

COURT OF APPEALS OF VIRGINIA

Record No. 1132-25-1

ORVILLE PETERS

v.

PORTSMOUTH PLUMBING SERVICES, INC., ET AL.

Present: Judges O’Brien, Chaney and Raphael

Argued by videoconference

Opinion Issued September 29, 2026

FROM THE VIRGINIA WORKERS’ COMPENSATION COMMISSION

Philip J. Geib (Philip J. Geib, P.C., on brief), for appellant.

Adam E. Strauchler (Teumer & Drash, on brief), for appellees.

PUBLISHED OPINION BY JUDGE STUART A. RAPHAEL

In 2018, the Workers’ Compensation Commission approved a lump-sum settlement agreement between claimant Orville Peters, his employer, and the employer’s insurance carrier. The Commission’s order memorializing the settlement provided that the employer and its insurance carrier would remain “responsible for authorized and necessary medical bills . . . related to the . . . injury . . . up until the date of the” settlement order. In 2019, Peters’s counsel asked the Workers’ Compensation Commission to order the employer and carrier to pay the balance allegedly due on some underpaid medical bills from 2013 and 2014. The Commission ultimately rejected the claim in 2025, ruling that the claim had been extinguished by the 2018 settlement order. The Commission did not resolve the employer and carrier’s fallback argument that no medical debt remained, at least according to a 2016 billing summary from the medical provider.

We reverse and remand this case to the Commission for further proceedings. The Commission erred in concluding that the 2018 settlement order discharged the alleged debt. The plain language of the order made the employer and carrier “responsible for authorized and necessary medical bills . . . up until the date of” the settlement order. We held in 2017 that the nearly identical provision—which the Commission includes in its sample forms on its website—imposed liability on the employer and carrier for unpaid medical bills through the date of the settlement order. *Northrop Grumman Shipbuilding, Inc. v. Wardell Orthopaedics, P.C.*, 67 Va. App. 420, 429 (2017) (*Wardell*). But because the Commission did not make a factual finding on whether any medical debt remained on the old bills, we remand this case for further proceedings consistent with this opinion.

BACKGROUND

On September 20, 2012, Peters was working as a master plumber for Portsmouth Plumbing Services, Inc. when he suffered a laceration to his right hand while operating a saw. Peters filed a claim for benefits with the Commission. Portsmouth and its insurance carrier, Nationwide Mutual Insurance Company (collectively, “Portsmouth”), agreed to pay him ongoing temporary total disability benefits. On March 19, 2013, the Commission entered an order approving the agreement and awarded Peters lifetime medical benefits for his injury.

Peters obtained medical treatment from various health care providers for the work-related injury. He received treatment from Gershon Pain Specialists, resulting in medical bills from February 21, 2013, through March 8, 2017. Portsmouth paid the bulk of those treatment charges, leaving an unpaid balance of \$994.82. Peters also received physical therapy from The Therapy Network (TTN) at various times from March 21, 2013, through January 9, 2014. Portsmouth paid most of those charges as well. Peters achieved maximum medical improvement for his injuries on July 8, 2014.

On August 8, 2016, Peters notified the Commission that Portsmouth had only partially paid his disability benefits and asked the Commission to award him the remaining amount due. Peters was represented by Philip J. Geib, who continues to represent Peters here. Portsmouth moved to terminate Peters's disability benefits, alleging that he had returned to work on July 14, 2016. On November 9, 2017, a deputy commissioner denied Portsmouth's motion and ordered that it pay temporary total disability benefits.

The month after Mr. Geib entered his appearance for Peters in 2016, an account summary from TTN, dated August 24, 2016, showed that the balance due for Peters's treatment was zero.

In July 2018, the parties jointly petitioned the Commission to approve a compromise lump-sum settlement. The petition included an affidavit from Peters that he understood that if the Commission approved the settlement, he "[could not] obtain any additional compensation or medical benefits from the employer and insurer, other than those agreed to in the settlement." He also acknowledged that approval of the settlement would "forever close[] my case, including any and all compensation or medical benefits except those specifically listed in the settlement." (Emphasis altered). The parties submitted a proposed joint order endorsed by counsel. Mr. Geib also filed a letter with the Commission attesting to having advised Peters of the implications of the settlement and stating that the settlement was in Peters's best interests.

The Commission may not approve a compromise settlement unless it "is clearly of the opinion that the best interests of the employee or his dependents will be served thereby." Code § 65.2-701(A). The Commission approved the proposed settlement on July 27, 2018, entering the parties' proposed order.

The settlement order provided as follows, with the key language relevant to this dispute in paragraph C:

A. Employer and Carrier agrees [sic] to pay a lump sum of One Hundred Fifty-Nine Thousand Dollars and No Cents (\$159,000.00) to settle this workers' compensation claim;

B. Claimant agrees to accept a lump sum payment of sum of One Hundred Fifty-Nine Thousand Dollars and No Cents (\$159,000.00) to settle his workers' compensation claim;

C. Employer and Carrier shall be responsible for authorized and necessary medical bills incurred by Claimant related to the September 20, 2012 injury by accident up until the date of the entry of the Order approving the compromise settlement, but no longer; and,

D. Claimant shall be responsible for all medical bills related to the September 20, 2012 injury subsequent to the date of entry of the Order approving the compromise settlement by the Virginia Workers' Compensation Commission.

The order also extinguished “all claims of any nature for . . . medical expenses, except as provided herein.” Peters’s affidavit, which was incorporated into the settlement order, stated “that this settlement forever close[d] [his] case, including any and all compensation or medical benefits except those specifically listed in the settlement.” (Emphasis altered).

About six months later, on February 11, 2019, Mr. Geib entered an appearance in Peters’s case “to represent the interests of the healthcare provider *Gershon Pain Specialists*,” asserting a “protective claim” for Gershon. A “protective claim” attempts to toll the one-year limitations period under Code § 65.2-605.1(F) for a medical provider to file a claim with the Commission for payment. *See Majors v. Whole Foods*, JCN VA00001200056, slip op. at 3-4, 2025 VA Wrk. Comp. LEXIS 17, at *4 (Jan. 14, 2025), *aff’d sub nom. Integrative Pain Specialists v. Whole Foods*, No. 0167-25-1, 2026 Va. App. LEXIS 102 (Feb. 17, 2026).¹

¹ The Commission held in *Majors* that a medical provider could not file a protective claim to toll the limitations period because it would “thwart the legislative intent” in Code § 65.2-605.1(F) to bar untimely claims on unpaid medical bills. *Majors*, slip op. at 6, 2025 VA Wrk. Comp. LEXIS 17, at *8. A panel of our Court disagreed with that conclusion (but affirmed on other grounds) in *Integrative Pain Specialists*, slip op. at *3-6, 2026 Va. App. LEXIS 102, at *3-7. The validity of a protective claim has not yet been addressed in a precedential appellate decision.

A few weeks later, on March 4, 2019, Mr. Geib filed a letter with the Commission—this time on behalf of Peters—requesting a hearing on his contention that Portsmouth had “only made partial payments to . . . Gershon Pain Specialists, . . . leaving outstanding medical expenses that remain unpaid in the amount of \$994.82.” The letter added that an outstanding balance was also owed to TTN “in the amount of \$6,879.90.” But that account balance did not match the attachment from TTN, dated August 24, 2016, which showed a zero balance due.

On May 6, 2019, Mr. Geib filed a letter with the Commission claiming to represent Peters and seeking payment of the balances allegedly owed to Gershon and TTN. His letter again attached the August 24, 2016 statement from TTN showing a zero balance due. According to the record before the Commission at R. 2084, Mr. Geib told Portsmouth on May 13, 2019 that he now represented both Gershon and TTN.

In April 2020, the Commission approved a stipulated order resolving the underpayment claim for Gershon. Portsmouth agreed to pay Gershon directly “100% of the underpaid and/or unpaid amount which totals \$994.82.” Although Geib was still counsel of record for Gershon, he endorsed the agreed order as counsel for Peters.

Mr. Geib withdrew his appearance as counsel for Gershon in May 2021. He withdrew his appearance for TTN on February 7, 2022.² See R. 2090.

² The Commission has previously ruled that Mr. Geib’s simultaneously representing the claimant and medical provider is not a per se violation of Virginia Rule of Professional Conduct 1.7—assuming that both clients consent in advance in writing after full disclosure—except when the clients’ interests are directly adverse in a way that makes the conflict unwaivable. *Compare Fetty v. City of Chesapeake*, JCN VA00000688079, slip op. at 8, 2016 VA Wrk. Comp. LEXIS 414, at *11 (Sep. 20, 2016) (“We do not find that there is presently a concurrent conflict of interest so as to limit counsel’s representation of the medical provider or the claimant.”), and *id.*, slip op. at 7, 2016 VA Wrk. Comp. LEXIS 414, at *10 (“[M]ere ‘imagined scenarios of conflict’ are not sufficient to create a concurrent conflict of interest.”), with *Farr v. Lincoln Prop. Co.*, JCN VA02000002128, slip op. at 8, 2015 VA Wrk. Comp. LEXIS 402, at *12-13 (Jan. 9, 2015) (affirming deputy commissioner’s order removing Geib as counsel for Gershon Pain Specialists where a third-party settlement created an impermissible conflict of interest between the claimant and Gershon); see generally Va. R. Prof. Conduct 1.7(b) (permitting representation in the same

Two years later—on September 13, 2023—Mr. Geib renewed his request to the Commission on behalf of Peters to make full payment to TTN in the amount of \$6,971.10 for its underpaid bills from 2013 and 2014. Mr. Geib attached a letter from TTN addressed to the Commission, dated April 21, 2019, in which TTN claimed that it had been underpaid in that amount and requested that the claim “be placed on the [Commission’s] docket to be heard for payment in full.” The record does not reflect that TTN itself ever filed that letter with the Commission. Mr. Geib told us at oral argument that he had requested that statement from TTN.

On April 18, 2024, Mr. Geib submitted his position statement to the deputy commissioner on behalf of Peters. He attached to that filing a new letter from TTN, dated March 19, 2024, in which TTN again asked that its request for “payment in full” be placed on the Commission’s docket. Again, that letter was not filed by TTN; it was submitted only by Mr. Geib, ostensibly on behalf of Peters. Confusingly, however, Mr. Geib attached to that letter the August 24, 2016 account statement from TTN that showed a zero balance due.

Peters argued in his position statement to the deputy commissioner that the plain language of the settlement order preserved Portsmouth’s liability for “authorized and necessary medical bills . . .

proceeding despite a concurrent conflict of interest provided “each affected client consents after consultation, and (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client; (2) the representation is not prohibited by law; (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and (4) the consent from the client is memorialized in writing”).

Neither the deputy commissioner nor the Commission voiced any concern below that Mr. Geib’s representation of the claimant simultaneously with his representation of the medical provider for whom he is seeking compensation created a disqualifying conflict of interest. Nor has Portsmouth. We note and agree with the Commission, however, that the fact that a tribunal has not affirmatively investigated a lawyer’s ethical conduct in a particular case does not amount to a finding that the lawyer’s “ongoing representation of any particular client is appropriate,” and it remains the lawyer’s “ongoing responsibility as an attorney who is regularly representing multiple parties in various litigated matters to monitor for conflicts of interest and take appropriate action when they arise.” *Pruitt v. Gutter Works, Sols.*, JCN VA00000109473, slip op. at 11, 2020 VA Wrk. Comp. LEXIS 586, at *16-17 (Dec. 30, 2020).

up until the date” of the settlement order. Among other authorities, Peters cited our published decision in *Wardell*, where we affirmed the Commission’s order holding the employer liable for the claimant’s medical bills through the date of a similarly worded settlement order. *See Wardell*, 67 Va. App. at 435.

On January 29, 2025, the deputy commissioner issued an opinion denying the claim. The opinion failed to mention *Wardell* or the language of the settlement order highlighted by Peters. The deputy commissioner instead cited the provision stating that claims not set forth in the settlement agreement were extinguished. The deputy commissioner found “controlling” the Commission’s decision (before it was reversed on appeal) in *Wagner v. Food Lion, LLC*, JCN VA00000241598, 2024 VA Wrk. Comp. LEXIS 27 (Feb. 1, 2024), *rev’d*, No. 0318-24-1, 2025 Va. App. LEXIS 628 (Oct. 14, 2025). The Commission in *Wagner* had relied on a similar “extinguishment” provision to conclude that the claimant was not entitled to seek further payment for medical providers than what had been previously ordered. *See id.*, slip op. at 4-5, 2024 VA Wrk. Comp. LEXIS 27, at *5-7. The deputy commissioner in this case reasoned, “Here, just as in *Wagner*, the claimant also extinguished his right to pursue this balance billing claim by express language in the order.”

The Commission affirmed. *See Peters v. Portsmouth Plumbing Servs., Inc.*, JCN VA00000669832, 2025 VA Wrk. Comp. LEXIS 127 (June 12, 2025). The Commission began by quoting the provision of the settlement order that made the employer and carrier responsible for authorized and necessary medical bills for services “up until the date” of the settlement order. *Id.*, slip op. at 1, 2025 VA Wrk. Comp. LEXIS 127, at *1. Still, the Commission agreed with the deputy commissioner that the extinguishment provision controlled. *Id.*, slip op. at 3, 2025 VA Wrk. Comp. LEXIS 127, at *3-4. The Commission did not address *Wardell* and did not explain

how the extinguishment provision overrode the express language preserving Portsmouth's liability for medical bills through the date of the settlement order. Peters noted a timely appeal.

ANALYSIS

A. We need not resolve whether the standard of review requires deference to the Commission's interpretation of its settlement order.

The parties disagree at the outset about the appropriate standard of review. Peters argues for de novo review of the Commission's interpretation of the settlement order. He maintains that the order simply memorialized the parties' own settlement agreement—a contract—so the Commission's interpretation of the contract is not entitled to any appellate deference. Portsmouth counters that the settlement order is an order of the Commission and the Commission, like a trial court, has “the authority to interpret [its] own orders.” *Rusty's Welding Serv., Inc., v. Gibson*, 29 Va. App. 119, 129 (1999) (en banc). Appellate deference to a lower court's interpretation of its own order is required when that interpretation is “reasonable.” *Roe v. Commonwealth*, 271 Va. 453, 458 (2006); *Davis v. Commonwealth*, 70 Va. App. 722, 732 (2019). Portsmouth argues that the same deference is owed to the Commission's interpretation of its settlement order.

Our appellate courts have not yet resolved this question in a published appellate decision. A panel of our Court held in *Wagner v. Food Lion, LLC*, No. 0318-24-1, 2025 Va. App. LEXIS 628 (Oct. 14, 2025), that de novo review applies to the Commission's interpretation of a settlement order.³ Slip op. at 6, 2025 Va. App. LEXIS 628, at *8. The panel in *Wagner* relied on the Commission's statement that a “Settlement Order memorialize[s] the final agreement of the parties, and should be interpreted in the same manner as any other contract.” *Id.* (alteration

³ The Supreme Court refused the petition for appeal in *Wagner*. See *Food Lion, LLC v. Wagner*, No. 251051 (Va. Apr. 28, 2026) (order).

in original) (quoting *Wagner*, slip op. at 5, 2024 VA Wrk. Comp. LEXIS 27, at *6). As our panel decision in *Wagner* is unpublished, however, it is not binding authority. See Rule 5A:1(f).

There are plausible arguments on both sides as to whether an appellate court owes deference to the Commission's interpretation of a settlement order. The argument for de novo review is supported by analogy to the normal appellate rules for reviewing a trial court's interpretation of a contract. Appellate courts review "a circuit court's interpretation of a contract de novo" because the appellate court has "an equal opportunity to consider the words of the contract within the four corners of the instrument itself." *Schuiling v. Harris*, 286 Va. 187, 192 (2013) (quoting *Uniwest Constr., Inc. v. Amtech Elevator Servs.*, 280 Va. 428, 440 (2010)).

The argument for de novo review may also find support in the standard for reviewing a trial court's interpretation of a consent decree. "A consent decree contains some elements of a judgment rendered after trial but in other respects resembles a contractual agreement." *McLane v. Vereen*, 278 Va. 65, 71 (2009). "[A] consent decree or order is to be construed for enforcement purposes basically as a contract" *United States v. ITT Cont'l Baking Co.*, 420 U.S. 223, 238 (1975). Still, "consent decrees 'have attributes both of contracts and of judicial decrees,' a dual character that has resulted in different treatment for different purposes." *Local Number 93, Int'l Ass'n of Firefighters v. Cleveland*, 478 U.S. 501, 519 (1986) (quoting *ITT Cont'l Baking*, 420 U.S. at 236 n.10).

Federal precedent provides mixed support for a de novo review standard. Several federal circuits apply de novo review to a district court's interpretation of a consent decree.⁴ But others

⁴ See, e.g., *Cnty. of Suffolk v. Long Island Lighting Co.*, 266 F.3d 131, 137 (2d Cir. 2001) ("Although few persons are in a better position to understand the meaning of a consent decree than the district judge who oversaw and approved it, we review the district court's interpretation of the Settlement *de novo*." (quoting *SEC v. Salomon Inc.*, 78 F.3d 802, 805 (2d Cir. 1996))); *Holland v. N.J. Dep't of Corrs.*, 246 F.3d 267, 277-78 (3d Cir. 2001) ("This Court . . . has held many times that a district court's construction and interpretation of a consent decree is subject to straightforward plenary or de novo review." (collecting cases)); *Frew v. Janek*, 820 F.3d 715,

apply a hybrid “deferential de novo” review if the district court entered or superintended the consent decree at issue.⁵ The Third Circuit has criticized that approach, calling “the concept of ‘deferential de novo’ (or ‘deferential plenary’) review . . . an oxymoron.” *Holland v. N.J. Dep’t of Corrs.*, 246 F.3d 267, 278 (3d Cir. 2001). *Holland* said that “[i]t strains imagination to conceive how [an appellate court’s] review could be both ‘anew, complete, absolute and unqualified,’ while at the very same time deferential to the District Court’s interpretation.” *Id.*; see also *Frew v. Janek*, 780 F.3d 320, 326 (5th Cir. 2015) (stating that the Fifth Circuit has “never followed this [‘deferential de novo’] rule”). The Fourth Circuit has noticed the federal

723 (5th Cir. 2016) (“Unlike some of our sister circuits, this Court does not defer to a district court’s interpretation of a consent decree. Instead, we review questions of consent decree interpretation *de novo*.” (footnotes omitted)); *Paradise v. Prescott*, 767 F.2d 1514, 1525 (11th Cir. 1985) (“Appellate review of a district court’s construction of a consent decree is akin to review of a district court’s contract interpretation; in this aspect of the case, we thus are not bound by either the clearly erroneous rule or the abuse of discretion standard.”), *aff’d on other grounds*, 480 U.S. 149 (1987); *United States v. Microsoft Corp.*, 147 F.3d 935, 945 (D.C. Cir. 1998) (“Our review of a district court’s interpretation of a consent decree is *de novo*.”).

⁵ See *Sault Ste. Marie Tribe of Chippewa Indians v. Engler*, 146 F.3d 367, 371 (6th Cir. 1998) (“Where as here, though, we are reviewing the interpretation of a consent judgment by the district court that crafted the consent judgment, it is probably more accurate to describe our standard of review as ‘deferential de novo.’”); see also *Doe v. Pataki*, 481 F.3d 69, 76 (2d Cir. 2007) (“Often deference is given to the interpretation made by the district judge who approves the decree, a precept especially appropriate in circumstances where the judge has played a role in supervising the negotiation of the terms of the decree.”); *McCoy v. Chi. Heights Election Comm’n*, 880 F.3d 411, 414 (7th Cir. 2018) (“A consent decree is a form of contract, the interpretation of which is typically subject to *de novo* review. We have recognized an exception to that rule, however, and have given deference to the district court’s interpretation where the judge who interprets the decree had involvement in its creation and oversaw the litigation for an extended period of time.” (citation omitted)); *ASARCO, LLC v. Union Pac. R.R. Co.*, 762 F.3d 744, 749 (8th Cir. 2014) (“[W]e typically afford a large measure of deference to the interpretation of the district court that actually entered the decree. But [w]hen, as here, a district court’s interpretation of a consent decree is based solely on the written document, we review the court’s interpretation *de novo*.” (second alteration in original) (citations and internal quotation marks omitted)); *United States v. Walker River Irrigation Dist.*, 890 F.3d 1161, 1169 (9th Cir. 2018) (“The district court’s interpretation of a judicial decree is also reviewed *de novo*, although this court typically ‘give[s] deference to the district court’s interpretation based on the court’s extensive oversight of the decree from the commencement of the litigation to the current appeal.’” (alteration in original) (quoting *Labor/Cnty. Strategy Ctr. v. L.A. Cnty. Metro. Transp. Auth.*, 263 F.3d 1041, 1048 (9th Cir. 2001))).

circuit split, leaving open whether an appellate court’s “plenary review [of the parties’ negotiated order] incorporates some measure of deference.” *Consumer Fin. Prot. Bureau v. Klopp*, 957 F.3d 454, 462 n.3 (4th Cir. 2020).

Portsmouth’s argument for appellate deference, by contrast, finds support in *Bajgain v. Bajgain*, 64 Va. App. 439 (2015). We gave deference there to the trial court’s interpretation of the parties’ negotiated stipulation—which the court had entered as a consent order—about the effect of certain Nepalese proceedings on the parties’ equitable-distribution rights. We said that, “[b]ecause the stipulation was the subject of a court order, the [trial] court was, in effect, construing the scope of its own order.” *Id.* at 452-53. We explained that we give “‘deference to the interpretation adopted by the lower court’ of its own order,” provided the interpretation is “reasonable.” *Id.* at 453 (quoting *Rusty’s Welding*, 29 Va. App. at 129). *But see Dietz v. Commonwealth*, 294 Va. 123, 136 n.5 (2017) (“Our construction of the stipulation presents an issue of law subject to de novo review.”).

The case for deference may also find support in the Commission’s supervisory role in approving compromise settlements. The Commission cannot just rubber-stamp the parties’ agreement. The “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.” Code § 65.2-701(A). The parties must present such “facts as will enable the Commission to determine if approval serves the best interests of the claimant or the dependents.” Va. Workers’ Comp. Comm’n R. 1.7(A)(5). To evaluate whether a settlement is in the claimant’s best interests, the Commission would need to understand the benefits to the claimant and the benefits the claimant will forgo. That makes the Commission’s approval of a settlement agreement different in kind from a trial court’s entry of the parties’ negotiated consent order.

“A judge entering a consent decree ordinarily does not engage in any adjudication of the facts or the law that may be applicable to the decree’s terms.” *McLane*, 278 Va. at 71.

Recognizing good arguments on both sides of this question, we leave for another day the standard for reviewing the Commission’s interpretation of a settlement order. This appeal does not require that we resolve that dispute. For as explained below, even assuming that deference is owed to the Commission’s interpretation of its own settlement order, the Commission’s interpretation here is both unreasonable and contrary to binding precedent.

B. The Commission erred in concluding that the settlement order released Peters’s claim that additional bills from TTN remain outstanding.

The Commission affirmed the deputy commissioner’s rejection of Peters’s request for full payment of the bill for TTN based on the Commission’s earlier decision in *Wagner*. The Commission reasoned that, like what happened in *Wagner*, “the parties expressly agreed that the settlement Order . . . ‘shall be a complete extinguishment and complete payment of any and all claims of any kind or nature which Claimant . . . might have against Employer and Carrier, including but not limited to claims for . . . medical benefits.’” (Second and third alterations in original).

But the Commission failed to account for the plain language of the settlement order that “Employer and Carrier shall be responsible for authorized and necessary medical bills incurred by Claimant related to the September 20, 2012 injury by accident up until the date of the entry of the Order approving the compromise settlement, but no longer.” The “extinguishment” language did not extinguish that obligation. Rather, the settlement agreement extinguished “all claims of any nature for . . . medical expenses, *except as provided herein*.” (Emphasis added).

The Commission thereby repeated the error it made in *Wagner*, where we reversed the Commission’s order for overlooking similar express language in the settlement order. The settlement order in *Wagner*, as here, required the defendant to “pay for reasonable, necessary and

related medical expenses through the date of entry of the Order approving the parties' settlement agreement." *Wagner*, slip op. at 2, 2025 Va. App. LEXIS 628, at *2. The order also contained a similar extinguishment provision for medical bills incurred for treatment after the date of the order. *Id.*, slip op. at 2-3, 2025 Va. App. LEXIS 628, at *3-4. We held that "Wagner preserved her right to have her previously incurred medical expenses paid, subject to the specific limitations under the Workers' Compensation Act, but [she] waived her right to sue for medical expenses incurred later on." *Id.*, slip op. at 12, 2025 Va. App. LEXIS 628, at *16.

The Commission—both in *Wagner* and here—overlooked our controlling precedent in *Wardell*. *Wardell* affirmed the Commission's decision interpreting the settlement order there to make the employer responsible for the outstanding balance on medical bills incurred for treatment up to date of the settlement order. 67 Va. App. at 429. Like the settlement order in *Wagner* and here, the *Wardell* settlement order provided that "Employer shall be responsible for medical treatment . . . incurred by the Claimant through the date of the entry of the Order approving the settlement." *Id.* at 425, 429. The similarity of the settlement provision's language in *Wardell*, *Wagner*, and here is no accident. The Commission suggests that language in the guidance documents on its public website. See Virginia Workers' Compensation Commission, Petition and Order Requirements at 5, <https://perma.cc/V6QH-PCU4>, and sample Order at 2, <https://perma.cc/588U-6VS3>.

In short, even assuming without deciding that the Commission's interpretation of the approved settlement order is entitled to deference, *see* Part A *supra*, the Commission's interpretation was unreasonable. The Commission misconstrued the plain language of the settlement order and failed to follow our binding precedent in *Wardell*. It therefore erred in finding that the settlement order extinguished Peters's claim for authorized and necessary medical bills from TTN for services before the date of the settlement order.

C. The Commission should determine on remand the amount of any unpaid debt to TTN.

Medical bills for services provided to an employee claimant covered by the Workers' Compensation Act are "subject to the approval and award of the Commission." Code § 65.2-714(A). The Commission has "exclusive jurisdiction over all disputes concerning such fees or charges." *Id.* In exercising that authority, the Commission has rejected claims by claimants and medical providers for further payment of underpaid medical bills after finding, for example,

- insufficient proof that any balance was still due, *see Hanson v. YMCA of S. Hampton Roads*, JCN VA00000493234, slip op. at 8-10, 2025 VA Wrk. Comp. LEXIS 163, at *11-12 (Aug. 7, 2025);
- that the claim was barred by laches, *see Atkinson v. Distinctive Event Rentals*, JCN 1952050, slip op. at 7, 2025 VA Wrk. Comp. LEXIS 38, at *8 (Feb. 7, 2025); or
- that no balance remained owing according to the medical provider's own account statements, *see Greatheart v. City of Hampton*, JCN VA00001102641, slip op. at 6, 2022 VA Wrk. Comp. LEXIS 110, at *8 (Apr. 12, 2022), *aff'd*, No. 0689-22-1, 2023 Va. App. LEXIS 308 (May 16, 2023).

Indeed, we affirmed the Commission's award in *Greatheart* on such grounds, denying the claimant's request that we order further payment to the medical provider; "the balance due was \$0.00 and . . . the medical provider was not seeking any additional payments." *Greatheart v. City of Hampton*, No. 0689-22-1, slip op. at 9-11 & n.5, 2023 Va. App. LEXIS 308, at *13-15 & n.5 (May 16, 2023).

Another aspect of this case echoes what we said in *Greatheart*. We observed there that the claimant could not be "balance billed" by his medical providers because such balance billing is squarely prohibited by Code § 65.2-714(D).⁶ *Id.*, slip op. at 11, 2023 Va. App. LEXIS 308, at

⁶ Code § 65.2-714(D) provides:

No physician, hospital, or other health care provider . . . shall balance bill an employee in connection with any medical treatment, services, appliances, or supplies furnished to the employee in connection with an injury for which (i) a claim has

*14-15. We added that a medical provider’s “claim to the Commission contesting the sufficiency of payment for health care services” is subject to a one-year statute of limitations under Code § 65.2-605.1(F).⁷ *Id.*, slip op. at 10, 2023 Va. App. LEXIS 308, at *13-14. So any claim by the medical provider there was time-barred. Even so, we found that Greatheart had standing to ask the Commission “that the terms of his agreement with [his employer] [be] honored” so that his “healthcare providers are fairly compensated.” *Id.*, slip op. at 6, 2023 Va. App. LEXIS 308, at *8. We found “that the parties’ settlement vested Greatheart with a right to have the medical bills at issue paid by the [employer].” *Id.*, slip op. at 7-8, 2023 Va. App. LEXIS 308, at *10.⁸

Although that standing determination does not bind us because *Greatheart* is unpublished, *see* Rule 5A:1(f), neither the Commission nor Portsmouth has questioned Peters’s

been filed with the Commission . . . , (ii) payment has been made to the health care provider . . . , or (iii) an award of compensation is made For the purpose of this subsection, a health care provider “balance bills” whenever (a) an employer or the employer’s insurance carrier declines to pay all of the health care provider’s charge or fee and (b) the health care provider seeks payment of the balance from the employee. . . .

⁷ Code § 65.2-605.1(F) provides:

No health care provider shall submit a claim to the Commission contesting the sufficiency of payment for health care services rendered to a claimant unless (i) such claim is filed within one year of the date the last payment is received by the health care provider pursuant to this section or (ii) if the employer denied or contested payment for any portion of the health care services, then, as to that service or portion thereof, such claim is filed within one year of the date the medical award covering such date of service for a specific item or treatment in question becomes final.

⁸ A panel of this Court held in an earlier unpublished opinion involving a similar settlement-order provision that the employee enjoyed the “right to pursue enforcement of the settlement agreement, which requires payment for ‘all reasonable, necessary and authorized medical expenses . . . incurred.’” *Bockelman v. Millers Landscaping Sprinkler*, No. 1170-21-1, slip op. at 8, 2022 Va. App. LEXIS 258, at *10 (June 28, 2022) (alteration in original).

standing to ask the Commission to force Portsmouth to make full payment to TTN.⁹ So we do not consider that question here. *Accord Gray v. Va. Sec’y of Transp.*, 276 Va. 93, 102 n.5 (2008) (“The Plaintiffs’ standing to bring this action was not challenged in the circuit court and thus is not a question before this Court.”).

Nor has Portsmouth argued that the statutory bar that “[n]o *health care provider* shall submit a claim” beyond the one-year limitations period, Code § 65.2-605.1(F) (emphasis added), prevents *the claimant* from submitting a claim effectively on the health-care provider’s behalf. Thus, we do not consider that “important” question either.¹⁰ In other words, we assume without

⁹ Mr. Geib told us at oral argument—as he did at oral argument in *Greatheart*—that employee claimants have an interest in seeing their old medical bills paid off to avoid having such debts mar their credit rating. The record is silent on whether Peters’s credit report has ever been adversely affected by underpaid medical bills subject to the Workers’ Compensation Act. It is undisputed, however, that the debt at issue here is now more than a decade old. The Fair Credit Reporting Act “prohibits a consumer reporting agency from providing a consumer report containing ‘accounts placed for collection or charged to profit and loss which antedate the report by more than seven years.’” *Gillespie v. Equifax Info. Servs., L.L.C.*, 484 F.3d 938, 940 (7th Cir. 2007) (quoting 15 U.S.C. § 1681c(a)(4)). “When the seven-year threshold for these items is reached, [credit-reporting agencies] may no longer lawfully report that data: in industry parlance, it has ‘aged off’ the consumer’s credit report.” *Seamans v. Temple Univ.*, 744 F.3d 853, 860 (3d Cir. 2014); *see also Gonzales v. Arrow Fin. Servs., LLC*, 660 F.3d 1055, 1059 (9th Cir. 2011) (“All of these debts were more than seven years old; accordingly, pursuant to the Fair Credit Reporting Act, 15 U.S.C. § 1681c(a)(4), none of these debts could be reported to a credit reporting agency.”).

¹⁰ The Commission concluded in a divided opinion in 2020 that a claimant who asked the Commission to make further payments to the medical provider was not subject to the one-year limitations period in Code § 65.2-605.1(F) that would have barred the medical provider from bringing the claim itself. *Miles v. Petsmart, Inc.*, JCN VA00001276768, slip op. at 6-8, 2020 VA Wrk. Comp. LEXIS 299, at *7-8 (June 4, 2020), *aff’d on other grounds sub nom. Petsmart, Inc. v. Miles*, No. 0765-20-4, 2021 Va. App. LEXIS 1 (Jan. 12, 2021). Commissioner Rappaport concurred but expressed concern that the claimant “did not participate in the case and stands to gain nothing as a result of these proceedings. The medical providers involved made no claim and did not participate in the hearing.” *Id.*, slip op. at 10, 2020 VA Wrk. Comp. LEXIS 299, at *12 (Rappaport, Comm’r, concurring). Commissioner Rappaport lamented that “these types of cases represent the modern Slough of Despond.” *Id.* Commissioner Newman would have applied the one-year bar. *Id.*, slip op. at 10-11, 2020 VA Wrk. Comp. LEXIS 299, at *13-14 (Newman, Comm’r, dissenting). He warned that this issue is “important” and that allowing such claims incentivized “an employee’s attorney to coopt his client’s name and the health care providers’ claim for the sole purpose of securing a fee.” *Id.*, slip op. at 11, 2020 VA Wrk. Comp.

deciding that the claimant may properly ask the Commission to order the employer and carrier to make further payments to the medical provider, even though no apparent benefit accrues to the claimant and despite that the claim would be barred if the medical provider itself had brought it.

Peters argues that upon reversing the Commission’s award, we should order Portsmouth to pay the \$6,879.90 balance that is allegedly owed to TTN. Peters’s counsel told us at oral argument that we can determine that amount from the record before us. For its part, Portsmouth has consistently argued—both before the Commission and here—that Peters failed to prove that any unpaid balance was owed to TTN.

As with “[a] judgment . . . or decree of a circuit court,” an “award of the Virginia Workers’ Compensation Commission may be affirmed, or it may be reversed, modified, or set aside by the Court of Appeals for errors appearing in the record.” Code § 17.1-412. Although Code § 17.1-412 authorizes us to modify the Commission’s award, it does not authorize appellate factfinding in the first instance. *See* Code § 65.2-706(A) (“The award of the Commission . . . shall be conclusive and binding as to all questions of fact.”). “The scope of a judicial review of the fact finding function of [the C]ommission . . . is ‘severely limited, partly in deference to the agency’s expertise in a specialized field.’” *Roske v. Culbertson Co.*, 62 Va. App. 512, 517 (2013) (quoting *Southside Va. Training Ctr. v. Ellis*, 33 Va. App. 824, 828 (2000)). “Consequently, on appeal, ‘we do not retry the facts before the Commission nor do we review the weight, preponderance of the evidence, or the credibility of witnesses.’” *Jeffreys v. Uninsured Emp.’s Fund*, 297 Va. 82, 87 (2019) (quoting *Caskey v. Dan River Mills, Inc.*, 225 Va. 405, 411 (1983)).

LEXIS 299, at *14. Although the Commission’s divided ruling was appealed in *Petsmart*, the panel did not reach the merits because the Commission’s judgment was supported by an alternative ground that the appellant had not questioned. *See Petsmart*, slip op. at 4-5, 2021 Va. App. LEXIS 1, at *7-8.

So when the proper disposition of an appeal requires a factual determination that the Commission did not make, we must ordinarily remand the case for the Commission to make that finding. *See, e.g., Fairfax Cnty. Sch. Bd. v. Martin-Elberhi*, 55 Va. App. 543, 548 (2010) (“In cases where, as here, the commission’s express ruling on a dispositive point is too ‘unclear’ for us to fairly infer an implied holding, we prefer to restate the governing legal principles and to permit the commission on remand to address the case anew.”). “That is particularly true when we conclude [that] the commission applied ‘an incorrect legal standard’ and ‘truncated the factfinding task necessary under the correct legal standard.’” *Id.* (quoting *Dowden v. Hercules, Inc.*, 51 Va. App. 185, 197 (2008) (en banc) (plurality opinion)).

Whether any debt remains owing to TTN for treatment received by Peters before the July 27, 2018 settlement order is hotly disputed. Contrary to Peters’s representation at oral argument, that question was not answered by the deputy commissioner’s opinion. The deputy commissioner wrote that “[t]he claimant *asserts* a claim for the balance billing of an underpaid amount of \$6,971.10 from [TTN].” (Emphasis added). He made no finding about the truth of that assertion. In reviewing the deputy commissioner’s ruling, the Commission’s opinion twice noted that Peters had attached TTN’s zero-balance statement to his filings with the Commission. The Commission also noted the discrepancy between the amounts that Peters claimed were unpaid: on March 4, 2019, Peters represented that the amount owed was \$6,879.90; but on May 6, 2019, he said it was \$6,971.10. Having rejected Peters’s claim as barred by the settlement order, however, the Commission made no factual finding about the amount of any unpaid debt to TTN.

We therefore remand this case to the Commission to determine whether any medical debt incurred by Peters up until the date of the settlement order remains due to TTN. “In its discretion, the commission may provide the parties an opportunity to reopen the evidentiary record to specifically address [that] issue.” *Martin-Elberhi*, 55 Va. App. at 548.

CONCLUSION

The Commission erred in finding that its July 27, 2018 settlement order extinguished Peters's claim for authorized and necessary medical bills from TTN for treatment up until the date of that order. The case is remanded for further proceedings consistent with this opinion.

Reversed and remanded.