

TOPIC 7 MEDICAL BENEFITS

7.1 MEDICAL TREATMENT NEVER TIME BARRED

A claim for medical benefits is never time-barred. Colburn v. General Dynamics Corp., 21 BRBS 219, 222 (1988). Employer has a continuing obligation to pay an injured employee's medical expenses, even if the claim for Section 8 compensation is time-barred by Section 12 or 13, Strachan Shipping Co. v. Hollis, 460 F.2d 1108 (5th Cir.), cert. denied, 409 U.S. 887 (1972); Wilson v. Southern Stevedore Co., 1 BRBS 123 (1974), if the employee is no longer employed by the employer, see Todd Shipyards Corp. v. Black, 717 F.2d 1280, 16 BRBS 13 (CRT) (9th Cir. 1983), affg 13 BRBS 682 (1981), cert. denied, 466 U.S. 937 (1984), or if employer is granted relief under Section 8(f).

Section 8(f) does not apply to Section 7 medical costs. Barclift v. Newport News Shipbuilding & Dry Dock Co., 15 BRBS 418 (1983), vacated and remanded on other grounds sub nom. Director, OWCP v. Newport News Shipbuilding & Dry Dock Co., 737 F.2d 1295, 16 BRBS 107 (CRT) (4th Cir. 1984); Scott v. Rowe Mach. Works, 9 BRBS 198 (1978); Spencer v. Bethlehem Steel Corp., 7 BRBS 675 (1978) (attendant care); Duty v. Jet America, 4 BRBS 523 (1976) (no dollar limit on employer's Section 7 liability).

Similarly, an award for medical expenses is independent of awards for, or denial of, Section 8 compensation or Section 9 death benefits, Union Stevedoring Corp. v. Norton, 98 F.2d 1012 (3d Cir. 1938), and must be paid during the three days following the injury, which are non-compensable under Section 8. 33 U.S.C. § 906(a); Ocean S.S. Co. v. Lawson, 68 F.2d 55 (5th Cir. 1933).

Medical benefits are available for workers who have suffered work-related hearing loss injury even if that injury does not satisfy the requirements for entitlement to disability benefits. Ingalls Shipbuilding, Inc. v. Director, OWCP, 991 F.2d 163 (5th Cir. 1993). However, the **Fifth Circuit** went on to state that, while the claimant is entitled to medical benefits, he could not receive an award for benefits absent evidence of medical expenses incurred in the past or **treatment necessary in the future**. The court added that the worker could file a claim for medical benefits **if and when treatment becomes necessary in the future**.

[ED. NOTE: In a non-LHWCA consolidated claim for 174 separate, but virtually identical civil actions filed by seaman allegedly exposed to asbestos on board vessels, the Ninth Circuit held that the Jones Act does not permit recovery for medical monitoring for plaintiffs who have no yet developed symptoms of disease. In Re: Marine Asbestos Cases v. American Hawaii Cruises, Inc., 265 F.3d 861 (9th Cir. 2001) (D.C. CV-97-77777-HG) (September 10, 2001).]

Depending on the circumstances, physician's fees may be recovered from employer either as costs of litigation under Section 28 or as medical expenses under Section 7. Gott v. National Steel & Shipbuilding Co., 16 BRBS 190 (1984). See Bradshaw v. J.A. McCarthy, Inc., 3 BRBS 195

(1976), petition for review denied mem., 547 F.2d 1161 (3d Cir.), vacated and remanded, 433 U.S. 905 (1977), petition for review denied mem., 564 F.2d 89 (3d Cir. 1977).

If the employer defaults, the Special Fund is responsible for paying medical expenses. 33 U.S.C. § 918(b); Duty, 4 BRBS at 530. (For more of Section 8(f) Special Fund Relief, see Topic 8.7.)

It is the **claimant's burden to establish the necessity of treatment** rendered for his work-related injury. See generally Schoen v. U.S. Chamber of Commerce, 30 BRBS 112 (1996); Wheeler v. Interocean Stevedoring, Inc., 21 BRBS 33 (1988); Ballesteros v. Willamette Western Corp., 20 BRBS 184 (1988).

In 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), however, the **Ninth Circuit** held that medical providers (a medical doctor and a physical therapist) were entitled to recover interest and attorney fees where they intervened in a LHWCA proceeding and the judge ruled that the claimant was disabled and that the treatment the medical providers rendered was reasonable and appropriate under the LHWCA.

The **Ninth Circuit**, noting that the LHWCA "provides that a 'party in interest' may petition the Secretary for an award of 'the reasonable value of ... medical or surgical treatment' provided to an injured longshore worker, 33 U.S.C. § 907(d)(3)," reasoned that it could "discover no statutory impediment to the view that the 'reasonable value' of medical services rendered includes interest on sums that are overdue." Id. at 422, 27 BRBS at 87-88.

The court went on to state that the remedial purposes of the LHWCA would be undermined if employers were allowed to withhold medical payments--no less than disability payments--interest free. Id. at 422, 27 BRBS at 88. The court also noted that permitting recovery of attorney fees forces employers to bear the cost of a wrongful refusal to pay benefits. Id. at 424, 27 BRBS at 91.

As a matter of policy, the **Ninth Circuit** agreed with the reasoning in Lazarus v. Chevron USA, Inc., 958 F.2d 1297, 25 BRBS 145 (CRT) (5th Cir. 1992), that in some instances medical benefits may be considered "compensation" under the LHWCA 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. The court further noted that if interest were not payable on overdue medical benefits, the result have be a "chilling effect" on the provision of medical services and would result in a windfall to employers.

With Ion v. Duluth, Missabe and Iron Range Railway Co., 31 BRBS 75 (1997), the Board adopted the Ninth Circuit's position in Hunt that interest should be awarded on all past due medical benefits, whether costs initially borne by the claimant or medical providers. The Board specifically overruled its decisions in Pirozzi v. Todd Shipyards Corp., 21 BRBS 294 (1988)(judge had erred in awarding interest on the medical expenses the claimant had paid because there was no evidence in the record indicating that the claimant had in fact made any direct payments to the health care providers.) and Caudill v. Sea Tac Alaska Shipbuilding, 22 BRBS 10 (1988), aff'd on other grounds mem. sub nom. Sea Tac Alaska Shipbuilding v. Director, OWCP, 8 F.3d 29 (9th Cir. 1993)(Held that a claimant is not entitled to a Section 14(f) assessment on medical benefits that were not timely paid within 10 days after the award.).

7.3 MEDICAL TREATMENT PROVIDED BY EMPLOYER

7.3.1 Necessary Treatment

Section 7(a) of the LHWCA provides that:

The 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).

In order for a medical expense to be assessed against the employer, the expense must be both reasonable and necessary. Pernell v. Capitol Hill Masonry, 11 BRBS 532, 539 (1979).

Medical care must be appropriate for the injury. See 20 C.F.R. § 702.402. Therefore, a judge may reject payment for unnecessary treatment. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 187 (1988); Turner v. Chesapeake & Potomac Tel. Co., 16 BRBS 255 (1984); Scott v. C & C Lumber Co., 9 BRBS 815 (1978).

A claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. Turner, 16 BRBS at 257-58. A judge has no authority to deny a medical expense on the ground that a physician's expertise, customary fees, or result of treatment were not documented. Id. at 257. Employer is only liable, however, for the reasonable value of medical services. See 20 C.F.R. § 702.413; Bulone v. Universal Terminal & Stevedoring Corp., 8 BRBS 515, 518 (1978); Potenza v. United Terminals, Inc., 1 BRBS 150 (1974), aff'd, 524 F.2d 1136, 3 BRBS 51 (2d Cir. 1975).

The judge is required to make specific findings of fact regarding an employer's claim that a particular expense is non-compensable. Monrote v. Britton, 237 F.2d 756 (D.C. Cir. 1956). The employer must raise the reasonableness and necessity of treatment before the judge. Salusky v. Army Air Force Exch. Serv., 3 BRBS 22 (1975). A court of appeals will not consider this issue unless there is evidence regarding it in the record. Crescent Wharf & Warehouse Co. v. Pillsbury, 93 F.2d 761 (9th Cir.), cert. denied, 304 U.S. 571 (1938). The Board will not consider requests first raised before it. Luna v. General Dynamics Corp., 12 BRBS 511 (1980).

Although the judge has the authority to order payment for already incurred medical expenses and to generally order future medical treatment for a work-related injury, the judge may not set forth a specific health care facility for whose charges employer will be held liable in the future. McCurley v. Kiewest Co., 22 BRBS 115, 120 (1989) (ALJ had ordered employer to pay for future treatment at a specific pain clinic).

In Slade v. Coast Engineering & Manufacturing Co., (BRB Nos. 98-646 & 98-646A)(Feb. 2, 1999)(Unpublished), the Board vacated an ALJ's finding that Employer was not liable for a medically prescribed jacuzzi. The Board held that when the record contains evidence that a qualified physician specifically recommends that claimant use a jacuzzi in his physical therapy program for home treatment, the fact that the treatment may be only palliative and curative does not prevent employer from being liable if the jacuzzi is found to be both reasonable and necessary.

In Caudill v. Sea Tac Alaska Shipbuilding, 25 BRBS 92, 98 (1991), the employer, relying on McCurley, argued that the judge had exceeded the scope of his authority in directing the employer to authorize a specific future surgical procedure. The Board found, however, that McCurley was distinguishable. In Caudill, the claimant had requested authorization from the employer for a single medical procedure and authorization was denied. The Board explained that the judge has the authority to determine the reasonableness and necessity of a procedure refused by employer. Thus, the Board affirmed the judge's order directing employer to pay for the claimant's surgery. Caudill, 25 BRBS at 98-99.

In Ingalls Shipbuilding, Inc. v. Director, OWCP [Baker], 991 F.2d 163 (5th Cir. 1993), the **Fifth Circuit** held that a "claimant is entitled to medical expenses for an injury resulting in zero impairment only upon a demonstration that the expenses are reasonably necessary and that an evidentiary basis exists to support such an award." 991 F.2d at 166. This is especially true where the award is for future medical expenses. Kirksey v. I.T.O. Corp. of Baltimore, (BRB No. 96-0794)(Feb. 25, 1997) (Unpublished) (claimant suffered from a hearing loss injury with a zero impairment).

In the Nonappropriated Fund Instrumentalities Act case of Zeigler v. Dept. of the Army/NAF, (BRB No. 99-0122)(Oct. 7, 1999)(Unpublished), the Board held that the claimant and doctor's good faith belief that treatment for lyme disease was necessary is a reasonable, compensable medical expense.

7.3.2 Treatment Required by Injury

The claimant must establish that the medical expenses are related to the compensable injury. Pardee v. Army & Air Force Exch. Serv., 13 BRBS 1130 (1981); Suppa v. Lehigh Valley R.R. Co., 13 BRBS 374 (1981). The employer is liable for medical services for all legitimate consequences of the compensable injury, including the chosen physician's unskillfulness or errors of judgment. Lindsay v. George Wash. Univ., 279 F.2d 819 (D.C. Cir. 1960); see also Austin v. Johns-Manville Sales Corp., 508 F. Supp. 313 (D. Me. 1981).

The employer is liable for all medical expenses which are the **natural and unavoidable result of the work injury**, and not due to an intervening cause. For example, an employer must pay for the treatment of the claimant's myocardial infarction, if the judge finds that it is causally related to a prior work-related injury. See Atlantic Marine v. Bruce, 661 F.2d 898, 14 BRBS 63 (5th Cir. 1981), affg 12 BRBS 65 (1980).

If the disability results, however, from aggravation of an injury compensable under the LHWCA, incurred while the employee is working for a second covered employer, the second employer is liable for medical expenses due to the "reinjury." Abbott v. Dillingham Marine & Mfg. Co., 14 BRBS 453 (1981), aff'd mem. sub nom. Willamette Iron & Steel Co. v. Office of Workers Comp. Programs, 698 F.2d 1235 (9th Cir. 1982).

An employer is not liable for medical expenses due to the degenerative processes of aging. Haynes v. Rederi A/S Aladdin, 362 F.2d 345 (5th Cir. 1966), cert. denied, 385 U.S. 1020 (1967).

Any injury sustained during the course of a medical examination scheduled at the employer's request for an alleged work-related injury is covered under the LHWCA, because such an injury necessarily arises out of and in the course of employment. Weber v. Seattle Crescent Container Corp., 19 BRBS 146, 148 (1986).

The law of supervening independent causes is unsettled. Bludworth Shipyard v. Lira, 700 F.2d 1046, 15 BRBS 120 (CRT) (5th Cir. 1983). In Lira v. Bludworth Shipyard, 14 BRBS 682 (1982), the Board held that an employer must pay for an injured employee's detoxification from narcotics when the employee, a former drug addict, became re-addicted as a result of treatment for a work-related back injury. On appeal, however, the order of payment was reversed on the ground that the re-addiction was not due to the work-related injury, but rather to the employee's intentional concealment of his past addiction.

This supervening independent cause was sufficient to sever the causal relationship between the claimant's work-related back injury and his readdiction to heroin following treatment with narcotics. In reference to the law in this area, the **Fifth Circuit** stated that the law begins with the rule that the concept of proximate cause, as it is applied in the law of torts, is not applicable in the LHWCA setting. Voris v. Texas Employers Ins. Ass'n, 190 F.2d 929, 934 (5th Cir. 1951), cert. denied, 342 U.S. 932 (1952); Southern Stevedoring Co. v. Henderson, 175 F.2d 863, 865 (5th Cir. 1949).

There are different focuses between tort law and compensation law in this regard. Proximate cause analysis in a typical tort case focuses on the question whether a party, in the conduct of his everyday affairs, should be held legally responsible for remote consequences of his acts. The inquiry under the LHWCA is much narrower. The court's sole function is to determine whether the injury complained of was one "arising out of" the employment. Once causation in fact is established, with only a few exceptions, the court's function is at an end.

One exception to this rule is when there is a supervening, independent cause of the injury in question. See Atlantic Marine v. Bruce, 661 F.2d 898 (5th Cir. 1981) (heart attack suffered by claimant/patient who temporarily had left the hospital to get a haircut on the day he was scheduled for a second myelogram, was caused by employee's continuing emotional distress coupled with apprehension and therefore medical expenses associated with heart attack should be paid);

Mississippi Coast Marine v. Bosarge, 637 F.2d 994, modified and reh'g denied, 657 F.2d 665 (5th Cir. 1981).

The **Fifth Circuit** noted that under the supervening independent cause theory, some cases require a "worsening" while others require "overpowering and nullifying effects" in order to find an interruption in the causal chain. In Bludworth, 700 F.2d 1046, 15 BRBS 120 (CRT), the claimant's conduct satisfied either test.

Corrective lenses necessitated by a compensable injury are also covered. Fraley v. Todd Shipyards, 4 BRBS 252 (1976), vacated and remanded in part and rev'd in part on other grounds, 592 F.2d 805, 10 BRBS 9 (5th Cir. 1979).

The Board has also affirmed a finding that **modifications to a claimant's home** necessitated by his work injury are covered under Section 7 of the LHWCA, because (1) the modifications qualified as "apparatus" and (2) they also constituted "medical ... and other attendance or treatment" within the meaning of Section 7. Dupre v. Cape Romain Contractors, 23 BRBS 86, 94 (1989).

In Dupre, the claimant was a paraplegic with total lack of sensation from the waist down, and the modifications, which included ramps, widened doorways, and handicapped-accessible plumbing fixtures, were necessary for claimant to utilize the bathroom and even to move about his home. The Board agreed with the judge that interpreting the medical benefits section of the LHWCA to exclude these items from coverage would not promote the purposes of the LHWCA. Id. at 88, 95.

Section 7 does not require that an injury be economically disabling in order for a claimant to be entitled to medical expenses, but only that the injury be work-related. Frye v. Potomac Elec. Power Co., 21 BRBS 194 (1988); Ballesteros, 20 BRBS at 187; Winston v. Ingalls Shipbuilding, 16 BRBS 168 (1984).

Treatment is compensable even though it is due only partly for a work-related condition. Turner, 16 BRBS at 258. In Kelley v. Bureau of National Affairs, 20 BRBS 169, 172 (1988), the Board held that where relevant evidence established that the claimant's psychological condition was occasioned, at least in part, by her work injury, treatment received by the claimant for this condition was compensable under the LHWCA.

In the Nonappropriated Fund Instrumentalities Act case of Zeigler v. Dept. of the Army/NAF, (BRB No. 99-0122)(Oct. 7, 1999)(Unpublished), the Board held that the claimant and doctor's good faith belief that treatment for lyme disease was necessary is a reasonable, compensable medical expense.

The employer must respond to a request for treatment upon learning of the injury, even if it is uncertain as to whether it was work-related. Rieche v. Tracor Marine, 16 BRBS 272 (1984). The employee is similarly required to request authorization for treatment, even if he is unaware of the

work-relatedness of his illness. Mattox v. Sun Shipbuilding & Dry Dock Co., 15 BRBS 162 (1982).

The employer may be charged for medical appointments which its employee fails to either cancel or keep, as the charge is reasonable and necessary to compensate the physician for non-productive time, but only if the employee had a legitimate reason for neither attending nor canceling. Parnell, 11 BRBS at 540.

The **Fifth Circuit** has held that since an employer has a statutory responsibility to pay the reasonable cost of its employee's medical care, the government is entitled to reimbursement from the employer for any medical services provided to the employee by a Veterans Administration hospital. United States v. Bender Welding & Mach. Co., 558 F.2d 761 (**5th Cir.** 1977), *rev'g* Simmons v. Bender Welding & Mach. Co., 3 BRBS 222 (1976) and Love v. Bender Welding & Mach. Co., 3 BRBS 183 (1976). Similarly, the employer must reimburse any hospital association or other organization which has contracted with its employee to provide general medical care. Contractors, Pac. Naval Air Bases v. Pillsbury, 105 F. Supp. 772 (**N.D. Cal.** 1952); *see* LaFortez v. I.T.O Corp. of Baltimore, 2 BRBS 102 (1975) (employer must pay entire bill if hospital charges flat rate, even if some treatment unrelated to injury).

7.3.2.1 Medically Redundant

The Board has held that when a claimant is in possession of a prescribed therapeutic modality, the addition of a second therapeutic modality would be medically redundant and cumulative unless the medical record can establish the second therapeutic modality is reasonable and necessary. *See* Nides v. 1789, Inc., (BRB No. 99-0162)(Oct. 18, 1999) (Unpublished). In Nides, the claimant was already in possession of a treadmill, for which the employer paid, but he also sought reimbursement for a stationary bicycle. The ALJ and the Board held that the use of both the treadmill and the stationary bicycle would be medically redundant and cumulative as to the claimant's low back complaints in the absence of medical testimony showing the bicycle was reasonable and necessary.

7.3.2.2 Treatment After An Altercation At Work

In Mays v. Avondale Industries, BRB No. 98-1084 (May 3, 1999) (unpublished), the Board vacated the ALJ's denial of medical benefits after the claimant was injured at work during an altercation. The Board held that the employer would be liable for any reasonable and necessary medical expenses sought by the claimant.

7.3.3 Biofeedback Treatment

The definition of medical care includes laboratory, x-ray, and other technical services, prosthetic devices, and any other medical service or supply recognized as appropriate by the medical profession for the care and treatment of the injury or disease. *See* 20 C.F.R. § 702.401.

In Barbour v. Woodward & Lothrop, Inc., 16 BRBS 300 (1984), the Board held that the fact that biofeedback treatment was prescribed by a treating physician, who found such treatment helpful, was sufficient to establish that the treatment was appropriate under 20 C.F.R. § 702.401. The claimant does not have the burden to show that treatment is medically accepted. Additionally, it was not necessary that the biofeedback therapist be licensed to administer such therapy. Id. at 303.

7.3.4 Chiropractic Treatment

Chiropractors need not be paid for treatment rendered before October 11, 1977, because only then was the regulation amended to allow payments to them. Blanchard v. General Dynamics Corp., 10 BRBS 69 (1979).

Chiropractic treatment is **reimbursable only to the extent** that it consists of manual manipulation of the spine to correct a subluxation shown by x-ray or clinical findings. Physicians may interpret their own x-rays. See 20 C.F.R. § 702.404.

7.3.5 Travel Expenses

Costs incurred for transportation for medical purposes are recoverable under Section 7(a). Day v. Ship Shape Maintenance Co., 16 BRBS 38 (1983). A van with an automatic lift for a quadriplegic, while not an "apparatus," is chargeable to his employer as a reasonable means to provide necessary transportation for medical purposes. Id. at 39. Parking fees and tolls incurred while traveling to or attending medical appointments may also be reimbursed. Castagna v. Sears, Roebuck & Co., 4 BRBS 559 (1976), aff'd mem., 589 F.2d 1115 (D.C. Cir. 1978). The employee may be reimbursed for moving expenses if reasonable and based on his medical needs. Miranda v. Excavation Constr., 13 BRBS 882 (1981) (physician prescribes a move to a warmer climate to ease pain); Gilliam v. Western Union Tel. Co., 8 BRBS 278 (1978) (first-class airplane fare).

However, expenses incidental to the employee's attending a hearing or for compensation for leave from work used to attend medical appointments are not recoverable. Castagna, 4 BRBS at 561.

The Board has noted 20 C.F.R. § 702.403 in cases dealing with reimbursable travel expenses. The regulation states in pertinent part:

In determining the choice of physician, consideration must be given to availability, the employee's condition, and the method and means of transportation. Generally, 25 miles from the place of injury or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into account.

In Reed v. Jamestown Metal Marine, (BRB No. 97-881)(March 23, 1998) (Unpublished), the Board held the employer liable for the claimant's mileage and travel costs associated with her treatment for her work injury which involved her traveling 197 miles round-trip. The Board noted

that § 702.403 normally provides 25 miles to be a reasonable distance, but, in this case, the Board emphasized that “the importance of claimant’s maintaining her relationship with her current treating physician and the uniqueness of [her physician’s] day treatment program, made it evident that [her physician’s] treatment is reasonable and necessary even though claimant must travel more than 25 miles.”

When competent medical care is available close to a claimant’s residence (Houston), the claimant’s medical expenses can reasonably be limited to those costs that would have been incurred had the treatment been provided locally rather than where the treatment was actually incurred (Boston). Schoen v. United States Chamber of Commerce, 30 BRBS 112 (1996), See generally Welch v. Pennzoil Co., 23 BRBS 395. In Schoen, the Board noted that the ALJ had considered the treatment available at both clinics, their professional accreditations and success rates, and the experience of each clinic’s director, and then reasonably concluded based on the record, that the claimant’s claim for reimbursement for the Boston clinic was unreasonable because adequate comparable treatment was available in Houston at a lesser cost..

In Nides v. 1789, Inc., (BRB No. 99-0162)(Oct. 18, 1999)(Unpublished), the Board held that when the employer did not challenge the claimant’s credibility regarding travel records, the ALJ should sustain those costs. The Board noted 20 C.F.R. § 702.401(a) which defines medical care, in pertinent part, as including “the reasonable and necessary cost of travel ... which is recognized as appropriate by the medical profession for the care and treatment of [claimant’s] injury or disease.” **Parking expenses**, and **highway and bridge toll expenses**, incurred for obtaining medical treatment for which an employer is liable are chargeable to the employer as transportation costs. Castagna v. Sears, Roebuck & Co., 4 BRBS 558 (1976).

However, a **claimant is not entitled to reimbursement of annual leave** taken while obtaining medical treatment. Castagna.

7.3.6 Medical Insurance

An insurance carrier providing coverage for non-occupational injuries or illnesses may intervene to recover amounts erroneously paid for a work-related injury. Aetna Life Ins. Co. v. Harris, 578 F.2d 52 (3d Cir. 1978), vacating and remanding Harris v. Sun Shipbuilding & Dry Dock Co., 6 BRBS 494 (1977). Similarly, a medical provider may intervene to recover medical benefits to the extent that the benefits are owed to the provider in satisfaction of unpaid bills. Hunt v. Director, OWCP, 999 F.2d 419 (9th Cir. 1993), 27 BRBS 240 (CRT) (1993). In Hunt, the Ninth Circuit has held that there is no distinction between those cases in which a claimant seeks reimbursement for medical services and those cases where the employer owes payment to the medical provider directly. Hunt, 999 F.2d at 421 - 423; 27 BRBS at 87 - 89 (CRT).

In In the Matter of St. Mary’s Hospital & Medical Center, Claimant v. Army & Air Force Exchange Service, 30 BRBS 894 (ALJ) (1996), the ALJ held that the medical provider/hospital was a “party in interest” under Section 7(d)(3) and could bring a separate claim for reimbursement under

Sections 7(d)(3) and 19(c), and 5 U.S.C. § 8173. In St. Mary's, the medical provider treated the claimant after she settled her LHWCA claim (except for medical benefits). The ALJ found that the provider had a right to bring this action even though the provider had not intervened in the claimant's LHWCA claim.

In St. Mary's, the employer had contended that, as an arm of the United States Government, it was protected from suit in this case by the doctrine of sovereign immunity, and that St. Mary's only remedy was a suit in the Court of Federal Claims under the Tucker Act, 28 U.S.C. § 1346, or the Contract Disputes Act of 1978, 41 U.S.C. § 601 et seq. The ALJ, citing the Nonappropriated Fund Instrumentalities Act at 5 U.S.C.A. § 8173, noted that section not only waived sovereign immunity in actions brought by "any other person" entitled to damages as a result of the disability or death of an employee of a nonappropriated fund instrumentality, but says that St. Mary's is precluded from bringing its action, in contract or otherwise, against AAFES under any statute other than the LHWCA.

An employer is not liable, however, to such third parties for medical services which are always *gratis*, Bender Welding, 558 F.2d at 764, and not liable to a claimant for expenses already paid by **employer's** non-occupational-injury carrier to prevent double recovery. Luker v. Ingalls Shipbuilding, Inc., 3 BRBS 321 (1976). Distinguishing Luker, the Board has also held that a claimant may be reimbursed for sums paid by the claimant's private insurer. Employer is absolutely liable for furnishing medical expenses. Turner v. New Orleans (Gulfwide) Stevedores, 5 BRBS 418 (1977), rev'd and remanded on other grounds, 661 F.2d 1031, 14 BRBS 156 (5th Cir. 1981).

In the more recent case of Nooner v. National Steel & Shipbuilding Co., 19 BRBS 43 (1986), the Board held that an employer need reimburse a claimant only for his own out-of-pocket expenses for necessary medical care, not for care mistakenly paid for by private non-occupational insurers. However, the mistaken insurers may intervene and recover such payments. Id. at 46.

In Quintana v. Crescent Wharf & Warehouse Co., 18 BRBS 254, 257-58 (1986), the Board held that the claimant was not entitled to assert Medi-Cal's (Medicare of California) rights for reimbursement for medical services it provided to the claimant, since the claimant had no standing.

On reconsideration, the Board modified its Decision and Order of May 5, 1986, holding that the ALJ erred in not allowing Medi-Cal to intervene for reimbursement of medical expenses. An insurance carrier providing coverage for non-occupational injuries can intervene and recover amounts mistakenly paid out for injuries determined to be work-related where the claimant is entitled to such expenses. Quintana v. Crescent Wharf & Warehouse Co., 19 BRBS 52, 53 (1986) (Order on Reconsideration); Bazor v. Boomtown Belle Casino, ___ BRBS ___ (BRB No. 00-0928B)(July 11, 2001).

In Ozene v. Crescent Wharf & Warehouse Co., 19 BRBS 9 (1986), the issue presented was whether a carrier has an independent right to reimbursement of medical costs where the employee does not comply with the statutory requirements, a matter of first impression before the Board. The

Board held that the right to such reimbursement is solely derivative of a claimant's right to such expenses under the LHWCA.

Thus, inasmuch as the ALJ had properly determined that the decedent had failed to request authorization for his medical treatment as required by § 7(d), the Board affirmed his finding that the carrier was not entitled to reimbursement of sums it mistakenly paid for decedent's occupationally-related condition. Ozene, 19 BRBS at 11.

Similarly, a state's right to reimbursement for a claimant's medical expenses paid through a state compensation act is contingent upon the claimant obtaining an award of medical benefits under the LHWCA. McDougall v. E.P. Paup Co., 21 BRBS 204, 211 (1988). In McDougall, the Board noted that while the State appeared to have an action against the claimant under state law, an intervenor's right to reimbursement of medical benefits under the LHWCA is a derivative right. Id.

7.3.7 Attendants

Medical expenses may also include an attendant, where such services are necessary because the employee is totally blind, has lost the use of both hands or both feet, is paralyzed and unable to walk, or is otherwise so helpless as to require constant attendance. See 20 C.F.R. § 702.412(b). Fees for such an attendant are controlled by 20 C.F.R. § 702.413.

It has been held that if 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. Gilliam, 8 BRBS at 279-80; Timmons v. Jacksonville Shipyards, 2 BRBS 125 (1975) (wife as provider).

In Falcone v. General Dynamics Corp., 21 BRBS 145, 147 (1988), the Board found that the judge had properly held employer responsible for paying for home health care services where the claimant would be "better off" remaining with his family than being cared for in a nursing home.

In Sanders v. Marine Terminals Corp., 31 BRBS 19 (1997), the Board found that initially the district director has the jurisdiction to determine if medical care is appropriate; however, once there is a disputed factual issue the matter transfers to the jurisdiction of the OALJ for a full evidentiary hearing and determination of the issue. 31 BRBS at 21-23; 33 U.S.C. §919(d); see generally Toyer v. Bethlehem Steel Corp., 28 BRBS 347 (1994) (McGranery, J., dissenting) (the excusing of late filing of a physician's first report is a discretionary function of the district director); Maine v. Brady-Hamilton Stevedore Co., 18 BRBS 129, 131 (1986); 702.412(b). The Board went on to uphold the judge's determination that home health care was an appropriate medical treatment where the treating physician had recommended home care to prevent the aggravation of an existing work related injury.

In Jackson v. Universal Maritime Service Corp., 31 BRBS 103 (1997), the Board held that the granting of a change in physician is a purely discretionary act under the sole power of the district director. See also 33 U.S.C. §907(b). The case revolved around the employer's request for a formal

change of physician to the doctor who's treatment was most successful. The Board found that the request was appropriate since the employer or the director can request a change of physician, against the employee's wishes, where it is in his best interest. 33 U.S.C. §907(b). This is distinguished from the Sanders scenario where there is a question of fact as to whether the actual treatment is required.

7.4 FREE CHOICE OF PHYSICIAN

7.4.1 Authorization by Secretary

The claimant has the right to choose an attending physician authorized by the Secretary to provide the required medical care. The Secretary is required to actively supervise the medical care provided and to receive periodic reports about it. The Secretary, through the district director, has the authority to determine the necessity, character, and sufficiency of present and future medical care, and may order a change of physicians or hospitals if the Secretary deems it desirable or necessary to the claimant's interest, either on the director's own initiative, or at employer's request. See 33 U.S.C. § 907(b).

Active supervision of the injured employee's medical care is to be performed by the Director through the district directors (formerly called deputy commissioners) and their designees. 20 C.F.R. § 702.407. See Roulst v. Marco Constr. Co., 15 BRBS 443 (1983) (the Board held that the deputy commissioner may order a change of physicians under Section 7(b)). The 1984 Amendments add a provision that the Secretary may also order such a change where the charges exceed those prevailing in the community for the same or similar services or exceed the provider's customary charge. 33 U.S.C. § 907(a).

The term "**physician**" includes doctors of medicine, surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopaths, and chiropractors, within the scope of their practice, as defined by state law. [For more on chiropractors, see **Topic 7.3.4, supra**]

A pastoral counselor must document his credentials to show whether he is a physician within the meaning of the regulation or qualified to perform "other" compensable treatment. Turner, 16 BRBS at 258.

Under Section 7(b) and (c), the employer bears the burden of establishing that physicians who treated an injured worker were not authorized to provide treatment under the LHWCA. Roger's Terminal & Shipping Corp. v. Director, OWCP, 784 F.2d 687, 18 BRBS 79 (CRT) (**5th Cir.**), cert. denied, 479 U.S. 826 (1986).

The 1972 version of Section 7(c) allowed the Secretary to designate the physicians who were **authorized** to render medical care under the LHWCA and required her to make available to employees the names of the authorized physicians in their community. This subsection was amended by the 1984 Amendments, and now requires the Secretary to annually prepare a list of physicians and health care providers in each compensation district who are **not authorized** to render medical care or services under the Act and to make this list available to employees and employers in each compensation district. See 33 U.S.C. § 907(c)(1).

7.4.2 Emergencies

If the employee cannot choose an attending physician due to the nature of his injury and the injury requires immediate treatment, the employer is to select a physician for him.

If the employer selected a physician in an emergency situation, the employee may change physicians when he is able to make a selection, on written authorization from the employer, or, if employer withholds consent, from the deputy commissioner. See 20 C.F.R. § 702.405. The regulation contemplates severe injuries, unconsciousness, or similar incapacity in order for the employer to select a physician due to the necessity of immediate treatment. Bulone v. Universal Terminal & Stevedoring Corp., 8 BRBS 515, 517 (1978).

Medical services provided by physicians or health care providers who are on the list published pursuant to Section 7(c)(1) shall not be reimbursable except in emergency situations. 33 U.S.C. § 907(c)(1)(C). It is the employer's burden to establish physicians providing treatment were not authorized. Roger's Terminal & Shipping Corp. v. Director, OWCP, 784 F.2d 687, 18 BRBS 79 (CRT) (**5th Cir.**), cert. denied, 479 U.S. 826 (1986).

7.5 CHANGE OF PHYSICIANS

Prior to the 1984 Amendments, the regulation at 20 C.F.R. § 702.406 detailed the procedures to be followed to obtain a change in physicians once a claimant has made his initial free choice of physicians pursuant to Section 7(b). The 1984 Amendments incorporated this regulation into Section 7(c)(2) of the LHWCA.

Section 7(c)(2) of the 1984 LHWCA provides that when the employer or carrier learns of its employee's injury, either through written notice or as otherwise provided by the LHWCA, it must authorize medical treatment by the employee's chosen physician. Once a claimant has made his initial, free choice of a physician, he may change physicians only upon obtaining prior written approval of the employer, carrier, or deputy commissioner. See 33 U.S.C. § 907(c)(2); 20 C.F.R. § 702.406.

Employer is ordinarily not responsible for the payment of medical benefits if a claimant fails to obtain the required authorization. Slattery Assocs. v. Lloyd, 725 F.2d 780, 787, 16 BRBS 44, 53 (CRT) (**D.C. Cir.** 1984); Swain v. Bath Iron Works Corp., 14 BRBS 657, 664 (1982). Failure to obtain authorization for a change can be excused, however, where the claimant has been effectively refused further medical treatment. Lloyd, 725 F.2d at 787, 16 BRBS at 53 (CRT); Swain, 14 BRBS at 664; Washington v. Cooper Stevedoring Co., 3 BRBS 474 (1976), aff'd, 556 F.2d 268, 6 BRBS 324 (**5th Cir.** 1977); Buckhaults v. Shippers Stevedore Co., 2 BRBS 277 (1975). (See refusal of treatment discussion at Section 7(d)).

Where the authorized physician withdraws/retires from the practice of medicine and refers his patients to a new doctor, no new authorization is required. According to the Board, the reasonable conclusion is that the claimant's initial physician provided the care of another physician whose services were necessary for the proper care and treatment of the claimant's compensable injury, and the new doctor must be considered to be the physician authorized to provide medical treatment. Maguire v. Todd Pac. Shipyards Corp., 25 BRBS 299, 301-02 (1992).

7.5.1 Specialists

Consent to change physicians **shall** be given when the employee's initial free choice was not of a specialist whose services are necessary for, and appropriate to, proper care and treatment. Consent may be given in other cases upon a showing of good cause for change. Slattery Assocs. v. Lloyd, 725 F.2d 780, 16 BRBS 44 (CRT) (**D.C. Cir.** 1984); Maguire, 25 BRBS at 301-02; Swain v. Bath Iron Works Corp., 14 BRBS 657 (1982). The regulation only states that an employer **may** authorize a change for good cause; it is **not required** to authorize a change for this reason. Swain, 14 BRBS at 665.

In Senegal v. Strachan Shipping Co., 21 BRBS 8, 11 (1988), the Board held that an employer was not required to consent to a change of physicians where the claimant, who sustained a pulmonary injury and initially chose to see a physician who was not a pulmonary specialist, later

decided to undergo treatment from a pulmonary specialist. The employer was not required to give consent because the initial physician had sent the claimant to other specialists skilled in treating pulmonary injuries (resulting from the exposure to fumes), and thus the initial physician provided the care of a specialist whose services are necessary for the proper care and treatment of the compensable injury pursuant to Section 7(b) and 20 C.F.R. § 702.406(a).

In contrast, in Armfield v. Shell Offshore, 25 BRBS 303, 309 (1992), the Board affirmed the judge's conclusion that the claimant was not required to seek prior authorization for her psychiatric treatment where the evidence indicated that the claimant had been referred to the psychiatrist by her treating physician. The initial physician was thus providing the care of a specialist whose services were necessary for the proper care and treatment of the compensable injury pursuant to § 7(b) and (c)(2) of the LHWCA. Id.

7.6 REIMBURSEMENT

Section 7(d)(1) details when a claimant who has paid his own medical expenses can be reimbursed by the employer. Section 7(d)(1) of the LHWCA, as amended in 1984, states:

An employee is not entitled to reimbursement of money which he paid for medical or other treatment or services unless:

(A) his employer refused or neglected to provide them and the employee has complied with subsections (b) and (c) and the applicable regulations, or

(B) the nature of the injury required the treatment and services and, although his employer, supervisor, or foreman knew of the injury, he neglected to provide or authorize them.

33 U.S.C. § 907(d)(1).

Prior to the 1984 Amendments, the LHWCA provided that a claimant could not be reimbursed unless he requested authorization for such services and the employer refused to provide them, or, if treatment was required for an injury, the employer, having knowledge of the injury, refused or neglected to provide treatment.

An employee cannot receive reimbursement for medical expenses under this subsection unless he has first requested authorization, prior to obtaining the treatment, except in cases of emergency or refusal/neglect. 20 C.F.R. § 702.421; Shahady v. Atlas Tile & Marble Co., 682 F.2d 968 (D.C. Cir. 1982) (per curiam), rev'g 13 BRBS 1007 (1981), cert. denied, 459 U.S. 1146 (1983); McQuillen v. Horne Bros., Inc., 16 BRBS 10 (1983); Jackson v. Ingalls Shipbuilding Div., Litton Sys., 15 BRBS 299 (1983); Schoen v. U.S. Chamber of Commerce, 30 BRBS 112 (1996).

The **Fourth Circuit** has reversed a holding by the Board that a request to the employer before seeking treatment is necessary only where the claimant is seeking reimbursement for medical expenses already paid; the court held that the prior request requirement applies at all times. Maryland Shipbuilding & Drydock Co. v. Jenkins, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979), rev'g 6 BRBS 550 (1977).

A claimant's right to an initial free choice of physician pursuant to subsection (b) does not negate the prior request requirement. Beynum v. Washington Metro. Area Transit Auth., 14 BRBS 956 (1982); Betz v. Arthur Snowden Co., 14 BRBS 805 (1981) (prior request requirement applies to treatment rendered by claimant's first physician of choice); Shahady v. Atlas Tile & Marble Co.,

13 BRBS 1007 (1981) (overruling Bulone), rev'd on other grounds, 682 F.2d 968 (**D.C. Cir.** 1982), cert. denied, 459 U.S. 1146 (1983).

Additionally, the Section 7(d) requirement of prior request is not excused because claimant is not aware that his illness is work-related at the time of seeking outside treatment. Mattox v. Sun Shipbuilding & Dry Dock Co., 15 BRBS 162, 171-72 (1982). Before an employer could be said to have neglected to provide care, there must first have been a request for such care. Jackson v. Navy Exch. Serv. Center, 9 BRBS 437 (1978).

A decedent's failure to comply with the Section 7(d) request for authorization requirement bars the claimant widow's right to reimbursement of medical expenses. Lustig v. Todd Shipyards Corp., 20 BRBS 207, 210 (1988).

A **misdiagnosis** by the **employee's** chosen physician does not excuse the employee's failure to request treatment. Jackson v. Navy Exch. Serv. Center, 9 BRBS at 439. See also Baker v. New Orleans Stevedoring Co., 1 BRBS 134 (1974) (employer's offer of treatment by one of its panel of physicians and its employee's failure to request treatment preclude reimbursement).

It has been held that transfer of the employee's records to her private physician could constitute authorization, when the employer should have known that the military hospital to which it originally sent her could provide only emergency care to ineligible civilians. Base Billeting Fund, Laughlin Air Force Base v. Hernandez, 588 F.2d 173, 9 BRBS 634 (**5th Cir.** 1979); see also Rieche v. Tracor Marine, 16 BRBS 272, 275 (1984) (employer's paramedic referred the employee to employee's own physician--tantamount to refusal or neglect to provide treatment).

Similarly, an employer's failure to object to its employee's resorting to a physician other than the one authorized, when the authorized physician was unavailable in an emergency situation, has been found equivalent to authorizing later treatment by him and his chosen hospital and nurse. Bethlehem Shipbuilding Corp. v. Monahan, 62 F.2d 299 (**1st Cir.** 1932); see also White v. Sealand Terminal Corp., 13 BRBS 1021 (1981) (employee need not request authorization for emergency treatment).

7.6.1 Employer Refuses

Once the employer has refused to provide treatment or to satisfy a claimant's request for treatment, the claimant is released from the obligation of continuing to seek employer's approval. Pirozzi v. Todd Shipyards Corp., 21 BRBS 294 (1988); Betz, 14 BRBS at 809. See generally Lloyd, 725 F.2d 780, 16 BRBS 44 (CRT). The claimant then need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury, in order to be entitled to such treatment at the employer's expense. Rieche, 16 BRBS at 275; Beynum, 14 BRBS at 958.

In Wheeler v. Interocean Stevedoring, 21 BRBS 33 (1988), the Board stated that for medical expenses to be compensable, an employee need not seek the employer's authorization of medical treatment once the employer has **unreasonably** refused to provide treatment or to satisfy the employee's request for treatment. This standard, however, is incorrect. The employer's refusal **need not** be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment. See generally 33 U.S.C. § 907(d)(1)(A). Accordingly, Betz, 14 BRBS 805, and other decisions setting forth the "unreasonable refusal" standard should not be cited in discussions of this authorization issue.

The **proper standard** is set forth in Wheeler, 21 BRBS 33, as corrected by an errata sheet issued by the Board on May 26, 1988. (see 6/3/88 slip-opinion packet--corrected page apparently not published in BRBS).

In Wheeler (corrected version), the Board reiterated the standard for compensable medical expenses: although medical services must generally be authorized by the employer to be compensable, an employee is released from the obligation of seeking employer authorization once the employer has refused to provide treatment or to satisfy the employee's request for treatment. In this situation, the employee need only establish that the unauthorized medical services were necessary to treatment of his work injury for the services to be compensable. Id.

Where a claimant first saw a doctor for evaluation purposes, then selected another physician and requested treatment which employer refused to authorize, the **Fifth Circuit** affirmed the award of medical expenses for treatment by the selected doctor and a specialist to whom he referred the claimant. Roger's Terminal, 784 F.2d at 693, 18 BRBS at 86 (CRT).

The employee need not request treatment when such a request would be futile, Shell v. Teledyne Movable Offshore, 14 BRBS 585, 590 n.2 (1981), such as when an employer fires its employee because it did not believe the employee's medical complaints. Mitchell v. Sun Shipbuilding & Dry Dock Co., 7 BRBS 215 (1977), aff'd mem. in pert. part, 588 F.2d 823 (**3d Cir.** 1978).

If an employer has no knowledge of the injury, it cannot have neglected to provide treatment, and the employee therefore is not entitled to reimbursement for any money spent before notifying the employer. McQuillen v. Horne Bros., Inc., 16 BRBS at 16.

An employer is considered to have knowledge when it knows of the injury and has facts that would lead a reasonable person to conclude that it might be liable for compensation and should investigate further. Harris v. Sun Shipbuilding & Dry Dock Co., 6 BRBS 494 (1977), rev'd on other grounds sub nom. Aetna Life Ins. Co. v. Harris, 578 F.2d 52 (**3d Cir.** 1978).

An employer has not, however, neglected to provide or authorize treatment after the employer is aware of the injury if the claimant never gave employer the opportunity to refuse or authorize treatment. Marvin v. Marinette Marine Corp., 19 BRBS 60 (1986); Mattox, 15 BRBS at 172. In

Mattox, the employer's mere knowledge did not establish neglect or refusal because the claimant never requested care. Id.

An employer's physician's statement that the employee is recovered and discharged from treatment may be tantamount to the employer's refusing to provide treatment. Shahady, 682 F.2d at 970; Walker v. AAF Exch. Serv., 5 BRBS 500 (1977); Buckhaults v. Shippers Stevedore Co., 2 BRBS 277 (1975), as may be testimony by employer's physicians at the hearing opposing the treatment request, Atlantic & Gulf Stevedores v. Neuman, 440 F.2d 908 (5th Cir. 1971), a mistaken diagnosis, Cooper Stevedoring v. Washington, 556 F.2d 268, 6 BRBS 324 (5th Cir. 1977), aff'g 3 BRBS 474 (1976); Matthews v. Jeffboat, Inc., 18 BRBS 185 (1986); McGuire v. John T. Clark & Son, Inc., 14 BRBS 298 (1981), or employer's physician urging that the employee return to work. Rivera v. National Metal & Steel Corp., 16 BRBS 135 (1984).

Where an employer's physician's actions constitute a refusal of treatment, the employee is justified in seeking treatment elsewhere, without the employer's authorization, and is entitled to reimbursement for necessary treatment subsequently procured on his own. Matthews, 18 BRBS at 189; Rivera, 16 BRBS at 138.

In Slattery Associates v. Lloyd, 725 F.2d 780, 16 BRBS 44 (CRT) (D.C. Cir. 1984), rev'g 15 BRBS 100 (1980), the court reversed the Board's holding that a physician's conduct constituted a refusal of treatment. The court stated that the physician's positive diagnosis and release for work did not amount to a refusal of treatment; an employer is not considered to have refused to provide treatment merely because its physician proposes a different method of treatment from a claimant's physician, **unless** the treatment is demonstrably improper and medically unacceptable.

The court additionally held that the Board erred in concluding that the physician was "employer's physician" so that the physician's "refusal" could be imputed to employer. A chain of referrals does not necessarily establish this relationship, if the physicians are independent; neither does the employer's calling the physician as a witness. Lloyd, 725 F.2d at 78, 16 BRBS at 52 (CRT).

A physician's letter stating to the employer's workers' compensation carrier, and not to the employee, that the employee is recovered is not a refusal. Betz, 14 BRBS at 809. A discharge from treatment does not imply that a request for pain medication would be futile. Scott, 9 BRBS at 824.

The Board has affirmed a finding that a physician's misdiagnosis and recommendation that the claimant return to work was tantamount to a refusal to treat, thereby excusing the claimant's failure to get the employer's authorization and consent to obtain medical treatment, and the physician's failure to file the required reports with employer. Thus, an award of medical benefits was affirmed. Matthews, 18 BRBS at 189.

7.6.2 Employer Ignores

Where an employer takes no action on a claimant's request to be examined by a physician, the employer has effectively refused or at least neglected to provide treatment or services within the meaning of the LHWCA. Rogers v. Pal Servs., 9 BRBS 807, 801-11 (1978).

7.6.3 Physician's Report

For the claim to be valid and enforceable against the employer, the employee's treating physician must furnish the employer and the deputy commissioner, within 10 days following the first treatment, with a report of the injury or treatment on a form prescribed by the Secretary. Such notice must also be provided when the claimant is hospitalized. Holmes v. Garfield Memorial Hosp., 123 F.2d 166 (D.C. Cir. 1941).

The Secretary may excuse the physician's failure to do so if he finds it to be in the interests of justice. See 33 U.S.C. § 907(d)(2). 20 C.F.R. § 402.422 delegates the Secretary's authority to the deputy commissioner and the judge. See Lloyd, 725 F.2d at 787, 16 BRBS at 54 (CRT). In Roger's Terminal, 784 F.2d at 694, 18 BRBS at 87 (CRT), a finding of no prejudice was affirmed.

The **burden of proof** regarding compliance with this requirement is on the employee. Jenkins, 594 F.2d at 407, 10 BRBS at 8.

In Lloyd, the **District of Columbia Circuit** stated that a judge **may** excuse a physician's failure to file a report based on an employer's refusal to provide or authorize treatment but is never required to do so as a matter of law. The court held that the earlier **D.C. Circuit** case of Shahady v. Atlas Tile & Marble Co., 682 F.2d 968 (D.C. Cir. 1982) (per curiam), cert. denied, 459 U.S. 1146 (1983), which held that the judge abused his discretion if he did not excuse the failure to file in that situation, was based on a misreading of Buckhaults, 2 BRBS 277, in which the Board held merely that such a refusal might be good cause for failure to file. Lloyd, 725 F.2d at 787, 16 BRBS at 54-55 (CRT). See also Nardella v. Campbell Mach., 525 F.2d 46, 3 BRBS 78 (9th Cir. 1975); Rieche, 16 BRBS at 276 ("An administrative law judge's decision to make such a finding is fully within his discretion."); Cherry v. Newport News Shipbuilding & Dry Dock Co., 8 BRBS 857 (1978) (disability evaluation report not sufficient); Arnold v. Mast, 1 BRBS 246 (1974).

The Board has held that even if employer explicitly refused treatment, the employee is still obligated to file reports. Mattox, 15 BRBS at 172.

In Roger's Terminal, the **Fifth Circuit** held that a treating physician's failure to provide the employer with a report of the worker's injury within 10 days following the first treatment did not prejudice the employer, who remained liable for the injured worker's medical expenses. In that instance, a full report had been delivered 15 days after the first treatment, the employer had actual notice of the injury on the day of its occurrence, and the employer was notified of treatment by telephone prior to submission of the written report. Roger's Terminal, 784 F.2d at 693-94, 18 BRBS

at 87. (The **Fifth Circuit** found that the employer had not suffered prejudice, since, prior to receiving the initial care report, the employer had actual notice of the injury on the day it occurred.)

Similarly, in Maguire v. Todd Pacific Shipyards Corp., 25 BRBS 299 (1992), the Board found that although the physician, who had taken over treatment of the claimant when the claimant's authorized physician retired, had failed to provide a report to employer within 10 days of the first treatment, the employer had not provided any evidence to suggest that the treatment was unnecessary or unrelated to the claimant's work injury. Thus, the Board concluded that an excusal of the delay was in the interests of justice. Id.

On the other hand, in Force v. Kaiser Aluminum & Chemical Corp., 23 BRBS 1, 6-7 (1989), aff'd in part, rev'd in part sub nom. Force v. Director, OWCP, 938 F.2d 981, 25 BRBS 13 (CRT) (**9th Cir.** 1991), the Board affirmed a finding that the decedent's spouse was not entitled to reimbursement of decedent's medical expenses where she had not notified the employer during the period of treatment and the decedent's physician had not filed the requisite first report of injury.

7.7

UNREASONABLE REFUSAL TO SUBMIT TO TREATMENT

Section 7(d)(4) of the LHWCA as amended in 1984 provides that the Secretary or judge may, by order, suspend the payment of all further compensation to an employee during any period in which he unreasonably refuses to submit to medical or surgical treatment, or to an examination by the employer's chosen physician, unless the circumstances justified the refusal. Furthermore, Section 7(d)(4) cannot be applied retroactively. It is inconsistent with the statutory language and case law to apply Section 7(d)(4) to terminate payments for a period prior to the employer's raising the issue. Dodd v. Newport News Shipbuilding & Dry Dock Co., 22 BRBS 245 (1989).

The Board has held that this is a **two-prong test**. The refusal must be both "**unreasonable**" and **not "justified"** by the circumstances. Further, the Secretary has **discretion** to suspend compensation or not, even if the employee fails both prongs. Pettus v. American Airlines, 6 BRBS 461 (1977). The **Fourth Circuit** vacated Pettus, however, holding that the Board was bound to suspend compensation based on a Virginia state workers' compensation proceeding which found the employee's refusal to be unjustified under the Virginia Act. Pettus v. American Airlines, 587 F.2d 627, 8 BRBS 800 (**4th Cir.** 1978), cert. denied, 444 U.S. 883 (1979).

In Hrycyk v. Bath Iron Works Corp., 11 BRBS 238 (1979), the Board followed its holding in Pettus and held that the **burden of proof is on the employer** to show that the refusal was unreasonable; if carried, the burden shifts to the employee to show that the circumstances justify the refusal. The Board additionally defined reasonableness of refusal as an objective inquiry (i.e., what course would an ordinary person in the claimant's position pursue?), and justification as a subjective inquiry (i.e., focusing on the individual claimant's particular reasons for refusal). Hrycyk, 11 BRBS at 241-42.

[ED. NOTE: The Board has dubbed the Section 7(d)(4) test as the "Hrycyk Test." This is a dual test for determining whether benefits may be suspended as a result of a claimant's failure to undergo surgical treatment. First, the employer must make an initial showing that the claimant's refusal to undergo surgical treatment is unreasonable; the reasonableness of the claimant's actions must be appraised in objective terms. Second, if the employer meets this burden, the burden shifts to the claimant to show that the circumstances justify his refusal; appraisal of the justification of the claimant's actions is a subjective inquiry.]

It has been held reasonable, as a matter of law, for an employee to refuse surgery when no physician says that it would be helpful and the treating physician advises the claimant not to undergo it. Adams v. Brookfield & Baylor Constr. Co., 5 BRBS 512 (1977). Similarly, if the judge finds that the employee never received notice of a scheduled examination, no "unreasonable refusal" took place. Toraiff v. Triple A Mach. Shop, 1 BRBS 465 (1975).

The Board has held that Section 7(d) does not allow suspension of compensation if a claimant refuses to undergo **rehabilitation evaluation or training**. Simpson v. Seatrain Terminal, 15 BRBS 187 (1982) (evaluation) (Ramsey, J., dissenting); Morgan v. Asphalt Constr. Co., 6 BRBS

540 (1977) (training); see Carpenter v. Potomac Iron Works, 1 BRBS 332 (1975), aff'd mem., 535 F.2d 1325 (**D.C. Cir.** 1976) (held, refusal to undergo vocational rehabilitation reasonable because state and federal authorities advised that rehabilitation was not indicated). But see Naimoli v. Sun Shipbuilding & Dry Dock Co., 5 BRBS 590 (1977) (reluctance to undergo rehabilitation treatment should be pursued under Section 7(d)).

Section 7(d) does, however, apply to a refusal to be examined by employer's chosen physician for purposes of a **medical** vocational rehabilitation **evaluation**. Mendez v. Bernuth Marine Shipping, 11 BRBS 21, 27 (1979), aff'd mem., 638 F.2d 1232 (**5th Cir.** 1981).

Judge Ramsey dissented in Simpson, and stated that he would hold that where a claimant unreasonably refuses to undergo a rehabilitation evaluation, the deputy commissioner can suspend compensation under Section 7(d). 15 BRBS at 193. Cf. Villasenor v. Marine Maintenance Indus., 17 BRBS 99, motion for recon. denied, 17 BRBS 160 (1985) (held, refusal to undergo rehabilitation evaluation is a factor which must be considered in evaluating the extent of disability). See also Calicutt v. Sheppard Air Force Base Billeting Fund, 16 BRBS 111 (1984) (affirmed deputy commissioner's finding that Section 7(d) does not apply where the claimant was physically incapable of undergoing the rehabilitation evaluation at the time requested).

A judge cannot excuse a claimant's failure to cooperate with employer's chosen examining physician on the grounds that the claimant lacks confidence in the physician, although that might be a valid reason to refuse him as a treating physician. Jenkins, 594 F.2d at 407; 10 BRBS at 8-9. See also McCabe v. Ball Builders, 1 BRBS 290 (1975) (bitterness towards employer's physician).

A judge may not award compensation when suggested surgery could significantly alter the degree of the claimant's disability and the deputy commissioner has not yet ruled on whether the claimant's refusal of surgery is reasonable under Section 7(d). Rucker v. Lawrence Mangum & Sons, Inc., 18 BRBS 74, 76 (1986).

Under the pre-1984 amended LHWCA, reasonableness of refusal can only be decided by a deputy commissioner; a judge may not make such a finding under Section 7(d). Hike v. Billeting Fund, Robins Air Force Base, 13 BRBS 1059 (1981); Jonson v. C & P Tel. Co., 13 BRBS 492 (1981); Ogundele v. American Sec. & Trust Bank, 15 BRBS 96 (1980). Accordingly, a judge cannot delegate to the employer the right to suspend compensation, as he himself does not have the power to do so. Murphy v. Honeywell Inc., 8 BRBS 178 (1978), clarifying Unger v. National Steel & Shipping Co., 5 BRBS 377 (1977).

Before remanding a case to the deputy commissioner to make a Section 7(d) finding, however, a judge may make a finding as to the nature of the disability, that is, whether it will be permanent or temporary, if the proposed treatment would only effect the extent thereof. Dionisopoulos v. Pete Pappas & Sons, 14 BRBS 523 (1981), overruling in part Hrycyk v. Bath Iron Works Corp., 8 BRBS 300 (1978). Cf. Rucker v. Lawrence Mangum & Sons, Inc., 18 BRBS 74 (1986) (ALJ may not award compensation where surgery could significantly alter the degree of

disability and the deputy commissioner has not yet ruled on whether the refusal to undergo surgery was reasonable). The judge may decide the other issues before remanding the claim. Murphy, 8 BRBS at 181-82.

New Section 7(d)(4), as amended in 1984, allows the judge to make unreasonableness/suspension findings. Dodd v. Newport News Shipbuilding & Dry Dock Co., 22 BRBS 245 (1989).

In Mitchell v. Randolph Air Force Base, (BRB No. 99-0380)(Dec. 23, 1999)(Unpublished), the ALJ held, and the Board affirmed under Section 7(d)(4), that it was “unreasonable to expect [the claimant] to maintain a regimen [to lose weight] that she did not embrace prior to her injury.” The claimant’s treating physician noted that the claimant was “corpulent” at the time of her injury, and she had been unable to lose weight given her background of unsuccessful diet programs.

7.8 IMPARTIAL EXAMINER (IME)

Under Section 7(e), if medical questions are raised, the Secretary may have the claimant examined by a physician employed or chosen by the Secretary and receive from the physician a report estimating the claimant's physical impairment and other appropriate information. Any party dissatisfied with the report may request a review or a reexamination of the employee by one or more different physicians employed or chosen by the Secretary, which the Secretary shall order, unless the Secretary finds it clearly unwarranted, and which shall be completed within two weeks from the date ordered, unless the Secretary finds that extraordinary circumstances require a longer period. See 20 C.F.R. §§ 702.408, 702.409. See generally Grbic v. Northeast Stevedoring Co., 13 BRBS 282 (1980).

The district director may order an examination of the claimant by an independent medical examiner when a medical question exist with regards to the claimant's diagnosis. Augillard v. Pool Co., 31 BRBS 62, 64 (1997). The Board, hearing the issue of what constituted a medical question for the first time, applied a "plain meaning of the term" analysis to determine what constituted a medical question. They held that a medical question clearly existed whenever the treating physician recommended a claimant consult a second physician regarding some aspect of the claimant's condition or injury. Id.

The Secretary may charge the cost of examination or review to the employer, if self-insured; to the carrier, if appropriate; or to the Special Fund. See Duty, 4 BRBS at 530; 20 C.F.R. § 702.412(a).

The Director, through the district director, may appoint especially qualified physicians to evaluate medical questions regarding appropriate diagnosis, extent, effect of, appropriate treatment, and the duration of any care or treatment, or to make appropriate inquiries in the case of death. Findings should be reported expeditiously. Appropriate action will be taken upon the receipt of their reports. See 20 C.F.R. § 702.408. See also Atlantic & Gulf Stevedores v. Donovan, 274 F.2d 794 (5th Cir. 1960).

Although the Secretary (or district director) has the power to request an impartial examination, the Secretary need not do so. Moreover, the examining physician's findings on such an examination are not binding on any party, but are only intended to provide the deputy commissioner with a reliable, independent evaluation of the employee's condition. Shell, 14 BRBS at 589.

Section 7(f) provides that the employee must submit to a subsection (e) physical examination at a reasonably convenient place designated by the Secretary. No physician selected by the employer, carrier, or employee may attend or participate in any way in the examination, and the examining physician will not be provided with any such physician's conclusion on nature, extent, or cause of impairment unless the Secretary orders otherwise for good cause.

The employer or carrier is entitled, on request, to have the employee examined immediately thereafter, on the same premises by qualified physicians, in the presence of the employee's chosen physician, if any. If the employee refuses to submit to the examination, the proceedings shall be suspended and no compensation is to be paid during the period of refusal.

This subsection is implemented by 20 C.F.R. § 702.410, which leaves decisions regarding suspension to the deputy commissioner, and 20 C.F.R. § 702.411(a), (b). The latter regulation emphasizes the attempt to preclude prejudice by the impartial examiner but allows any party or the Director to provide him with opinions, reports, or conclusions on impairment or its effect on wage-earning capacity, if the deputy commissioner finds good cause. Any party shall be given a copy of all materials provided to the impartial examiner on request.

If the claimant does not intend to submit to the impartial examination, he should **appeal** to the Board. If the claimant does not do so and fails to appear for the examination, the deputy commissioner should promptly decide, in writing, on the appropriate sanction. If none is imposed, the employer may appeal to the Board. Grbic, 13 BRBS at 288. There is a limit, however; an employer who requested four independent examinations and canceled compensation five times was found not entitled to yet another examination. Grbic, 13 BRBS at 290.

7.9 MEDICAL FEES LIMITS

All fees and other charges for medical examinations, treatment, or services are limited to the prevailing charges in the community for such treatment and may be regulated by the Secretary, who is to issue regulations listing the nature and extent of medical expenses chargeable against the employer without his or its authorization. See 33 U.S.C. § 907(g).

Where a dispute arises concerning the amount of a medical bill, the Director shall determine the prevailing community rate using the OWCP Medical Fee Schedule (as described in 20 C.F.R. 10.411) to the extent appropriate and where not appropriate, may use other stat or federal fee schedules. See 20 C.F.R. § 702.413.

The Director, may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing community charges for similar treatment, services or supplies or the provider's customary charges. The OWCP medical fee schedule shall be used by the Director, where appropriate, to determine the prevailing community charges for a medical procedure by a physician or hospital (to the extent such procedure is covered by the OWCP fee schedule). The Director's investigation may initially be conducted informally through contact of the medical care provider by the district director. If this informal investigation is unsuccessful, further proceedings may be undertaken. These proceedings may include, but not be limited to: an informal conference involving all interested parties; agency interrogatories to the pertinent medical care provider; and issuance of subpoenas duces tecum for documents having a bearing on the dispute. See 20 C.F.R. §702.414(a).

A claim by the provider that the OWCP fee schedule does not represent the prevailing community rate will be considered only where certain circumstances are presented. See 20 C.F.R. § 702.414(1) and (2). After any proceeding in regards to medical fee disputes, the Director shall make specific findings as to whether the fee exceeded the prevailing community charges (as established by the OWCP fee schedule, where appropriate) or the provider's customary charges and provide notice of these findings to the affected parties. See 20 C.F.R. 702.414(1)(c) and (d).

If the provider refuses to adjust it, the Director is to refer the matter to the Chief Administrative Law Judge for formal hearing. See 20 C.F.R. § 702.415. The necessary parties at such a hearing are the person whose fee or charge is in question and the Director, or their representatives. The employer or carrier may also be represented, as may other parties or associations with an interest in the proceedings at the administrative law judge's discretion. See 20 C.F.R. § 416.

If the final Decision and Order upholds the Director's finding, the person claiming the fee or charge will be given 30 days to adjust it. If he still refuses, he shall not be authorized to provide further treatments, services, or supplies, and any subsequent fees or charges will not be reimbursed, even if necessary and appropriate or for services rendered in a different case. The provider shall

remain debarred until he demonstrates to the Director's satisfaction that he will charge fees in accordance with the prevailing community standards. 20 C.F.R. § 702.417.

In the case of Newport News Shipbuilding & Dry Dock Co. v. Loxley, 23 BRBS 215 (1990), rev'd, 934 F.2d 511, 24 BRBS 175 (CRT) (4th Cir. 1991), cert. denied, 504 U.S. 910 (1992), the question presented was who had the burden of proof with respect to whether a medical fee exceeds the prevailing community rate (20 C.F.R. § 702.413 does not address who bears this burden). The judge had determined that the burden lies with the health care provider. The Board reversed this finding, holding that because the employer was the proponent of the rule that the doctor's fees were excessive, the employer had the burden of proof. Id. at 221.

On appeal, the **Fourth Circuit** reversed the Board and affirmed the judge's determination that the doctor's charges exceeded the prevailing rate regardless of who carried the burden of proof. Thus, the court stated that it need not decide upon whom the burden falls.

The court went on to address the issue, however, concluding that a **physician who seeks an order compelling full payment of his charges carries the burden of proof** at the administrative hearing. The court noted that according to 20 C.F.R. § 702.416, the only necessary parties to such a proceeding were the health care provider and the Director; thus, it reasoned that one of the necessary parties must bear the burden. Newport News Shipbuilding & Dry Dock Co. v. Loxley, 934 F.2d 511, 516-17, 24 BRBS 175, 184-86 (CRT) (4th Cir. 1991), rev'g 23 BRBS 215 (1990), cert. denied, 504 U.S. 910 (1992).

Regarding the issue of whether the doctor's charges exceeded the prevailing rate, the **Fourth Circuit** found that the use by the employer of the Current Procedural Terminology (CPT) codes, a uniform coding of procedures and services performed by physicians that has been adopted by the American Medical Association, to determine prevailing rates for certain procedures was acceptable. Loxley, 934 F.2d at 515, 24 BRBS at 182-83.

[ED. NOTE: In 1995, 20 C.F.R. §702.413 was amended. It still does not specifically state who has the burden of proof. It does state, "Where a dispute arises concerning the amount of a medical bill, the Director shall determine the prevailing community rate using the OWCP Medical Fee Schedule (as described in 20 C.F.R. 10.411) to the extent appropriate, and where not appropriate, may use other state or federal fee schedules."]

7.10 THIRD-PARTY SUITS

The employer's liability for medical treatment is unaffected by the fact that its employee was injured through the fault or negligence of a third party not in the same employment, or that the third party is being sued; however, the employer has a cause of action against the third party to recover any amounts which it paid for medical treatment. 33 U.S.C. § 907(h). See 33 U.S.C. § 933(b); Doleman v. Levine, 295 U.S. 221 (1935). For a case where the employer waived its right to Section 33(f) offset of medical benefits, see O'Brien v. Evans Financial Corp., 31 BRBS 54 (1997)(Held, employer was liable for claimant's post third-party settlement medical benefits when employer gave written approval of settlement and therefore waived its right to § 33(f) offset of medical benefits.).

For a detailed history of the use of this provision, see generally Cella v. Partenreederei MS Ravenna, 529 F.2d 15 (1st Cir. 1975), cert. denied, 425 U.S. 975 (1976).

7.11 WORKERS' COMPENSATION CLAIMS

Unless the parties agree, the Secretary shall not employ or choose any physician to make subsection (a) examinations or reviews who, during such employment or the two years prior thereto, has been employed by, accepted, or participated in any fee relating to a workers' compensation claim from any insurance carrier or self-insurer. See 33 U.S.C. § 907(i).

This subsection is implemented by 20 C.F.R. § 702.411(c). It is irrelevant that there may be no prejudice. Jones v. I.T.O. Corp. of Baltimore, 9 BRBS 583 (1979).

7.12 DEBARMENT

Section 7(j) of the LHWCA provides that the Secretary has the authority to make rules and regulations and establish procedures for carrying out the provisions of subsection (c), that is, the preparing of the list of physicians and health care providers who are not authorized to render medical care or services under the LHWCA, including the nature and extent of the proof and evidence necessary and the procedures for taking and furnishing such proof and evidence. See 33 U.S.C. § 907(j)(1).

[ED. NOTE: For an example of a Final Decision and Order under the LHWCA debarment provisions, see In the Matter of Vernon D. Clausing, D.O., (ALJ Case No. 86-LHC-1)(Sept. 29, 1993) (Unpublished).]

20 C.F.R. § 702.431 sets forth **grounds for debarment** as follows:

- (1) knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact for use in a claim for compensation or claim for reimbursement of medical expenses under the Act;
- (2) knowingly and willfully submitting or causing to be submitted a bill or request for payment under the Act containing a charge which the Director finds to be substantially in excess of the charge for the service, appliance, or supply prevailing within the community or in excess of the provider's customary charges, unless the Director finds that there is good cause for the bill or request containing the charge;
- (3) knowingly or willfully furnishing a service, appliance, or supply which is determined to be substantially in excess of the need of the recipient or to be of a quality which substantially fails to meet professionally recognized standards; and
- (4) being convicted under any criminal statute, without regard to a pending appeal, for fraudulent activities in connection with a federal or state program for which payments are made to physicians or providers of similar services, appliances, or supplies; or has otherwise been excluded from participation in such program.

The Secretary shall base any decision under this section on specific findings of fact and shall provide notice of these findings and an opportunity for a hearing for a provider who would be affected by such decision. A request for a hearing must then be filed with the Secretary within 30 days after notice of the findings is received by the provider. If a hearing is held, the Secretary shall,

on the basis of evidence adduced at the hearing, affirm, modify, or reverse the findings of fact and proposed action under this section. See 33 U.S.C. § 907(j)(2).

This section further provides that after any final decision of the Secretary made after a hearing, the physician or health care provider, who was a party at the hearing, may obtain a review of that decision by a civil action commenced within 60 days after the mailing of notice of the decision to him. The pendency of such review shall not operate,, however, as a stay upon the effect of the decision of the Secretary. The action is to be brought in the court of appeals for the judicial circuit in which the plaintiff resides or has his principal place of business. See 33 U.S.C. § 907(j)(4).

Detailed procedures regarding the debarment process can be found at 20 C.F.R. §§ 702.432, 702.433, 702.434.

Notwithstanding any debarment under this section, the Director shall not refuse a claimant reimbursement for any otherwise reimbursable medical expense if the treatment, service, or supply was rendered by a debarred provider in an emergency situation. The claimant will be directed, however, to select a duly-qualified provider upon the earliest opportunity. See 20 C.F.R. § 702.435.

7.13 SPIRITUAL HEALING

Naturopaths, faith healers, and other unlisted practitioners of the healing arts are not physicians. See 20 C.F.R. § 702.404. However, subsection 7(k), added by the 1984 Amendments, provides that the LHWCA does not prevent an employee whose injury or disability has been established thereunder from relying in good faith on treatment solely by prayer or spiritual means, by an accredited practitioner of a recognized church or religious denomination, or on nursing services rendered in accordance with its tenets and practice, without suffering loss or diminution of the compensation or benefits under the LHWCA.

This subsection does not except an employee from all physical examinations required by the LHWCA. See 33 U.S.C. § 907(k)(1). It applies to claims filed after or pending on December 27, 1984, its effective date. See 1984 Amendments, §§ 7(e), 28(b).

However, an employee who refuses medical or surgical services solely because he relies on prayer or spiritual means alone for healing, in adherence to the tenets and practice of a recognized church or religious denomination, has not "unreasonably refused" medical or surgical treatment under subsection (d). 33 U.S.C. § 907(k)(2).