

The Employer's Obligation to Provide Medical Care in Workers' Compensation Cases

Virginia Workers' Compensation Commission

The Virginia Workers' Compensation Act creates a comprehensive remedy for workers who are injured on the job. Once the claimant¹ establishes the compensability of his or her injury under the Act, the Act provides a series of benefits to which the claimant may be entitled. The first of these is compensation for wages lost as a result of the work-related disability. The second benefit is medical coverage for treatment of the disabling condition that is shown to be causally related to the compensable injury.² The employer's³ obligation to provide this second category of benefits is the focus of this discussion.

Generally, the employer's liability for medical treatment depends upon three factors: (1) whether the medical attention is causally related to the work injury; (2) whether such attention was necessary; and (3) whether the authorized treating physician rendered the treatment or referred the claimant for additional treatment.⁴ The claimant has the burden of proving that these criteria are satisfied if coverage becomes an issue. The employer remains liable for treatment meeting these criteria for the claimant's lifetime unless the claimant relinquishes the entitlement by certain actions, including settling the claim.

¹ In workers' compensation cases, the injured worker is referred to as "the claimant."

² The claimant may also be eligible to receive other benefits not relevant to this discussion. These other benefits include provision of durable medical equipment, vocational rehabilitation services, and modifications to the home. Code Section 65.2-603 provides a complete list of available benefits.

³ The Act views the employer and its workers' compensation insurance carrier as a single entity. Both are coextensively liable for benefits. Therefore, a reference to the "employer" includes the insurance carrier.

⁴ See *Volvo White Truck Corp. v. Hedge*, 1 Va.App. 195, 199, 336 S.E.2d 903,906 (1985).

The threshold inquiry in assessing the employer's liability for medical care is whether the treatment is causally related to the compensable work injury. Although this first criterion seems straightforward, this conceptual analysis may become very convoluted, particularly if the claimant has a pre-existing condition or if there is a dispute as to how the accident occurred. Such situations highlight the pivotal role medical evidence plays in workers compensation cases.

The employer's obligation to provide causally related medical treatment begins immediately following the work-related accident.⁵ Initially, the employer must provide the claimant a panel of at least three physicians selected by the employer. The panel must include a minimum of three physicians who are not in the same practice group or who do not otherwise share a community of interest. The initial panel may include medical care providers whose special area of practice is relevant to the medical condition.

The claimant chooses one physician from this panel who then becomes the primary or authorized treating physician for the work-related injury. Generally, the employer is liable for all reasonable and necessary medical treatment causally related to the work injury, including diagnostic measures, provided or prescribed by the treating physician and by physicians to whom the primary treating physician refers the claimant.⁶ Emergency room treatment may also be covered where warranted. If the employer fails to provide the claimant with a proper panel at the appropriate time, the employer may be liable for all treatment related to the compensable injury rendered by any physician.

⁵ The Act also provides coverage for diseases shown to be caused by the employment. Coverage for disease is addressed in Chapter 4 of the Act, Code Sections 65.2-400 and following. Because work related accidents give rise to a majority of claims filed with the Commission, the discussion here will be limited to issues relating to injuries sustained by accident. Similar principles apply to cases involving diseases.

⁶ Generally, chiropractic care is included. See Code Section 65.2-603 D.

The determination as to what constitutes reasonable and necessary medical treatment is one for the treating physician. The treating physician may refer the claimant to specialists and prescribe diagnostic measures and medication, as he or she deems appropriate. Although the insurance carrier may take an active role in monitoring the claim, it cannot manage the claimant's medical care. What constitutes improper medical management by the carrier is a question that has resulted in much litigation before the Commission. Precise definition of the concept is beyond the scope of this article.

Having discussed the categories of treatment for which the employer may be liable, we now look at the monetary extent of the employer's liability. The amount of the employer's liability for these charges is limited by Code Section 65.2-605 to

such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person[.]

Thus, the employer is required to reimburse the provider for services and treatment modalities based upon the rate that is usual and customary in the geographic location where the treatment is rendered. If the treatment is rendered outside Virginia, the Commission may determine the appropriate community for purposes of calculating the amount of reimbursement. Rule 14 of the Commission's Rules defines the geographic locations within the state relevant to this determination.⁷

Virginia's statutory scheme for pricing of covered medical charges differs significantly from that of many other states. There is no fee schedule in Virginia. Instead, reimbursement rates are determined by market forces in the relevant community

⁷ All statutes, regulations and case law referred to in this article can be located through the Commission's website at www.vwc.state.va.us. The site also includes a section designed specifically for medical providers.

rather than by regulation. This flexible approach, designed to accommodate regional pricing variance, is administered by the Commission primarily through adjudication.

The purpose of this article is to provide a general overview as to medical benefits under the Act. Each topic discussed raises many questions that simply cannot be addressed in this limited space. The next article will provide a brief overview of the Commission's claims and adjudication processes, and the manner by which health care providers may invoke those processes.