VIRGINIA:
IN THE WORKERS' COMPENSATION COMMISSION

Opinion by NEWMAN
Commissioner

Aug. 7, 2025

WIL HANSON v. YMCA OF SOUTH HAMPTON ROADS
SENTINEL INS CO, Insurance Carrier
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC, Claim Administrator
Jurisdiction Claim No. VA00000493234
Claim Administrator File No. 0760088217000101600
Date of Injury: August 03, 2011

Philip J. Geib, Esquire
For the Claimant.

Robert M. McAdam, Esquire
For the Defendants.[1]

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

The claimant requests review of the Deputy Commissioner's November 25, 2024 Opinion which denied payment of the balances alleged to be due to three medical providers. We AFFIRM.

I. Material Proceedings

The claimant suffered injuries on August 3, 2011, for which he was awarded medical benefits.[2] On May 15, 2014, the claim was settled with terms including the claimant's receipt of a lump sum and the extinguishment of his entitlement to medical treatment rendered after March 28, 2014.

[1] Christopher R. Wilson, Esquire, represented the defendants before the Deputy Commissioner and filed their responsive statement on review. On April 10, 2025, KPM Law filed a letter stating that Attorney Wilson was no longer employed by the firm and requesting that he be removed as counsel of record. On May 6, 2025, Robert M. McAdam, Esquire, noted his representation of the Claim Administrator.

[2] We limit our discussion to only those facts relevant to the limited issues on review.

On March 29, 2022, the claimant filed an application seeking full payment of medical bills relating to treatment received prior to March 28, 2014.[3] At issue is whether any remaining balance is owed to three of his medical providers. The defendants argue to the contrary, contending the providers either wrote off the unpaid balances or accepted a reduced payment in full satisfaction for services rendered.

The Deputy Commissioner denied the requested relief, finding the claimant failed to establish that any amount remained outstanding on the subject bills and that the claimant failed to prove that the charges did not exceed the prevailing community rate .

The claimant requests review.

II. Findings of Fact and Rulings of Law

The gravamen of this protracted dispute is the claimant's allegation that a portion of the charges associated with medical treatment he received over a decade previous remains unpaid. The lengthy delay between treatment and the filing of this claim is pertinent in several regards, including that in the intervening years, the Virginia legislature enacted a fee schedule dictating an employer's liability for the cost of medical treatment rendered to an injured worker.[4] Because of the age of the treatment at issue here, we are compelled to revisit a principle of law rendered obsolete with the inception of the fee schedule - the prevailing community rate.

[3] The Deputy Commissioner initially denied this claim in a December 28, 2022 Opinion, finding the claimant lacked standing to pursue the claim for unpaid medical expenses. The full Commission reversed this ruling in an August 7, 2023 Opinion, remanding the matter to the Deputy Commissioner to determine whether further payment was due to the claimant's medical providers. *See Greatheart v. City of Hampton*, No. 0689-22-1 (Va. Ct. App. May 16, 2023).

[4] Virginia Code § 65.2-605 (2016).

Under Virginia Code § 65.2-603, an employer is liable to pay for medical treatment for as long as is necessary to treat a compensable injury.[5] Prior to the enactment of fee schedules, the benchmark capping an employer's liability to pay was articulated in Code § 65.2-605, limiting the costs to "such charges as prevail in the same community for similar treatment when such treatment is paid for by the [employee]."[6] This nebulous litmus test was colloquially abbreviated to, "the prevailing community rate" (hereinafter, "PCR").

Disputes arising out of a claimant's entitlement to medical treatment are common and come in multiple forms.[7] Particularly vexing to claimants, employers, medical providers, insurers, and the Commission are such disputes where the sole contest is over the amount the employer has been charged and whether such amount exceeds the PCR. Understanding the ease by which the Act's humanitarian ideals could be frustrated by obstructing the claimant's access to awarded medical treatment through incessant disputes over costs, the Commission imposed upon the employer the evidentiary burden of proving that a disputed bill exceeded the PCR. Stated otherwise, a tendered bill was accepted as prima facie evidence that the charge was consistent with the PCR and the burden fell upon the employer to prove otherwise. *Armstrong v. Ceres Marine Terminals, Inc.*, JCN 201-47-33 (July 27, 2011) (citing *Rabineau v. McDonald's/RJK Corp.*, VWC File No. 156-99-57 (Oct. 15, 1993), *aff'd*, No. 1603-11-2 (Va. Ct. App Mar. 6, 2012)).

[5] The statute provides that "[a]s long as necessary after an accident, the employer shall furnish or cause to be furnished, free of charge to the injured employee, a physician chosen by the injured employer from a panel of at least three physicians selected by the employer and such other necessary medical attention." Va. Code § 65.2-603.

[6] This remains the standard for allowable reimbursement for certain medical providers, such as online pharmacies.

[7] For example, an insurer may argue that charges were reduced by operation of a contract. *See Orthopaedic & Spine Ctr. v Muller Martini Mfg. Corp.*, 61 Va. App. 482, 487 (2013). A claim may also be defended on the grounds that a full and final settlement extinguished a claimant's rights to seek full payment of medical expenses. *See Winkler v. Spartannash*, JCN VA00001219191 (Aug. 17, 2020).

In *Ceres Marine Terminals v. Armstrong*, 59 Va. App. 694 (2012), the Court of Appeals of Virginia sanctioned this practice, deeming it "reasonable," when viewed in the light of two policy considerations. *Id.* at 703. The Court first noted that adopting a contrary rule would impose an undue burden on the claimant's medical provider and create an obstacle to the claimant's receipt of medical treatment. *Id.* at 703-704. Secondly, such a rule would place an excessive burden on the Commission:

> If the claimant had the burden of proving that the reasonableness of the charge for such medical treatment, the commission would likely find itself constantly evaluating the propriety of the charges for particular medical treatment whenever a claim is brought for payment, rather than doing it in the relatively isolated cases where the employer asserts that the charges are excessive.

Id. at 704-05.

Deeming a medical bill prima facie evidence undoubtedly protected claimants' right to receive medical treatment unencumbered by incessant disputes over the costs of treatment. However, it did nothing to protect the Commission from a tsunami of litigation compelling us to wrestle with a number of competing issues having nothing to do with whether the claimant was receiving awarded treatment.[8] Case in point—the dispute presently before us.

The Opinion below acknowledged that even in those cases where claimants seek the payment of the unpaid balance of medical expenses, the bill in question constitutes prima facie evidence that it conformed to the PCR. Citing *Ceres Marine*, the Deputy Commissioner held:

> In routine practice before the Commission, defendants do not contest the amount asserted [to be] owed for the services rendered. The employer/insurer instead concede[s] the difference between the amount asserted by the medical provider and

[8] The multitude of frustrating issues presented by these claims was acknowledged by the Court of Appeals of Virginia, which noted in *Orthopaedic & Spine Ctr. v. Keystone Auto. Indus.*, No. 0917-14-1 (Va. Ct. App. Dec. 23, 2014), that "[t]his case calls upon us to descend into a modern Slough of Despond, otherwise known as medical billing."

> the amount they paid and submit evidence to meet "the burden of proving that the medical fee was excessive on the employer," and that the amount they paid met the prevailing community rate standard of Virginia Code § 65.2-605.

(Op. 6.) (quoting *Ceres Marine*, 59 Va. App. at 703) (citation omitted).

The Deputy Commissioner noted the defendants did not allege the medical charges exceeded the prevailing community rate. Rather, their defense was more fundamental, disputing the existence of a debt and contesting the accuracy of evidence submitted at hearing as proof of a debt. The defendants attacked "the sufficiency of the evidence presented to establish [the claimant's] prima facie case," and the Deputy Commissioner "found that this attack succeeded." (Op 6.) Consequently, the claimant was not entitled to rely upon a presumption that submitted billing records were consistent with the PCR. Absent the benefit of that presumption, the claimant bore the burden to prove that the charges were consistent with the PCR. Having failed to introduce any evidence relevant to the point, the claimant's case fails. The claimant contends this was error and argues that his evidence, unrebutted by the defendants, satisfied his burden to prove a prima facie case.

As noted by the Deputy Commissioner, this is not the typical case where billed charges and payments are undisputed, leaving only the question of whether the bills exceed the PCR. Arguably, the PCR is irrelevant until there is evidence of the existence of a debt. As a threshold matter, a party seeking reimbursement of medical expenses must establish payment is owed for the treatment at issue. *See Johnson v. New Beginnings Assisted Living*, VWC File No. 230-03-07 (Apr. 10, 2009) (holding that a medical provider "satisfied his burden of proof regarding the amount of the bill" by claiming a "specific amount in his application" and submitting "sufficient evidence to support the Deputy Commissioner's finding that he was entitled to recover this

amount"). A "necessary precondition to the claimant's right to pursue payment of unpaid medical charges is the existence of [] unpaid charges." *Winkler v. Spartannash*, JCN VA00001219191 (Aug. 17, 2020). Without proof of unpaid bills, there is no "corresponding cause of action for the claimant to pursue." *Id.*; *see Hand v. Tidewater Termite & Repair Inc.*, JCN VA00000096701 (Mar. 18, 2021) (Newman, Concurring) ("This is a claim predicated upon the existence of a debt. The evidence establishes no debt exists.").

In *Greatheart v. City of Hampton*, No. 0689-22-1 (Va. Ct. App. May 16, 2023), the Court of Appeals addressed multiple issues raised in an appeal of a decision by the Commission denying the payment of a claimed balance on a submitted bill. The procedural posture of the case was identical to that at present, with the claimant attempting to recover the balance of medical bills for services rendered prior to a settlement. Pertinent to the circumstance here, the Court affirmed the denial of additional payment based upon the Commission's factual finding that no balance was due. The medical provider accepted the sum tendered as payment in full, marking the balanced owed on the bill as "$0.00." The Court noted that "[t]here is nothing within the language of the [settlement] order that states the medical treatment payments cannot be adjusted or that providers cannot accept a lesser sum than initially charged." *Id.*

Here, the claimant averred an unpaid balance was due to three of his medical providers. The first, Therapy Concepts, ceased operation in 2022, and its original billing records were destroyed. In support of his application, the claimant submitted a reconstructed transaction ledger. Michelle Braxton-Barone, its former owner, testified in her August 20, 2024 deposition that she signed an affidavit stating that Therapy Concepts had not been paid $8,793.99 for treatment rendered to the claimant. However, Barone denied preparing the affidavit or calculating what

balance remained due. She testified to her belief that calculations had been performed by claimant's counsel after review of bills provided by his client. Nevertheless, Barrone confessed ignorance of how the ledger had been reconstructed and would have had "to take a look at everything across the board" to perform her own calculations regrading what Therapy Concepts was owed. (Defs.' Pos. S. Ex. 1.) That, she did not do.

The claimant alleged APM Spine and Sports ("APM") was owed $652.64. APM closed its doors in December of 2018, and as was the case with Therapy Concepts, its original billing records were not presented. The claimant submitted two letters prepared by Tracy Patrick, a billing consultant hired by a physician formerly employed by APM. The first, dated January 25, 2024, states there was a $305.64 balance due on the claimant's account for services provided from February 6, 2012 through March 18, 2014. (Defs.' Pos. S. 165-66.) An August 13, 2024 letter from Patrick states she "revised the amount due [] from $305.64 notated on my original to $652.64 to include the date of service 08/15/2011," and was "attaching a revised spreadsheet that indicates this balance." (Cl.'s Pos .S. 38, 46.) This spreadsheet, titled an "Account Information Report," is a list of debts and credits, and its final entry shows no balance due. In an August 13, 2024 deposition, Patrick testified that APM's billing system required each entry to show a balance of zero, and the differences between the initial charges and payments received were listed as contractual adjustments. However, Patrick could neither confirm nor deny that a contract providing

for the reduction of charges existed between APM and the insurer, nor was she able to state another reason why the reductions were applied.[9] (Defs.' Pos. S. Ex 7.)

Lastly, the claimant averred Norfolk Chiropractic Center ("Norfolk Chiropractic") was owed $544.96. Billing records were submitted stating the claimant had been charged $2,340 for treatment and the insurer paid $1,795.04. The bill did not state any further balance was due, listing $544.96 as an "Insurance Write-off." Dr. Michael Scott Niblo, the owner of Norfolk Chiropractic, in his August 13, 2024 deposition, initially denied the provider had written off the unpaid balance. However, he later conceded that whether or not to write off the unpaid balance would have been decided by the practice's office manager rather than himself. Noting that the treatment at issue had been provided approximately twelve years ago, Dr. Niblo confessed ignorance of whether the office manager had written off the balance. (Defs.' Pos. S. Ex 4.)

We agree with the defendants that the evidence does not establish further payment is due for the claimant's medical treatment. In so ruling, we find the Court's reasoning in *Greatheart* particularly relevant. In the case of each provider, no efforts were undertaken to seek the balance due until many years after treatment was last rendered, and after Therapy Concepts and APM were out of business. Therapy Concepts' former owner, Michelle Braxton-Barone, did not prepare the Affidavit introduced as evidence of a debt, she reviewed no records to confirm the accuracy of the

[9] On review, the defendants argue in their responsive written statement that the claimant failed to prove the absence of a contract. This argument misstates the burden of proof, as "[t]he party claiming that the default statutory standard has been displaced by a contractual agreement bears the burden of proving such an agreement." *Orthopaedic & Spine Ctr. v. Keyston Auto. Indus.*, No. 0917-14-1 (Va Ct. App. Dec. 23, 2014); *Bloomberg-Michael Furniture Co. v. Coppes Bros. & Zook*, 141 Va. 18, 32 (1925) (holding the party alleging the existence of a contract to "establish by a preponderance of the evidence the existence of [such] a contract . . . .").

Affidavit, and professed ignorance of the accuracy of the ledger and Affidavit. We find Barone's Affidavit and Therapy Concepts' ledger unworthy of any evidentiary weight.

With regards to APM, the only evidence of unpaid charges was a report prepared by Tracy Patrick, who was hired by a former physician at the practice to collect additional payments for the then-shuttered business. Patrick admitted that the only basis she had for determining whether a debt existed was whether 100% of the charges had been paid. On those cases in which the billings exceeded payment, Patrick had no information about possible contractual reductions and conducted no investigation as to why payment was less than the amount billed.

Norfolk Chiropractic likewise failed to prove the existence of a debt for services rendered. The bill tendered on its behalf recorded both a zero balance and a write-off of the amount presently claimed to be due. We find Dr. Niblo's explanation that the "Insurance Write off" noted on the bill was not *actually* an insurance write off wholly unpersuasive.

For the reasons noted, we do not find the evidence submitted establishes the existence of a debt. Even were we to conclude otherwise, we would find that the providers accepted payment tendered in full without the intention to pursue any remaining balance. Finally, we find no basis to grant the claimant the benefit of a presumption that he has established a prima facie case. Nothing here would serve the noble ideals expressed in *Ceres Marine*. Long ago, the claimant settled his claim and forfeited his right to medical treatment. This dispute cannot frustrate an entitlement to medical benefits that was surrendered for a lump sum payment. Nor has the presumption unburdened the Commission from vexatious litigation instituted by disgruntled medical providers. The medical providers have not complained. If a debt existed, they allowed it

to lay fallow until two of the three providers went out of business and the third provider wrote the debt off. We find that this case is manufacturing a dispute where none exists.[10]

III. Conclusion

The Deputy Commissioner's November 25, 2024 Opinion is AFFIRMED.

This case is ORDERED removed from the review docket.

MARSHALL, COMMISSIONER, Concurring:

I join the majority as to the result. I agree the evidence presented is too tenuous to be a reliable basis for imposing the regular presumption of reasonableness for the allegedly underpaid charges.

I do not join the conclusion that the claimant's delay in filing a claim to recover underpayments of medical expenses is "pertinent" since the legislature subsequently enacted a medical fee schedule. In applying a required legal standard, our interpretations should not be shaped by the import of subsequent legislative enactments. That is to say, except for equitable doctrines such as laches, the time after a new legislative enactment in which assertion of a prior legal right is attempted is not a relevant factor in deciding whether to recognize that right.

The Supreme Court of Virginia has long affirmed, "although the words of a statute are broad enough in their literal extent to comprehend existing cases, they must be construed as applicable only to cases that may thereafter arise, unless a contrary interpretation is unequivocally

[10] The defendants raised an additional defense to the claim by arguing the Settlement Order's language extinguished the claimant's right to file further claims. The Deputy Commissioner did not reach this argument because the claim was denied on other grounds, and the defendants argue it should have been addressed. As we are affirming the denial of the claim, we likewise make no rulings on this issue. We note for the record the asserted defense and assignment of error so it will be preserved, if necessary, for further appeals.

expressed therein." *Campbell & Co. v. Nonpareil F. B. & K. Co.*, 75 Va. 291, 298 (1881). "It is a settled rule of interpretation of statutes that subsequent enactments dealing with the same subject are not to be construed as taking away the pre-existing jurisdiction of such courts, unless such intention plainly appears." *Shirkey v. Kirby*, 110 Va. 455, 458 (1909); *Durett v. Davis*, 65 Va. 302, 314 (1874); *Wayland v. Tucker*, 45 Va. 267 (1868). "No statute is construed as interfering with vested rights unless that intention is expressly declared." *Ferguson v. Stokes*, 287 Va. 446, 454 (2014); *see* Va. Code §1-239.

I do not join the conclusion that the prevailing community rate was or is a "nebulous litmus test." Virginia's prevailing community rate was, and is, well defined through case law from the Commission and the appellate courts. *See, e.g., Ceres Marine Terminals v. Armstrong*, 59 Va. App. 694 (2012); *Griffin v. Suffolk City Pub. Schs.*, 71 O.W.C. 217, 219 (1992).

I do not join the majority's conclusion that the claimant is not entitled to a remedy because he failed to establish a "debt," or that "the PCR is irrelevant until there is evidence of the existence of a debt." (Maj. Op. 5). This interpretation seems an artifice to undercut the presumption of reasonableness recognized by the appellate courts. A claim for underpayment of medical expenses is not dependent on what the bill shows as the remaining balance. Rather, the Commission may consider the submission of a medical bill "as prima facie evidence that the *charges* were consistent with the requirements of the Act." *Armstrong*, 59 Va. App. at 703.[11]

[11] In this case, we do not have the normal evidence required for accord and satisfaction, to-wit: proof that the evidence "that the debtor intend[ed] that the proffered amount be given in full satisfaction" of the dispute and that the creditor "accept that amount in accordance with the debtor's intent." *Northrop Grumman Shipbuilding, Inc. v. Wardell Orthopaedics, P.C.*, 67 Va App. 420, 434 (2017) (quoting *Gelles & Sons Gen. Contr. v. Jeffrey Stack, Inc.*, 264 Va. 285, 289-90 (2002)).

As a threshold showing, the claimant need only show what the medical provider's charges were and that those charges have not been paid in full.[12] This then places the burden "of proving that the medical fee was excessive on the employer." *Id*. At the most basic level, the presentation of a current "zero" balance on a bill to the claimant does not preclude a finding that an employer underpaid a medical bill, or that the charges reflected thereon are not prima facie evidence of reasonableness. *See Mccabe v. Farm Fresh Supervalu, Inc.*, JCN VA00001216541 (Jan. 9, 2020) (it is "irrelevant whether third parties paid towards the bills such that they now reflect a zero balance owed."). Under the Workers' Compensation Act, a claimant has a right to have his employer pay his causally related medical expenses. *Miller v. Potomac Hosp. Found*, 50 Va. App. 674, 685 (2007); *Combustion Eng'g v. Lafon*, 22 Va. App. 235, 238 (1996). I rely on the reasoning of my concurrence in *Winkler v. Spartannash*, JCN VA00001219191 (Aug. 17, 2020).

I disagree this case is manufacturing a dispute where none exists. While the majority's expressed distaste for having to interpret and apply prevailing community rate to bills that long ago were paid in part is apparent, that is not a legal or, on this record, an equitable basis to deny a remedy.

For these reasons, I respectfully concur.

[12] *New Beginnings* does not stand for the proposition cited by the majority. The cited language was in response to the Uninsured Employer's Fund's assignment as error of the Deputy Commissioner's refusal to direct it to pay the medical provider's bills generally, without an amount, to afford them an "opportunity to apply their usual cost containment procedures," and to consider the "itemized bills and CPT codes." There is no such request for extraordinary relief here.

APPEAL

You may appeal this decision to the Court of Appeals of Virginia by filing a Notice of Appeal with the Commission and a copy of the Notice of Appeal with the Court of Appeals of Virginia within thirty (30) days of the date of this Opinion. You may obtain additional information concerning appeal requirements from the Clerks' Offices of the Commission and the Court of Appeals of Virginia.