Medical Benefits Under Section 7 of the LHWCA: Select Issues

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[This article is also scheduled to be published in the Benefits Review Board Service Longshore Reporter (August 2017). It was prepared by Ms. Zaslavskaya in her capacity as a member of the Advisory Board of the BRBS Longshore Reporter, and it does not constitute the official opinion of the Department of Labor or the Office of Administrative Law Judges.]

This commentary highlights several issues that may arise in connection with claims for medical benefits under Section 7, 33 U.S.C. § 907, of the Longshore and Harbor Workers' Compensation Act ("LHWCA" or "the Act").

Authority of Administrative Law Judge vs. District Director

Section 7(b) of the Act, 33 U.S.C. § 907(b), and its implementing regulation, 20 C.F.R. § 702.407, address the authority of the Secretary of Labor to actively supervise an injured employee's medical care. Section 702.407 of the regulations mandates active supervision of medical care by the District Director, including his: receiving periodic medical reports; determining "the necessity, character and sufficiency of any medical care furnished or to be furnished;" determining whether a change of physicians or hospitals is warranted; and, overseeing the "further evaluation of medical questions arising in any case under the Act, with respect to the nature and extent of the covered injury, and the medical care required therefore." 20 C.F.R. § 702.407.

Case law further details the District Director's role in supervising medical care. Pursuant to § 7(b) of the Act and §§ 702.406(b) and 702.407(b) and (c) of the regulations, only the District Director, and not the Administrative Law Judge ("ALJ"), has the authority to change claimant's treating physician. *Jackson v. Universal Maritime Service Corp.*, 31 BRBS 103 (1997); *see also Roulst v. Marco Constr. Co.*, 15 BRBS 443 (1983); *cf. Lynch*, 39 BRBS 29.[1] Similarly, deferring to the OWCP Director's interpretation of § 7(d)(2) and § 702.422(b), the Benefits Review Board ("Board" or "BRB") has held that only the District Directors have the authority to

[1] In *Lynch*, the BRB held that the District Director had the authority to address employer's objection to claimant's choice of physician on the ground that he was not a spine specialist. Inasmuch as the claims examiner's conclusion raised a disputed question of fact, the ALJ had the authority to make findings on this issue. The ALJ's decision, however, must be based on the evidence of record. Here, the ALJ relied on the "testimony" of claimant's counsel to find that the physician treated spinal injuries. As claimant's counsel was a not a witness, and his statements were not part of the evidentiary record, the ALJ's finding was vacated. Because claimant had ample opportunity to put in evidence on this issue, the BRB declined to remand the case to the ALJ, but remanded it to the District Director to issue an order resolving the issue.

make a determination as to whether a physician has shown good cause for failing to file a first report of treatment in a timely manner.[2] *Toyer v. Bethlehem Steel Corp.*, 28 BRBS 347 (1994). In both *Jackson* and *Toyer*, the Board reasoned that the language of the statute is discretionary and therefore there is no role for the ALJ to play in the determination of these medical issues.

Further, in *McCurley v. Kiewest Co.*, 22 BRBS 115 (1989), the Board held that, while the ALJ has the authority to order payment for already incurred medical expenses and to generally order future medical treatment for a work-related injury, the ALJ erred in directing ongoing future treatment at the specified pain clinic.[3] If authorization for such care is properly requested and the care is necessary and reasonable, employer may be liable for claimant's expenses at this clinic. However, ongoing treatment must be supervised by the District Director as provided in the regulations. *Id.* More recently, in *Potter, et al. v. Electric Boat Corp.*, 41 BRBS 69 (2007), the Board held that, pursuant to § 702.407(b), the District Director, and not the ALJ, has the authority to address the choice of pharmacy issue raised by the parties, as the District Director supervises the medical care of injured employees. Thus, the parties did not raise any factual issues requiring adjudication by an ALJ.

Similarly, in *Shumabukuro v. Chugach Management Services, Inc.*, BRB No. 90-989 (Mar. 10, 2014) (unpub.), a Defense Base Act case, the Board held that the District Director was not required to refer the claim to an ALJ as there were no factual issues raised requiring adjudication. In 2011, the District Director had ordered employer to pay housing and meals per diems to claimant who was injured while working on Kwajalein Atoll and had to undergo treatment in Honolulu. Claimant's treatment resulted in complications and her employment was terminated. In 2013, the District Director issued a compensation order terminating per diem, as it was no longer reasonable or necessary for employer to pay for claimant to stay in Honolulu. Citing *Potter*, the Board rejected claimant's contention that the District Director had no authority to issue the 2013 order because there were disputed issues of fact requiring that the case be transferred to an ALJ. The Board stated that a party does not have an absolute right to a hearing before an ALJ on issues that are left to the discretion of the District Director. Here, the "disputed facts" raised by claimant were not material to the District Director's decision and thus referral to an ALJ was not required. Moreover, the Board stated that claimant had not established that the District Director abused his discretion in terminating the per diem payments.

While District Directors have discretionary authority to supervise an employee's care, ALJs have the authority to resolve factual disputes which arise over non-discretionary matters.

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[2] Prior to 1986, § 702.422 delegated this authority to the deputy commissioner (now District Director) and the ALJ.
[3] The BRB explained the limits of this holding in *Caudill v. Sea Tac Alaska Shipbuilding*, 25 BRBS 92 (1991), *aff'd mem. sub nom. Sea Tac Alaska Shipbuilding v. Director, OWCP*, 8 F.3d 29 (1993). The BRB affirmed the ALJ's order directing employer to pay for claimant's work-related surgical fusion at C6-7, which it had denied, as the ALJ rationally found the procedure to be reasonable and necessary. The BRB reasoned that claimant requested authorization from employer for a single medical procedure, whereas in *McCurley*, the claimant sought ongoing, open-ended, non-specific treatment at a specific health care facility.

A claim for medical benefits that raises disputed factual issues must be referred to an ALJ for resolution of the disputed factual issues in accordance with Section 19(d) of the Act and the Administrative Procedure Act, 5 U.S.C. § 554. *See Weikert v. Universal Maritime Service Corp.*, 36 BRBS 38 (2002);[4] *Sanders v. Marine Terminals Corp.*, 31 BRBS 19 (1997);[5] *Green v. Ceres Marine Terminals, Inc.*, 43 BRBS 173 (2010), *rev'd on other grounds*, 656 F.3d 235, 45 BRBS 67(CRT) (4th Cir. 2011).[6] *Cf. McCurley*, 22 BRBS 115; *Potter*, 41 BRBS 69. Disputes over whether authorization for treatment was requested by claimant, whether employer refused the request for treatment, whether the treatment obtained was reasonable and necessary, or whether a physician's report was filed in a timely manner, are all factual matters within the ALJ's authority to resolve. *Weikert*, 36 BRBS 38.

When a dispute arises regarding a fee for medical treatment or services due claimant, the District Director must make the initial determination as to whether the fee in dispute exceeds the prevailing community charges. 20 C.F.R. § 702.413. Section 702.414(a) provides that the District Director may, upon his own initiative or the written complaint of a party, investigate any fee that appears to exceed prevailing medical charges. In accordance with § 702.413, the District Director must determine the prevailing community rate for the disputed service. The District Director then must make specific findings as to whether the fee in dispute exceeds the prevailing community charges. 20 C.F.R. § 702.414(c). After the District Director issues his specific findings, any affected party may seek, pursuant to § 702.415, a hearing before the Office of ALJs, on the issue. *See Newport News Shipbuilding & Dry Dock Co. v. Loxley*, 934 F.2d 511, 24 BRBS 175(CRT) (4th Cir. 1991), *cert. denied*, 504 U.S. 910 (1992). *See also Watson v. Huntington Ingalls Indus.*, __ BRBR __ (2017).[7]

The Board's recent decision in *McDonald v. Armorgroup Int'l Ltd.*, 50 BRBS 181(UBD), BRB No. 16-0147 (Sept. 28, 2016) (unpub.), highlights the separation of functions between the District Director and the ALJ. The issues presented for adjudication by the ALJ involved the necessity and cost of attendant care services for claimant residing in Western Australia. The ALJ initially issued an order stating that the only issue properly raised before him was the necessity of

[4] In *Weikert*, the BRB held that the ALJ erred in remanding the case to the District Director where findings of fact on the necessity of hearing aids were needed. While active supervision of a claimant's medical care is performed by the District Director, issues which involve factual disputes, as opposed to those which are purely discretionary, are for the ALJ to decide.

[5] In *Sanders*, the BRB rejected the Director's contention that only the District Directors have the authority to determine the appropriateness of medical care and held that a claim for medical benefits that raises disputed factual issues such as the need for specific care or treatment for a work-related injury must be referred to an ALJ.

[6] *See* "Reasonable Expenses/Distance," *infra*.

[7] In *Watson*, employer disputed a medical provider's charges, asserting that contracts among employer, United Healthcare and its affiliates, and the medical provider entitled it to a reduced fee. The provider filed a claim, and the District Director determined that employer paid less than what is allowed under the OWCP Medical Fee Schedule, and owed the difference. Following referral to OALJ, the ALJ denied employer's motion to dismiss based on lack of subject matter jurisdiction. The BRB accepted an interlocutory appeal and 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 the rights of any party under the private contracts.

attendant care, and that the remaining issues raised by the parties, including employer's responsibility for the payment of claimant's outstanding medical expenses, the reasonable value of attendant care, who is the "proper recipient" of benefits for the attendant care (*i.e.*, claimant or the provider), and who is entitled to choose claimant's attendant care provider, were not properly before him and would not be addressed.[8] The ALJ subsequently awarded claimant 24-hour attendant care, and he remanded the case to the District Direct or to determine the value of such care pursuant to § 702.413 and to "perform all calculations necessary to effect" the award. The Board rejected employer's contention that the ALJ erred in remanding the case to the District Director for findings pursuant to § 702.413.[9] The Board stated that the additional issues that the ALJ refused to address (*e.g.*, employer's contention that any payments should be made after, and not before, the services are rendered) are within the purview of the District Director pursuant § 7(b) and § 702.407, and could be raised before the District Director on remand.

In practice, unless parties expressly dispute specific past medical bills or future treatment, ALJs typically award medical benefits in general terms (after resolving all pertinent disputed issues, such as disputes regarding causation) and direct the District Director to make all calculations necessary to effectuate the compensation order. The District Director may make any calculations required to effectuate a compensation order, as this task is ministerial. *See Keen v. Exxon Corp.*, 35 F.3d 226, 28 BRBS 110(CRT) (5th Cir. 1994); *Estate of C.H. [Heavin] v. Chevron USA, Inc.*, 43 BRBS 9 (2009); *Cretan v. Bethlehem Steel Corp.*, 24 BRBS 35 (1990), *aff'd in part and rev'd in part*, 1 F.3d 843, 27 BRBS 93(CRT) (9th Cir. 1993), *cert. denied*, 512 U.S. 1219 (1994). A decision may not be enforceable until these calculations are made. *Id.*; *see also Lazarus v. Chevron U.S.A., Inc.*, 958 F.2d 1297, 25 BRBS 145(CRT) (5th Cir. 1992).[10] However, if additional fact finding is required, the case must be referred to an ALJ. *See, e.g.*,

[8] *McDonald v. Armorgroup Int'l Ltd.*, 2010-LDA-00430 (ALJ Order of Oct. 2, 2015).

[9] The BRB further concluded that the District Director erred on remand in summarily finding employer liable for weekly attendant care benefits of $4,000 per week based on its prior voluntary payment of this amount. Although the ALJ specifically remanded the case to the District Director for a determination of the prevailing rate for the awarded attendant care, the District Director did not undertake the required analysis. The BRB remanded the case to the District Director to undertake such analysis.

[10] In *Lazarus*, the Fifth Circuit held that medical benefits are included in "compensation" for purposes of enforcement proceedings under § 18(a). Thus, the district court erred in dismissing claimant's petition for enforcement of the deputy commissioner's supplementary order compelling employer to pay claimant's medical expenses on the ground that medical expenses are not included in compensation. Nonetheless the court affirmed the district court's dismissal of claimant's petition on the ground that the ALJ's underlying compensation order was not final and enforceable since it did not specify the amount of the medical expenses to be awarded and the method for calculating them. The ALJ's order stated that "the specific dollar computations of the compensation award shall be administratively performed by the Deputy Commissioner." The court also held that the deputy commissioner further compounded this error by issuing the supplementary order without resolving the amount of medical expenses at issue in an informal conference and by simply accepting the amount claimant asserted was in default.

Plappert v. Marine Corps Exchange, 31 BRBS 13 (1997), *aff'd on recon. en banc*, 31 BRBS 109 (1997).[11]

Covered Expenses

Pursuant to Section 7(a) of the Act, an employer "shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a); *see also* 20 C.F.R. § 702.402.[12] The relevant regulations provide that "medical care"

> shall include medical, surgical, and other attendance or treatment, nursing and hospital services, laboratory, X-ray and other technical services, medicines, crutches, or other apparatus and prosthetic devices, and any other medical service or supply, including the reasonable and necessary cost of travel incident thereto, which is recognized as appropriate by the medical profession for the care and treatment of the injury or disease.

20 C.F.R. § 702.401(a); *see also* 20 C.F.R. § 702.412(b).

Medical care must be appropriate for the injury. 20 C.F.R. § 702.402. In order for a medical expense to be assessed against the employer under Section 7(a) of the Act, the expense must be both reasonable and necessary for treatment of a work injury, and the claimant bears the burden of establishing both the reasonableness and the necessity of the expense. *Ramsey Scarlett & Co. v. Director, OWCP [Fabre]*, 806 F.3d 327, 49 BRBS 87(CRT) (5th Cir. 2015);[13] *Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996); *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979).

The ALJ has the authority to determine the necessity of medical care based on the evidence of record. *Weikert*, 36 BRBS 38; *Green*, 43 BRBS 173. In order to be entitled to medical benefits under § 7, claimant must provide an adequate evidentiary basis sufficient to support the award. *See Ingalls Shipbuilding, Inc. v. Director, OWCP [Baker]*, 991 F.2d 163, 27 BRBS 14(CRT) (5th Cir. 1993); *Green*, 43 BRBS 173; *cf. Buckland v. Dep't of the Army/ NAF/CPO*, 32 BRBS 99 (1997).[14] Claimant is not afforded the benefit of a presumption of

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[11] In *Plappert*, the BRB vacated that portion of the District Director's order which held employer liable for contested medical bills which were not part of the record before the ALJ, as he exceeded his authority in awarding payment of those contested bills. Claimant may request referral to an ALJ if she wishes to pursue payment of the bills.

[12] § 702.402 provides that "[i]t is the duty of the employer to furnish appropriate medical care . . . for the employee's injury, and for such period as the nature of the injury or the process of recovery may require."

[13] In *Ramsey*, the Fifth Circuit held that the ALJ rationally relied on the opinion of claimant's treating physician in concluding that flu and pneumonia vaccines are necessary treatments for claimant's work-related asbestosis.

[14] In *Buckland*, the BRB vacated the ALJ's denial of medical benefits. Although the ALJ stated that there was no issue regarding medical benefits for him to decide because claimant presented no bills for payment, claimant's counsel asserted employer's responsibility for medical benefits and the ALJ should have addressed this issue. There was evidence that could be sufficient to establish that claimant was undergoing treatment necessary for her work-related injury.

reasonableness of treatment under § 7 by virtue of § 20(a) of the Act. *Schoen*, 30 BRBS 112. A claimant establishes a *prima facie* case for compensable medical treatment where a qualified physician indicates the treatment is necessary for the work-related condition.[15] *Turner v. Chesapeake & Potomac Telephone Co.*, 16 BRBS 255 (1984);[16] *Romeike v. Kaiser Shipyards*, 22 BRBS 57 (1989). *See generally Barbour v. Woodward & Lothrop, Inc.*, 16 BRBS 300 (1984);[17] *Miranda v. Excavation Constr., Inc.*, 13 BRBS 882 (1981) (physician prescribed a move to a warmer climate to ease pain); *R.C. [Carter] v. Caleb Brett, L.L.C.*, 43 BRBS 75 (2009);[18] *Grimlan v. Dyncorp Int'l, LLC*, 50 BRBS 115(UBD), 2016 WL 8315555 (July 5, 2016)(unpub.).[19] *Cf. Weikert*, 36 BRBS at 40 n.3;[20] *Gilliam v. Western Union Telegraph Co.*, 8 BRBS 278 (1978) (affirming ALJ's award of first class airplane fare where a physician recommended relocation to a warmer climate).

Notably, in *Amos v. Director, OWCP*, 153 F.3d 1051 (1998), *amended*, 164 F.3d 480, 32 BRBS 144(CRT) (9th Cir. 1999), *cert. denied*, 528 U.S. 809 (1999), the Ninth Circuit held that the opinion of claimant's treating physician is entitled to special weight,[21] and that claimant is entitled to choose his course of treatment in consultation with his own doctor when presented with reasonable options. Thus, the ALJ was required to credit the claimant's treating physician's

[15] § 702.404 provides, in relevant part, that "[t]he term *physician* includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation shown by X-ray or clinical findings." Where claimants provided a physician's opinion indicating that a specific expense is medically necessary, ALJs have considered opinions provided by non-physicians, *e.g.*, occupational therapists and life care experts, as further evidence on this issue. *Carroll v. M. Cutter Co., Inc.*, 38 BRBS 53 (2004); *Kahue v. Pacific Environmental Corp.*, 2010-LHC-00361 (ALJ Dec. 22, 2010).

[16] In *Turner*, the BRB held that the ALJ may not deny a medical expense simply because a physician's expertise, customary fees, or result of treatment were not documented.

[17] In *Barbour*, the BRB held that the fact that biofeedback therapy was prescribed by a treating physician, who found such treatment helpful, was sufficient to establish that the treatment was appropriate under § 702.401; claimant does not have the burden to show that treatment is medically accepted. Further, it was not necessary that the biofeedback therapist be licensed to administer such therapy.

[18] In *R.C. [Carter]*, the BRB reversed the ALJ's denial of medical benefits, holding that claimant's massage therapy, prescribed by his treating physician, a chiropractor, for treatment of a subluxation and performed by a massage therapist in the chiropractor's office, is compensable. While § 702.404 defines when a chiropractor is considered a "physician" under the Act, § 7(a) and § 702.401(a) define which medical care performed by a non-physician is compensable. As the care rendered by Ms. Oliver, a non-physician, was prescribed by claimant's treating physician for treatment of his work-related subluxation, and as the ALJ found the therapy to be reasonable and necessary, the massage therapy is compensable.

[19] *See* "Employer-provided Housing and Related Expenses," *infra*.

[20] In *Weikert*, the BRB remanded the case to the ALJ for a determination as to whether hearing aids recommended by an audiologist are necessary and reasonable treatment. Contrary to employer's contention, the absence of a prescription for hearing aids from a medical doctor, allegedly required by Virginia law, does not make claimant ineligible for hearing aids, or medical benefits, under the Act. While claimant must comply with specific provisions under Virginia law before he is able to obtain hearing aids, claimant's compliance or non-compliance with state requirements does not affect the authority of the ALJ to adjudicate claimant's entitlement to medical benefits under the Act.

[21] The court stated that according special weight to a treating physician's opinion is premised on the reasoning that the treating physician is employed to cure and has a greater opportunity to know and observe the patient as an individual.

opinion regarding a proposed course of treatment since his opinion was entitled to special deference and since it was not shown by the testimony of other doctors to be unreasonable. Further, in *Monta v. Navy Exchange Service Command*, 39 BRBS 104 (2005), the Board affirmed the ALJ's finding that when presented with two valid options for treatment, the decision should be left with the claimant to choose between them, and employer is liable for the option she chooses. In practice, these holdings reduce litigation over possible differences in medical opinions regarding the preferred course of treatment.

The Board's decisions reflect a liberal interpretation of what items may qualify as "apparatus" and which services may qualify as "medical … and other attendance or treatment ..." within the meaning of § 7. A determination whether a specific expense is covered under § 7(a) is generally a fact-specific inquiry. The following items have been approved as "medical care" under § 7(a) because they were determined to be "reasonable and necessary" for the treatment of work-related conditions: house modifications;[22] attendant care;[23] domestic services;[24] biofeedback therapy;[25] transportation costs, including a van with an automatic lift;[26] moving expenses;[27] and parking fees and tolls.[28]

Employer-provided Housing and Related Expenses

In *Grimlan v. Dyncorp Int'l, LLC*, 50 BRBS 115(UBD), 2016 WL 8315555 (July 5, 2016) (unpub.), the Board addressed the evidentiary burden that a claimant must carry to establish entitlement to various expenses related to employer-provided housing. In *Grimlan*, employer built a handicapped-accessible home for claimant, but disputed liability for certain associated expenses. Upon conducting a review of what has been considered "medically necessary" under § 7(a) of the Act, as well as a review of the law in various states, the ALJ concluded that the general rule is as follows: an employer is liable for expenses that a medical

[22] *Dupre v. Cape Romain Contractors, Inc.*, 23 BRBS 86 (1989) (modifications to claimant's house necessitated by his disability, including ramps, widened doorways, handicapped-accessible plumbing fixtures, and "other changes" were covered under § 7).

[23] 20 C.F.R. §702.412(b). *See also M. Cutter Co., Inc. v. Carroll*, 458 F.3d 991, 40 BRBS 53 (CRT) (9th Cir. 2006); *Falcone v. Gen. Dynamics Corp.*, 21 BRBS 145 (1988). Fees for such an attendant are addressed by 20 C.F.R. § 702.413.

[24] Where an employee's injuries are so severe as to require domestic services, the employer must provide them, even to the extent of reimbursing a family member who performs them. *Carroll v. M. Cutter Co., Inc.*, 38 BRBS 53 (2004) (en banc), *aff'g* 37 BRBS 134 (2003), *aff'd*, 458 F.3d 991, 40 BRBS 53 (CRT) (9th Cir. 2006) (if the credited physician states claimant requires 24-hour care, employer is liable for it; family members are not free); *Gilliam v. Western Union Telegraph Co.*, 8 BRBS 278 (1978) (housekeeping services are clearly provided for under § 7(a) as it provides for medical assistance and treatment and "other" assistance and treatment); *Timmons v. Jacksonville Shipyards*, 2 BRBS 125 (1975) (wife as provider).

[25] *Barbour*, 16 BRBS 300.

[26] *Day v. Ship Shape Maintenance Co.*, 16 BRBS 38 (1983) (van with an automatic lift for a quadriplegic, while not "apparatus," is chargeable to his employer as a reasonable means to provide necessary transportation for medical purposes).

[27] *Miranda v. Excavation Constr., Inc.*, 13 BRBS 882 (1981) (affirming an award of relocation expenses where a physician prescribed a move to a warmer climate to ease claimant's pain).

[28] *Castagna v. Sears, Roebuck & Co.*, 4 BRBS 559 (1976), *aff'd mem.*, 589 F.2d 1115 (D.C. Cir. 1978).

provider has deemed "medically necessary;" however, the employer's liability is limited by the amount exceeding that which the injured employee was paying for those expenses prior to his injury.[29] On the facts of that case, the ALJ found that because claimant's doctor deemed electricity, water, air conditioning, land telephone line, carbon monoxide monitoring, fire monitoring, and "general maintenance"[30] "medically necessary" for claimant's injury, employer was liable for these costs.[31] However, claimant did not establish entitlement to employer-paid property taxes, homeowner's insurance, and guardianship costs. In affirming these findings, the Board stated:

> In this case, the [ALJ] determined that employer is not liable for property taxes and homeowner's insurance because no physician stated such expenses are 'medically necessary.' …. This is the proper test for determining whether employer is liable for the requested costs. *See, e.g., Ramsey Scarlett & Co.*, 806 F.3d 327, 49 BRBS 87(CRT). As there is no evidence of record that any physician determined that claimant's property taxes and homeowner's insurance are 'medically necessary' for the treatment of claimant's work-related condition, we affirm the [ALJ's] finding. *See generally Arnold v. Nabors Offshore Drilling, Inc.*, 35 BRBS 9 (2001), *aff'd mem.*, 32 F.App'x 126 (5th Cir. 2002).[[32]] We reject claimant's assertion that Section 7(a) should be interpreted so broadly as to encompass all expenses which have not been specifically deemed 'medically necessary' merely because they derive from items a doctor has deemed 'medically necessary.' Claimant must establish the reasonableness and necessity of every claimed treatment or expense. *Schoen*, 30 BRBS 112.

Id. at *3 (citation to ALJ decision omitted).[33] Similarly, claimant did not present any evidence that guardianship costs were "medically necessary" for the treatment of his work-related disability. *Id.*, citing *Ezell v. Direct Labor, Inc.*, 37 BRBS 11 (2003).[34]

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[29] Because claimant lived at home with his parents and, thus, was not paying rent or utility costs before his injury, the ALJ held employer liable for the claimed amounts in their entirety, and this finding was not appealed.

[30] The ALJ awarded claimant "general maintenance" expenses to be determined by the parties based on "sound reason and good judgment." *Grimlan v. Dyncorp Int'l, LLC*, 2012-LDA-00413 (ALJ Decision and Order June 27, 2015) at 27. He instructed that "[a]ccording to Claimant's expert life care planner, … common examples of 'general maintenance' include plumbing or electrical problems. Accordingly, 'general maintenance' should include a universe of tasks involving more than the menial changing of a light bulb, and should not be the burden of Employer/Carrier unless it concerns a major system of the house structure or its foundation, to include such services as plumbing, electricity, air conditioning, fire monitoring, or carbon-monoxide monitoring, all of which are not intended to be an exhaustive list." *Id.* These findings were not appealed.

[31] Neither the ALJ nor the BRB found binding precedent under the Act directly addressing such expenses.

[32] In *Arnold*, the BRB affirmed the ALJ's finding that employer is not liable for the treatment provided by Dr. Raffai, as the ALJ rationally found that claimant's work-related back condition had resolved prior to the treatment and that Dr. Raffai's treatment was not necessary for the work-related back condition.

[33] *See generally Larson's Workers' Compensation Law*, § 94.03 (collecting cases addressing whether specially equipped automobiles, housing, or swimming pools are covered under state workers' compensation statutes; and concluding that "[i]n a few instances, the result may turn on whether the expenditure was supported by a sufficiently definite doctor's prescription").

[34] In this regard, the BRB noted that "[t]he proper test is not a 'but for' test: not all expenses a claimant incurs post-injury are to be borne by his employer merely because he would not have incurred them but for his injury. As

In *McCarthy v. Aegis Defense Services, Ltd.*, 2015-LDA-00239 (ALJ July 6, 2017), while stipulating that claimant is entitled to a handicapped-accessible home, employer disputed claimant's entitlement to several accommodations recommended by his accommodations expert, an architect, including separate bedrooms for attendant care providers. Employer also disputed liability for homeowner's insurance, utilities, taxes, maintenance, and home furnishings. The ALJ rejected employer's contentions that the claimed expenses are not covered under § 7, as a matter of law, because they are "[l]iving expenses … unrelated to a work injury" and/or because "[h]ome maintenance is an expense incurred by all individuals, regardless of disability status." However, the ALJ found that claimant only established the medical necessity of expenses attendant to the purchase of a home, relocation expenses, and additional heating and cooling expenses, based on his physicians' opinions documenting medical necessity. The ALJ denied accommodations and expenses not specifically recommended by physicians of record.

Reasonable Expenses/Distance

There is no dollar limit on employer's § 7 liability. *Duty v. Jet America, Inc.*, 4 BRBS 523 (1976). Occasionally, the reasonableness of the cost of treatment may be expressly disputed in ALJ proceedings. Employer/carrier may be asserting that the cost of specific treatment exceeds the prevailing community rate, or that it is unreasonable in light of less costly alternatives. The latter challenge is usually premised on the availability of less costly treatment in claimant's local community.

Section 7(g) of the Act provides that "[a]ll fees and other charges for medical examinations, treatment, or service shall be limited to such charges as prevail in the community for such treatment. . . ." Section 702.413 of the regulations implements Section 7(g).[35] *See Newport News Shipbuilding & Dry Dock Co. v. Loxley*, 934 F.2d 511, 24 BRBS 175(CRT) (4th Cir. 1991), *cert. denied*, 504 U.S. 910 (1992); *Bulone v. Universal Terminal & Stevedoring Corp.*, 8 BRBS 515 (1978); *Potenza v. United Terminals, Inc.*, 1 BRBS 150 (1974), *aff'd*, 524 F.2d 1136, 3 BRBS 51 (2d Cir. 1975).

Although § 702.413 acts as a ceiling for compensable fees, it does not preclude the ALJ from awarding a lesser amount where comparable less expensive treatment was available to claimant locally. *Schoen*, 30 BRBS 112; *see generally Ezell*, 37 BRBS 11;[36] *Welch v. Pennzoil*

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discussed, the proper test under § 7(a) is medical necessity. Generally speaking, a claimant's disability benefits are 'wage replacement' from which he pays his other living expenses." *Id.* at *4 n.13. The ALJ subsequently awarded claimant employer-paid guardianship expenses based on his treating doctor's opinion that it was medically necessary for claimant's financial affairs to be managed by guardian. *Grimlan v. Dyncorp Technical Servs.*, 51 BRBS 19 (ALJ Jan. 17, 2017).

[35] The applicable procedural regulations are discussed under "Authority of Administrative Law Judge vs. District Director," *supra*.

[36] In *Ezell*, the BRB affirmed the ALJ's conclusion that treatment allegedly administered by Dr. Vogel was unreasonable and unnecessary as substantial evidence supported the findings that claimant saw Dr. Vogel with

Co., 23 BRBS 395 (1990).[37] *Cf. Amos*, 153 F.3d 1051, *amended*, 164 F.3d 480, 32 BRBS 144(CRT) (when faced with valid medical alternatives, claimant in consultation with his own doctor has the right to choose his own course of treatment); *Monta*, 39 BRBS 104 (same). Relatedly, § 702.403 provides that the employee shall have the right to choose his attending physician, *see* 33 U.S.C. § 907(b), and that in determining the choice of physician, availability, the employee's condition and the method and means of transportation must be considered. It further provides that a reasonable travel distance generally is 25 miles from the place of injury or employee's home, but other factors must be considered.

In *Schoen*, 30 BRBS 112, the Board held that in determining the reasonableness of the costs of treatment claimant, a resident of Austin, Texas, procured at a pain center in Boston, the ALJ did not err by comparing the costs of the Boston treatment to that of similar treatment available in Houston, Texas. While the proximity of the medical care to claimant's residence is a factor to be considered in determining the reasonableness of medical treatment, where competent care is available locally, claimant's medical expenses may reasonably be limited to those costs which would have been incurred had the treatment been provided locally. In this case, the ALJ properly compared treatment available at a local pain center in Houston with the treatment procured by claimant in Boston, and, after considering the treatment available, the professional accreditations and success rates, and the experience of each clinic's director, rationally determined that adequate comparable treatment was available locally at a lesser cost. *Id.*

In *Green*, 43 BRBS 173, the Board held that the ALJ's finding that claimant is entitled to hearing aids was supported by substantial evidence. However, neither party is entitled, by statute or regulation, to choose which hearing aid is to be procured. The Board affirmed the ALJ's finding that the lower cost Phonak hearing aid was a reasonable and necessary treatment, based on its cost and functionality, as it was supported by substantial evidence. The Board separately discussed the amount to be awarded for the hearing aids. The ALJ had found that hearing aids are not listed in the OWCP Medical Fee Schedule, and he concluded that he must look to the fee schedule in South Carolina to determine the amount. The Board modified the ALJ's award of $3,000 for the hearing aids to reflect employer's liability for the actual cost of the hearing aids to claimant, $2,500. The Board found that, on the facts of this case, the ALJ erred in looking to any fee schedule for the cost of the hearing aids. Pursuant to § 702.413, the

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regard to an unrelated state court claim, the record contained no treatment records by Dr. Vogel or any indication that claimant went to Dr. Vogel for continued treatment of his work-related condition, and claimant was referred to Dr. Vogel by his attorney and not by any treating physician. The ALJ, moreover, rationally concluded that it was not reasonable for claimant to seek treatment with Dr. Vogel because of the considerable distance between claimant's residence in Houma, Louisiana, and Dr. Vogel's office, located in New Orleans, especially since other equally qualified physicians who were chosen by claimant, were in the Houma area.

[37] In *Welch*, the BRB remanded the case for the ALJ to address the proximity of a physician's office to claimant's residence in determining whether claimant was entitled to the services of Dr. LaRocca, a Board-certified orthopedic surgeon to whom claimant was referred by her treating physician, as Dr. LaRocca's practice is some 313 miles distant from claimant's home, employer offered the services of a nearby specialist, and § 702.403 provides that 25 miles is generally a reasonable travel distance for medical care.

use of fee schedules is appropriate when there is a dispute about the prevailing community rate of a given medical service or supply. In this case, there was no such dispute and thus, resort to a fee schedule was not necessary. The parties did not contest the cost of each of the two types of recommended hearing aids, but disagreed over which pair would be appropriate for claimant.

Past Medical Expenses

In *Marshall v. Pletz*, 317 U.S. 383 (1943), the Supreme Court stated that medical benefits are generally not considered to be "compensation" because, in the normal case, the insurer defrays the expense of medical care but does not pay the injured employee anything on account of such care. Only if an employer and insurer fail to furnish such care does the employee procure it for himself and then obtain an award of reimbursement. *See also Lazarus*, 958 F.2d 1297, 25 BRBS 145 (CRT) (stating that § 7 envisions that employers would provide medical care by directly paying the provider). However, monetary payments to employees for medical expenses become necessary in cases where the employer has refused to provide medical care and the employee must obtain it himself and file a claim against the employer.[38] Section 7(d)(1) provides requirements which must be met in order for employer to be held liable for medical treatment.[39] A claim for medical benefits is never time-barred. *Siler v. Dillingham Ship Repair,* 28 BRBS 38 (1994)(*en banc*) .

Additionally, Section 7(d)(3) provides that "[t]he 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). An employer is liable to claimant for all medical expenses related to the injury paid by claimant and is liable for all medical expenses related to the injury paid by claimant's private health insurer, provided the private insurer files a request for reimbursement of same. *Plappert v. Marine Corps Exchange*, 31 BRBS 109 (1997), *aff'g on recon. en banc* 31 BRBS 13 (1997). An insurance carrier providing coverage for non-occupational injuries can intervene and recover amounts mistakenly paid for injuries determined

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[38] *See* BRB Longshore Deskbook *at* https://www.dol.gov/brb/References/Reference_works/lhca/lsdesk/dbsec7.htm.

[39] It states:

> An employee shall not be entitled to recover any amount expended by him for medical or other treatment or services unless—
>
> (A) the employer shall have refused or neglected a request to furnish such services and the employee has complied with subsections (b) and (c) and the applicable regulations; or
>
> (B) the nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize same.

33 U.S.C. § 907(d)(1). Thus, an employee cannot receive reimbursement for medical expenses under § 7(a) unless he has first requested authorization, except in cases of emergency or refusal/neglect by employer to provide requested care. 20 C.F.R. § 702.421; *Shahady v. Atlas Tile & Marble Co.*, 682 F.2d 968 (D.C. Cir. 1982) (*per curiam*), *cert. denied*, 459 U.S. 1146 (1983).

to be work-related where claimant is entitled to such expenses.[40] *Quintana v. Crescent Wharf & Warehouse Co.*, 19 BRBS 52 (1986), *modifying on recon.* 18 BRBS 254 (1986);[41] *Ozene v. Crescent Wharf & Warehouse Co.*, 19 BRBS 9 (1986).[42] Claimant is not entitled to reimbursement of medical expenses paid by the private insurer. *Nooner v. Nat. Steel & Shipbuilding Co.*, 19 BRBS 43 (1986) (rejecting claimant's argument that employer owes him for medical bills paid by his private insurers and the state of California for bills paid by Medi-Cal; he may only recover amounts which he himself expended for medical treatment); *Quintana*, 18 BRBS 254 (claimant has no standing to assert Medi-Cal's rights to reimbursement for medical services it provided to claimant).

Medical providers may also seek payment by employer of unpaid medical expenses pursuant to § 7(d)(3). *See, e.g.*, *Hunt v. Director, OWCP*, 999 F.2d 419, 27 BRBS 84 (CRT) (9th Cir. 1993), *rev'g Bjazevich v. Marine Terminals Corp.*, 25 BRBS 240 (1991); *Pozos v. Army & Air Force Exchange Service*, 31 BRBS 173 (1997).[43] In *Hunt*, the Ninth Circuit held that medical providers who intervene in a claim have no independent entitlement to medical benefits but do have a derivative right under § 7(d)(3) based on claimant's entitlement to recover medical benefits. Agreeing with the Director, the court held that § 7(d)(3) grants medical providers standing to "seek benefits" on behalf of an employee where the benefits are owed to the provider for medical services rendered. In other words, although the Act does not confer any "benefits" on medical providers as such, it allows providers to seek to recover an injured employee's medical benefits to the extent that the benefits are owed to the provider in satisfaction of unpaid bills.

Medical providers are also entitled to interest on overdue benefits, *Hunt*, 999 F.2d 419, 27 BRBS 84 (CRT),[44] and attorney's fees, *id.*;[45] *Grierson v. Marine Terminals, Corp.*, 49 BRBS

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[40] However, an employer is not liable to such third parties for medical services which are always gratis, *United States v. Bender Welding & Machine Co.*, 558 F.2d 761, 764 (5th Cir. 1977), and is not liable to claimant for expenses already paid by employer's non-occupational injury carrier to prevent double recovery. *Luker v. Ingalls Shipbuilding*, 3 BRBS 321 (1976).

[41] In *Quintana*, the case was remanded for the ALJ to determine who should reimburse Medi-Cal. If employer has not yet paid claimant, employer must reimburse Medi-Cal, but if employer has paid claimant, claimant will reimburse Medi-Cal.

[42] In *Ozene*, the BRB held that an intervenor's right to reimbursement of medical costs is solely derivative of claimant's right to reimbursement of such expenses under § 7; as claimant did not comply with § 7(d), the intervenor could not be reimbursed.

[43] In *Pozos*, citing *Hunt*, the BRB rejected employer's contention that the ALJ lacked jurisdiction to hear a claim brought by claimant's medical provider, St. Mary's Medical Center. As employer refused to pay for St. Mary's treatment of claimant, St. Mary's sought to recover claimant's medical benefits to the extent that the benefits were owed to the provider in satisfaction of unpaid bills, a right it had under § 7(d)(3).

[44] In *Hunt*, the court noted that interest may be included in the "reasonable value" of medical services pursuant to § 7(d)(3).

[45] In *Hunt*, the Ninth Circuit held that the BRB erred in concluding that claimant's attorney could have adequately represented the medical providers before the ALJ and that therefore the attorney they retained did not serve a "necessary" function under § 702.132(a). Claimant had no particular incentive to prove that his physicians' charges were "prevailing community charges" as required by § 7(g) of the Act and 20 C.F.R. 702.413. The court agreed with the Fifth Circuit's statement in *Lazarus*, 958 F.2d 1297, 25 BRBS 145 (CRT), that in some instances medical

27 (2015);[46] *Buchanan v. Int'l Transportation Servs.*, 31 BRBS 81 (1997).[47] In *Ion v. Duluth, Missabe & Iron Range Ry. Co.*, 31 BRBS 75 (1997), the Board adopted the approach espoused in *Hunt* and advocated by the Director, and held that claimant is entitled to interest on past-due medical benefits, whether the costs were initially borne by claimant or the medical providers.[48] The Board further rejected employer's contention that interest was not payable in that case because, unlike in *Hunt,* claimant's medical providers did not intervene to seek payment of their bills. It noted that the interest is payable by employer to whomever payment is owed, either claimant or the provider.

In *Truex v. United States Navy Exchange*, BRB No. 03-0800 (Aug. 24, 2004) (unpub.), the Board summarized the case law governing reimbursement of unpaid medical expenses:

> Employer further contends that it cannot determine which bills claimant has paid. Employer's liability for the bills is unaffected by whether claimant paid the bills. If claimant has paid the bills, employer must reimburse claimant. 33 U.S.C. §907(d)(1); *see generally* [*Nooner*, 19 BRBS 43]. If claimant has not paid the bills, employer is liable to the provider. 33 U.S.C. §907(d)(3); *see Hunt*[, 999 F.2d 419, 27 BRBS 84(CRT)]; *Pozos* [31 BRBS 173].

Id., slip op. at 4.[49] *See generally R.H. [Harvey] v. Baton Rouge Marine Contractors, Inc.*, 43 BRBS 63 (2009) ("[n]either claimant, the health care provider, nor a private insurer can recover doubly under the Act"), *aff'd sub nom. Louisiana Ins. Guar. Ass'n v. Director*, OWCP, 614 F.3d 179, 44 BRBS 53(CRT) (5th Cir. 2010).[50] Nevertheless, ALJ decisions reflect some ambiguity

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benefits may be considered "compensation" under the Act because an employee is personally liable for his medical expenses and such liability may be just as debilitating as a loss of income due to a work injury.

[46] In *Grierson*, the BRB held that, under § 7(d)(3), the ILWU-PMA Welfare Plan is a "party in interest" seeking the "value" of medical treatment it provided to claimant, such that the employer may be held liable for the Plan's attorney's fee under § 28(a), as the Plan was a "person seeking benefits."

[47] *Cf. Duhagon v. Metropolitan Stevedore Co.*, 31 BRBS 98 (1997), *aff'd*, 169 F.3d 615, 33 BRBS 1 (CRT) (9th Cir. 1999) (BRB rejected Dr. Meyers' contention that the ALJ erred in failing to hold employer liable for his attorney's fee. Unlike in *Hunt*, Dr. Meyers did not seek payment of benefits for his treatment of claimant; rather, he sought payment for his appearance at a deposition. As his action was not a derivative claim under § 7, he was not a "person seeking benefits" under § 28).

[48] In so holding, the BRB overruled its own contrary holdings in *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294 (1988), and *Caudill v. Sea Tac Alaska Shipbuilding*, 22 BRBS 10 (1988), *aff'd mem. sub nom. Sea Tac Alaska Shipbuilding v. Director, OWCP*, 8 F.3d 29 (9th Cir. 1993). In *Pirozzi*, the BRB held that interest on medical payments is not available where the medical provider, rather than the employee, bears the out-of-pocket costs of medical treatment while the employer's responsibility to pay is being contested.

[49] In *Truex*, noting that claimant provided adequate evidence, subject to cross-examination, regarding his unpaid medical bills, which employer did not refute, the BRB affirmed the ALJ's finding that employer is liable for the expenses identified by claimant, "to be paid either to claimant or to the provider as appropriate." *Id.*

[50] In *Harvey*, in affirming the finding that LIGA is liable for claimant's medical benefits as the responsible carrier, the BRB rejected LIGA's contention that there could be a double recovery. If claimant paid the medical benefits himself, he is entitled to be reimbursed by employer, pursuant to § 7(d). If a private health insurer paid medical benefits, it has a statutory right to intervene to recover from employer the "reasonable value of such medical or surgical treatment" obtained by the employee, pursuant to § 7(d)(3).

with regard to payment of outstanding medical expenses where no medical provider had filed a claim under § 7 or participated in the case as a party. In *Kelley v. Navy Exchange Service Command*, 2012-LHC-01320 (Aug. 7, 2015), the ALJ found that "[w]hether a claimant may be compensated for unpaid medical bills that are reasonable and necessary is an open question," and he noted that "[d]ecisions at the ALJ level go both ways." *Id.* at 40. The ALJ observed that *Nooner* did not fully resolve the issue,[51] and he concluded that "declining to compensate [claimant] for her unpaid medical bills represents the more practical approach" because "[t]oo many unanswered questions arise were I to do otherwise" (*e.g.*, whether claimant could negotiate the amount with her providers, and what would happen if claimant were to keep the money). *Id.* at 41.

In practice, parties rarely request specific findings by an ALJ with respect to the exact amount of, or the proper recipient for, an award of past medical expenses. Thus, an award of medical benefits is often made in general terms.[52] Following such an award, the parties are usually successful in identifying specific medical expenses and the proper recipient, and these issues are rarely referred by the District Director for additional formal adjudication.

Conclusion

Section 7 of the Act, the applicable regulations, and case law detail claimant and employer's rights and obligations regarding medical treatment and other compensable services necessitated by a work-related injury. The District Directors and, in a subset of cases, the ALJs have an important role to play in effectively resolving disputes that may arise. Additionally, effective cooperation of all interested parties is essential to minimizing such disputes.

[51] The ALJ stated that the language of *Nooner* which restricts recovery to what the claimant actually expended, seems inconsistent with the BRB's holding, as it affirmed the ALJ's order to compensate claimant for unpaid bills.
[52] *See also* "Authority of Administrative Law Judge vs. District Director," *supra*.