

Virginia Workers' Compensation Commission

An industry leader in workers' compensation



What is an Ombudsman?



OMBUDSMAN

Ombuds Department provides educational information and assistance to people that are not represented by counsel.

- *We do not give legal advice, but,
- * We do explain things and discuss options that are available.
- *All communications with Ombuds Department are confidential.

With some exceptions...



HOW TO CONTACT US

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What is workers' compensation?



Workers' Compensation

Workers' Compensation is a mandatory insurance requirement under Virginia law, which requires every employer who regularly employs more than two workers to carry workers' compensation insurance coverage.

The Virginia Workers' Compensation Commission administers the Virginia Workers' Compensation Act and acts as the court system. We do not pay benefits.



What is covered?

Workers' Compensation



Injury by Accident

- Must result in an “injury”
 - Medical question = structural or mechanical change in body
- Specific event/happen at a reasonably definite time
- Occur at work or during a work function
 - Time and place
 - Also called “in course of” employment
- Be caused by a specific work activity
 - “arising out of” the employment
 - Actual risk of the employment



Occupational Disease

A **disease** arising out of and in the course of employment, but not an ordinary disease of life to which the general public is exposed outside of the employment.

It is not a condition of the neck, back, or spinal column.



Ordinary Disease of Life

A disease that the general public is exposed to outside of the employment may be covered as an occupational disease...

If you can show that:

it did not come from sources outside of work

it arose out of and in the course of employment

and was caused by conditions specific to the employment.

There is a higher burden of proof- clear and convincing evidence.



Just for Firefighters

Presumptions



Injury by Accident due to Weather

If weather conditions constitute a particular risk of employment, and you can show that your injury arose out of and in the course of employment, absent any misconduct, the injury by accident will be compensable.



Presumption: Hypertension or Heart Disease

If you have worked five years or more as a firefighter...

Hypertension or heart disease

Will be presumed to be occupational diseases suffered in the line of duty if you have suffered some sort of impairment or wage loss as a result of the disease.



Presumption: Cancers

If you have worked five years or more as a firefighter...

Leukemia or pancreatic, prostate, rectal, throat, ovarian, breast, colon, brain, testicular, bladder or thyroid cancer.

Will be presumed to be occupational diseases suffered in the line of duty if you have suffered some sort of impairment or wage loss as a result of the disease.

For colon, brain, or testicular cancer, the presumption only applies if it was diagnosed after July 1, 2020 and for bladder and thyroid cancer, if it was diagnosed after July 1, 2023.



Presumption: Hypertension or Heart Disease

Respiratory Diseases

shall be presumed to be occupational diseases suffered in the line of duty if you have suffered some sort of impairment or wage loss as a result of the disease.



Presumption: Infectious disease

If you have a **documented** occupational exposure to blood or body fluids

Hepatitis, meningococcal meningitis, tuberculosis or HIV

shall be presumed to be occupational diseases, suffered in the line of duty if you have suffered some sort of impairment or wage loss as a result of the disease..



Presumption: Covid-19

COVID-19

shall be presumed to be an occupational disease suffered in the line of duty, if you suffer some sort of impairment or wage loss as a result of the disease between July 1, 2020 and December 31, 2021, AND...

it was...

- diagnosed by a licensed physician after
- a presumptive positive test or a lab confirmed test, and
- you had signs and symptoms of COVID-19 that required medical treatment.



PRESUMPTION - BUT #1

If you were asked to get a pre-employment physical, you had to have gotten the pre-employment physical

- (i) Before making any claim that will rely on the presumption,
- (ii) performed by a physicians of the employer's choice,
- (iii) included the lab work required by the employer, and
- (iv) found you free of whatever respiratory diseases, hypertension, cancer or heart disease at the time of the examination.



PRESUMPTION BUT # 2

All of these presumption can be rebutted if evidence shows that it is not caused by employment and that there is a non-work related cause.



What can you get?

Benefits Available



Benefits Potentially Available

- Medical Benefits

- Reasonable, necessary, authorized and causally-related medical treatment
 - Doctor's visits
 - Hospitalization
 - Physical therapy
 - Medical tests
 - Prescriptions
 - Prosthetics
 - Mileage

- Lost wages

- Temporary total disability
- Temporary partial disability
- Permanent Partial disability
 - Loss of use, scarring, amputation, vision loss, hearing loss

- Death Benefits

(TOTAL OF 500 weeks)

- Permanent Total Disability Benefits-

(Rest of Life)



How Are Compensation Benefits Determined?

Everything based on your Average Weekly Wage (AWW)

This is usually calculated by adding your wages for the 52 weeks before your injury or diagnosis, divided by 52.

For example: if you earned \$57,200 in the 52 weeks before your injury, your average weekly wage would be \$1,100.00.



Compensation rate

The amount of compensation to which the injured worker is entitled by an award from the Commission for **temporary total, permanent total, and permanent partial disability** benefits.

2/3 of the average weekly wage

(multiply your average weekly wage by .66667)

EXAMPLE: \$1100 x .66667 = \$733.37- compensation rate



But what if you are working...

Temporary Partial Disability

If you are working, but *earning less* than your average weekly wage...

the compensation rate is calculated by taking the difference between your pre-injury average weekly wage and the weekly wage you are earning at the new job, and multiplying that amount by .66667.

EXAMPLE: If you are earning \$500 per week after the injury, then your temporary partial disability rate would be

$$\text{\$1100} - \text{\$500} = \text{\$600} \times .6667 = \text{\$400.02 per week.}$$



FYI- Looking for a job ...

Job Search Requirements

If you are not under an award AND

You have light duty work restrictions, AND

You are not working or are working, but asking for an increase in your benefits,

You will need to look for a job.



FYI-Looking for a job ...

FACTORS THE COMMISSION CONSIDERS:

1. Nature and extent of the disability
2. Injured workers' training, education, age, and experience
3. Nature and extent of the job search
4. Availability of jobs in the area suitable for the injured worker
5. Other factors affecting the injured worker's ability to find suitable employment.



FYI-Looking for a job ...

Evidence of Reasonable Effort

- Register with Virginia Employment Commission
- Look for at least 5 jobs per week where you have a reasonable belief that there is a job you can do within your restrictions
- If appropriate, check with your Employer
- Keep a record of your searches.



Vocational Rehabilitation

If you are under an award, and have an ability to work, you can ask for help finding a job.

Even if you do not ask, the Employer can assign a vocational counselor to help you find a job.



Death Benefits

- Burial expenses up to \$10,000
- Transportation expenses up to \$1,000
- Benefits to a spouse and/or dependent children under the age of 18 and under 23 years old if enrolled in an accredited educational institution.

Dependents can include spouse, children (including step-children, legally adopted children and acknowledged illegitimate children, but not married children) and parents in destitute circumstances (including stepparents and parents by adoption)



COLA

For temporary total, permanent total, or death benefits

You are entitled to a cost of living (COLA) increase beginning October 1st of each year as long as:

1. your date of injury was before July 1 of that year, and
2. your compensation rate and Social Security Disability Benefits are less than 80% of your pre-injury earnings.

Cost of living increases must be specifically requested by the injured worker each year.



Post Traumatic Stress Disorder



Statute enacted in 2020

PTSD is compensable if:

1. A mental health professional
2. Diagnoses you with PTSD,
3. Resulting from a qualifying event,
4. That occurred in the line of duty.



- Qualifying event means an event that occurred after July 1, 2020, AND
- a. resulted in serious bodily injury or death, OR
 - b. involved a minor who was been injured, killed, abused or exploited, OR
 - c. involved an immediate threat to your life or the life of someone else, OR
 - d. involved mass casualties, OR
 - e. occurred while responding to crime scenes for investigation.



OTHER REQUIREMENTS

The firefighter complied with OSHA standards;

The qualifying event was a substantial factor in causing the PTSD;

Another event or source of stress was not the primary cause of the PTSD; and

The PTSD did not result from any disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action of the firefighter.



PTSD- BENEFITS

Benefits include medical treatment, temporary total and temporary partial benefits.

* Benefits only last for 52 weeks from the date of diagnosis.

TTD or TPD plus retirement benefits, Social Security benefits, and long term or short disability benefits cannot exceed the average weekly wage.

Benefits, whether medical or lost wages, have to be awarded within four years of the date of the qualifying event.



How to get benefits



Report it

Injury by Accident

30 Days

Occupational Disease

60 days



PANEL OF DOCTORS

When an injury or disease is reported, the employer should provide the injured worker with a list of at least three medical providers from which to choose to receive treatment.

File a Claim with the Commission

Claim Form Virginia Workers' Compensation Commission
Access your claim online: webfile.workcomp.virginia.gov

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.					
<input type="checkbox"/> Lifetime Medical Award (coverage for related medical expenses).					
<input type="checkbox"/> Wage Loss Replacement (Temporary Total Disability - Completely out of work):					
From: _____ To: _____ <input type="checkbox"/> continuing From: _____ To: _____ <input type="checkbox"/> continuing					
<input type="checkbox"/> Wage Loss Replacement (Temporary Partial Disability - Partially out of work/light duty):					
From: _____ To: _____ <input type="checkbox"/> continuing From: _____ To: _____ <input type="checkbox"/> continuing					
<input type="checkbox"/> Compensation for Permanent Loss (Permanent Partial Disability):					
<input type="checkbox"/> Loss of use of a body part <input type="checkbox"/> Disfigurement/Scarring <input type="checkbox"/> Amputation <input type="checkbox"/> Hearing/Vision loss <input type="checkbox"/> Lung disease					
<input type="checkbox"/> Payment/reimbursement for the following expenses (attach medical records, itemized bills, receipts, or mileage log):					
<input type="checkbox"/> Medical bills <input type="checkbox"/> Mileage/Transportation <input type="checkbox"/> Prescriptions					
<input type="checkbox"/> Death benefits to dependents and/or funeral expenses.					
<input type="checkbox"/> 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	

An original claim for benefits shall be in writing, signed and should set forth:

- 1. Employee's name and address;
- 2. Employer's name and address;
- 3. Date of accident or date of communication of occupational disease;
- 4. Nature of injury or occupational disease;
- 5. Benefits sought: temporary total, temporary partial, permanent total, permanent partial or medical benefits;
- 6. Periods of disability, if appropriate.



File a Claim with the Commission

Filing a Claim is the responsibility of the injured worker.

Even if the employer has paid lost wages or provided medical care, it is still the employee's responsibility to file a claim with the Commission.

If no claim is filed with the Commission or no award entered, the employer may stop paying medical expenses or wage loss at any time.



Time Limits to File the Claim- Injury

Generally, the original claim must be filed with the Workers' Compensation Commission within **two years from the date of the accident.**

There are many exceptions to this timeframe.



Time Limits to File the Original Claim- Occ. Disease

Generally, claims for an occupational disease must be filed within **two years from the date of diagnosis and that the disease is work related, or five years from the date the employee was last exposed** to the work condition causing the disease, whichever is sooner.

There are exceptions to this timeframe.



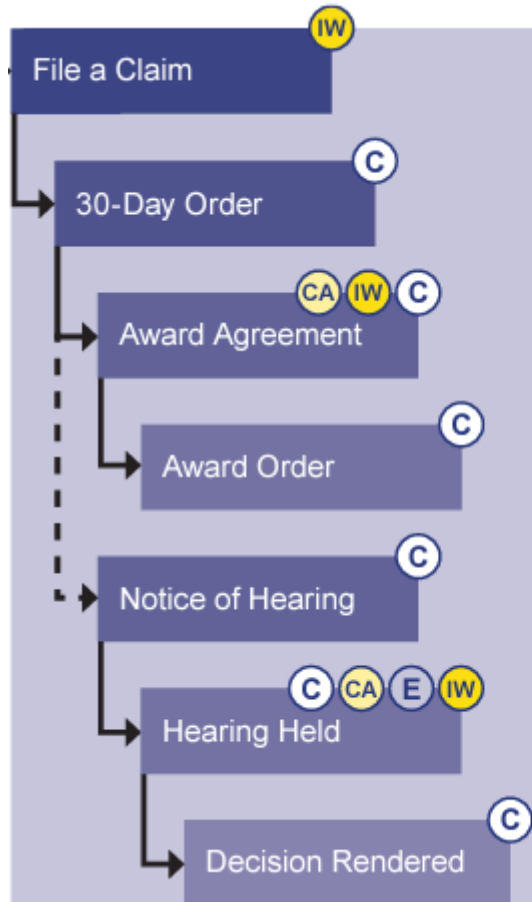
Time Limits to File- Firefighters and Cancer

Claims for cancer covered by the presumption must be filed within **two years from the date of discovering that the disease is work related, or ten years from the date the employee was last exposed** to the work condition causing the disease, whichever is sooner...

...as long as the claim is filed **before the employee reaches 65 years of age**. Once the injured worker reaches 65 years of age, the claim for cancer is barred.



Process after Claim is Filed with Commission



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.

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**.

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.

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

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.

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

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



How to Change an Award

Claimant's Edition




Making Changes to an Award

Changes can be made to Awards that have already been entered. These are called change in condition claims.

Examples may include:

- Going back out of work due to the work injury.
- Medical treatment is denied by the employer/carrier.
- Mileage or reimbursements are being denied.

File a Change in Condition with the Commission

Claim Form		Virginia Workers' Compensation Commission			
Access your claim online: webfile.workcomp.virginia.gov					
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.					
<input type="checkbox"/> Lifetime Medical Award (coverage for related medical expenses).					
<input type="checkbox"/> Wage Loss Replacement (Temporary Total Disability - Completely out of work):					
From: _____ To: _____ <input type="checkbox"/> continuing From: _____ To: _____ <input type="checkbox"/> continuing					
<input type="checkbox"/> Wage Loss Replacement (Temporary Partial Disability - Partially out of work/light duty):					
From: _____ To: _____ <input type="checkbox"/> continuing From: _____ To: _____ <input type="checkbox"/> continuing					
<input type="checkbox"/> Compensation for Permanent Loss (Permanent Partial Disability):					
<input type="checkbox"/> Loss of use of a body part <input type="checkbox"/> Disfigurement/Scarring <input type="checkbox"/> Amputation <input type="checkbox"/> Hearing/Vision loss <input type="checkbox"/> Lung disease					
<input type="checkbox"/> Payment/reimbursement for the following expenses (attach medical records, itemized bills, receipts, or mileage log):					
<input type="checkbox"/> Medical bills <input type="checkbox"/> Mileage/Transportation <input type="checkbox"/> Prescriptions					
<input type="checkbox"/> Death benefits to dependents and/or funeral expenses.					
<input type="checkbox"/> 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		

A change in condition claim must be in writing and state the change in condition relied upon. A copy of the claim should be sent to the employer.



Change in Condition Claims

Change in Condition claims should generally be filed within **two years of the date for which you were last paid compensation under an award.**

As always, there may be exceptions.

If you are claiming wage loss, the Commission **can only award benefits up to 90 days before the change in condition is filed.**



Keep Up

It is the injured workers' job to
keep up with the claim.



Burden of Proof

It is always the injured workers' job to prove that the benefits the claimant is seeking are causally related to the work injury or occupational disease.



How to Change an Award

Employer's Edition

Employer's Application for Hearing

An employer who wishes to suspend or terminate ongoing compensation benefits must file an application and/or termination of wage loss form with the Commission.

The general rule is compensation must be paid through the date the application is filed with the Commission. Exceptions to this rule include instances of a return to work, refusal of selective employment or refusal of medical treatment.

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219

Employer's Application for Hearing
SEE SPECIAL INSTRUCTIONS ON THE REVERSE SIDE

Employee _____ JCN _____
Address _____ Date of Accident _____
City/State/Zip _____

The Commission is requested to suspend benefits for the following reason(s) [attach supporting documentation]:

- _____ The employee returned to pre-injury work on _____.
- _____ The employee was released to return to pre-injury work on _____ per Dr. _____'s report dated _____.
- _____ The employee returned to light-duty work on _____ at an average weekly wage of \$ _____.
- _____ The employee's current disability is unrelated to the industrial accident noted in Dr. _____'s report(s) dated _____.
- _____ The employee failed to report to an employer-requested medical examination with Dr. _____ on _____.
- _____ The employee refused selective employment within the employee's physical capacity at _____ on _____.
- _____ The employee failed to cooperate with vocational rehabilitation efforts (documentation must be attached).
- _____ The employee has refused medical treatment offered by Dr. _____ as noted in the medical report dated _____.
- _____ Other _____

Request: _____ Termination/suspension of the outstanding award
_____ Change of an outstanding award for temporary total to temporary partial
_____ Credit
_____ Other _____

Compensation was paid through _____ at the rate of \$ _____ per week.

I hereby certify under penalty of perjury that the statements in this application are true and correct to the best of my knowledge and that a copy of this application, INCLUDING INSTRUCTIONS ON THE REVERSE SIDE, and all attached supporting documents were sent to the employee at the above address, and to the employee's attorney (if known) at _____, and to the Virginia Workers' Compensation Commission on _____ (date).

APPLICANT'S NAME AND TITLE: _____ EMPLOYER/CARRIER _____

SIGNATURE OF APPLICANT: _____ DATE: _____

Registered WebFile Users: type in your signature if submitting through your WebFile account.

Notice to the employee: If the Virginia Workers' Compensation Commission approves this application, your compensation benefits will be suspended. Please refer to the additional instructions on the back of this form.

Employer's Application for Hearing
VWC Form No. 5A (rev. 11/21)



What Happens After EAH is Filed ...

The Commission shall review the application for compliance with the Workers' Compensation Act and Rules. (If not technically acceptable, it will be rejected.) Pending acceptance or rejection of the application, the employer may suspend or modify compensation payments as of the date for which compensation was last paid.

If the employer's application is technically acceptable, the claimant is permitted 15 days from the date of the application to present evidence in opposition to the application

If rejected, the Commission shall advise the employer of the reason for rejection and compensation shall be reinstated immediately.

If accepted, the application shall be referred:

- a. To Alternative Dispute Resolution Department,
- b. For an On The Record Hearing, or
- c. For an evidentiary hearing.



Questions?

If you have specific questions about your injury or disease, you should contact an attorney.