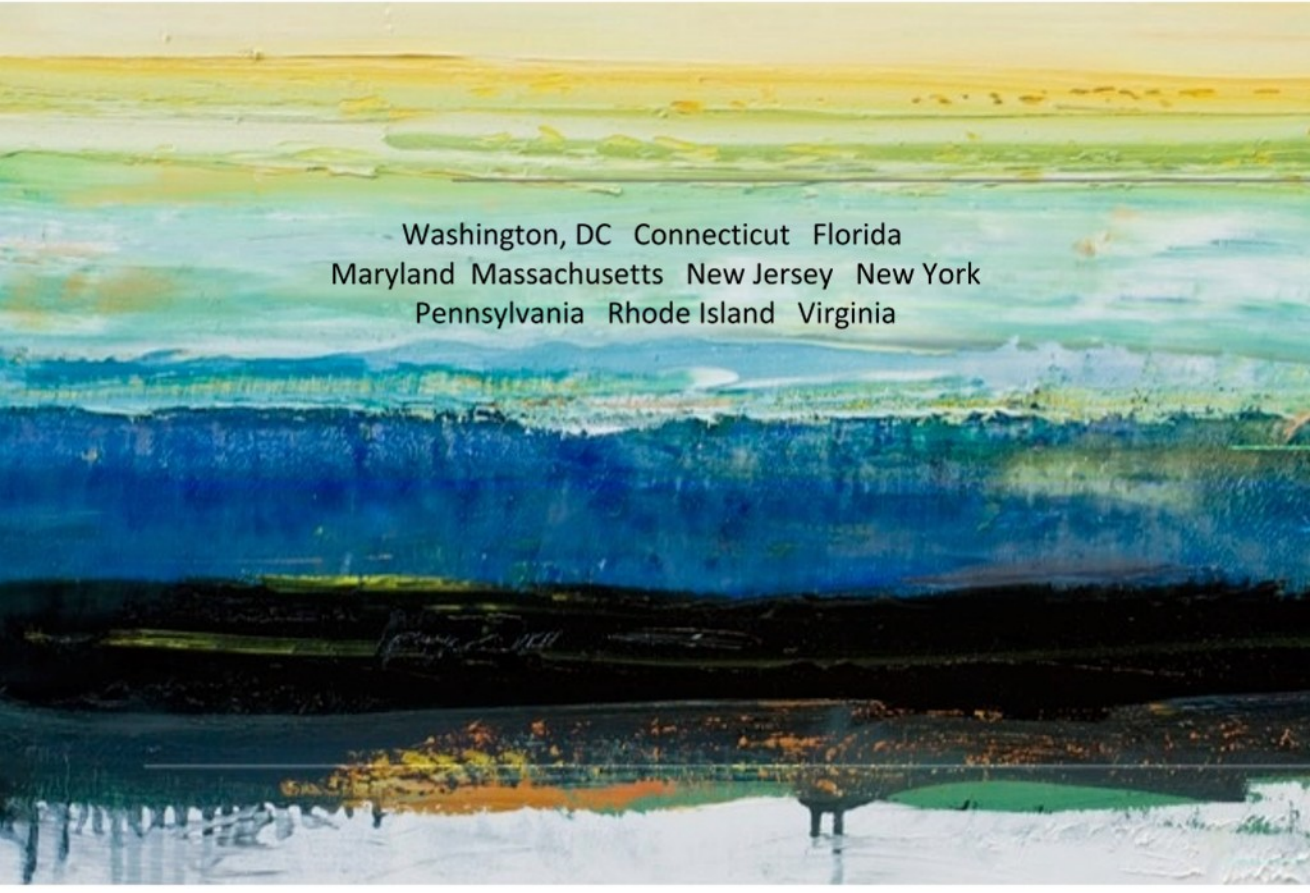
KIERNAN TREBACH



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About Us

Kiernan Trebach is a mid-sized law firm with offices throughout the Northeast and Mid-Atlantic regions of the United States – from Maine to Florida.

Kiernan Trebach represents the evolution of a firm founded in the 1980s that was structured to ensure its vitality and success long after the careers of its founding members. Kiernan Trebach began as a small insurance defense and coverage firm with one primary client. In the ensuing decades, we have grown by demonstrating to our clients that we can achieve better results in a more cost-effective manner than many of our competitors. We pride ourselves on evaluating cases for early resolution to provide certainty and cost containment for our clients. When a case cannot be resolved, we have the talent and experience to litigate the case through trial and appeal, if necessary.

Kiernan Trebach began in 1989 with a single office in Washington, D.C. and a handful of attorneys. We are proud of our progress through the years, maturing into a firm of more than 100 attorneys with offices throughout the Northeast and Mid-Atlantic states. We have focused on a slow and sustainable growth process to create a diverse working environment, while remaining sensitive to the needs of our employees and their families. Kiernan Trebach has become respected for our effective defense of clients ranging from Fortune 100 companies to individuals and small business owners. We take pride in knowing our clients, understanding what they want, and exceeding their expectations.

Kiernan Trebach's clients rely on the firm's expertise to manage risk in major cases throughout the country. We have a proven record as dedicated litigators who are mindful of the financial and business impacts of litigation. Our practice is devoted exclusively to the representation of corporations, insurers, and self-insureds. We are actively engaged in advising and counseling clients on risk management, claim resolution, insurance coverage, and every aspect of defense-related litigation.

Kiernan Trebach's focus on the client has allowed us to establish lasting relationships with clients who rely on us whenever they need counsel, for matters large and small. Kiernan Trebach's client partners include well known entities such as McDonald's Corporation, Howard University, Amtrak, Target, UPS, and some of the most respected insurance companies in the world.

If you are a current client, we thank you for your support and loyalty throughout the years. If you are looking for a law firm who will partner with you and work to achieve your goals, we would welcome the opportunity to meet with you.

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Practice Areas

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Construction
Workers Compensation

Education

University of Maryland School of Law, J.D., with Honors, 1990
University of Wisconsin, Madison, Bachelor of Science, 1987

Court Admissions

District of Columbia
Maryland
District of Columbia Court of Appeals
Court of Appeals of Maryland
United States District Court for the District of Columbia
United States District Court for the District of Maryland
United States Court of Appeals, District of Columbia Circuit
Supreme Court of the United

Experience

David M. Schoenfeld is the Senior Workers' Compensation Partner in the Washington, D.C. Office. He has nearly thirty years of experience in workers' compensation insurance defense matters and in the representation of home builders in construction related concerns.

Mr. Schoenfeld represents large national carriers, local carriers, self-insured's and home builders before administrative agencies, court trials and before the appellate courts in Maryland and the District of Columbia. Many appellate matters he has handled have positively impacted the interpretation of the law in his practice area.

Mr. Schoenfeld is a graduate of the University of Wisconsin, Madison (1987), and the University of Maryland School of Law, with Honors (1990). While in law school, Mr. Schoenfeld served as an Asper Fellow for the Honorable Joseph Howard, Judge on the Federal District Court in Baltimore. Bar admissions include the Supreme Court of the United States, Maryland Court of Appeals, District of Columbia Court of Appeals, Federal District Court of Maryland, and Federal District Court for the District of Columbia.

Mr. Schoenfeld served for three years as the President of the Associate of Compensation Insurance Attorneys, Co-chaired the Workers' Compensation Section for the Montgomery County Bar Association and served as the Section Chair for the Law Firm

States of America

Professional Affliations

Past President, Association for Compensation Insurance Attorneys, 2005-2008
Co-Chair, Worker's Compensation Section, Montgomery County Bar Association, 2008 – 2009
Co-Host, Law School for The Public Television Program
Volunteer Judge, Teen Court, States Attorney Office, Montgomery County Circuit Court
"AV" Martindale-Hubbell; Peer Review Rated
10/10 "Superb AVVO Rated SuperLawyer Awarded Workers' Compensation Ins. Defense Lawyer of the Year in Washington, DC, 2019 & 2020 – Global Law Experts

Management Section for the Montgomery County Bar Association for three years. Mr. Schoenfeld was honored to have been selected as a Bar Leader of the Montgomery County Bar Association. He appears regularly as a Host of the Law School for the Public Television Program produced by the Montgomery County Bar Association and is a volunteer Montgomery County Circuit Court Judge for Teen Court, a diversionary juvenile criminal court administered by the Montgomery County State's Attorney's Office.

Mr. Schoenfeld is Martindale Hubbell Peer Review "AV" (Preeminent) rated; AVVO "Superb" 10/10 rated, has been selected as a Washington DC Super Lawyer and is Global Law Experts 2019 and 2020 recipient for the Workers' Compensation Ins. Defense Lawyer of the Year in Washington, DC. He has been selected as a presenter at numerous continuing education seminars. In 2017 Mr. Schoenfeld was honored to receive the William Neal Award for Volunteerism from State's Attorney John McCarthy for his service to the Montgomery County Teen Court and in 2019 Mr. Schoenfeld was further honored to receive the Community Service Award from the Montgomery County Bar Foundation for his service as a Host on the Law School for the Public television series.

LISA A. ZELENAK

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Practice Areas

Alternative Dispute Resolution
Transportation
Workers Compensation

Education

The Catholic University of America, Columbus School of Law, J.D., 2002
Indiana University of Pennsylvania, B.A., 1999

Court Admissions

District of Columbia
Maryland
Virginia
U.S. District Court of Maryland

Experience

Lisa is a partner in the firm’s Washington, DC office. Lisa has been practicing workers' compensation and employment law for over 20 years, both in private practice, and as in-house counsel to an insurance company.

Lisa represents both national and local insurance carriers, self-insureds, third-party administrators and employers in all aspects of industry from retail to construction. She has extensive experience appearing before administrative agencies, and trial and appellate courts.

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Practice Areas

Alternative Dispute Resolution
Construction
Employment
Workers Compensation

Education

Walter F. George School of Law, Mercer University, J.D., 1981, Delta Theta Phi
Wake Forest University, B.A., cum laude, 1978

Court Admissions

District of Columbia
Maryland
U.S. Court of Appeals District of Columbia
U.S. Court of Appeals for the Fourth Circuit
U.S. Court of Appeals for the Fifth Circuit
U.S. District Court for the District of Columbia
U.S. District Court for the District of Maryland
U.S. District Court Eastern District of Virginia
U.S. District Court Western District of Virginia

Experience

Doug is a Partner in Kiernan Trebach's Rockville, Maryland office. Prior to joining Kiernan Trebach, Mr. Datt practiced for more than 30 years with a firm he co-founded in 1992. He is an experienced trial attorney and counselor working on behalf of both businesses and individuals. His excellent legal abilities translate not only to satisfied clients, but also to recognition by his peers.

Doug began his legal career as an Assistant District Attorney in the Atlantic Judicial Circuit in Hinesville, Georgia. After gaining valuable trial experience prosecuting major felonies, he returned to Maryland in 1983 where he served as Assistant State's Attorney for Charles County, MD. Doug was responsible for prosecuting a variety of crimes including murder, rape, child abuse and theft-related offenses, among others.

Doug's civil litigation practice includes advising clients and litigating in the areas of personal injury, construction defects and accidents, breach of contract, workers' compensation and general tort defense litigation. Doug regularly counsels corporate and business clients on a variety of complex issues in matters ranging from collections, breach of contract, corporation formation, asset sales, purchases, employment-related issues, and responses to government subpoenas. Doug is a court-appointed mediator for the District of Columbia Court of Appeals, providing mediation services in Workers' Compensation

Professional Affliations

Maryland Bar Association
Montgomery County Bar Association
DRI

cases, and also mediates cases privately for parties.

Notable Matters

- Cheeks of N. Am., Inc. v. Fort Myer Constr. Corp., No. 11-7117, 2012 U.S. App. LEXIS 15496 (D.C. Cir. July 26, 2012)
- EEOC v. Conn-X, LLC, Civil Case No. L-09-2881, 2012 U.S. Dist. LEXIS 16316 (D. Md. February 8, 2012)
- Bastian v. D.C. Dept. of Employment Services, 16 A.2d 975 (D.C. 2011)
- Mackey v. D.C. Dept. of Employment Services, 976 A.2d 224 (D.C. 2009)
- Capitol Paving of D.C., Inc. v. District of Columbia, 496 F. Supp. 2d 54 (D.D.C. 2007)
- Dillon v. D.C. Dept. of Employment Services, 912 A.2d 556 (D.C. 2006)
- D.C. Water & Sewer Auth. v. D.C. Dept. of Employment Services, 843 A.2d 750 (D.C. 2004)
- Hudson Trail Outfitters v. D.C. Dept. of Employment Services, 801 A.2d 987 (D.C. 2002)
- Park Ctr, III Ltd. P'ship v. Pa. Mfrs. Ass'n Ins. Co., 30 Fed. Appx. 64 (4th Cir. 2001)
- Anderson v. Russell, 247 F.3d 125 (4th Cir. 2001)
- Glass v. State, 171 Ga. App. 156, 319 S.E.2d 60 (1984)
- White v. State, 169 Ga. App. 207, 312 S.E.2d 199 (1983)
- Holloman v. State, 168 Ga. App. 683, 310 S.E.2d 734 (1983)
- Holloman v. State, 167 Ga. App. 683, 307 S.E.2d 266 (1983)
- Blair v. State, 166 Ga. App. 434, 304 S.E.2d 535 (1983)
- Griffin v. State, 166 Ga. App. 176, 303 S.E.2d 514 (1983)
- Williams v. State, 165 Ga. App. 553, 301 S.E.2d 908 (1983)
- Petouvis v. State, 165 Ga. App. 409, 301 S.E.2d 483 (1983)
- Jones v. State, 165 Ga. App. 180, 300 S.E.2d 534 (1983)
- McKenzie v. State, 162 Ga. App. 522, 292 S.E.2d 722 (1982)
- Weathers v. State, 160 Ga. App. 581, 287 S.E.2d 565 (1981)
- Baxter v. State, 160 Ga. App. 181, 286 S.E.2d 460 (1981)

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Practice Areas

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Healthcare
Premises Liability
Workers Compensation

Education

The George Washington University, J.D., 2002
Fairfield University, B.S., 1999

Court Admissions

District of Columbia
Maryland
Virginia
U.S. District Court for Maryland
U.S. District Court for the Eastern District of Virginia
U.S. Court of Appeals for the Fourth Circuit
U.S. Court of Appeals for Veterans Claims

Experience

Kathleen has been representing clients in insurance defense and workers compensation matters for nearly twenty years, and has tried cases at the administrative, district, and circuit court levels. Her education and background in biology, as well as her five years working as a pharmacy technician prior to entering law school, have allowed Kathleen to provide specialized counsel to her clients on complicated medical and scientific issues. In addition, Kathleen has experience handling matters involving securities, telecommunications, veterans affairs, insurance coverage, guardianship, and business and commercial litigation.

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General Litigation
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Education

Loyola University New Orleans College of Law, J.D.
Health Law Certificate
George Washington University, BA Psychology, Public Health

Court Admissions

District of Columbia
Maryland
New York
U.S. District Court for the District of Columbia
U.S. District Court Western District of New York

Professional Affliations

New York State Bar Association
Maryland State Bar Association
American Health Lawyers Association
Haitian Lawyers Association

Experience

Gabriela Saint-Louis is an Attorney at Kiernan Trebach's Washington, D.C. office. Ms. Saint-Louis dedicates her practice to personal injury and health law. She is driven by a lifelong passion for helping others, as well as a commitment to securing the justice her clients deserve.

Gabriela was born in Haiti and grew up in New Orleans, Louisiana. She now calls Washington, D.C. home, having lived in the area for nearly 14 years. During her time in law school, Gabriela served as a student law practitioner in the family law clinic, helping indigent clients with issues such as child custody, child support, and divorce. She was also a member of the Trial Advocacy Program, a board officer of the Black Law Students Association, and both an inductee and a board member of the Phi Delta Phi Legal Honors Society.

Intellectual curiosity helped get Gabriela through law school, and it motivates her to find answers for her clients to this day. She is empathetic and understanding of what others are going through. As an immigrant, she understands what it is like to face significant legal challenges. In relating to her clients, Gabriela likes to put herself in their shoes. She tries to remember that, although she may have encountered situations similar to theirs many times, for that client, at that moment, it may be the worst thing that has ever happened, and that person is trusting her to fix it. This motivates her to do everything she can to help.

Gabriela likes to volunteer with a variety of local organizations. She has done volunteer work for Food and Friends, a community-based organization in D.C., preparing meals specifically tailored for individuals with serious illnesses. She has also volunteered periodically to help raise funds to build homes for homeless families and to provide meals for vulnerable and destitute people struggling with hunger in Haiti.

In her free time, Gabriela enjoys watching sports, as well as re-watching her favorite shows, cooking, and spending time with her friends and family. She is fluent in Kreyol (Creole) and French, as well as conversational in Spanish.

Notable Matters

- Successfully conducting over ten trials at both District and Circuit Court level
- Winning a two District Court verdicts

VIRGINIA WORKERS' COMPENSATION BASICS

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VIRGINIA WORKERS' COMPENSATION BASICS

1) History:

a) Virginia was the 37th State to pass a Workers' Compensation law in 1919. Found in 65.2 of the Virginia Code.

b) Approximately 98% of the Virginia work force is covered by the statute.

c) The Second Injury Fund was added in 1975 and amended in 1980 to encourage Employers to hire disabled workers.

d) The Uninsured Employers Fund is part of the statute.

e) Medical Costs Peer Review Program began in 1981 to provide a mechanism for the review of panel physicians as an alternative to the Commission. Only applies to Osteopaths.

2) The Commission:

a) **The Full Commission** - The Commission is referred to as the full commission when acting conjointly. The commission is overseen by three Commissioners elected by a joint vote of the General Assembly for six year terms. Not more than one member can be a prior representative or affiliate of Claimant's and not one can be a prior representative or affiliate of Employers.

b) **Chief Deputy Commissioner and Deputy Commissioners** - Are appointed by the Full Commission. They run the day to day operations of the Commission and conduct hearings on the record in disputed cases. The Chief Deputy Commissioner oversees the Deputy Commissioners.

c) **Six Regional Offices -** Hearings are held in the City or County where the injury occurred or in a contiguous City or County unless otherwise designated by the Commission.

d) **Rules of the Commission**: http://vwc.state.va.us/sites/default/files/documents/Rules-of-the-Commission.pdf

3) Employer/Employee Relationship:

a) **Insurance** -Any Employer who has three or more regular employees in the same business in Virginia must have Workers' Compensation Insurance. Regulars can include part time employees.

b) **Exclusions** - casual employees, domestic servants, farm and horticultural laborers, with certain exceptions.

c) **Election of Coverage** -Sole Proprietors, Partners may elect coverage for themselves even if not covered.

d) **Independent Contractors -** VA uses similar analysis as other states, right to hire, right to dismiss, obligation to pay taxes and power to control.

e) **Statutory Employer** - Can be liable for payment when immediate Employers are not insured. Usually applies in a subcontractor situation.

4) Accidental Injury:

a) **Definition**-Must arise out of and in the course of employment. Employee must prove an identifiable incident sustained at a reasonably definite time. Evidence concerning a group of multiple events not enough.

b) **Idiopathic Injuries-**not recognized by Virginia.

c) **Injuries by Co-Employees**- Assaults are not compensable unless it is proven that the assault was directed against the co employee as a result of the employment or the employees' status. An innocent victim of horseplay will be entitled to benefits.

d) **Unexplained Death During Employment** - Presumed to arose out of employment unless there is evidence to show the death occurred otherwise.

e) **Assaults by Third Parties** - if directed against the Claimant because of his employment it is compensable so long as the assault occurs while the employee is on or at least partially on the Employers business.

f) **Coming and Going Rule**- Applies in Virginia. Exceptions, special errand rule, personal comfort rule, etc.

g) **Burden-** Generally on the Claimant to Show that the relationship of the injury to employment. A medical opinion showing probability is sufficient but not possibility.

5) Defenses to Accidental Injury:

a) **Willful Misconduct -** Violation of a safety rule that caused the injuries. Employer must show that the safety rule was enforced and known by the Claimant.

b) **Intoxication -** rebuttable presumption of intoxication at the time of injury if the employee has a positive drug test for a no prescribed controlled substance of a BAC the equals or exceeds the statutory minimum for driving offenses. Presumption does not apply if employee dies. Can be rebutted with clear and convincing evidence and by showing it was not the proximate cause of the injury.

c) **Knowing violation of medical restrictions -** It is the Employee's responsibility to abide by his restrictions. However if the Employer knows of the restrictions and refuses to honor them this negates the defense.

d) **Fraud and Misrepresentation on Employment Application -** Really tough defense to win but available.

6) Occupational Diseases:

a) **Carpel Tunnel Syndrome and Hearing Loss** - May be compensable if diagnosed after July 1, 1997, as ordinary diseases of life. The standard to be used is clear and convincing not mere probability which is a higher standard. However, other similar conditions such as epicondylitis and tenosynovitis are not compensable if they result from cumulative trauma caused by repetitive motion.

b) **Communication of Diagnosis of Occupational Disease** - Is the Date of accident. The Employee must be diagnosed and told that it is related to his or her employment.

c) **Statute of Limitations** - Claim must be filed within two years from the date of the communication or five years from the date of the last injurious exposure whichever occurs first. Tolling provision if Employer fails to file first report does not apply here.

d) **Written Notice** - Should be given within 60 days but can be waived if no prejudice.

e) **Last Injurious Exposure** - Applies meaning last Employer exposing the Claimant to the harms of the OD can be responsible for the whole claim.

f) **Hernias -** Not Compensable as occupational diseases.

g) **Psychological Conditions-**Emotional harm following physical injury is compensable. With regard to mental mental cases the focus is on the individual case and whether what the person is experiencing is an ordinary disease of life or something specific to the employment.

h) **COVID-19 –** COVID-19 that causes the death of, or any health condition or impairment resulting in total or partial disability of, any health care provider, who as part of the provider's employment is directly involved in diagnosing or treating persons known or suspected to have COVID-19, will be presumed to be a covered occupational disease unless such presumptions are overcome by a preponderance of competent evidence to the contrary. This presumption does not apply if the Employer has offered a vaccine, unless the worker's physician determines in writing that the vaccine would pose a significant risk to their health. This provision was enacted on July 1, 2021, and is retroactive to January 1, 2020.

COVID-19 that causes the death of or any health condition or impairment that results in a total or partial disability for a firefighter, law enforcement officer, correctional officer, or regional jail officer is considered an occupational disease that was suffered in the line of duty. COVID-19 must be established by a positive diagnostic test for COVID-19, an incubation period consistent with COVID-19, and signs and symptoms of COVID-19 that require medical treatment. The presumption applies to a person entitled to invoke them if, prior to their employment and at the request of their Employer, they underwent appropriate testing and were found to be free of COVID-19 at the time of the examination. This provision applies to persons hired after July 1, 2021. The presumptions apply only to persons diagnosed with COVID-19 on

or after July 1, 2021 and whose death or disability occurred on or after July 1, 2021.

7) Benefits:

a) **Average Weekly Wage**

i) If employed in same position for a year or longer, than the AWW is calculated by dividing the employee's earnings by the 52 weeks prior to the accident by 52.

ii) If a period of 7 consecutive days or more were lost by the employee the lost time is excluded from the calculation.

iii) If employed for less than 52 weeks, the employee's total earnings are divided by the number of weeks and parts thereof that have been worked;

iv) If either of these methods is impractical or unjust, the AWW for the previous 52 weeks of a person employed in the same grade and under the same conditions, who works in the same class of employment, in the same locality or community, may be used and if this does not work the parties can agree on something.

b) **Wage Stacking-** Is permitted if the Employee is working two jobs at the time of the injury, but the employment must be of the same character.

c) **TTD-** 66 2/3 of AWW subject to State cap. Cap of 500 weeks.

d) **TPD and PPD (non-scheduled) -** Claimant has a duty to market any remaining work capacity. Paid at 66 2/3 of the difference between the Employee's AWW before and after the injury. Maximum of 500 weeks.

e) **Scheduled Loss-** The number of weeks that a Claimant receives TTD added to the number of scheduled loss weeks cannot exceed 500 weeks unless the injury occurred between 1991 and 1997. An Employee cannot receive both disfigurement and scheduled loss for the same body part.

Thumb	60 weeks
Index Finger	35 weeks

Second Finger	30 weeks
Third Finger	20 weeks
Little Finger	15 weeks
Great Toe	30 weeks
Any other Toe	10 weeks
Hand	150 weeks
Arm	200 weeks
Foot	125 weeks
Leg	175 weeks
Eye	100 weeks
Ear	50 weeks

f) **Permanent Total Capacity-** loss of both hands, both arms, both legs, both feet and both eyes is presumed to be PTD. 500 week limitations do not apply.

g) **Disfigurement**- Maximum of 60 weeks and is a legal opinion.

h) **Death Benefits**- Death must occur within nine years of the accident and the claim must be filed within two years of an employee's death. Maximum benefit of 10K for burial expenses allowed and 1K for body transportation.

i) **Total Dependency**- weekly payment of 66 2/3 of employee's AWW. Claimant must have relied on the contributions of the employee in whole or in part as a means of support and maintenance in accordance with social positions and accustomed mode of living.

ii) **Partial Dependency-** the Commission determines the benefit in proportion to the level of dependency.

8) Medical Benefits:

a) **Presumption in Favor of Treating Physician**

b) **Employer Must Provide Panel-** At least three different doctors from three different medical groups must be provided as promptly as possible or the employee can select a doctor of his or her choice.

c) **Employee Must Request Change in Treating Doctor from Commission or Employer**

d) **Travel** -to and from medical treatment is reimbursed at 55.5 cents a mile as of July 2021 (this rate has been in place since July 2011). Advance payment can be requested.

e) **Length of Benefits**- Benefits are lifetime for medical care.

f) **Peer Review**- Employer can Request by panel for treatment.

g) **Refusal of Medical Attention**- Can be grounds for termination of benefits but only if it is not reasonable.

h) **Vocational Rehabilitation**

- i) Must be certified providers
- ii) Can file voc dispute with the VWC
- iii) Claimant has a duty to market.
- iv) Claimants are given the opportunity to cure failure to accept job offers.
- v) Total disability not affected by incarceration.

i) **Fee Schedule**

- i) As of January 1, 2018, a Medical Fee Schedule (MFS) will be applied to health care services provided after that date, regardless of date of injury
- ii) MFS outlines maximum fees for health care services to injured workers
- iii) Exceptions to the MFS include services provided for traumatic injuries, serious burns, services subject to a separate written contract between a health care

provider and an Employer/insurance carrier, voluntary payments made in excess of the MFS, physician dispensed retail or mail-order pharmaceutical drugs, durable medical equipment dispensed through a DME retailer, and air ambulances.

iv) Health care services provided prior to the effective date of the MFS continue to be paid at a rate commensurate with a "customary fee in the area" for the particular service.

9) Settlements:

a) **Approved by Commission.**

b) No hearing required for Pro Se Claimant.

c) Closed medicals okay subject to normal CMS guidelines.

10) Claims Handling:

a) **Web file**- Can file documents 24 hours a day and be served online.

b) **Claims Reports**

i) **First report of injury-** (except for minor injuries must be filed within 10 days after notification) must be filed regardless of the severity of injury. A later report of medical or indemnity payments or decision to deny the claim is called a subsequent report of injury (10 days of the payment and then quarterly every 90 days from the month of the injury). Must be E-filed.

ii) **Minor injury-** is one where the injury does not meet ANY of the criteria below:

-time lost from work or partial incapacity exceeds 7 days

-Medical expenses exceed $1,000

-Compensability is denied or issues are disputed

-Medical reports indicated PPD or disfigurement

-a fatality occurred

-The Commission has requested additional details about the accident beyond those required to be reported in a typical minor injury.

First reports on minor injuries must be filed within 30 days of the notification by filing of a FROI UR. Less information is required in this report. However an Employer can voluntarily report a minor injury in the same way as a regular one.

c) **Penalties**

i) Up to $500 for failure to file a report

ii) Or up to $5000 if found to be done willfully.

11) Uncontested Claims:

a) If not contested, parties shall complete an award agreement and file with the VWC within 14 days of its execution and failure to do so is a 1K fine. The VWC approves. A party can withdraw consent anytime within 30 days after approval and a hearing is set.

b) Once an agreement is entered you must file documents to terminate it. No unilateral termination.

12) Contested Claims:

a) **Form**- Use of the claim form not required. Any form of document that contains sufficient information to assert a claim counts.

b) **Concurrent claims**- are allowed with VA and other states but credit is permitted.

c) **Statute of Limitations**- 2 years after the accident or claim barred forever. If Employer voluntarily pays for more than 6 months (indemnity or medical), limitations is tolled until the date of the last payment after 6 months. Limitations is also tolled if Employer fails to timely file the first report upon receipt of notice of injury; statute begins to run upon filing of the report. A showing of prejudice to the employee is not required in order for the statute to be tolled.

13) Medical Evidence:

a) Must promptly provide the other side with medical records. Must also be filed with the VWC if a hearing has been requested.

b) Claim will not be docketed until medical evidence is filed. Can be dismissed on Employer's motion if not filed within 90 days.

14) 20 Day Order:

a) Unless denied a 20 day Order is sent out to the insurer asking for their position. Response is not legally binding but if do not respond subject to a penalty.

b) If the Insurer accepts the case the VWC will pass an Order.

15) Employer's Application for Hearing:

a) Permitted

b) Usually to terminate Orders.

16) Discovery:

a) **Interrogatories and Depositions**- are allowed. Leave of VWC needed to take depositions of non-parties. Can take depositions of doctors without it.

b) **Subpoenas**- can be issued by lawyers and send out by lawyers in state only.

c) Requests for admissions allowed and requests for production.

17) Hearings:

a) Medical Reports come in.

b) Decisions issued as opinions in writing at a later date.

18) Awards:

a) **Late Payment**-must be made within 2 weeks after it becomes due or a 20% penalty will be added. The first day to be counted is the day following the award. This is discretionary and the VWC can waive if beyond Employer's control.

b) Must be made directly to the Claimant even if represented by counsel. If it is sent to counsel and counsel does not send it along the E/I is penalized.

19) Change in Condition:

a) **90 Day Rule**-Additional compensation cannot be awarded more than 90 days prior to the time the claim for change in condition is filed.

b) **TTD-** no review shall be made after 24 months have passed since the last TTD payment has been made.

c) **PPD -** 36 months from the last indemnity payment made.

d) **No Compensation Paid -** 36 months from the date of the injury.

e) **Wages paid for light duty -** Count as payment for the 24 month period, but only for 24 months.

20) Appeals:

a) **First Level** - Full Commission-Filed within 30 days and *stays* payment. No oral arguments unless the Commission requests it. On the record and appeal of right.

b) **Second Level**- Virginia Court of Appeals-Filed Within 30 days-Appeal of Right-No new evidence-do not pay on appeal but post $500 bond.

c) **Third Level**-VA Supreme Court-Cert must be granted.

d) Interest is added on appeal.

Claim Form

Access your claim online: webfile.workcomp.virginia.gov

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Injured Worker Information			Employer Information		
Name			Name of Company		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Primary Phone	Gross Weekly Earnings		Employer's Phone		

Injury

Date of Injury*	Where Injury Occurred (City or County)	Parts of Body Injured

How Injury Occurred

***If claiming an occupational disease** (use separate claim form for Coal Workers' Pneumoconiosis)**:**

Name of Occupational Disease	Date last worked for employer	Date doctor stated the disease was caused by work

Request for Benefits

I need assistance obtaining the following benefits. If the benefits are denied, this form will serve as a hearing request.

☐ Lifetime Medical Award (coverage for related medical expenses).

☐ Wage Loss Replacement (Temporary Total Disability - Completely out of work):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Wage Loss Replacement (Temporary Partial Disability - Partially out of work/light duty):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Compensation for Permanent Loss (Permanent Partial Disability):

☐ Loss of use of a body part ☐ Disfigurement/Scarring ☐ Amputation ☐ Hearing/Vision loss ☐ Lung disease

☐ Payment/reimbursement for the following expenses (attach medical records, itemized bills, receipts, or mileage log):

☐ Medical bills ☐ Mileage/Transportation ☐ Prescriptions

☐ Death benefits to dependents and/or funeral expenses.

☐ Other: _____

Signature

I hereby file this claim to protect my right to benefits under the Virginia Workers' Compensation Act for the injury or disease described above.

SIGNATURE (Required) PRINT DATE

Claim Form Process & Instructions

Injury

When an individual has experienced an injury or an occupational disease in the workplace, it is important to give immediate notice to the employer about the injury. Employers are required to file a First Report of Injury (FROI) within ten (10) days of having knowledge of any injury.

Ombudsman Office

Have questions about the Virginia Workers' Compensation Commission and no lawyer? Call the Ombuds Department at 833-448-1681, or email ombuds@workcomp.virginia.gov. We cannot give legal advice, but all conversations will be kept confidential.

Claim Form

Pursuant to Va. Code §65.2-601, a claim for specific benefits must be filed within two (2) years from the date of injury. Even if the Claim Administrator is voluntarily paying benefits, rights are not protected unless there is an Award Order.

Award Order

If the Claim Administrator accepts the claim, an Award Agreement is sent to the injured worker. Once signed by all parties, the Award Agreement must be filed with the Commission for entry of the Award Order. An Award Order protects the injured worker's rights to benefits.

Alternative Dispute Resolution (ADR)

Mediation is a voluntary and confidential informal dispute resolution process where a neutral third party (mediator) facilitates communication to assist the parties in mediating an agreeable solution. The purpose of mediation is to identify issues, clarify misunderstandings, explore solutions and mediate an agreement. For further information, contact the ADR Department at 804-205-3139.

Hearing

A hearing may be necessary to resolve disputed issues. A completed Claim Form and medical records* to support the claim must be filed for this to occur. The primary objective is to hear and decide disputed claims and issues arising under the Virginia Workers' Compensation Act in a prompt, fair and impartial manner.

*Medical Records & Subpoenas

Copies of medical records may be obtained from the physician. However, if copies of medical records and/or bills cannot be obtained, a subpoena can be requested by sending the name and address of the medical provider to the Clerk of the Commission. A $12 money order made payable to the Sheriff of the city or county where the medical provider is located must be included for each subpoena.

Benefits Covered under the Virginia Workers' Compensation Act

- **Lifetime Medical** - payment for medical treatment/expenses for the injury or occupational disease, now and in the future.
- **Temporary Total Disability -** wage loss replacement while completely out of work. Must be medically authorized.
- **Temporary Partial Disability -** wage loss replacement while partially out of work, or working light duty. Must be medically authorized.
- **Permanent Partial Disability -** compensation for loss of use of a body part, amputation, disfigurement/bodily scarring, loss of hearing, loss of vision or lung disease. Must be medically supported.
- **Medical Expenses -** payment/reimbursement of medical bills, or out of pocket expenses, such as prescription and mileage/transportation. Must provide bills, receipts and/or mileage logs.
- **Death Benefits -** payment/reimbursement of funeral/transportation expenses or wage loss replacement for surviving spouse, children, or certain other dependents. Death Certificate, Marriage License and/or Birth Certificate(s) must be provided.
- **Other -** benefits not previously mentioned (vocational rehabilitation, specific medical treatment/procedure, panel of physicians, etc).

Toll-Free: 877-664-2566 | **Online:** workcomp.virginia.gov | **Mail:** 333 E. Franklin St., Richmond, Virginia 23219

Virginia Workers' Compensation Commission

"I've been hurt on the job, now what?"

Workers' Compensation Claims Process

Task for: IW Injured Worker | E Employer/Insurer | C Commission | CA Claim Administrator

Report of Injury and Notification of Rights

Report to Employer (IW)

It is important to give immediate notice to your employer about your injury. If not done **within thirty (30) days** you may lose your rights to any workers' compensation benefits.

First Report of Injury (E)

Employers are required to file a First Report of Injury (FROI) with the Commission **ten (10) days** of having knowledge of any injury or death in the course of employment **(30 days for minor injuries).** This is not a claim and does not protect your rights.

Notification of Rights (C)

Once the Commission receives the FROI, the Commission will send the injured worker information about their rights and responsibilities.

Claim Filing & Process

File a Claim (IW)

When filing a Claim Form, the injured worker is free to pursue a claim through the Virginia Workers' Compensation hearing process. The injured worker should indicate the benefits sought and request a hearing.

30-Day Order (C)

Once a submitted claim is processed by the Commission, a 30-Day Order is sent out to all parties. The Claim Administrator is required to complete and return an Order Response Form to the Commission **within 30 days.**

Award Agreement (CA, IW, C)

If the Claim Administrator accepts the claim, an Award Agreement is sent to the injured worker. Once signed by all parties, the agreement must be filed with the Commission. The Commission will enter an Award Order which protects the injured worker's rights.

Award Order (C)

After the Award Order has been entered in the system, the Commission will send the Award Order to all parties.

Notice of Hearing (C)

If the Claim Administrator denies the claim, a hearing may be scheduled by the Commission if/once medical records are received; and a Notice of Hearing letter will be sent out to all parties.

Hearing Held (C, CA, E, IW)

A Deputy Commissioner hears evidence presented by both the injured worker and the employer/insurer at a hearing.

Decision Rendered (C)

A written decision, Judicial Opinion, is mailed to involved parties after a case is heard and the record is closed.

If you need additional information regarding the hearing process, please contact the Commission at 1-877-664-2566 **www.workcomp.virginia.gov**

Virginia Workers' Compensation Commission

"My claim has been denied, now what?"

Disputed Workers' Compensation Claims Process

Task for: IW Injured Worker | E Employer/Insurer | C Commission | CA Claim Administrator

Report of Injury and Notification of Rights

- Report to Employer (IW)
- First Report of Injury (E)
- Notification of Rights (C)

See front page for additional details.

Claim Filing & Process

File a Claim (IW)	When filing a Claim Form, the injured worker is free to pursue a claim through the Virginia Workers' Compensation hearing process. The injured worker should indicate the benefits sought and request a hearing.
30-Day Order (C)	Once a submitted claim is processed by the Commission, a 30-Day Order is sent out to all parties. The Claim Administrator is required to complete and return an Order Response Form to the Commission **within 30 days.**
Notice of Hearing (CA IW C)	If the Claim Administrator denies the claim, a hearing may be scheduled by the Commission if/once medical records are received; and a Notice of Hearing letter will be sent out to all parties.
Hearing Held (C CA E IW)	A Deputy Commissioner hears evidence presented by both the injured worker and the defendant (employer/insurer) at a hearing.
Decision Rendered (C)	A written decision, Judicial Opinion, is mailed to involved parties after a case is heard and the record is closed.
Appeal to the Full Commission (C CA E IW)	Any party has thirty (30) days from the date the Judicial opinion is issued to file an appeal with the Virginia Workers' Compensation Commission.
Appeal to the Court of Appeals (C CA E IW)	Any party has thirty (30) days from the date of the opinion of the Full Commission to appeal to the Virginia Court of Appeals.
Appeal to the Supreme Court of Virginia (C CA E IW)	Any party has thirty (30) days from the date of the Virginia Court of Appeals' decision to file a request for appeal to the Supreme Court of Virginia.

If you need additional information regarding the hearing process, please contact the Commission at 1-877-664-2566 **www.workcomp.virginia.gov**

Year	Weekly Minimum Effective July 1	Weekly Maximum Effective July 1	Percentage of Weekly Wage	Maximum Benefit Weeks	Cost of Living Adjustment (COLA) Effective October 1	Limit of Medical Benefits	Mileage Reimbursement Rate	Burial and Transportation Expenses
2023	$335.75	$1,343.00	66 2/3 %	500	6.40%	Life	$0.655 effective 1/1/23	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2022	$322.50	$1,290.00	66 2/3 %	500	7.40%	Life	$0.585 effective 4/1/22 $0.625 effective 7/1/22	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2021	$298.75	$1,195.00	66.2/3%	500	1.40%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2020	$284.25	$1,137.00	66 2/3 %	500	2.30%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2019	$275.50	$1,102.00	66 2/3 %	500	1.85%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2018	$270.50	$1,082.00	66 2/3 %	500	2.15%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2017	$260.75	$1,043.00	66 2/3 %	500	2.05%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2016	$249.00	$996.00	66 2/3 %	500	0.55%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2015	$243.75	$975.00	66 2/3 %	500	0.55%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2014	$241.75	$967.00	66 2/3 %	500	1.50%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2013	$238.75	$955.00	66 2/3 %	500	1.70%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2012	$233.75	$935.00	66 2/3 %	500	3.10%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2011	$226.25	$905.00	66 2/3 %	500	1.60%	Life	0.555	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2010	$221.25	$885.00	66 2/3 %	500	3.05%	Life	0.505	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2009	$223.75	$895.00	66 2/3 %	500	0.25%	Life	0.505	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2008	$210.25	$841.00	66 2/3 %	500	4.20%	Life	$0.445 $0.505 effective 7/1/08	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2007	$204.00	$816.00	66 2/3 %	500	2.45%	Life	0.445	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2006	$193.25	$773.00	66 2/3 %	500	3.45%	Life	$0.325 $0.445 effective 10/1/06	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2005	$184.00	$736.00	66 2/3 %	500	3.35%	Life	$0.270 $0.325 effective 10/1/05	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2004	$176.50	$706.00	66 2/3 %	500	1.75%	Life	0.270	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2003	$172.75	$691.00	66 2/3 %	500	2.40%	Life	0.270	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2002	$170.25	$681.00	66 2/3 %	500	1.45%	Life	0.270	Burial not exceeding $10000.00 Transportation not exceeding $1000.00

Year	Weekly Minimum Effective July 1	Weekly Maximum Effective July 1	Percentage of Weekly Wage	Maximum Benefit Weeks	Cost of Living Adjustment (COLA) Effective October 1	Limit of Medical Benefits	Mileage Reimbursement Rate	Burial and Transportation Expenses
2001	$161.25	$645.00	66 2/3 %	500	3.40%	Life	0.270	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
2000	$151.50	$606.00	66 2/3 %	500	2.70%	Life	0.270	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
1999	$141.75	$567.00	66 2/3 %	500	1.60%	Life	0.270	Burial not exceeding $10000.00 Transportation not exceeding $1000.00
1998	$133.50	$534.00	66 2/3 %	500	1.60%	Life	0.270	Burial not exceeding $5000.00 Transportation not exceeding $500.00
1997	$128.25	$513.00	66 2/3 %	500	3.30%	Life	0.270	Burial not exceeding $5000.00 Transportation not exceeding $500.00
1996	$124.00	$496.00	66 2/3 %	500	2.50%	Life	0.240	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1995	$120.00	$480.00	66 2/3 %	500	2.70%	Life	0.240	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1994	$116.50	$466.00	66 2/3 %	500	2.60%	Life	0.240	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1993	$112.75	$451.00	66 2/3 %	500	2.90%	Life	0.240	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1992	$108.50	$434.00	66 2/3 %	500	2.95%	Life	0.240	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1991	$104.50	$418.00	66 2/3 %	500	6.10%	Life	0.240	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1990	$101.00	$404.00	66 2/3 %	500	4.60%	Life	$0.240 effective 1/1/91	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1989	$95.50	$382.00	66 2/3 %	500	4.40%	Life	0.220	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1988	$90.50	$362.00	66 2/3 %	500	4.50%	Life	0.220	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1987	$86.00	$344.00	66 2/3 %	500	0.90%	Life	0.220	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1986	$81.50	$326.00	66 2/3 %	500	3.70%	Life	0.200	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1985	$77.75	$311.00	66 2/3 %	500	3.75%	Life	0.200	Burial not exceeding $3000.00 Transportation not exceeding $500.00
1984	$73.75	$295.00	66 2/3 %	500	3.55%	Life	0.200	Burial not exceeding $3000.00 (no dependants) Burial not exceeding $2000.00 (with dependants) Transportation not exceeding $500.00
1983	$69.25	$277.00	66 2/3 %	500	3.90%	Life	0.200	Burial not exceeding $2000.00 Transportation not exceeding $500.00
1982	$63.25	$253.00	66 2/3 %	500	8.80%	Life	0.200	Burial not exceeding $2000.00 Transportation not exceeding $500.00
1981	$57.75	$231.00	66 2/3 %	500	12.45%	Life	0.200	Burial not exceeding $2000.00 Transportation not exceeding $500.00

Year	Weekly Minimum Effective July 1	Weekly Maximum Effective July 1	Percentage of Weekly Wage	Maximum Benefit Weeks	Cost of Living Adjustment (COLA) Effective October 1	Limit of Medical Benefits	Mileage Reimbursement Rate	Burial and Transportation Expenses
1980	$53.25	$213.00	66 2/3 %	500	13.30%	Life	0.170	Burial not exceeding $1000.00 Transportation not exceeding $300.00
1979	$49.75	$199.00	66 2/3 %	500	9.00%	Life	0.170	Burial not exceeding $1000.00 Transportation not exceeding $300.00
1978	$46.75	$187.00	66 2/3 %	500	6.80%	Life	0.150	Burial not exceeding $1000.00 Transportation not exceeding $300.00
1977	$43.75	$175.00	66 2/3 %	500	4.80%	Life	0.150	Burial not exceeding $1000.00 Transportation not exceeding $300.00
1976	$40.50	$162.00	66 2/3 %	500	7.00%	Life	0.120	Burial not exceeding $1000.00 Transportation not exceeding $300.00
1975	$37.25	$149.00	66 2/3 %	500 monetary limit removed 7/1/75		Life	0.100	$800.00
1974	$27.00	$91.00	66 2/3 %	500 $45500.00		Life	$0.100 $0.120 effective 1/1/75	$800.00
1973	$25.00	$80.00	66 2/3 %	500 400 for other dependants in fatal $40000.00 $32000.00			$0.080 $0.100 effective 1/1/74	$800.00
1972	$14.00	$70.00	66 2/3 %	500 450* max Lifetime for PT under 65- 1.56 (18) & 54			0.080	$800.00
1970	$14.00	$62.00	60 %	500 400-death 500-part.				$300.00
1968	$14.00	$51.00	60 %	500 $20400.00 400-death				$300.00
1966	$14.00	$45.00	60 %	500 400-death				$300.00
1964	$14.00	$39.00	60 %	500 300-death $15600.00 $11700.00				$300.00
1962	$12.00	$37.00	60 %	500 (death) $14800.00 $11100.00				$300.00

Year	Weekly Minimum Effective July 1	Weekly Maximum Effective July 1	Percentage of Weekly Wage	Maximum Benefit Weeks	Cost of Living Adjustment (COLA) Effective October 1	Limit of Medical Benefits	Mileage Reimbursement Rate	Burial and Transportation Expenses
1960	$12.00	$35.00	60 %	500 (death) $14000.00 $10500.00				$300.00
1958	$6.00	$33.00	60 %	500 (death) $13200.00 $9900.00				$300.00
1956	$6.00	$30.00	60 %	500 (death) $12000.00 $9000.00				$300.00
1954	$6.00	$27.00	60 %	500 (death) $10800.00 $8100.00				$300.00

frVIRGINIA:

IN THE WORKERS' COMPENSATION COMMISSION

JOHN HURTWORKER, Claimant

v. JCN: 00000000000

UNITED ENGINEERING, INC., Employer

WORKING FOR A SAFE WORKPLACE, Insurer

ORDER

This day came the parties and filed their joint Petition requesting approval of a compromise settlement involving workers' compensation benefits to the claimant as a result of his compensable accident of March 1, 2015, whereby the parties have agreed upon a lump sum compromise settlement for the sum of $75,000, and further agreed that payment for reasonable and necessary medical treatment pursuant to Va. Code Ann. 65.2-603, relating to the injury of March 1, 2015, shall continue for the period from the date of the accident and the date of this Order.

UPON CONSIDERATION WHEREOF, from statements made by the parties in the record and in the Petition, which is incorporated herein by reference, the Commission being clearly of the opinion that the best interest of the Claimant will be served by approving the compromise settlement as set forth in the Petition of the parties, and that this settlement should be approved under those terms,

IT IS ORDERED that the compromise settlement is approved by the Commission and is a full and final settlement of any and call claims for benefits under the Virginia Workers' Compensation Act (Title 65.2 of the Code of Virginia), including, but not limited to, claims for additional compensation, permanency, or death, in the future arising out of the claimant's compensable accident of March 1, 2015 to his left foot and leg, and any compensable consequence and change in condition, and will forever discharge the employer and carrier.

IT IS FURTHER ORDERED that the employer and insurer pay the claimant the lump sum of $75,000, it is further

ORDERED, that the employer and insurer shall pay for all reasonable and necessary medical treatment pursuant to Va. Code Ann. §65.2-603 relating to the injury of March 1, 2015 for the period from the date of the accident to the date of this Order.

The anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is not greater than $250,000. The parties have been informed by the Center for Medicare Services (CMS) that approval of a workers' compensation settlement by CMS is not necessary unless (1) the claimant is a Medicare recipient and the proceeds of the settlement are greater than $25,000, or (2) the claimant is reasonable expected to receive Medicare benefits within the next 30 months and the value of the settlement is $250,000 or more. The claim does not meet Medicare's current review threshold as described in the July 11, 2005 and April 24, 2006 Medicare Policy Memoranda. As such, the claim does not require review and/or approval from CMS.

The parties agree that this settlement of $75,000 is reasonable compensation for any future medical and indemnity benefits to which the claimant may be entitled for these work injuries. The parties agree and the Commission so finds that Medicare's interests have been considered and that this settlement is in no way an attempt by any party hereto to shift the responsibility for any future medical payments to Medicare.

The parties recognize that the Social Security Act provides for the apportionment of workers' compensation benefits received in the form of a lump sum settlement in determining the extent of any offset of workers' compensation against the receipt of Social Security Disability benefits. Considering the above, the parties state that the claimant was born on April 7, 1980, and that pursuant to Va. Code §8.01-419, the claimant has a life expectancy of 40.9 years or 2126.8 weeks. It is therefore

ORDERED that the settlement proceeds of this compromise settlement should be apportioned as follows:

A. Legal Fees and Expenses: _____

B. Medical Expenses: The claimant will be responsible for payment of all future medical bills. The parties designate $5,000.00 of the settlement proceeds toward that future medical expense.

C. Vocational Rehabilitation Expenses: As the claimant forgoes any right to further vocational rehabilitation services as part of this settlement, the parties designate that $2,000.00 shall be apportioned for future vocational rehabilitation expenses in accordance with POMS Section 52001.535, this amount being deemed to be reasonable in light of the type of injury and expenses incurred.

D. Remainder of Lump Sum (Prorated Compensation Rate): The remainder of the lump sum represents the settlement and compromise of all future claims for disability benefits, including permanent total disability benefits. These benefits potentially could have been paid over the remainder of the claimant's life. Pursuant to Va. Code § 8.01-419, 1950, as amended, claimant's life expectancy is 40.9 years. Prorating the balance of the net settlement proceeds, _____, by 2126.8 weeks (40.9 years x 52 weeks) yields a weekly compensation rate of $_____, which shall be the sum Social Security uses to determine any offset based upon claimant's receipt of this additional workers' compensation payment. If the above apportionment is rejected by the Social Security Administration, the settlement proceeds will be apportioned in whatever method allowed by the Social Security Administration.

It is further ORDERED that the defendants shall pay from the proceeds to claimant's counsel the sum of $_____ for costs expended and $_____for legal services rendered the claimant in this case. The balance of the settlement in the amount of $_____ shall be paid directly to the claimant. These amounts, which total $75,000, shall be due within ten (10) days after entry of this Order, and medical expenses incurred for reasonable and necessary medical treatment related to the injury of March 1, 1998,

are payable pursuant to Va. Code § 65.2-603 for the period between the date of the accident and the date of this Order.

**** Additional language if ancillary agreement part of settlement**

The parties agree that any ancillary agreement shall not be construed to affect the claimant's rights or responsibilities with respect to Medicare, or to affect the claimant's rights with respect to any claim under the jurisdiction of the Commission. It is ORDERED that the Commission's approval of the settlement of the claimant's workers' compensation claim referenced herein shall not be construed as the approval of the terms of any ancillary agreement.

Entered this _____ day of _____, 20___.

VIRGINIA WORKERS' COMPENSATION COMMISSION

_____
Deputy Commissioner

_____
John Hurtworker
Address
Phone Number

_____
Name of Claimant's Counsel
Address
Phone Number
Counsel for Claimant

_____
Name of Defense Counsel
Address
Phone Number
Counsel for Employer/Carrier

Employer Name
Address

Insurer Name
Address

COMMONWEALTH OF VIRGINIA
VIRGINIA WORKERS' COMPENSATION COMMISSION
333 EAST FRANKLIN STREET, RICHMOND VA 23219
www.workcomp.virginia.gov
804 205-3586

Workers' Compensation Insurance Information for Employers

Workers' Compensation
Virginia law requires that most employers carry workers' compensation insurance in order to cover their workers in the event of a work injury. Workers' compensation provides a tradeoff for both employers and employees. For the employer, it provides an exclusive remedy, shielding the employer from civil suit. For the injured worker, it provides prompt but limited benefits.

When is an Employer Required to Have Coverage?
Virginia law requires that an employer who regularly employs more than two part-time or full-time employees carry Virginia workers' compensation coverage. If a business hires subcontractors to perform the same trade, business or occupation, or to fulfill a contract of the business, the subcontractor's employees are included in determining the total number of employees. For those employers required to have coverage, it is mandatory, there are no waivers and no exceptions.

Contractor and Subcontractor Issues
A business or contractor that hires subcontractors to assist in their work or fulfill a contract must count the subcontractor's employees as well as their own when considering if they have more than two employees, if yes, the business /contractor is required to carry workers' compensation coverage. This is true even if all subcontractors have their own coverage. A contractor should be aware that their insurance carrier can charge insurance premium for any subcontractor that is hired, even a sole proprietor with no employees, therefore a contractor should request and maintain proof of coverage for all subcontractors hired and have such proof available for audit.

Who is an "Employee"?
To properly count employees and determine if a business needs coverage it is important to know who counts as an employee. All of the following are considered employees:

- Corporate officers and LLC managers, even if they are not performing regular work for the business or earning a regular salary
- Family members that perform work for the business
- Undocumented workers
- Temporary, seasonal and part-time workers
- Minors
- Workers that perform work for churches, charities and non-profits

Does Virginia Have a Waiver or Exemption Form for a Sole Proprietor?
No. Virginia law does not lend itself to providing a waiver or exemption form for a sole proprietor or other employer that considers it not required to insure under the Act.
Independent Contractor vs. Employee

Some business owners will designate a worker as "independent contractor" or pay them on a 1099. Under workers' compensation law, the designation and 1099 are not important. In the event a worker is injured, the facts of the work relationship are considered. The courts will particularly consider: 1) was the worker selected, 2) can the worker be dismissed, 3) does the worker earn pay or wages, and 4) does the business owner have the ability to exert control over the manner or means of how the worker's work is performed. If employer control is found, an "employee" relationship is established.

Limited Liability Company (LLC)

A Manager of a LLC is treated as an employee under the Act. A LLC may have one or more managers that are elected or appointed in accordance with the articles of organization or operating agreement. Conversely, the Act specifically states that a LLC having only one member shall only be covered upon electing to be covered. Members of a LLC are generally not viewed as employees under the Act. However, additional questions may be asked of a member. If the LLC member performs work or earns pay they are covered under the Act by virtue of being an employee.

How to Obtain Coverage

In Virginia there are four means of insuring for workers' compensation in Virginia: 1) commercial coverage 2) self-insurance 3) group self-insurance, or 4) through a registered professional employer organization (PEO). Commercial coverage is available from an insurance agent or carrier. The two Virginia insurance organizations that maintain membership of most Virginia insurance agents are listed:

1. The Independent Insurance Agents of Virginia, telephone 804-747-9300
2. The Professional Insurance Agents Association of Virginia, telephone 804-264-2582

Proper Virginia Coverage

Virginia requires proper Virginia coverage for work performed in Virginia. Out of state employers sometimes lack valid Virginia coverage. For most out of state employers with a policy based outside Virginia, valid Virginia coverage can be accomplished by adding the Virginia Amendatory Endorsement on the existing policy. Virginia must be added to item 3A of the policy for the entity and FEIN (Federal employer ID) to be covered in Virginia. 3A of the policy lists the states where the business performs work and has "known exposure." Virginia 3C listing is not sufficient.

If the out of state employer's policy is with a carrier that is not licensed in Virginia, then the Virginia 3A endorsement cannot be added. Monopolistic state funds cannot cover Virginia. In the event Virginia endorsement cannot be added to a policy, the only way to properly insure is to obtain a Virginia workers' compensation policy with a Virginia licensed insurance carrier.

Employer Responsibilities

- Review coverage requirements
- Carry proper workers' compensation coverage when required by law
- Report work injuries promptly to your insurance carrier using carrier's preferred method
- Post a Workers' Compensation Notice (VWC Form 1) in the workplace
- Be aware the cost of workers' compensation cannot be deducted from employee wages

How Much Does Workers' Compensation Insurance Cost?

The cost varies depending on how hazardous work is in your industry. The three main factors that establish how workers' compensation premium is calculated are: 1) classification code (industry) 2) payroll; and 3) experience modifier, which is based on claim/loss history. A higher premium will be charged in a more hazardous industry, with higher payroll and when there are more claims.

How Can I Reduce the Cost of Workers' Compensation?
Employers can take a variety of actions to reduce costs. Employers who are proactive with workplace safety, training and prevention have fewer work injuries which can lower premium. Reporting work injuries promptly and ensuring injured workers receive prompt medical treatment can reduce claim costs. Providing transitional duty and return to work opportunities for injured workers can also reduce claim costs.

Are There Penalties if an Employer is Uninsured?
Yes. An employer that fails to insure for workers' compensation when required by law shall be assessed a civil penalty of up to $250 for each day uninsured, subject to a maximum penalty of $50,000. plus costs pursuant to § 65.2-805. Such employer shall also be liable to any employee for compensation for their injuries. Continued failure to obtain workers' compensation coverage can result in an order prohibiting an employer from operating their business and can subject the employer to criminal prosecution. Uninsured employers are also at risk of suit by employees for damages resulting from work injuries.

Insurance Underwriting Question and Disputes
Bureau of Insurance in State Corporation Commission regulates underwriting and can advise on such matters as rates, premium, classification codes and audits. You may contact the Bureau by phone at: (804) 371-9185 or by email at bureauofinsurance@scc.virginia.gov.

Workers' Compensation Insurance Questions
For additional information or questions please utilize the following resources:
Insurance Department main number, hours 8:30 a.m. – 4:45 p.m., M-F: (**804) 205-3586**
Insurance Department e-mail: **vwcinsurance@workcomp.virginia.gov**

Workers' compensation and payments

There can be a delay between when a bill is filed for the work-related illness or injury and when the workers' compensation insurance decides if they'll pay the bill. Medicare can't pay for items or services that workers' compensation will pay for promptly (generally 120 days). Medicare may make a conditional payment if the workers' compensation insurer denies payment for your medical bills pending a review of your claim (generally 120 days or longer).

> **Note**
>
> This isn't the same as when your workers' compensation case has been settled and you're using Workers' Compensation Medicare Set-aside Arrangement (WCMSA) funds to pay for your medical care. See below for more information on WCMSAs.

If the state workers' compensation insurance denies payment, and if you give Medicare proof that the claim was denied, then Medicare will pay for Medicare-covered items and services.

In some cases, workers' compensation insurance may not pay your entire bill. Workers' compensation insurance may agree to pay only a part of your bill if both of these are true:

- You had an injury or illness before you started your job (called a " pre-existing condition ")
- The job made it worse

This is because the job didn't cause the original problem. You and workers' compensation insurance may agree to share the cost of your bill. If Medicare covers the treatment for your pre-existing condition, then Medicare may pay its share for part of the doctor or hospital bills that workers' compensation doesn't cover.

Settle your workers' compensation claim

If you want to settle your workers' compensation claim, you or your lawyer should contact the recovery contractor. Settlements of workers' compensation claims are handled differently than a settlement of a no-fault or liability insurance claim. As part of settling your workers' compensation claim, you must repay Medicare for any Medicare payments for workers' compensation claim-related services you already got.

Workers' Compensation Medicare Set-aside Arrangements (WCMSA)

If you settle your workers' compensation claim, you must use the settlement money to pay for related medical care before Medicare will begin again to pay for related care. In many cases, before a settlement is reached, the workers' compensation agency asks Medicare to approve an amount to be set aside to pay for future medical care. Medicare will look at certain medical documentation and approve an amount of money from the settlement. This money must be used up first before Medicare starts to pay for related care that's otherwise covered and reimbursable by Medicare.

You and the workers' compensation agency aren't required to set up a WCMSA—it's completely voluntary. However, you must make sure the settlement money is used only for related medical care. To get approval for a proposed WCMSA account for you to manage, or for more information about WCMSAs, visit go.cms.gov/wcmsa.

Using money in your WCMSA

To find out how to manage (self-administer) your WCMSA account, visit go.cms.gov/WCMSASelfAdm. Keep these in mind:

- Money placed in your WCMSA is for paying future medical and/or prescription drug expenses related to your work injury or illness/disease that otherwise would have been covered by Medicare.
- You can't use the WCMSA to pay for any other work injury, or any medical items or services that Medicare doesn't cover (for example, dental services).
- Medicare won't pay for any medical expenses related to the injury until after you have used all of your set-aside money appropriately.
- If you aren't sure what type of services Medicare covers, call Medicare before you use any of the money that was placed in your WCMSA.

- Keep records of your workers' compensation-related medical and prescription drug expenses. These records show what items and services you got and how much money you spent on your work-related injury, illness or disease. You need these records to prove you used your WCMSA money to pay your workers' compensation-related medical and/or prescription drug expenses.
- After you use all of your WCMSA money appropriately, Medicare can start paying for Medicare-covered and otherwise reimbursable items and services related to your workers' compensation claim.

Related Resources

How Medicare works with other insurance

CMS.gov

Workers' Compensation Medicare Set Aside Arrangements

A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a financial agreement that allocates a portion of a workers' compensation settlement to pay for future medical services related to the workers' compensation injury, illness, or disease. These funds must be depleted before Medicare will pay for treatment related to the workers' compensation injury, illness, or disease.

All parties in a workers' compensation case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving cases that include future medical expenses. The recommended method to protect Medicare's interests is a WCMSA.

The amount of the WCMSA is determined on a case-by-case basis. To assist you in determining if a WCMSA is reasonable, please review Section 15.1 (Criteria) in the *WCMSA Reference Guide*. The guide contains information for attorneys, Medicare beneficiaries, claimants, insurance carriers, representative payees, and WCMSA vendors and is available in the Downloads section at the bottom of this page.

When to submit a WCMSA for CMS Review

While there are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review, submission of a WCMSA proposal is a recommended process. More information on this process can be found on the WCMSA Submissions page.

If you choose to submit a WCMSA for review, CMS requires that you comply with its established policies and procedures. CMS will only review WCMSA proposals that meet the following criteria:

- The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or
- The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00

For more information on Review Thresholds, please see Section 8.1 (Review Thresholds) of the *WCMSA Reference Guide* available in the Downloads section found at the bottom of this page.

If you decide to submit a WCMSA for review, it can be submitted electronically through the WCMSA Portal (WCMSAP) or by paper/CD through the mail. The portal submission is the recommended approach for submitting a WCMSA as it is significantly more efficient than sending this information via the mail. For more information about this application, please see the WCMSAP page.

Note: For general information on CMS's Coordination of Benefits & Recovery activities, please see the COB&R page.

How to sign-up for WCMSA Web page updates

CMS provides you the ability to be notified when new information is posted on the WCMSA web pages. If you have not already signed up for these notifications, please enter your e-mail address in the "Receive E-Mail Updates" box at the bottom of this page. Next, select "Worker's Compensation Agency Services" and any other topics you would like to receive notifications on. When notifications and new information, regarding WCMSA are available, you will be notified at the provided e-mail address.

Downloads

WCMSA Reference Guide Version 3.8 (PDF)

CMS.gov

Conditional Payment Information

Under Medicare Secondary Payer law (42 U.S.C. § 1395y(b)), Medicare does not pay for items or services to the extent that payment has been, or may reasonably be expected to be, made through a no-fault or liability insurer or through a workers' compensation entity. Medicare may make a conditional payment when there is evidence that the primary plan does not pay promptly conditioned upon reimbursement when the primary plan does pay. The Benefits Coordination & Recovery Center (BCRC) is responsible for recovering conditional payments when there is a settlement, judgment, award, or other payment made to the Medicare beneficiary. When the BCRC has information concerning a potential recovery situation, it will identify the affected claims and begin recovery activities. Beneficiaries and their attorney(s) should recognize the obligation to reimburse Medicare during any settlement negotiations.

If Medicare is pursuing recovery directly from the insurer/workers' compensation entity, the beneficiary and beneficiary's attorney or other representative will receive a copy of recovery correspondence sent to the insurer/workers' compensation entity. The beneficiary does not need to take any action on this correspondence. However, if Medicare is pursuing recovery from the beneficiary, the BCRC will send recovery correspondence to the beneficiary.

Conditional Payment Letter (CPL)

A CPL provides information on items or services that Medicare paid conditionally and the BCRC has identified as being related to the pending claim. For cases where Medicare is pursuing recovery from the beneficiary, a CPL is automatically sent to the beneficiary within 65 days of issuance of the Rights and Responsibilities letter (a copy of the Rights and Responsibilities letter can be obtained by clicking the Medicare's Recovery Process link). All entities that have a verified Proof of Representation or Consent to Release authorization on file with the BCRC for the case will receive a copy of the CPL. Please refer to the Proof of Representation and Consent to Release page for more information

on these topics. The CPL includes a Payment Summary Form that lists all items or services the BCRC has identified as being related to the pending claim. The letter includes the interim total conditional payment amount and explains how to dispute any unrelated claims. The total conditional payment amount is considered interim as Medicare might make additional payments while the beneficiary's claim is pending.

You can obtain the current conditional payment amount and copies of CPLs from the BCRC or from the Medicare Secondary Payer Recovery Portal (MSPRP). To obtain conditional payment information from the BCRC, call 1-855-798-2627. To obtain conditional payment information from the MSPRP, see the "Medicare Secondary Payer Recovery Portal (MSPRP)" section below. If a settlement, judgment, award, or other payment occurs, it should be reported to the BCRC as soon as possible so the BCRC can identify any new, related claims that have been paid since the last time the CPL was issued.

For more information about the CPL, refer to the document titled *Conditional Payment Letters (Beneficiary)*. This document can be accessed by clicking the Medicare's Recovery Process link.

Contact information for the BCRC may be obtained by clicking the Contacts link.

Conditional Payment Notification (CPN)

A CPN is issued to the beneficiary in lieu of a CPL when a settlement, judgment, award, or other payment has already occurred. A CPN provides conditional payment information and advises what actions must be taken because the settlement, judgment, award, or other payment has already occurred. After the CPN has been issued, the recipient is allowed 30 days to respond. If a CPN is received, any of the items listed below should be forwarded to the BCRC if they have not previously been sent:

- Proof of Representation documentation.
- Proof of any items and/or services that are not related to the case, if applicable.

- All settlement documentation if you are providing proof of any items and/or services not related to the case.
- Procurement costs and fees paid by the beneficiary.
- Documentation for any additional or pending settlements, judgments, awards, or other payments related to the same incident.

If a response is received within 30 calendar days, the correspondence will be reviewed, and a demand letter will be issued. If a response is not received in 30 calendar days, a demand letter will automatically be issued requesting repayment on all conditional payments related to the case without a proportionate reduction for fees or costs.

For more information about a CPN, refer to the document titled *Conditional Payment Notice (Beneficiary)*, which can be accessed using the Medicare's Recovery Process link.

Disputing Claims on a CPL or CPN

If the beneficiary or his or her attorney or other representative believes any claims included on the CPL or CPN should be removed from Medicare's conditional payment amount, documentation supporting that position must be sent to the BCRC. The documentation provided should establish that the claims are not related to what was claimed or were released by the beneficiary. This process can be handled via mail, fax, or the MSPRP. See the “Medicare Secondary Payer Recovery Portal (MSPRP)” section below for additional details. The BCRC will adjust the conditional payment amount to account for any claims it agrees are not related to what has been claimed or released. Upon completion of its dispute review process, the BCRC will notify all authorized parties of the resolution of the dispute.

Demand Calculation Option

If the beneficiary is settling a liability case, he or she may be eligible to obtain Medicare's demand amount prior to settlement or to pay Medicare a flat percentage of the total settlement. Click the Demand Calculation Options link to determine if the beneficiary's case meets the required guidelines.

Medicare Secondary Payer Recovery Portal (MSPRP)

The MSPRP is an online self-service tool that may be used by attorneys to report a case and manage cases that have been reported to the BCRC. The MSPRP allows users to obtain updated conditional payment amounts, request a copy of a current conditional payment letter or make an electronic payment. Please click the MSPRP link for further details.

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7500 Security Boulevard, Baltimore, MD 21244

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Mandatory Insurer Reporting (NGHP)

Mandatory Insurer Reporting for Non-Group Health Plans (NGHP)

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation, collectively referred to as Non-Group Health Plan (NGHP) or NGHP insurance. Note: Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 is sometimes referred to as "Section 111". The term "Section 111" will be used on these pages for ease of reference.

The provisions for Liability Insurance, No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8):

- Added reporting rules, but did not eliminate any previously existing Medicare Secondary Payer (MSP) statutory provisions or regulations
- Did not change existing processes for MSP recovery and self-reporting other insurance to CMS
- Include penalties for noncompliance
- Define who must report, a responsible reporting entity (RRE), as "an applicable plan": "...[T]he term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement: (i) Liability insurance (including self-insurance). (ii) No fault insurance. (iii) Workers' compensation laws or plans."
- Include what must be reported
- Specify the form and manner of reporting

The *Section 111 statutory language, Paperwork Reduction Act Federal Register Notice and Supporting Statement* can be found in the Downloads section below.

Who Must Report

An organization that must report under Section 111 is referred to as a responsible reporting entity (RRE). In general terms, NGHP RREs include liability insurers, no-fault insurers, and workers' compensation plans and insurers. RREs may also be organizations that are self-insured with respect to liability insurance, no-fault insurance, and workers' compensation.

You must refer to the information provided in the *MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide (NGHP User Guide) Chapter III: Policy Guidance* found as a download on the **NGHP User Guide** page for a complete explanation of who must report. The Responsible Reporting Entities section of this chapter provides a detailed definition of an NGHP RRE, including scenarios related to corporate structure, bankruptcy, self-insurance pools and other insurer relationships that have a bearing on what entity must report under various circumstances.

Reporting

The purpose of Section 111 reporting is to enable CMS to pay appropriately for Medicare-covered items and services furnished to Medicare beneficiaries. Section 111 NGHP reporting of applicable liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim information helps CMS determine when other insurance coverage is primary to Medicare, meaning that it should pay for the items and services first before Medicare considers its payment responsibilities.

Reporting is accomplished by either the submission of an electronic file of liability, no-fault, and workers' compensation claim information, where the injured party is a Medicare beneficiary, or by entry of this claim information directly into a secure Web portal, depending on the volume of data to be submitted. Upon receipt of this information, CMS checks whether the injured

party associated with the claim report is a Medicare beneficiary, and determines if the other insurance is primary to Medicare. CMS then uses this information in the Medicare claims payment process and, if Medicare paid first when it should not have, uses it to seek repayment from the other insurer or the Medicare beneficiary.

Reporting Requirements – NGHP User Guide and Alerts

Reporting requirements are documented in the NGHP User Guide which is available as a series of downloads on the **NGHP User Guide** page. The NGHP User Guide is made up of five chapters: Introduction and Overview, Registration Procedures, Policy Guidance, Technical Information, and Appendices. Each chapter can be referenced independently, but are designed to function together to provide complete information and instructions for NGHP reporting.

The NGHP User Guide is the primary source for Section 111 reporting requirements. RREs must also be sure to refer to important information published on the **NGHP Alerts** page. To obtain the most up to date information and requirements, refer to the NGHP User Guide and all pertinent alerts published subsequent to the current version of the User Guide. Comprehensive Computer-Based Training (CBT) modules covering all aspects of Section 111 reporting can be found on the **NGHP Training Material** page.

Please see the MMSEA Section 111 Mandatory Insurer Reporting Quick Reference Guide for Non-Group Health Plan (NGHP) Insurers download on this page for more general information.

Registration and the Section 111 COBSW

Section 111 RREs are required to register for Section 111 reporting and fully test the data exchange before submitting production files. The registration process provides notification to CMS of the RRE's intent to report data to comply with the requirements of Section 111 of the MMSEA.

NGHP RREs must register on the Section 111 COB Secure Website (COBSW), This interactive Web portal may also be used to maintain current account information,

monitor reporting file processing, query an individual's Medicare status and, for RREs with a low volume of information to report, directly enter NGHP claim information. Refer to the NGHP User Guide and the How to Get Started download found under the How To menu option of the Section 111 COBSW for registration instructions. The link to the Section 111 COBSW can be found in the Related Links section below

Reporting Assistance

After registration, you will be assigned an Electronic Data Interchange (EDI) Representative to assist you with the reporting process and answer related technical questions.

CMS conducts NGHP Town Hall Teleconferences to provide updated policy and technical information related to Section 111 reporting. Announcements for upcoming NGHP Town Hall events are posted to the NGHP **What's New** page. Transcripts from the current year can be found on the **NGHP Transcripts** Page while prior year transcripts can be found on the **Archive** page.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that Responsible Reporting Entities (RREs) may use to send CMS policy-related questions regarding the Medicare Secondary Payer (MSP) reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. RREs are requested to send only policy-related questions to the Section 111 Resource Mailbox.

If an RRE has a technical question, and if you are unable to contact your Electronic Data Interchange (EDI) Representative, for any reason, call the EDI Hotline at (646) 458-6740. If you have not registered to become an RRE, please directly contact the Benefits Coordination Recovery Center (BCRC) at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Comprehensive Computer-Based Training (CBT) modules covering all reporting and registration requirements can be viewed from the **NGHP Training Material** page.