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***RECENT SIGNIFICANT DECISIONS -- MONTHLY DIGEST # 276***
***November 2016***

*Stephen R. Henley*
*Chief Judge*

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## I. Longshore and Harbor Workers' Compensation Act and Related Acts

### A. U.S. Circuit Courts of Appeals[1]

[***Ed. Note*:** While the following case involved the determination of damages in a maritime tort action, the court discussed the relevant provisions of the LHWCA].

***Deperrodil v. Bozovic Marine*, 842 F.3d 352 (5th Cir. 2016).**

This case involved a maritime-tort action for back injuries arising out of plaintiff's being taken to a work site on a vessel operated by defendant, a third-party tortfeasor. Robert dePerrodil was a passenger on a vessel. He brought an action against the vessel owner, seeking to recover damages for back injuries sustained when the vessel encountered rough seas, and was awarded damages by the district court. The Fifth Circuit affirmed the district court's findings that the vessel owner was negligent through the captain's operation of the vessel, and that the passenger was 10% comparatively negligent. It further affirmed the district court's determination that the passenger's work-life expectancy was 75 years, rather than the average of 72 years from Bureau of Labor Statistics (BLS) data, as this finding was supported by evidence. However, the Fifth Circuit vacated the award of medical benefits to dePerrodil, holding that, in a maritime negligence action against a vessel owner, an injured passenger whose medical expenses were paid by his employer's LHWCA insurer could not recover from the vessel owner medical expenses that were billed but ultimately not paid and then were written off by the medical providers.

The collateral-source rule bars a tortfeasor from reducing his liability by the amount a plaintiff recovers from independent sources. In its simplest form, the rule asks whether the tortfeasor contributed to, or was otherwise responsible for, a particular income source; if not, the income is considered independent of, or collateral to, the tortfeasor, and the tortfeasor may not reduce its damages by that amount. In practice, the collateral-source

[1] Citations are generally omitted with the exception of particularly noteworthy or recent decisions. Short form case citations (*id.* at *__) pertain to the cases being summarized and refer to the Lexis or Westlaw identifier.

rule for awarding medical expenses as damages allows plaintiffs to recover expenses they did not personally have to pay; without the rule, however, a third-party income source would create a windfall for the tortfeasor.

The analysis is complicated when a tortfeasor contributes to a portion of the collateral source. An employer-tortfeasor may pay part of an employee's health-insurance plan, and in that situation, courts ask whether the collateral source is a bargained-for fringe benefit to determine whether the employee can recover medical expenses as damages under the collateral-source rule; if so, a fringe benefit is compensation to which the employee is already entitled, and an employer cannot reduce its liability by paying employment compensation. Thus, bargained-for fringe benefits are considered collateral to an employer's liability, and cannot reduce the employer's tort liability under the collateral-source rule.

On the other hand, when an employer obtains a liability-insurance plan, it is providing pre-accident insurance to protect itself from post-accident expenses; there, the collateral-source rule does not apply and the employer can reduce its tort liability by the amount paid by the insurance. In this case, dePerrodil's employer's LHWCA insurer paid his medical expenses, and the vessel owner played no role in securing that insurance coverage. Thus, the collateral-source rule applies, and the vessel owner is liable for the medical expenses the insurer paid on dePerrodil's behalf. (33 U.S.C. § 933 entitles insurers to subrogation for LHWCA payments.)

The Fifth Circuit further held that the LHWCA medical-expense payments are collateral to a third-party tortfeasor, only to the extent paid; thus, a plaintiff may not recover for expenses that were billed by his medical providers, but that ultimately were not paid and were then written off. DePerrodil was billed $186,080.30, but the LHWCA insurer was only required to pay $57,385.50; the balance was written off. Neither dePerrodil, his employer, nor the LHWCA insurer were ever liable for the write-off. Noting the lack of direct authority regarding the treatment of written-off LHWCA medical expenses in the maritime-tort context, the court looked to state and analogous maritime authority. It concluded that state laws differ as to their approach to written-off expenses in tort cases, and that the approach adopted in *Manderson v. Chet Morrison Contractors, Inc.*, 666 F.3d 373, 381 (5th Cir. 2012), is the most applicable. In *Manderson*, the court held that the appropriate amount for an award of cure to an injured seaman was the amount accepted by his medical providers as full payment, not the higher amount charged. This rationale is very persuasive because maritime cure and LHWCA insurance create similar obligations for employers. Like maritime cure, LHWCA creates a no-fault basis for paying a longshoreman's medical expenses. 33 U.S.C. § 904(b) ("Compensation shall be payable irrespective of fault as a cause for the injury."). When a third-party tortfeasor is responsible for the employee's injury, cure and LHWCA insurance function in the same manner: the employer (or its insurer) has an immediate duty to pay medical expenses even though it is not at fault. These similarities counsel that *Manderson*—prohibiting write-off recovery—provides the correct rule for both maritime cure and LHWCA maritime-tort cases. Thus, the district court erred in awarding the full amount billed. Instead, the proper measure of those damages is the lesser amount the insurer paid to cover dePerrodil's medical expenses.

### B. Benefits Review Board

[no published decisions to report]

## II. Black Lung Benefits Act

### A. Circuit Courts of Appeals

In *RB&F Coal, Inc., v. Mullins*, ___ F.3d ___, 2016 WL 6819672 (4th Cir. Nov. 18, 2016), the Fourth Circuit addressed an employer's appeal of a decision by the Benefits Review Board ("Board") holding it responsible for payment of benefits.

Relevant to the responsible operator issue, RB&F Coal, Inc. ("RB&F"), employed the miner between 1985 and 1986, and Wilder Coal ("Wilder") employed the miner between 1986 and 1988. Below, the District Director found that RB&F was the responsible operator. RB&F contested its liability, and requested a hearing before an ALJ, who agreed with the District Director's designation of RB&F as the responsible operator. Of note, Wilder had gone out of business by the time the miner filed his claim, and Wilder's insurer, Rockwood Insurance Co. ("Rockwood"), had been declared insolvent in 1991. Furthermore, while Rockwood was a member of the Virginia Property and Casualty Insurance Guaranty Association ("VPCIGA"), the ALJ determined that VPCIGA was not liable for the claim, as the claim at issue was filed well after the bar date controlling VPCIGA liability: August 26, 1992. Finding that RB&F failed to establish that Wilder or Rockwood was capable of assuming liability for the claim or that VPCIGA was obligated to assume liability, the ALJ found RB&F to have been properly named as the responsible operator.

RB&F appealed the ALJ's decision, and the Board affirmed the ALJ's finding and denied a motion for reconsideration filed by RB&F.

On appeal before the Fourth Circuit, RB&F grounded its argument on Rockwood, a member of VPCIGA, having fully covered Wilder's liability. RB&F argued that VPCIGA was under an obligation to pay benefits on the claim, and therefore that Rockwood could not be declared unable to assume liability. The court disagreed. In support, it noted the undisputed facts that neither Wilder nor Rockwood is capable of assuming liability. Therefore, the court construed the issue presented as being whether claims against Wilder are "otherwise guaranteed." The court answered this question in the negative, concluding that VPCIGA did not guarantee Wilder's obligations, as the miner's claim was filed some 17 years after the bar date controlling VPCIGA liability.

Furthermore, the court rejected RB&F's attempt to argue that holding it liable for benefits was contrary to prior Fourth Circuit precedent. The court also disagreed with RB&F's contention that, even if VPCIGA's liability is limited, the Black Lung Benefits Act ("BLBA" or "Act") preempts any such limitation, as the court concluded VPCIGA is not covered by the BLBA because it is not an "insurer" under the Act.

In light of the above, the court affirmed the Board's decision.

**[Insurance carrier as a named party: Insolvent carrier, liability of guaranty association]**

In addition, the Sixth Circuit issued an unpublished black lung decision in *Appleton & Ratliff Coal Corp. v. Ratliff*, ___ Fed. Appx. ___, 2016 WL 6694910 (6th Cir. Nov. 15, 2016).

### B. Benefits Review Board

In *McCormick v. National Coal Corp.*, BRB No. 16-0083 BLA (Nov. 28, 2016) (unpub.), the Board addressed an ALJ's Orders directing Claimant to submit to an employer-requested CT scan. The Board concluded that the ALJ applied the incorrect standard in addressing Employer's request to obtain the CT scan, as the ALJ considered whether Claimant could demonstrate that the CT scan request was unreasonable, as opposed to whether Employer could establish good cause to compel Claimant to submit to the CT scan. Furthermore, the Board determined that the evidence Employer proffered in the instant case was insufficient for it to establish good cause. The Board noted that Employer failed to demonstrate why a CT scan was needed, as opposed to the typical methods for diagnosing pneumoconiosis as prescribed by law. Characterizing the physician's affidavit that Employer submitted in support of its CT scan request as simply a blanket, unsupported statement, the Board concluded that such a statement fails to "establish the particularized showing required to establish good cause to exceed the evidentiary limitations." Slip op. at 6. The Board held that to require the "claimant to undergo a CT scan based on employer's general statement that it is medically necessary, without more, would . . . eviscerate the evidentiary limitations." *Id.*

In light of the above, the Board reversed the ALJ's Orders.

**["Good cause" standard for admitting evidence over limitations]**

In *Hatfield v. Director, OWCP*, BRB No. 16-0511 BLA (Nov. 30, 2016) (unpub.), the Board vacated the ALJ's decision denying benefits. In *Hatfield*, which involved a survivor's claim, the ALJ issued an Order allowing the parties 12 days in which to submit a letter stating why a decision on the record should not be issued.[2] Claimant was proceeding *pro se* and, within the 12-day period, agreed in writing to a decision on the record. The Director, who was the respondent in the case, indicated he did not object to a decision on the record. The ALJ eventually issued a decision denying benefits. In his decision, the ALJ found that, while the miner worked as a miner for at least 16 years in surface coal mine employment ("CME"), Claimant did not establish that the miner worked for at least 15 years in conditions substantially similar to those of an underground mine; therefore, the ALJ found Claimant could not invoke the 15-year rebuttable presumption. The ALJ further found that Claimant established that the miner suffered from pneumoconiosis arising out of his CME, but failed to establish that the miner died due to the disease. Accordingly, the ALJ denied benefits.

Claimant appealed the denial *pro se*. On appeal, the Director challenged, as contrary to law, the ALJ's Order allowing the parties only 12 days in which to state why a decision on the record should not be issued. The Director posited that the shortened timeframe "may have contributed to claimant's determination to waive her right to a hearing," and he further

[2] In his Order, the ALJ provided the parties with 12 days to respond, but noted that, if he did not receive a response 10 days following that deadline, he would assume the parties agreed to a decision on the record and not schedule a hearing.

argued that the ALJ's findings in his decision denying benefits "make clear that claimant was adversely impacted by her agreement to waive her right to a hearing." Slip op. at 1-2.

The Board agreed with the Director that the ALJ "erred in allowing the parties only twelve days to state why this case should not be decided on the record." *Id.* at 2. The Board emphasized that, according to the regulations, "[i]f the administrative law judge believes that an oral hearing is not necessary (for any reason other than on motion for summary judgment), the judge shall notify the parties by written order and allow at least thirty days for the parties to respond." *Id.*, quoting 20 C.F.R. §725.452(d). Noting the Director's concerns as to the shortened period in which Claimant was allowed to respond and how the absence of a hearing may have impacted her potential to prevail on the merits of her claim, the Board agreed "with the Director that claimant's right to a full and fair adjudication of her claim may not have been fully protected." *Id.*

Accordingly, the Board vacated the ALJ's decision denying benefits and remanded the matter "for a formal hearing."

**[Entitlement to a hearing: For claims filed after January 19, 2001]**