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RECENT SIGNIFICANT DECISIONS -- MONTHLY DIGEST # 282
June 2017

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

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

[there are no published court decisions to report]

B. Benefits Review Board

***Taylor v. SSA Cooper, LLC*, __ BRBS __ (2017).**

The Board held that, where claimant filed a claim for both medical and disability benefits, and employer paid only medical benefits within 30 days of its receipt of notice of the claim, claimant is entitled to employer-paid attorney's fee under § 28(a) for work performed by his attorney in successfully establishing entitlement to disability compensation.

Section 28(a) of the Act provides:

> "If the employer or carrier *declines to pay any compensation on or before the thirtieth day after receiving written notice of a claim* for compensation having been filed from the deputy commissioner, on the ground that there is no liability for compensation within the provisions of this chapter and the person seeking benefits shall thereafter have utilized the services of an attorney at law in the successful prosecution of his claim, there shall be awarded, in addition to the award of compensation, in a compensation order, a reasonable attorney's fee against the employer or carrier. . . ."

[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 Westlaw identifier.

33 U.S.C. §928(a) (emphasis added). It is well established that the definition of "compensation" in § 28(a) includes medical benefits in a contested case for purposes of establishing a "successful prosecution of the claim." *Oilfield Safety & Machine Specialties, Inc. v. Harman Unlimited*, 625 F.2d 1248, 14 BRBS 356 (5th Cir. 1980) (additional citations omitted). Thus, if other requirements are satisfied, a successful prosecution resulting in an award of medical benefits entitles the claimant to an employer-paid attorney's fee pursuant to § 28(a).

In this case, claimant filed a claim for benefits stemming from his work-related leg injury. Employer voluntarily paid medical benefits within 30 days of its receipt of notice of the claim, but declined to pay any disability benefits. The ALJ awarded claimant disability compensation, and claimant's counsel sought attorney's fees under § 28(a). Finding it undisputed that § 28(b), is inapplicable because no informal conference was held, and that employer "paid 'compensation' within the time set forth in §928(a)" because it voluntarily paid medical benefits during the 30-day period after receiving notice of the claim, the ALJ found that employer is not liable for an attorney's fee under the Act.

On appeal, claimant asserted that the phrase "declines to pay any compensation" in § 28(a) does not include medical benefits pursuant to § 2(12). He asserted that "compensation" either does not include medical benefits at all or does not include medical expenses paid directly to the provider, as here. Employer responded that "compensation" as used in § 28(a) includes medical benefits and that it did not "decline to pay any compensation" because it voluntarily paid medical benefits within the 30-day period. The Director, Office of Workers' Compensation Programs ("the Director") asserted that employer declined to pay disability benefits and is liable for claimant's attorney's fee, albeit for reasons that differ from claimant's.

The Board concluded that:

> "In order to satisfy the purposes of Section 28(a), and to maintain a consistent meaning of the term within that section, we agree with the Director that the term 'compensation' in Section 28(a) should be read as 'disability and/or medical benefits.' Its precise meaning in the phrase 'declines to pay any compensation' depends on what benefits are claimed and what benefits the employer paid or declined to pay in each case. Whether a claimant files a claim for both disability and medical benefits or for only one or the other type of benefit, fee liability under Section 28(a) depends on whether there is success in obtaining the claimed but denied benefit.
>
> Under the Director's interpretation, which we adopt, a claim may be made up of parts, *i.e.*, disability benefits, death benefits, medical benefits. If any type of benefit is denied and legal services are necessary to obtain the denied benefit, the claimant is entitled to an employer-paid fee because the employer's denial caused the need for attorney involvement. Specifically, if both medical and disability benefits are claimed, and the employer pays one but not the other type of benefit, the employer is liable for an attorney's fee if the claimant is later successful in obtaining the denied benefit. To hold

otherwise is to reduce the claimant's successfully-obtained benefits, which the employer had denied, by the amount of his attorney's fee."

Slip op. at 7-8 (footnotes and citations omitted). Here, claimant filed a claim for both medical and disability benefits, and employer paid medical benefits but declined to pay any disability benefits within 30 days of its receipt of notice of the claim. Claimant's counsel successfully prosecuted the claim, obtaining for claimant the disability benefits which had been wholly denied by employer; therefore, claimant is entitled to have his attorney's fee paid by employer pursuant to § 28(a). Accordingly, the Board reversed the ALJ's conclusion to the contrary and remanded for consideration of the fee petition.

[Topic 28.2 ATTORNEY'S FEES - 28(b) EMPLOYER'S LIABILITY; Topic 2.12 DEFINITIONS – § 2(12) COMPENSATION]

***Watson v. Wardell Orthopaedics, P.C.*, __ BRBS __ (2017).**

Agreeing with the OWCP Director, the Board held that the ALJ has the authority to determine the medical fees permitted by the Act and regulations, but does not have the authority to address employer's contention that contracts between employer, United Healthcare, and claimant's medical provider entitle employer to pay the provider reduced rates for its services.

Claimant injured his right knee while working for employer, and he filed a claim for benefits under the Act. Employer voluntarily paid claimant disability compensation and medical benefits. Wardell Orthopaedics ("Wardell") provided medical care for claimant's injury and submitted the charges for services to employer in the amount of $8,113.00. Employer paid Wardell $3,133.60. Wardell requested payment in full, and employer refused, asserting that a series of contracts among employer, United Healthcare and its affiliates, and Wardell entitled it to a reduced fee for Wardell's services. Wardell filed a claim with the District Director seeking payment in full. The District Director calculated that employer paid Wardell less than what is allowed under the OWCP Medical Fee Schedule and owed Wardell an additional $1,374.26.[2] Employer disagreed with the recommendation and requested the case be transferred to the Office of Administrative Law Judges ("OALJ").

Following referral to OALJ, employer filed a motion to dismiss Wardell's claim, asserting that the dispute centers on the interpretation of private contracts. Employer alternatively argued that Wardell does not have standing to bring an independent claim for payment of medical fees. The ALJ found that Wardell has standing to bring a claim, the OALJ has jurisdiction over the claim, and the contract matter is ancillary to the claim for compensation such that it is within her authority to address it. Employer appealed the ALJ's interlocutory orders, asserting that § 19(a) does not encompass jurisdiction over "medical re-pricing litigation" because it does not involve the rights of any injured worker. The Board accepted the interlocutory appeal in light of the issues raised and potential effect on other cases.

[2] Following this determination, Wardell sought this amount and no longer asserted entitlement to the full amount originally billed.

Section 19(a) of the Act states that the ALJ "shall have full power and authority to hear and determine all questions in respect of such claim." 33 U.S.C. § 919(a). The ALJ has the power to hear and resolve contractual issues which are necessary to the resolution of a claim under the Act, such as whether a contract for workers' compensation insurance covered the employer under the Act. The Fifth Circuit has held, however, that § 19(a) does not vest jurisdiction in an ALJ to interpret a contract dispute when the cause of action is wholly unrelated to the underlying claim for compensation.

In this case, there is no dispute that claimant is entitled to disability and medical benefits under the Act, that the medical treatment provided for his work injury was reasonable and necessary, and that employer is liable for claimant's benefits. The sole issue is the amount employer must reimburse the provider, Wardell, for the medical services rendered. A medical provider may bring his own claim for reimbursement of the cost of medical services provided to the claimant, as his entitlement to reimbursement is derivative of the claimant's entitlement to benefits. Section 7(d)(3) of the Act states: "The Secretary may, *upon application by a party in interest*, make an award for the reasonable value of such medical or surgical treatment so obtained by the employee." 33 U.S.C. § 907(d)(3) (emphasis added). The Act and regulations state that the provider is limited to receiving the prevailing community rates for his services. 33 U.S.C. § 907(g); 20 C.F.R. § 702.413. If there is a dispute over whether the provider's requested fees exceed the prevailing rates, the regulation at 20 C.F.R. § 702.415 provides for the District Director to investigate and the OALJ to hold a hearing to resolve any remaining dispute. 20 C.F.R. §§ 702.413-702.417.

Contrary to employer's argument, there is a dispute related to claimant's claim as to how much employer must pay Wardell for claimant's medical benefits *under the Act*. The Act and implementing regulations make clear that the amount of medical benefits owed to a provider is a question "in respect of" a claim for benefits over which the ALJ has authority. 33 U.S.C. § 907(g); 20 C.F.R. §§ 702.413-702.417. Accordingly, the Board rejected employer's contention that the existence of the contracts relieves the ALJ of jurisdiction entirely, and affirmed the ALJ's finding that she has the authority to address the issue of the amount employer must reimburse Wardell for medical services under the Act.

At the same time, the Board agreed with employer and the Director that the ALJ lacks the authority to resolve any party's rights under the private contracts, as the interpretation of those contracts is not "in respect of" a claim for compensation under the Act. Therefore, it is not within the ALJ's authority to address whether the series of non-party contracts commencing with Wardell and United Healthcare entitles employer to pay Wardell reduced rates for his services. The Board stated that:

> "Employer's defense against paying the medical fees calculated by the district director and claimed by Wardell is based on private contracts. Interpretation of these contracts goes beyond that which is necessary to resolve the claim *under the Act*. Under the Act, employer is liable, at most, for medical charges at the prevailing rates set forth in the OWCP Medical Fee Schedule. Any other rates, pursuant to private contracts, are beyond the scope of the claim under the Act and are 'unnecessary to the objective of the LHWCA proceedings.'

> Thus, employer's defense is not an issue 'in respect of [a] claim' under Section 19(a) of the Act. Accordingly, we hold that employer's contract-based defense cannot be adjudicated by the [ALJ]."

Slip op. at 8-9 (citations omitted).

Based on the foregoing, the Board affirmed the ALJ's interlocutory orders to the extent the ALJ found she has the authority to address employer's liability for medical treatment under the Act. However, the ALJ does not have the authority in this case to address the rights of any party pursuant to the private contracts. On remand, the ALJ must limit any proceedings to the issues concerning the amount of employer's liability to Wardell as permitted by the Act and its implementing regulations.

[Topic 19.1 SECTION 19(a) - THE CLAIM: GENERALLY; Topic 7 MEDICAL BENEFITS - Section 7(d)(3); Topic 21.2.5 BOARD APPELLATE PROCEDURE - Interlocutory Appeals]

II. Black Lung Benefits Act

A. U.S. Circuit Courts of Appeals

In *Helen Mining Co. v. Elliott*, __ F.3d ___, 2017 WL 2562585 (3rd Cir. June 14, 2017), the Third Circuit addressed, for the first time in a published decision, the validity of the recent regulatory amendments at 20 C.F.R. §718.305, which implements the revived 15-year rebuttable presumption at 30 U.S.C. §921(c)(4).

Following a summary of the history of the Black Lung Benefits Act ("Act") and the implementing regulations, the court reviewed the facts of the case and its procedural history. Initially, the Administrative Law Judge found that the miner had established total disability and at least 15 years of qualifying coal mine employment. Therefore, the Administrative Law Judge found Claimant invoked the 15-year presumption. The Administrative Law Judge further determined that Employer failed to rebut the presumption pursuant to Section 718.305(d)(1) and thus awarded benefits. On appeal, the Benefits Review Board specifically rejected Employer's contention that the Administrative Law Judge had erred in requiring it to meet the "rule out" standard on rebuttal because, according to Employer, the statute imposes this standard on only the Secretary of Labor, not employers. The Board affirmed the award, and the Employer thereafter filed a petition for review with the Third Circuit.

The court initially addressed Employer's challenge to the validity of Section 718.305(d)(1)(ii), to the extent that it requires employers or operators, and not only the Secretary, to rule out a connection between a miner's total disability and his or her pneumoconiosis arising out of coal mine employment. In considering this challenge, the court applied the two-step analysis of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc*., 467 U.S. 837 (1984). At the first step of this analysis, the court described Employer's argument that the "rule out" rebuttal standard at Section 718.305(d)(1)(ii) is contrary to Section 921(c)(4) of the Act:

> In a nutshell, Helen Mining's argument is that: (a) by providing miners with a presumption described as "rebuttable," Congress confirmed that any opposing party—whether the Secretary or an operator—has the opportunity to rebut disability causation; (b) Congress expressly constrained the Secretary to rebut disability causation by "establishing that ... [the miner's disease] did not arise out of, or in connection with, employment in a coal mine," 30 U.S.C. § 921(c)(4), and was silent as to the rebuttal standard for operators; *ergo* (c) Congress clearly and unambiguously intended to allow operators to rebut disability causation without having to "establish[ ] that ... [the disease] did not arise out of, or in connection with, employment in a coal mine," *id*.

Slip op. at 15-16. According to Employer's argument, then, the regulation is invalid to the extent that it requires an employer or operator to meet this "rule out" standard. The court disagreed, noting that "[t]he fact that Congress spoke explicitly to the rebuttal standard for the Secretary and was silent as to operators is the very reason we must conclude that Congress did not unambiguously reject or accept that rebuttal standard for operators." Instead, Congress's silence at Section 921(c)(4) of the Act left "a void for the agency to set the causal standard for operators seeking to rebut the presumption of entitlement." The court concluded that, if anything, the Supreme Court's opinion in *Usery v. Turner Elkhorn Mining Co*., 428 U.S. 1 (1976), confirms that the question of the validity of the regulation cannot be decided at step one of the *Chevron* analysis.

At the step two of this analysis, the court considered whether the Department's "regulation that fills a statutory gap is 'based on a permissible construction of the statute.'"

Id. at 20, citing *Chevron*, 467 U.S. at 843. In holding that the regulation constitutes the Secretary's permissible exercise of his rulemaking power, the court relied on three points: (1) that "the [r]egulation furthers Congress's goals in enacting [Section] 924(c)," which references the Secretary in the context of rebuttal and was first enacted "at a time when the Secretary was the only payor," (2) that the court has "long approved of the rule out standard as a reasonable burden of proof for operators seeking to disprove disability causation and to avoid paying black lung benefits," and (3) that it is proper for the court "to defer to the agency's interpretation of this statute because it forms the basis for a complex regulatory scheme."

Finally, the court addressed Employer's argument that, even assuming the validity of the regulation in question, it had rebutted the presumption in this case. In support, Employer alleged that the Administrative Law Judge had erred in relying on the preamble to the 2001 regulatory amendments when weighing its experts' opinions and by mischaracterizing the testimony of one of its experts. The court rejected each argument in turn.

In light of the above, the court denied the petition for review.

[Apply rebuttal standards at 20 C.F.R. § 727.203(b)(3) and (b)(4): Third Circuit]

In *Westmoreland Coal Co. v. Director, OWCP [Quillen]*, ___ Fed. Appx. ___, 2017 WL 2462787 (4th Cir. June 7, 2017) (unpub.), which involved a survivor's claim, the Administrative Law Judge found that Westmoreland Coal Co. was the responsible operator because an employer that employed the miner subsequently, Lady H, was neither insured nor self-insured on his last day of work with that company. The Administrative Law Judge also awarded benefits pursuant to the 15-year rebuttable presumption. Westmoreland appealed the decision to the Board, which affirmed the decision.

On appeal before the Fourth Circuit, Employer alleged that it was improperly named as the responsible operator. The court disagreed, first noting that the Administrative Law Judge's finding that Lady H was financially incapable of paying benefits was supported by substantial evidence:

> Westmoreland's argument ignores the fact that Labor Department regulations fix the coverage terms of BLBA policies. Under the mandatory BLBA endorsement, an insurer is liable if coverage was in effect on "the last day of the last exposure [to coal dust], in the employment of the insured." 20 C.F.R. § 726.203(a). Thus, once the district director determined that Lady H had no policy in place on Miner's last day of employment, he properly concluded that there "was no record of insurance coverage" for Lady H that covered Miner's claim. 20 C.F.R. § 725.495(d). The district director's statement to that effect was "prima facie evidence that [Lady H was] not financially capable of assuming its liability for [the] claim." 20 C.F.R. § 725.495(d). And because Westmoreland did not produce evidence that Lady H in fact was financially capable of assuming liability for the claim, substantial evidence supported the ALJ's finding that Lady H was not financially capable.

Slip op. at 9 (footnotes omitted). The court also rejected, as "simply incorrect," Westmoreland's contention "that regardless of whether there was any evidence that Lady H was financially capable of assuming liability for the claim, [Lady H's insurer] conceded that Lady H was financially capable." According to the court, Lady H's insurer specifically reserved its right to challenge the company's liability as the responsible operator.

Finally, the court concluded that the Administrative Law Judge's findings concerning Claimant's entitlement to benefits were supported by substantial evidence, and it therefore affirmed the award. Accordingly, the court denied Westmoreland's petition for review.

[Ability to pay: For claims filed after January 19, 2001]

In *Advent Mining LLC v. Davis*, ___ Fed. Appx. ___, 2017 WL 2629085 (6th Cir. June 19, 2017) (unpub.), which involved a subsequent miner's claim for benefits, the Administrative Law Judge found that Claimant invoked the 15-year rebuttable presumption of total disability due to pneumoconiosis arising out of his coal mine employment. The Administrative Law Judge further found that Employer did not rebut the presumption and therefore awarded benefits. On appeal, the Board affirmed the award.

The court first addressed Employer's argument that the Administrative Law Judge erred in finding Claimant suffers from a totally disabling pulmonary or respiratory impairment. The court disagreed, concluding that substantial evidence supported the Administrative Law Judge's total disability finding. Specifically, the court discerned no error in the Administrative Law Judge's weighing of the medical opinion evidence. Therefore, and in light of Claimant's length of coal mine employment history, the court rejected Employer's challenge to the finding that Claimant invoked the 15-year rebuttable presumption.

Finally, the court disposed of Employer's alternative argument that, even if Claimant did invoke the presumption, it had proffered evidence sufficient to disprove the existence of clinical and legal pneumoconiosis:

> We agree with the ALJ that there is insufficient evidence to rebut the fifteen-year pneumoconiosis presumption. Although some of the evidence is in conflict, we cannot conclude on the record before us that the ALJ impermissibly erred in finding that Advent failed to rebut the fifteen-year presumption. The ALJ considered a significant record—that included [Claimant's] testimony, medical-opinion testimony, x-rays, and other medical tests. Substantial evidence in the record supports the ALJ's finding regarding the fifteen-year presumption.

Slip op. at 13.

In light of the above, the court denied the petition for review.

[Fifteen-year presumption at 20 C.F.R. § 718.305]

B. Benefits Review Board

In *Malcomb v. Potomac Coal Co.*, BRB No. 16-0536 BLA (June 30, 2017) (unpub.), which involved a subsequent miner's claim before the Board for a second time, Claimant had invoked the rebuttable 15-year presumption that the miner was totally disabled due to pneumoconiosis arising out of his coal mine employment. On remand, the Administrative Law Judge found that Employer disproved the existence of both clinical and legal pneumoconiosis and that, therefore, Employer had rebutted the presumption. Accordingly, the Administrative Law Judge denied benefits.

On appeal, Claimant challenged the Administrative Law Judge's finding that Employer disproved the existence of legal pneumoconiosis.[3] Specifically, Claimant contended that the

[3] The Board affirmed, as not specifically challenged on appeal, the Administrative Law Judge's finding that Employer disproved the existence of clinical pneumoconiosis.

Administrative Law Judge improperly focused "on the sufficiency of Dr. Rasmussen's diagnosis of legal pneumoconiosis and whether there were other conditions that could explain the miner's respiratory or pulmonary impairment." Claimant also alleged that the Administrative Law Judge should have discredited Dr. Zaldivar's opinion[4] "because his explicit reliance on radiographic evidence to exclude a diagnosis of legal pneumoconiosis is contrary to the regulations."

The Board rejected both of these arguments, concluding that the first was without merit because the Administrative Law Judge, in the end, did not "rely on his weighing of Dr. Rasmussen's diagnosis of legal pneumoconiosis to find that employer rebutted the existence of the disease." As to the second argument concerning Dr. Zaldivar's opinion, the Board noted that "[t]he administrative law judge accurately summarized Dr. Zaldivar's medical report and deposition testimony, and explicitly considered whether claimant was correct in asserting that Dr. Zaldivar requires a diagnosis of clinical pneumoconiosis to diagnose legal pneumoconiosis." The Board affirmed, as rational and supported by substantial evidence, the Administrative Law Judge's finding that "Dr. Zaldivar did not exclude coal-mine dust exposure as a causal factor in claimant's restrictive disease because claimant's chest x-rays were not read as positive for clinical pneumoconiosis." The Board then went on to affirm the Administrative Law Judge's decision to credit Dr. Zaldivar's opinion and find that it disproved the presence of pneumoconiosis in accordance with 20 C.F.R. §718.305(d)(1)(i)(A).

In light of the above, the Board affirmed the Administrative Law Judge's rebuttal finding and denial of benefits.

[Apply rebuttal standards at 20 C.F.R. 727.203(b)(3) and (b)(4)]

[4] The Administrative Law Judge discredited the medical opinion of Employer's second physician, Dr. Castle, in light of what he would require on x-ray in order to diagnose legal pneumoconiosis.