motorist coverage carried by and at the expense of the employer. So, if it's the Claimant's own UM or UIM policy, the workers' compensation carrier has no right to those proceeds. This is an easily forgotten subrogation tip.

2. Custodial accounts for undocumented workers

Custodial accounts for undocumented workers are possible and may assist the cost of with future medical expenses in catastrophic cases. Undocumented workers are not entitled to Medicare, Medicaid, and cannot purchase health insurance on the health exchange. Lawfully present immigrants can purchase on the exchange, but undocumented cannot. For catastrophic contested claims this could be an impediment to settlement—how can an undocumented worker who is seriously injured settle a claim without medical benefits being covered, when they have no means to have "in network" charges by providers? Likewise, a carrier who believes they have solid defenses to a claim will hesitate to pay full value on future medical expenses.

In such a claim, the answer could be with a custodial account professionally administered, payable as an annuity. These professionally administered accounts are able to function similarly to health insurance, negotiating directly with providers to get reductions on medical services. The custodial account does not direct care and does not interfere with treatment, but makes payments directly to the provider. This serves as a method to ensure that the injured worker is getting the best value of their settlement.

3. New issues with Nonsubmit or EBMSAs

On January 10, 2022, CMS issued new revisions to the Worker's Compensation Medicare Set-Aside arrangement (WCMSA) reference guide, which have significant impact on non-CMS approved Worker's Compensation MSAs.

Previously, the longstanding position and guidance from CMS has been that CMS approval of the proposed WCMSA amount is not required. However, in section 4.3 of the new reference guide, CMS has made an addition in their published recommendations regarding non-submitted MSAs.

The new language on the guide states that "unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare's programs interests are adequately protected. As such, CMS treats the use of non-CMS approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement." (emphasis added). The guide goes on to state that CMS will deny payment for

medical services related to the workers' compensation injury up to the gross amount of the settlement, less procurement costs, before CMS will resume primary payment of obligation. The guide further states, "This will result in the Claimant needing to demonstrate a complete exhaustion of the net settlement amount, rather than a CMS approved WCMSA amount."

The change in the reference guide indicates that CMS is shifting its voluntary submission language to compulsory. Often, the parties may have a proposed MSA and choose not to submit to CMS for approval. The language in the reference guide essentially will cause a chilling effect of this type of settlement, as it effectively requires the parties to submit an MSA for CMS approval. If the parties choose to forego submission of their MSA, CMS will deny medical services to the full amount of the settlement, minus procurement costs, if there is no submission.

Certainly, the language in the new reference guide is contradictory to the additional information in the new version of the reference guide, which reiterates that CMS approval is currently voluntary. Further, it is unclear whether CMS intends to apply this new policy and practice prospectively or if they will retroactively review settlements prior to the date of release of the new reference guide on January 10, 2022.

Until there is additional clarification from CMS regarding non-submit MSAs, it is unlikely that Claimant's attorneys will agree to utilize evidence-based MSA's or non-submit MSA proposals moving forward. This raises particular concerns regarding valuation of a claim, since many CMS proposals require over inflation of future medical expenses, to include the utilization of opioids for the duration of the Claimant's lifetime. Such extrapolation of treatment over a lifetime is neither medically responsible nor supported by the medical evidence for a claim, and yet it is required in MSA proposals. Certainly, such impractical and unreasonable methods for measuring a Claimant's future lifetime Medicare-covered expenses have pushed parties who would like to settle to utilize indemnified or evidence-based MSA's, and to decide not to submit Medicare set-aside proposals to CMS.

4. Conditional payments as part of the total settlement, per CMS?!

As we all know, settlement over the CMS threshold of $25,000.00 must now be reviewed by CMS, when the Claimant is a Medicare beneficiary. But what counts as part of that settlement? The "total settlement amount" per CMS is often not a simple computation.

Attorney fees and costs are included in the total settlement, which makes sense, since it is a portion of the settlement via contingency, but so is the total payout of an annuity (not the cost), settlement advances, and repayment of conditional payments! It is thus possible that if there is an errant conditional payment that was processed under Medicare, and you've settled for less than the threshold of $25,000, the total value of the settlement could now be greater than the threshold, after the settlement! Even lien reductions by the carrier and liability settlement amounts on the same WC injury are included in the total settlement amount, so tread carefully when dealing with a Medicare recipient. Often a conditional payment search should be prepared if there is a risk of earlier treatment that is ultimately the carrier's responsibility to add to the total settlement.

Even prior settlements of the same claim are included in the total settlement, so if lost wage benefits were settled for $20,000.00 in 2012, and medicals are settled in 2021 for $10,000.00, this settlement needs to be submitted to CMS for approval, as it is above $25,000.00.

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**New status of payment of Functional Capacity Examination (FCE) used solely for PPD purposes**

Until recently, an FCE that was requested for the sole purpose of a PPD rating was not the responsibility of the employer/carrier. It was a litigation expense for a claimant. Note that this is different than and FCE that was requested by a treating physician to determine work status which has traditionally been a causally related medical expense. The cost of an FCE for purely PPD purposes, however, apparently has been shifted to the employer and carrier based on the Full Commission Opinion in, Kenneth Elliott v. Sam Green Vault Corporation (VA00001108316, Opinion Oct. 5, 2021). In this Opinion, the full Commission (on a 2-1 vote with Commissioner Rapaport dissenting) changed longstanding case law and provided a new paradigm for this issue. This case stands for the proposition that an FCE (under seemingly any circumstances) is now reasonable medical treatment and should be paid by the employer and carrier as provided by Section 65.2-603.

**When does Medicare coverage start?**

Medicare eligibility is not on your (or your client/claimant's) 65th birthday. It is actually on the first day of the month of the persons 65th birthday.

**Status of the COVID presumption found in Section 65.2-402.1**

In 2021 the General Assembly passed an amendment to Section 65.2-402.1 which provided a COVID presumption for certain types of employees. The statute specifically states that the presumption would apply for death or disability that occurred on or after March 12, 2020, and prior to December 31, 2021. As such, the presumption ended on the last day of 2021.

House Bill 932 has been introduced by the General Assembly to amend and extend the COVID presumption for health care providers. The current presumption was in effect from March 12, 2020 through December 30, 2021. The current Bill will extend the presumption until, "prior to December 31, 2022."

House Bill 932 has already passed the House with a 99-0 vote on February 11, 2022. On March 3, 2022, the Senate passed the Bill with a 39-0 vote. As of the filing of the written materials, the Governor had not signed it into law but that will likely be the case by the time of our presentation.

**What is Marketing?**

Marketing is one of those issues that we all wish had a bright line rule. As long as you do "X" you have sufficiently marketed. If you fall short of "X" you have not. However, as we all know, marketing is not that simple. In National Linen Service v. McGinn 8 Va. App. 267, 272 (1989) the Court of Appeals stated that in order for a claimant to receive temporary total disability benefits when she is partially disabled, the claimant must prove she made reasonable efforts to market her residual erring capacity. What constitutes reasonable marketing efforts, however, depends on the facts and circumstances of each case. Greif Cos. V. Sipe, 16 Va. App. 709, 715 (1993) (citing Great Atl. & Pac. Tea Co v. Bateman, 4 Va. App. 459, 467 (1987).

To try to help parties understand what valid marketing is, the Commission provides Guideline on Looking for Light Duty Work. These are seven guidelines that the Commission has advised it will consider when looking at marketing issues in a case. However, each case is reviewed on its own merits and claimants are not required to meet each guideline to prove marketing.

In the recent Court of Appeals case of Loudoun Cnty. Pub Schhs v. Hernandez, No 0870-20-4 (Va. Ct. App. Jan. 12, 2021) Court of Appeals affirmed the Full Commission's decision that the claimant reasonably marketed her residual work capacity. The Court of Appeals stated that while the marketing guidelines are helpful, the marketing guidelines are just that, guidelines. They are not Rules of the Commission nor are they statutes. As such, even though the claimant fell short of a number of the guidelines (less than 5 job contacts a week, failed to register with the VEC) the Courts still found her marketing efforts valid for this case given her background and efforts.

# And You Thought You Knew Everything

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**You may be able to obtain approval of $0 MSAs from CMS in cases with significant future medical needs if the carrier strongly disputes the compensability of the claim and other criteria are met.**

In disputed cases involving significant future medical treatment, odds of settlement may improve if counsel for the claimant and employer/insurance work together to submit proposals to CMS for approval of $0 MSA allocations. In order for a $0 MSA to be approved, certain key criteria should be present. First, the expectation would be that the carrier would have never made any payments (either indemnity or medical) toward the claim. However, there may be circumstances in which certain initial voluntary payments made during an investigation period could still survive an application for a $0 MSA. Additionally, evidence needs to be provided to CMS that the claim has never been accepted. Perhaps most importantly, evidence should be included with the application demonstrating a strong basis for denial of compensability either through a showing of strong contradictory medical evidence, or through a factual evidence demonstrating a strong factual defense to compensability.

Questions:

- At what thresholds do such proposals make sense from both a claimant perspective and a defense perspective?

- Are these only truly available in high value cases subject to CMS approval?

**Where the death presumption does not apply, circumstantial evidence may be insufficient to establish that an accident arose out of the employment.**

Virginia Code § 65.2-105 does not apply the death presumption where an employee dies from his injuries sustained after an accident, but regains consciousness after the accident. "Where the death presumption does not apply, the claimant has the burden of proving by a preponderance of the evidence that the decedent's fatal heart attack arose out of and in the course of his employment and that the conditions of the employment caused the injury." Puller v. Fairfax Sch. Bd., No. 0886-11-4, 2011 Va. App. LEXIS 379 (Ct. App. Dec. 6, 2011)

In Hazelwood v. Via Satellite, Inc., Record No. 0389-21-2 at 10 (2021), the decedent was driving a work van in the course and scope of his employment when he crossed the center line of the road in the middle of a curve and crashed head on into a tractor trailer coming from the opposite direction. The decedent sustained serious injuries, but survived in critical condition for eight months after the crash. He did regain consciousness, but he never gave a statement as to how or why the crash occurred. It was stipulated that the crash occurred in the course of his employment and that his death was the result of injuries he sustained in the crash.

Claimant hired an expert to opine that the decedent's speed through the curve, which was recorded by a GPS device within 90 seconds prior to his death, exposed him to a risk of overdriving the curve and crossing the center line due to the fact that the speed limit was not the recommended safe speed for the curve. The expert opined that the decedent's speed was the cause of his crash to a reasonable degree of engineering certainty. Despite this, the Commission found the Claimant's evidence to require "speculation" as to the cause of the crash. On appeal, the Virginia Court of Appeals affirmed holding that the record supported Commission's ruling that reliance on Plaintiff's expert and circumstantial evidence would require the Commission to speculate as to the cause of the crash. Hazelwood v. Via Satellite, Inc., Record No. 0389-21-2 at 10 (2021).

Questions:

- Under what circumstances would an unwitnessed work accident, where the Claimant is not entitled to the death presumption, but dies before giving testimony, be able to present circumstantial evidence that rises above "surmise or conjecture?" City of Waynesboro v. Griffin, 51 Va. App. 308, 314-315 (2008).

- Based on this ruling, should employers reconsider taking recorded statements in serious injury cases where there are no witnesses to a crash?

**Can an Employer's Application be filed to terminate a presumed or potential *de facto* award?**

"The *de facto* award doctrine applies only when the employer has stipulated to the compensability of a claim, has made payments to the employee for some significant period of time without filing a memorandum of agreement, and fails to contest the compensability of the injury. Only then is it reasonable to infer that the parties have reached an agreement." Lysable Trans., Inc. v. Patton, 57 Va. 408, 415 (2010).

Questions:

- Does filing of such an application implicitly acknowledge the existence of an "agreement" preceding the date of the filing?

- How does the filing of such an application mesh with Rule 1.4(C) "Compensation shall be paid..."

**Medicaid liens (probably) do not apply to workers' compensation settlements.**

Va. Code § 65.2-700 vests the Commission with jurisdiction to determine all questions arising under the Act. The Commission has exclusive jurisdiction to resolve disputes concerning attorney's fees and physician and hospital charges in covered workers' compensation cases. Va. Code §65.2-714. Section 65.2-714(C) provides that payment pursuant to Act discharges the obligation in full.

Va. Code § 65.2-531(A) states that all compensation is exempt from claims of creditors except for claims of child & spousal support.

However, Va. Code § 32.1-325.2(B) provides that the "Department of Medical Assistance Services shall be the payor of last resort to any insurer, including a group health plan as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a health services plan, a service benefit plan, a health maintenance organization, a managed care organization, a pharmacy benefits manager, or other party that is, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service for persons eligible for medical assistance in the Commonwealth."

Va. Code §32.1-325.2(C) provides that when "the Department of Medical Assistance Services has made payment for medical services where a third party has a legal obligation to make payment for such services, the Commonwealth shall automatically acquire all rights to such payment from the third party."

In Budnick v. Murphy Brown Waverly, VWC File No. 223-47-49 (Full Commission, 9/1/2010), Medicaid had paid a bill for treatment provided to the claimant at MCV Hospital. The claimant filed a claim for payment of the MCV bill in its entirety. The Full Commission first found that the defendants were responsible for the services provided by MCV. "The issue before us is how much the defendants must pay for the claimant's care at MCV since Medicaid has already paid a portion of that bill. If a third-party health care insurer had paid the bill, we would order the defendants to pay the entire bill, forcing the health care provider to reimburse the health care insurer. Medicaid is not a third-party health care insurer. The federal and state laws regarding Medicaid require a different outcome." Id. at 8.

"The claimant was entitled to Medicaid assistance, and MCV accepted that payment and cannot request additional payment from the claimant or the defendants. We find that the claimant cannot create an obligation which MCV could not create in a direct claim to the Commission. We find that federal and state statutes prohibit MCV from receiving payment from the defendants beyond the amount Medicaid has paid. DMAS can seek payment from the defendants. **Our ruling stands on the conclusion that DMAS cannot seek payment from the claimant**. We, therefore, affirm the Deputy Commissioner's determination that the defendants are responsible for the claimant's bill at MCV and reverse the Deputy Commissioner's award which required the defendants to pay the unpaid balance of that bill. The defendants are not required to make any payments to MCV, and we do not have jurisdiction to order them to pay DMAS/Medicaid directly." Id. at 10 (emphasis added).

**Questions:**

- Is the Commission's holding in Budnick more binding with regard to DMAS should it assert a claim directly against an injured worker?

- Can claimant and defense counsel relay on this in advising their respective client's regarding DMAS potential interests?

- What does the absence of federal or state guidance on this issue mean?

# And You Thought You Knew Everything

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# THE GOING AND COMING RULE REFRESHER

GENERAL PRINCIPLE

The rule stands for the proposition that employers are *not liable for injuries sustained by employees while traveling to or from work.* Ramey v. Bobbitt, 250 Va. 474, 478, 463 S.E.2d 437, 438 (1995). This is because they are not engaged in their employment at the time of the accident.[1]

In all of the cases, it is easy to see that the Courts and the Commission are struggling with the line of where work ends and one's personal "time" begins. This next iteration of a job's location, "work from home," will have further blurring effects on the boundary lines. Blurring effects that the Courts and the Commission will struggle with for the foreseeable future.

Analysis in these cases has remained pretty consistent since the first significant Supreme Court case on the matter even though the modes of travel have completely changed.

[1] However, "employment includes not only the actual performance of the work but also 'a reasonable margin of time and space necessary to be used in passing to and from the place where the work is to be done.'" Ramey v. Bobbitt, 250 Va. 474, 477, 463 S.E.2d 437, 439 (1995).

## EXCEPTIONS THAT REMOVE ANALYSIS FROM GOING AND COMING RULE

Before the analysis can even begin on the exceptions to the going and coming rule, there are a couple of "exceptions" that apply to actually remove the case from the going and coming rule analysis. The claimant, if they fit into one of these exceptions are not on their way to or from work, they are working. They include the nature of the employment and also the nature of the area where the injury occurred.

### STREET HAZARD

The going and coming rule would not apply to an employee who is:

> one of a class of employees **whose duties of employment require their presence or travel upon the public streets** and are covered from hazards incident to that presence or travel by workers' compensation.

Sentara Leigh Hosp. v. Nichols, 13 Va. App. 630, 634, 414 S.E.2d 426, 428 (1992) (rehearing en banc). This would clearly apply to truck drivers, cab drivers, bus drivers, police officers and essentially anyone who's job requires significant amounts of travel on the road. The exception becomes less clear for those who travel often for their jobs, but where the actual job is something other than driving (nursing, sales, etc...) as seen in Sentara Leigh.

### EXTENSION OF THE PREMISE

Covers injuries that occur outside of the four corners of the employer's property, but are for all intents and purposes used solely for work.

> For example, if a parking lot [neither owned nor maintained by an Employer but used exclusively by the employer's employees] where an accident occurred is considered an "extension of the employer's premises," then the going and coming rule does not bar compensability.

Somoza v. Daniel T Whang OD LLC, Jurisdiction Claim No. VA00001732701 (Apr. 6, 2021) (referencing Barnes v. Stokes, 233 Va. 249 (1987). Again, although the employee may be "going to" work by walking into the employer's site, it doesn't really implicate the going and coming rule because the employee is considered already on the premises. "[I]f an employee is injured while going to and from his work and while on the employer's premises, the injury is treated at law as though it

happens while the employee is engaged in [her] work at the place of its performance." Hunton & Williams v. Gilmer, 20 Va. App. 603, 605, 460 S.E.2d 235, 236 (1995).

## MAIN EXCEPTIONS TO THE GOING AND COMING RULE

If the claimant is on their way to or from work, then the analysis may continue here. The claimant must fit into one of the exceptions below:

1) Where in going to and from work the **means of transportation is provided** by the employer or the **time consumed is paid for** or included in the wages;[2]
2) Where the way used is the **sole and exclusive way of ingress and egress** with no other way, or where the way of ingress and egress is constructed by the employer; or
3) Where the employee on his way to or from work is **charged with some duty or task** in connection with his employment.[3]

GATX Tank Erection Co. v. Gnewuch, 221 Va. 600, 603–04, 272 S.E.2d 200, 203 (1980) (citing Kent v. Virginia-Carolina Chemical Co., 143 Va. 62, 66, 129 S.E. 330, 331-332 (1925)).

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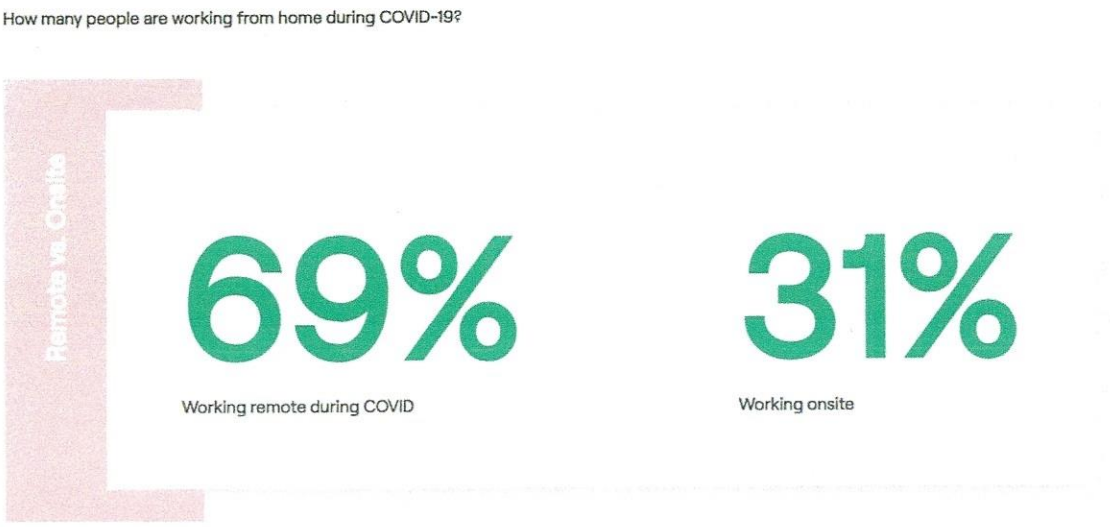
[2] But see LeWhite Const. Co. v. Dunn, 211 Va. 279, 283, 176 S.E.2d 809, 812–13 (1970) ( "employee furnished transportation by his employer, absent express or implied agreement or custom incidental to the employment contract, is not covered by the Act unless such transportation is beneficial to the employer"); Bristow v. Cross, 210 Va. 718, 720–21, 173 S.E.2d 815, 817 (1970) ("An injury sustained by workman who is provided with transportation to and from his work arises out of his employment when such transportation is the result of an express or implied agreement between employer and his employee or where the transportation is furnished by custom to the extent that it is incidental to and part of the contract of employment or when it is the result of a continued practice in the course of the employer's business which is beneficial to both employer and employee")

[3] The third exception is generally referred to as the "special errand" exception. Tierseron v. Circuit City Stores, Inc., VWC File No. 204-06-00, (June 6, 2002).

## WORK FROM HOME AGE




OwlLabs 2020 Report. Click on the above image to link to the full report.

Everyone is sick of hearing about Covid, but it clearly accelerated what was already occurring in the modern workforce, which is that professional services employees are working from home at least part of their work week on a massive scale. As many as 40 million workers in the United States expect to be somewhat or fully remote permanently within the next 5 years.

## PAST CASES DEALING WITH WORK FROM HOME ISSUES

Tierseron v. Circuit City Stores, Inc., VWC File No. 204-06-00, (June 6, 2002)

Claimant worked as a database engineer, who worked from the office, but also had a home office with a personal computer loaded with software from the Employer. Employer also supplied a modem and two pagers. During one particularly tough project, the claimant worked all day on it, left the office, and continued to work on the project at home. While on the way, the claimant was involved in a single vehicle accident when his vehicle slipped off the road.

The Commission started by stating "[i]n considering this matter, we must determine whether the claimant's "home office" is a worksite to the extent that traveling

from the home office to his regular place of employment should be considered traveling between two worksites"

Because the employer offered a cubicle at the office, the Commission determined that the employer's accommodation of his home office was a convenience to both but NOT a necessary element of employment. Because he had the option to work from the office, he thus chose to work from home on this particular occasion, so he was not traveling between worksites.

The Commission then said, since he was going to work, he must fit an exception. The Commission stated he did not fit exception 3 from above (the special errand exception) because he didn't need to go to the office that night to pick it up. There wasn't enough evidence that there was pressure or he was required to get the document that night. Benefits denied.

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Miller v. Walsworth Publ'g Co., Inc., VWC File No. 214-44-83 (Aug. 10, 2004)

The claimant, who worked from home, slipped on ice in her driveway. She was leaving her home office, on the way to get into her car to drive to a client meeting when she slipped. The ice was found to be a condition of the work place and her accident was compensable. Benefits granted.

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B&H Constr., Inc. v. Baker, Va. Ct. App. No. 1205-05-2, at *1 (Va. Ct. App. Apr. 25, 2006)

The claimant was the president and sole stockholder of the business. He operated his workplace out of a garage at his home. He was sitting in a chair on wheels which he pushed back from his desk and it flipped over, injuring him. He believed that the chair's rollers got stuck on a carpet a few inches behind his desk. The Commission found this accident arose out of the employment because the danger of the chair's wheels getting entangled in the rug behind his desk was a unique hazard of the claimant's employment. Benefits granted.

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Indep. Life & Acc. Ins. Co. v. Johnson, No. 0211-94-2 (Va. Ct. App., 1994)

> The employee worked out of his home in Crozet, Virginia, as an outside salesman for the employer. The employer's insurance agents were scheduled to meet in Fredericksburg, Virginia, every Friday at the company office to receive their premium collections for the week and were given a computer printout of accounts that were to be serviced during the following week. On Friday, January 31, 1992, the employee was injured in a motor vehicle accident, which occurred on the direct route between his home basein Crozet and the company office in Fredericksburg. The evidence established that the employee's primary workplace was his home office. Benefits granted

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Ashe v. Department of State Police, 66 OIC 39 (1987)

Claimant was a police officer who was "on call." He slipped and fell on ice while walking down his driveway to put documents in his patrol car. Benefits granted.

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# And You Thought You Knew Everything

06.09.2022

Jesse Narron
Partner
Penn Stuart
8550 Mayland Drive, Suite 100,
Richmond, VA 23294

# ATTACHMENTS

VIRGINIA:
IN THE WORKERS' COMPENSATION COMMISSION

**CORRECTED**[1]
Opinion by NEWMAN
Commissioner

**Oct. 5, 2021**

KENNETH ELLIOTT v. SAM GREEN VAULT CORPORATION
CINCINNATI INS CO (THE TRAVELERS), Insurance Carrier
THE CINCINNATI INSURANCE CO, Claim Administrator
Jurisdiction Claim No. VA00001108316
Claim Administrator File No. 2505897 TC
Date of Injury: August 16, 2015

Gregory P. Cochran, Esquire
For the Claimant.

Christopher M. Kite, Esquire
Roberta A. Paluck, Esquire
For the Defendants.

REVIEW on the record by Commissioner Marshall, Commissioner Newman, and Commissioner Rapaport at Richmond, Virginia.

The Deputy Commissioner's March 29, 2021 Opinion denied the claimant's application seeking physical therapy, finding that the subject referral was for purposes of obtaining a functional capacity evaluation to establish a permanent partial disability rating to the claimant's injured leg. The claimant requests review.[2] We REVERSE.

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[1] This Corrected Opinion replaces the Opinion issued on October 5, 2021, correcting the Deputy Commissioner's Opinion date from March 3, 2021 to March 29, 2021 in the Conclusion on page 11 . The issue date and time for filing an appeal remain the same.

[2] Considering the issues involved and the complete record developed at the hearing and before the Commission, we find oral argument is utnnecessary and would not be beneficial in this case. Va. Workers' Comp. R. 3.4; *see Barnes v. Wise Fashions,* 16 Va. App. 108, 112(1993).

## I. Material Proceedings

The claimant sustained a compensable injury to his left leg on August 16, 2015. The Commission entered an August 31, 2016 Award providing for a period of compensation and medical benefits. Presently before us is the claimant's November 3, 2020 application, seeking authorization for physical therapy. The defendants disputed responsibility for the treatment contending it was not for medical treatment but solely for the claimant to undergo a Functional Capacity Evaluation (FCE) to obtain a permanent partial disability rating. The Deputy Commissioner agreed and on the strength of existing Commission authority, held that the defendants were not responsible for the physical therapy referral.

## II. Findings of Fact and Rulings of Law

The claimant was working for the employer as a grave digger on August 16, 2015, when a tombstone toppled over and fell on his left leg, causing a tibia fracture. He underwent surgery and thereafter began treating with Dr. Seth Yarboro at UVA Health System. Dr. Yarboro performed a second surgery on September 8, 2017, and inserted screws to stabilize the fractured bone. A third surgery was performed on January 17, 2019 to remove one of the screws. According to the claimant's position statement "Except for a short period following removal of the screw, Claimant has been working at his regular gravedigging job without specified restrictions since December 15, 2015." (Cl.'s Pos. S. 2.)

The claimant returned to Dr. Yarboro on May 11, 2020, with a complaint of sharp anterior left knee pain aggravated by short periods of quick ambulation. Dr. Yarboro noted the claimant was otherwise largely asymptomatic. X-rays demonstrated a healed distal tibia fracture without complicating features. Dr. Yarboro assessed persistent left knee pain and opined the claimant had

reached maximum medical improvement. Dr. Yarboro wrote: "Tibia well healed, patient has anterior knee pain related to this injury. Plan FCE, Impairment rating since at MMI with persistent difficulty. No other intervention planned." The claimant was provided a work note. His weight bearing status was listed as weight bearing as tolerated on the left lower extremity. The After Visit Summary included the following:

> PLAN:
> Discussed that patient has reached MMI, FCE and impairment rating ordered.
> Work note provided today
> WB status: WBAT LLE
> F/u appt as needed
> ---
> Referrals placed today
> Ambulatory referral to Physical Therapy
> Multiple visits requested (expires 6/11/2021)

Dr. Timothy Hoggard in Dr. Yarboro's office completed an Ambulatory referral to Physical Therapy on May 11, 2020. The form indicates the following reason for referral: "Workers compensation case. Patient has reached MMI s/p left tibia IM nail. Please complete impairment rating." Under Referral Type, the note states "Consult and Treat." Dr. Hoggard also completed a return to work Order stating: "Patient has reached MMI. FCE and impairment rating ordered today."

On December 23, 2020, Dr. Hoggard responded to claimant's counsel's questionnaire. He indicated that the physical therapy referral dated May 11, 2020, "remains valid and still in effect."

The claimant requested authorization for the physical therapy ordered by Drs. Yarboro and Hoggard. The Deputy Commissioner denied the request. She held:

> The claimant seeks authorization for physical therapy. The defendants denied the claimant's claim on the grounds that the physician's referral was only for a disability assessment.

> Generally, a visit to a physician for the sole purpose of providing a disability rating does not constitute medical treatment under Virginia Code § 65.2-603 and is not the responsibility of the employer. *See Thompkins v. DBHDS/E. State Hosp.*, JCN 2388388 (Feb. 19, 2014); *Harris v. Cnty. of Henrico*, JCN VA010-0242-5961 (June 22, 2011); *Anderson v. Atl. Waste Disposal*, VWC File No. 218-46-84 (Mar. 15, 2006); *Morgan v. Proffitt's, Inc.*, VWC File No. 180-18-10 (Dec. 28, 2005).
>
> If the purpose of the permanency rating evaluation is not related to treatment but to support the claimant's claim for additional benefits under the Act, it is not the employer's responsibility. *Sutherland v. Craft Mach. Works, Inc.*, VWC File No. 194-35-92 (May 28, 2004) (citing *Gaylor v. Altadis USA*, VWC File No. 206-55-56 (July 21, 2003).
>
> Thus, where the evaluation is not "part of ongoing care or as a follow-up to ongoing care," but instead solely to obtain a permanency rating, it is not considered medical care under Virginia Code § 65.2-603. *Id.*
>
> In the instant case, there is no dispute that the claimant received a referral to physical therapy. We have reviewed Dr. Hoggard and Dr. Yarboro's medical records including their responses to the claimant's questionnaires. Upon careful review, we find the evidence preponderates to show that that (sic) the purpose of the referral to physical therapy was so an FCE could be conducted to provide an impairment rating. We find it significant that Drs. Hoggard and Yarboro concluded that the claimant's injuries have reached maximum medical improvement. They provided no reason why therapy was ordered. We do find the purpose of the referral to physical therapy, the FCE, or the impairment rating was medical treatment for the claimant's compensable injuries. Accordingly, we DENY the claimant's November 3, 2020 claim seeking authorization and payment of physical therapy.

(Op. 4-5.)

On review, the claimant argues that the defendants should be held responsible to pay for the claimant's additional course of physical therapy and assessment as ordered by the treating physicians. The claimant argues that the Deputy Commissioner erred in concluding that the record showed the referral was for an FCE only. Instead, the claimant asserts that the record as a whole