

VIRGINIA:
IN THE WORKERS' COMPENSATION COMMISSION

Opinion by the
Commission

Aug. 4, 2025

EARL HILL v. LOUDOUN COUNTY PUBLIC SCHOOLS
LOUDOUN COUNTY PUBLIC SCHOOLS, Insurance Carrier
PMA MANAGEMENT CORP., Claim Administrator
Jurisdiction Claim No. VA00001901843
Claim Administrator File No. 0035W55732
Date of Injury: October 15, 2021

Andrew J. Reinhardt, Esquire
John V. Cattie, Esquire (Pro Hac Vice),
For the Claimant.

J. David Griffin, Esquire
For the Defendants.

REVIEW before Commissioner Marshall, Commissioner Newman, and Commissioner Rapaport at Richmond, Virginia on July 2, 2025.

The parties jointly request review of the Deputy Commissioner's April 7, 2025 rejection of a proposed compromise settlement on the basis that it was not in the claimant's best interest as required by Virginia Code § 65.2-701. We AFFIRM the Deputy Commissioner's decision.¹

I. Material Proceedings

The claimant sustained a compensable injury by accident on October 15, 2021. A September 13, 2022 Award Order granted lifetime medical benefits for a concussion, and temporary total disability beginning January 27, 2022 and continuing. On December 9, 2022, the

¹ The parties have filed proposed settlement documents in multiple other claims before the Commission. However, the only matter before us on review is the parties' Request for Review of the Deputy Commissioner's rejection of the proposed settlement in JCN VA00001901843.

claimant filed a protective claim alleging a head/brain injury, traumatic brain injury, and injuries to the eyes, ears, and neck.

On July 21, 2023, the defendant filed an Employer's Application for Hearing seeking termination of the outstanding award on the basis that the claimant's disability was unrelated to the accident, based upon Dr. Seth Tuwiner's July 18, 2023 report. The claimant disputed the employer's allegation and the application was referred to the hearing docket. Rather than proceed with a hearing, the parties chose to participate in alternative dispute resolution.

The claimant filed claims seeking continuing temporary total disability benefits and alleging compensable consequences of his injuries, including: post-concussion syndrome, post-traumatic headaches, visio-vestibular disorder, occipital neuralgia, benign paroxysmal position vertigo, right ear tinnitus, post-traumatic vision syndrome, convergence insufficiency, cognitive communication disorder, dysexecutive disorder, depression, fatigue, sleep apnea, post-concussion syndrome with cervical/vestibular-oculomotor sequelae, and post-concussion photophobia.

On December 12, 2024, a Deputy Commissioner entered a Stipulated Order. The Order stated that the claimant had not received any benefits since July 26, 2023, as compensability was disputed. To avoid the costs of further litigation, the parties agreed the claimant would be paid a lump sum for permanent total disability benefits and agreed that this was a "cap to indemnity benefits of any kind or type[.]" The Stipulated Order further stated:

The parties agree that the stipulations set forth . . . and the Employer's payment of any permanent total disability are contingent upon the Claimant settling any and all claims against the employer in connection with his October 15, 2021 work accident referenced herein. The parties further agree the Employer is not bound by this permanent total disability stipulation if a settlement does not occur.

The parties filed proposed full and final settlement documents on March 28, 2025.² The parties agreed to a lump sum payment to fully extinguish and forever foreclose any and all claims against the employer for any injuries by accident sustained on October 15, 2021. The petition for compromise settlement stated that the claimant was a Medicare recipient. The parties asserted that the lump sum provided for by the settlement did not exceed the thresholds set by the Center for Medicare and Medicaid Services (CMS) for review of a Medicare Set Aside (MSA) and that the claim did not require an MSA.

On April 7, 2025, the Deputy Commissioner rejected the proposed settlement. He found that, because the Stipulated Order entered December 12, 2024 provided a sum for permanent total disability benefits contingent upon settlement of the claim, that sum was part of the settlement and placed the settlement over the threshold for approval of a Medicare Set Aside (MSA) by the Center for Medicare and Medicaid Services (CMS). He found, “the claimant’s failure to secure that approval would subject the claimant to potential penalties, including the loss of future Medicare benefits related to the compensable injuries.” In determining whether the settlement was in the

² The parties originally filed proposed full and final settlement documents on December 20, 2024.

On December 27, 2024, the Deputy Commissioner advised the parties he was unable to approve the proposed settlement. He found the documents did not comply with Commission Rule 1.7(A)(6), which requires that a petition for compromise settlement set forth “A statement on the claimant’s Medicare status.” The Deputy Commissioner also found that the benefits provided for by the December 12, 2024 Order were part of the settlement, thereby bringing the total amount of the settlement over the threshold for review of a Medicare Set Aside (MSA) by the Center for Medicare and Medicaid Services (CMS). He therefore found the settlement required approval of an MSA by CMS. The Deputy Commissioner provided the parties the opportunity to address these concerns by filing position statements. Afterwards, on January 29, 2025, the Deputy Commissioner rejected the proposed settlement, noting that the parties had taken the position “that CMS approval of an MSA is not required with respect to this or any proposed settlement,” and stating that he “decline[d] to reverse the Commission’s policies with respect to CMS review.”

The parties requested review. On March 19, 2025, the Commission issued an Order dismissing the parties’ Request for Review of the rejection of the settlement on the basis that it was not ripe for review, as the documents did not comply with Commission Rule 1.7(A)(6) and the Deputy Commissioner had not made a finding regarding whether the settlement was in the claimant’s best interest. The parties submitted revised settlement documents on March 28, 2025.

best interests of the claimant, as required by Virginia Code § 65.2-701, the Deputy Commissioner relied on the Commission’s policy requiring compliance with the intent of the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b). The Deputy Commissioner stated that, because the parties had failed to secure approval from CMS for the proposed settlement, he could not find the proposed settlement in the claimant’s best interest.

The parties filed a joint Request for Review. They assert the Deputy Commissioner erred in rejecting the settlement based on guidance from CMS rather than making a decision based on the best interests of the claimant.³

II. Findings of Fact and Rulings of Law

In deciding whether to approve the parties’ compromise settlement agreement, the Commission is bound by Virginia Code § 65.2-701, which states, in pertinent part:

- A. If after injury or death, the employer and the injured employee or his dependents reach an agreement in regard to compensation or in compromise of a claim for compensation under this title, a memorandum of the agreement in the form prescribed by the Commission shall be filed with the Commission for approval. The agreement may be prepared by the employee, the employer or the compensation carrier. If approved, the agreement shall be binding, and an award of compensation entered upon such agreement shall be for all purposes enforceable as provided by § 65.2-710. If not approved, the same agreement shall be void. Such agreement may be approved *only when the Commission, or any member thereof, is clearly of the opinion that the best interests of the employee or his dependents will be served thereby*
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- C. Nothing herein contained shall be construed so as to prevent settlements made by and between the employee and employer, but rather to encourage them, so long as the amount of compensation and the time and manner of payment are approved by the Commission. . . .

³ The parties’ Request for Review identifies numerous “assignments of error,” all of which are arguments related to this overarching issue.

While, as the statute states, we encourage parties to resolve claims by agreement, such agreements must be approved by the Commission. The statute places clear limits on when the Commission may approve an agreement. The Commission may “only” do so when a member of the Commission is “clearly”⁴ of the opinion that the agreement serves the “best interests of the employee.” Va. Code § 65.2-701.

In deciding whether a settlement is in the claimant’s best interest, the Commission looks to a number of factors, including whether the settlement has considered Medicare’s interests. This consideration stems from the requirements of the Medicare Secondary Payer Act, 42 U.S.C. § 1395y, which provides that payment for items or services may not be made by Medicare when “payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or States” 42 U.S.C. § 1395y (b)(2)(A)(ii). The statute further provides that, “A primary plan’s responsibility may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services against the primary plan or the primary plan’s insured, or by other means.” *See Id.* § 1395y (b)(2)(B)(ii). To the extent that Medicare’s interests are not considered with respect to future medical expenses, CMS has a priority right of recovery and can bring an action to recover payments made by Medicare. Department of Health & Human Services, Centers for Medicaid and Medicare Services, *Workers’*

⁴ Black’s Law Dictionary defines “Clearly” as “Visible, unmistakable, in words of no uncertain meaning. Beyond a question or beyond a reasonable doubt; honestly, straightforwardly, and frankly; plainly. Without obscurity, obstruction, entanglement, confusion, or uncertainty. Unequivocal.” *Clearly*, *Black’s Law Dictionary* (6th Ed. 1990).

Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide Version 4.3, COBR-Q2-2025-v4.3 (Apr. 7, 2025), <https://www.cms.gov/files/document/wcmsa-reference-guide-version-43.pdf>, at § 3.0; 42 USC § 1395y(b)(2)(B)(ii). Medicare may also refuse to pay for future medical expenses until the entire settlement is exhausted. *WCMSA Reference Guide*, at § 3.0.

For a workers' compensation claimant to protect themselves from these possible outcomes and protect Medicare's interests, CMS has set up a process by which parties may pursue a CMS-approved Workers' Compensation Medicare Set Aside (WCMSA). Per CMS's Reference Guide, "The goal of establishing a WCMSA is to estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-injury related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost." *Id.* When a proposed WCMSA is submitted to CMS for review and is approved, the approved WCMSA amount must be exhausted before Medicare will begin to pay for care related to the settled claim. *Id.* CMS has explained that when it reviews and approves a proposed WCMSA amount, "CMS stands behind that amount." *Id.* at 4.2. Yet, "Without CMS' approval, Medicare may deny related medical claims, or pursue recovery for related medical claims that Medicare paid up to the full amount of the settlement, judgment, award, or other payment." *Id.*

Based on its workload, CMS has created "thresholds" for when it will review a WCMSA. *Id.* at § 8.1. If a claimant is a Medicare beneficiary and the total settlement amount is greater than \$25,000, CMS will review a proposed WCMSA. *Id.* CMS's Reference Guide acknowledges that

submitting a proposed WCMSA to CMS for review is never required, but workers' compensation claimants must always protect Medicare's interests. *Id.* at § 4.2.

In accordance with the Medicare Secondary Payer Act, the Commission has required parties to establish that their proposed settlement appropriately considers Medicare's interests. The Commission's Petition and Order Requirements incorporate the guidelines established by CMS for review of a WCMSA. They provide,

All settlements closing out the defendants' responsibility for medical treatment must reflect in the Petition that Medicare's interests have been considered. If the claimant is currently entitled to Medicare and the settlement is over \$25,000 or the settlement is over \$250,000 and there is a reasonable expectation of Medicare entitlement within 30 months, then the parties must appropriately address the Medicare Secondary Payer Act, normally by a Medicare set-aside trust in an amount approved by the Centers for Medicare and Medicaid Services (CMS). If a Medicare set-aside trust is appropriate, documentation of CMS approval is required. CMS does not review WCMSA proposals for Medicare beneficiaries when the total settlement is less than \$25,000.

If the parties wish to settle before CMS review and approval of the proposed WCMSA, the Petition and Order can indicate the WCMSA will be submitted to CMS for approval and the defendants will be responsible for any additional amounts required by CMS. The medical provision should provide for treatment through the date of CMS Approval or the date of funding of the MSA.

In appropriate cases as determined by the Commission, the parties may use in the documents the following Commission approved indemnification language if it is accompanied by a professionally prepared MSA proposal which is based upon reasonable and supportable assumptions as to future treatment

Virginia Workers' Compensation Commission, *Petition and Order Requirements*, <https://workcomp.virginia.gov/documents/petition-and-order-requirements>, at (B.)(12.)

It is within this framework that we must decide whether the proposed settlement in this matter is in the claimant's best interest, Va. Code § 65.2-701(A). The claimant is a current Medicare beneficiary. The Petition for compromise settlement states that the claimant has not

received any benefits for his injury since July 26, 2023, and the employer will not be responsible for any additional medical benefits in connection with the accident after July 26, 2023, as compensability is disputed. The proposed Order allocates a portion of the lump sum for attorney's fees and a portion for medical benefits and expenses.⁵ The petition summarizes the claimant's medical status as follows:

Claimant sought initial treatment from Valley Health Employer Health and eventually came under the care of Gregory J. O'Shanick, MD. The Claimant was diagnosed with concussion without loss of consciousness, post-traumatic headaches, occipital neuralgia, visio-vestibular disorder, benign paroxysmal positional vertigo (BPPV), auditory processing disorder, tinnitus in right ear, post-traumatic vision syndrome, convergence insufficiency, cognitive communication disorder, dysexecutive disorder, anxiety, depression, and fatigue, which is being treated conservatively with ongoing bi-monthly office visits, medications, balance/vestibular therapy, and vision therapy with a neuro-optometrist. Dr. O'Shanick opined that the Claimant has been totally disabled from gainful employment from the date of the accident to present, and that he is more than likely to remain totally disabled on a permanent basis as a result of his injuries sustained as a result of the work accident of October 15, 2021. Claimant continues to treat with Dr. O'Shanick on a bi-monthly basis and was last seen by him on July 11, 2024. On June 2, 2023, the Claimant underwent an Independent Medical Examination by Dr. Seth Tuwiner, who opined that the Claimant had reached maximum medical improvement related to the work injuries, and that the Claimant's current symptoms and disability are due to pre-existing and unrelated Parkinson's disorder. Dr. Tuwiner also opined that the Claimant's condition is further complicated by pre-existing sleep apnea, insomnia, depression, and various orthopedic conditions.

We have reviewed the medical records, which corroborate this summary. The Commission's file also contains a questionnaire signed by Dr. O'Shanick on June 6, 2024, in which he agreed that the claimant needed ongoing medical treatment for his head/brain injury, concussion, post-concussive syndrome, post-traumatic headaches, post-traumatic vision disorder, neuralgia, sleep apnea, and

⁵ The December 12, 2024 Order allocated a lump sum for permanent total disability benefits.

cognitive communication disorder. He agreed these conditions and treatment were related to the October 15, 2021 work accident.

Regarding Medicare, the Petition for settlement states:

Claimant is currently receiving Social Security disability benefits and is a Medicare recipient. It is not the purpose of this settlement agreement to shift responsibility of medical care in this matter to the Medicare program. Instead, this settlement is intended to resolve a dispute between Claimant and Employer. This claim does not meet Medicare's current review thresholds as described in the July 11, 2005, and April 24, 2006, Medicare Policy Memoranda. As such, this claim does not require review and/or approval from CMS. The parties hereto agree that no Medicare Set Aside account is required to further consider CMS/Medicare's interests.

On review, the parties do not challenge the Deputy Commissioner's finding that the sums provided for in the December 12, 2024 Stipulated Order are properly considered part of the settlement, thereby placing the settlement amount above the thresholds for review of an MSA by CMS. Rather, the parties contend that the Commission should not require the approval of an MSA by CMS in this matter. They assert numerous reasons for taking this position, including: (1) that CMS guidelines do not have the force of law; (2) that submission of an MSA to CMS is voluntary; (3) that the claimant has taken steps to protect Medicare's interests in this matter; and (4) that the Commission should defer to the opinion of claimant's counsel that the settlement is in his best interest.

We have considered the parties' written and oral arguments in support of the settlement, the settlement documents themselves, and the other documentation in the Commission's file. We find the proposed settlement is not in the claimant's best interest. We acknowledge that CMS's guidelines are not laws and that submission of an MSA to CMS is a voluntary process not required by law. Nevertheless, we will not ignore the import of the Medicare Secondary Payer Act. Shifting

the responsibility for medical treatment related to the work injury to Medicare subjects the claimant to litigation and potentially significant financial impact, up to the total amount of his settlement. We cannot find that a settlement that ignores these possibilities is in the claimant's best interest. Also, the allocation of assets between a Stipulated Order, *contingent upon settlement* and a separate settlement agreement indirectly incorporating that Order cannot be used to circumvent our statutory best interest analysis.

The parties contend that Medicare's interest have been considered, as the claimant retained counsel specializing in Medicare issues, who advised that approval of a Medicare Set Aside was unnecessary in this matter. It is our understanding that counsel takes this position because CMS's MSA submission process is not mandated by any statute or regulation, but is simply a policy implemented by CMS based on its interpretation of the Medicare Secondary Payer Act. Counsel argues that following the Supreme Court of the United States' decision in *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (Jan. 17, 2024), a federal judiciary would not give deference to CMS's interpretation of the Medicare Secondary Payer Act. Thus, he contends, CMS's policies are subject to challenge. Yet, hypothetical challenges to a federal agency's policies are not relevant to our decision. Instead, our decision is determined by the claimant's best interest.

We find it would be in the claimant's best interest to ensure Medicare's interests are adequately protected, which insulates him from the potential consequences of failing to do so. We agree with the Deputy Commissioner's finding that the claimant's failure to secure approval of an MSA from CMS subjects him to potential penalties, including the loss of future medicare benefits, which is not in his best interest. In reaching this decision, we have considered CMS's

guidance regarding when an MSA may not be necessary. It states:

[A] WCMSA is not necessary under the following conditions because when they are true, they indicate that Medicare's interests are already protected:

- a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement); and
- b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment.

These conditions may be demonstrated through one of the following:

- The individual's treating physician documents in medical records that to a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury or illness; or
- The workers' compensation insurer or self-insured employer denied responsibility for benefits under the state workers' compensation law and the insurer or self-insured employer has made no payments for medical treatment or indemnity (except for investigational purposes) prior to settlement, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future or past medical or pharmacy services as a condition of settlement; or
- A Court/Commission/Board of competent jurisdiction has determined, by a ruling on the merits, that the workers' compensation insurer or self-insured employer does not owe any additional medical or indemnity benefits, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services; or
- The workers' compensation claim was denied by the insurer/self-insured employer within the state statutory timeframe allowed to pay without prejudice (if allowed in that state) during investigation period, benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services.

In addition, if a settlement leaves WC carriers with responsibility for ongoing medical and prescription coverage once the settlement funds are fully spent, then a WCMSA is not necessary.

WCMSA Reference Guide, at § 4.2.

In this case, the treating physician has opined that the claimant will need continued care for his work injury. The defendant previously accepted the claim and paid for medical treatment. The defendant now disputes the claimant's need for further medical treatment related to the work injury. There has been no adjudication of this dispute. The proposed settlement explicitly allocates a portion of funds for medical expenses and forever extinguishes the defendant's responsibility for medical treatment. These circumstances plainly do not meet CMS's conditions for establishing an MSA is unnecessary.

CMS has explicitly stated that, when the above conditions are not met, "CMS' voluntary, yet recommended, WCMSA amount review process is *the only process that offers both Medicare beneficiaries and Workers' Compensation entities finality, with respect to obligations for medical care required after a settlement, judgment, award, or other payment occurs.*" *Id.* (emphasis added). We are not persuaded that it would be in the claimant's best interest to enter into an agreement, closing out the defendant's responsibility for his injury-related medical care, without having finality with respect to his obligations for medical care. While there may be other ways of protecting Medicare's interests—for example, leaving the medical award in place and foreclosing only future indemnity claims, or setting up a non-CMS-approved MSA and adding an indemnification clause to the settlement—the parties have not availed themselves of these or any other options. Instead, the claimant has simply retained counsel who advised that an MSA was not required in this matter. Counsel represented at oral argument that he would defend the claimant against any future action by the federal government related to this matter. However, the assurance of legal counsel does not protect Medicare's interests or give the claimant finality with respect to

his financial obligations for medical treatment. And, those representations are not expressly recited within the Stipulated Order or the settlement Petition and supporting documents.

Finally, we have considered the claimant's assertions regarding why he agreed to the proposed settlement and how it will benefit him. We do not discount the benefits of the proposed settlement. However, the parties have not taken appropriate steps to protect Medicare's interests, thereby subjecting the claimant to potential litigation and unknown financial responsibility. We have weighed this circumstance against the benefits of the proposed settlement and are not "clearly of the opinion that the best interests of the employee . . . will be served" by the proposed settlement, Va. Code § 65.2-701. We find no error in the Deputy Commissioner's decision to reject the settlement based on a finding that it was not in the best interest of the claimant.

III. Conclusion

The Deputy Commissioner's April 7, 2025 rejection of the proposed compromise settlement is AFFIRMED.

This case is ORDERED removed from the review docket.

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.