U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation
Washington, DC 20210

BLBA BULLETIN NO. 16-05

Issue Date: May 26, 2016

Expiration Date: When incorporated into the Black Lung Benefits Act (BLBA) Procedure Manual (PM)

Subject: Implementing the Final Rule on Disclosure of Medical Information and Payment of Benefits

Background: On April 26, 2016, the Office of Workers' Compensation Programs (OWCP) published a final rule titled "Black Lung Benefits Act: Disclosure of Medical Information and Payment of Benefits." The final rule, which is effective on May 26, 2016, includes two new regulations. The first, codified at 20 CFR 725.310(e), requires liable coal mine operators to pay certain effective benefit awards before seeking modification of the underlying award. The second, codified at 20 CFR 725.413, requires all parties to exchange any medical information about a miner developed in connection with the claim, even when a party does not intend to offer the information into evidence. In addition to these new regulations, the final rule revises several existing rules. The reason for each regulatory change is summarized below and fully explained in the final rule's preamble, 81 *Federal Register* 24464-24479.

Applicability: All DCMWC Staff

Purpose: To provide guidance to DCMWC staff regarding implementation of the regulatory changes associated with the final rule on Disclosure of Medical Information and Payment of Benefits.

References: 20 CFR 725.310(e); 725.413; 725.414(a)(l); 725.414(a)(3)(iii); 725.601; 725.607

Action:

1. **20 CFR 725.310(e) – Modification**

    a. **New regulatory provisions concerning modification**

        i. This new regulation ensures that liable coal mine operators meet their existing payment obligations before pursuing modification of a benefits award. It applies to all operator modification requests filed on or after May 26, 2016.

        ii. The rule requires the adjudicator to deny any operator's modification request unless the operator proves that it has paid the following "effective" or "final" orders in the case:

1. Any effective award of monetary benefits, including retroactive benefits and interest payable to the claimant and reimbursement and interest due the Trust Fund;

2. Any effective award of additional compensation payable to the claimant;

3. Effective orders awarding particular medical treatment expenses, including any reimbursement and interest due the Trust Fund; and

4. Any "final" orders awarding attorney fees, expenses and witness fees, but only if the underlying award of benefits is final too.

iii. An "effective" order for these purposes is one issued by the district director and not timely contested by any party; an administrative law judge (ALJ) decision and order; or a Benefits Review Board (BRB) order. An attorney fee order is "final" generally when the time for appealing the underlying benefits award and the fee award have expired. See 20 CFR 725.406, 725.479(a), 725.419(d) and 725.502 for guidance on final and effective awards.

iv. An operator may avoid this requirement by obtaining a stay of payments from the BRB or appropriate court. The operator must submit documentary evidence demonstrating compliance with its request for modification; no evidence of the operator's compliance at the time of filing the modification request may be admitted in subsequent proceedings absent extraordinary circumstances.

v. Finally, an operator whose modification request is denied under this regulation may seek modification again so long as it demonstrates that it has fully complied with its payment obligations at that time.

b. Changes to the modification process

i. Under the current procedure, the first step when receiving a modification request is to determine if the request is timely filed. This remains unchanged:

1. Was the request filed within one year following the effective date of the last entitlement decision denying benefits?

2. Or, was the request filed within one year after the last payment of benefits?

ii. Generate a memorandum to file addressing the timeliness of the modification request.

iii. If the request is untimely, use the standard notice to deny the request as untimely.

iv. If the request is timely, and the operator is the requestor, review the record to determine if the operator has fully complied with any payment obligations resulting from the effective or final awards listed in section 1.a.ii. above.

c. Determining if the operator has met its payment obligations

i. Check the Automated Support Package (ASP) system for a closed ROPAY diary action code.

1. When reimbursement from the operator is initiated, a ROPAY diary action code is entered in the ASP. The date of the initial request is the start date of the code. When reimbursement is complete, an end date is entered in the system. When the system has a closed ROPAY diary action code, it indicates that the operator reimbursements are complete.

ii. Check the Black Lung Accounting System to determine if any reimbursements are outstanding.

1. When reimbursements are requested from the operator party, a "Type 2" accounts receivable is created under the operator's identification number.

2. When reviewing the account, confirm that interim benefits, diagnostic and treatment costs, and applicable interest charges were added to the account.

3. When all reimbursements to the Trust Fund are received and credited to the record, the account balance will be zero.

iii. Check the record to determine if there are any outstanding obligations such as retroactive benefits or additional compensation due the claimant or attorney fees. This may require contacting the claimant and/or attorney to verify that all payments have been received.

iv. Consider any information the operator or claimant has supplied about whether the operator has satisfied its payment obligations.

v. The adjudicator must complete the actions identified in sections 1.c.i through 1.c.iv to verify that all payment obligations are met before entertaining an operator's modification request. The operator bears the burden of establishing this fact. If there is any doubt regarding

compliance with payment obligations, the district director should contact their regional solicitor for guidance.

d. Issuing a decision on modification

i. If the operator has complied with all payment obligations, continue with the existing standard modification procedures.

ii. If the operator has not resolved all its payment obligations, the request for modification must be denied.

1. A new modification letter has been added to the Correspondence System (CORS) for a standard denial response when the operator has not met its payment obligations.

2. The adjudicator will update the ASP with a reconsideration (REC) adjudication data set to reflect denial of the modification request due to non-compliance with payment obligations.

a. Use the "determination basis" code 212 to document denial of the modification request. This code is currently defined as "other."

iii. NOTE: If, at any time during the modification process, questions about continued payments are raised, the adjudication officer must issue an order to show cause why the operator's modification request should not be denied and allow the parties to submit evidence on the issue.

2. <u>20 CFR 725.413 – Disclosure of Medical Information</u>

a. New regulatory provisions concerning exchange of medical information

i. This new regulation requires all parties—including the Director, OWCP—to exchange any "medical information" about the miner developed in connection with a claim for benefits, even if the party does not intend to offer the information into evidence. "Medical information" also includes medical data from a prior claim that was not put into the record or otherwise shared with the other parties. Generally the exchange must be made within 30 days of the party's receipt of the information. Failure to meet the rule's requirements may result in sanctions.

ii. This rule applies to:

1. all claims filed after May 26, 2016;

2. all claims pending on May 26, 2016 that have not yet been adjudicated by an ALJ. In these claims, medical information

received prior to May 26, 2016 and not previously disclosed must be provided to the other parties within 60 days of May 26, 2016 (i.e., by July 25, 2016);

3. all claims pending on May 26, 2016 that have already been adjudicated by an ALJ where the ALJ either reopens the record to receive more evidence (e.g., on remand from the BRB) or a party seeks modification.

iii. The rule broadly defines "medical information." The term includes:

1. any *examining* physician's findings, diagnoses, conclusions and test results, including any findings that do not pertain to the miner's respiratory status;

2. any *non-examining* physician's assessment of the miner's respiratory or pulmonary condition;

3. all results of tests or procedures related to the miner's respiratory or pulmonary condition, and any physician's or other medical professional's interpretation of such test results developed in response to a claim.

4. NOTE: Medical information *does not* include the miner's treatment records or communications from the party's representative (i.e., attorney or lay representative) to the medical expert.

iv. Except for evidence received prior to May 26, 2016 (see section 2.a.ii.2. above), each party must send a complete copy of the information to the other parties in the claim within 30 days after either the party or the party's agent receives it. For OWCP, the date of receipt is equal to the "receipt date" in the imaging system. If the case is already scheduled for hearing when the information is received, the exchange must be completed at least twenty days before the hearing. Significantly, medical information exchanged among the parties is not evidence for the adjudicator's consideration. Each party must designate and submit to the adjudicator the information it wishes to have considered as evidence.

b. Changes to procedures related to the handling of medical information received by the district offices in the imaged record

i. When medical information is received in the imaging system, it will be identified with the category of "Medical."

1. There is no change to the classification of the 413(b) examination and testing. Use the appropriate subject with the default "Doc

Class," if the medical evidence will be used as a "Director's Exhibit."

ii. The reviewer must determine if the information has been designated by the sender as affirmative, rebuttal or rehabilitative evidence; or whether the information was submitted under the exchange rule.

1. A letter covering the submission may provide that information.

2. If the submission includes the identification of the medical information as a type of evidence, the document will be indexed under the subject of "RO Medical" or "Claimant Medical," as appropriate.

3. The imaging system will default to the "Doc Class" of "Director's Exhibit."

4. If the medical information is identified as purely an exchange of information, the document will be indexed under the "subject" of "Other Medical" and the "Doc Class" of "blank."

5. The description box should be completed to further identify the submission, such as affirmative medical report, rebuttal of DOL x-ray; rehabilitative PFT statement.

iii. If the submission does not clearly designate the medical information as affirmative, rebuttal or rehabilitative evidence:

1. The reviewer will index the document under the subject of "Other Medical Documents" and change the "Doc Class" to "blank."

2. The description field should be noted to further identify the document.

3. The reviewer must then contact the submitting party to determine the intent of the submission, i.e., evidence type or only submitted under the "exchange rule." A fully documented conversation with the submitting party is sufficient; or, a letter may be sent. A standard letter has been added to CORS which can be used for this purpose.

4. When the response is received, the document will be re-indexed if the medical information is submitted as "evidence" to be considered in the adjudication process. This will include an update to the subject and the doc class, as described above.

5. If the medical information is not identified as "evidence," the document will remain under the subject of "Other Medical Documents" and "Doc Class" of "blank."

iv. The "Guide to Filing" has been updated to advise the parties of the requirement to exchange medical information. The Guide must be sent to all parties.

c. Consideration of non-evidence when issuing a decision

i. Unless a party to the claim specifically identifies medical information as their affirmative, rebuttal or rehabilitative evidence, that medical information cannot be considered in any decision and will not be included as evidence in any further proceeding. A new standard development letter has been added to CORS to assist all parties, including unrepresented claimants, in accurately designating medical information submitted in connection with a claim.

d. Imposing sanctions

i. An adjudication officer may, on his or her own initiative or at a party's request, impose sanctions on any party or his or her representative who fails to timely comply with this regulation's exchange requirements. The sanctions must be appropriate to the situation and may only be entered after giving the party an opportunity to show good cause for not exchanging the medical information. Sanctions may include drawing adverse inferences against the non-compliant party; limiting the non-compliant party's claims, defenses, or right to introduce evidence; dismissing the claim; or disqualifying the non-compliant party's attorney from the proceedings. Sanctions imposed by a district director are subject to review by an ALJ.

1. When a district office encounters a situation where a party fails to comply with this requirement, the district director should consult their regional solicitor for guidance on imposing sanctions.

e. Changes to the evidence development process for the district offices

i. Just like private parties, the Director and his counsel may be subject to these sanctions if medical information developed by the Department is not timely exchanged with the other parties. District offices are encouraged to issue the Schedule for Submission of Additional Evidence (SSAE) at the earliest possible date. In most cases, the district office will issue the SSAE within the 30 days following receipt of the medical information that OWCP will consider as evidence, i.e., the 413(b) exam results.

1. However, if the SSAE will not be issued within 30 days of the receipt of the 413(b) exam results, the information must be sent to all parties, prior to release of the SSAE and within 30 days of receipt.

2. Medical information developed by the district office after issuance of the SSAE (e.g., a supplemental report in a pilot-program case, a repeat pulmonary function test) must be sent to all parties within 30 days of receipt.

3. Medical information developed by the district office in prior claims not previously exchanged with the other parties or put into the record must also be sent to all parties. This requirement will be considered met if: (1) the district office issued an SSAE in the prior claim; (2) the parties to the current claim were served with the SSAE in the prior claim; and (3) the office is not aware of any specific circumstances that would have prevented the exchange of all medical information in the prior claim.

ii. Note: Medical information developed by the district office which is excluded from the record, such as for "substantial compliance" issues, must also be exchanged with all parties within 30 days of receipt.

1. Example: The original pulmonary function test was not valid; repeat testing is done. The original test would be excluded from the medical evidence. However, under the new rule, this test must be shared with the parties within 30 days of receipt.

3. 20 CFR 725.414(a)(l) – Supplemental medical reports

a. New regulatory provisions concerning supplemental medical reports

i. The final rule revises the definition of a "medical report" to clarify that a physician's initial and supplemental report (or reports) are considered one report for purposes of the evidence-limiting rules. The prior rule was ambiguous and had led to litigation; the revised rule codifies the result of that litigation.

ii. This rule applies to any parties' submission of a medical report and subsequent supplemental or clarifying reports by the same author in all pending claims as well as those filed after the rule's effective date.

b. Changes to the process of evaluating of medical reports

i. For purposes of the evidence-limiting rules (20 C.F.R. 725.414), a supplemental report submitted by any party will be considered a continuation of the original report. This includes supplemental reports

obtained by the district office. The original report and any supplemental report from the original author will count as one medical report under the limitation rules. But, as with any other medical information developed in connection with a claim, the submitting party must choose whether to submit a supplemental report as evidence for the adjudicator (20 C.F.R. 725.413).

4. **20 CFR 725.414(a)(3)(iii) – Operators who cease to defend claims**

   a. **New regulatory provisions concerning operators who cease to defend claims**

      i. The final rule includes a new provision that permits the Director to initiate medical-evidence development allotted to the liable coal mine operator for purposes of the evidence-limiting rules when the operator stops defending a claim due to adverse financial developments (e.g., bankruptcy, insolvency). The prior rule only allowed the Director to exercise the operator's rights to submit evidence when the district director was unable to identify an operator or had dismissed all potentially liable operators. The revised rule adds a third scenario: when the district director has "identified a liable operator that ceases to defend the claim on grounds of an inability to provide for payment of continuing benefits[.]" This rule applies to all pending claims as well as those filed after the rule's effective date.

   b. **Changes to current processes**

      i. If the district office becomes aware of an operator that ceases to defend a claim due to adverse financial developments, the district director should immediately notify the Responsible Operator Section in BSRP. BSRP will investigate the matter, and in conjunction with the Solicitor's office, provide specific guidance to the district offices on a case-by-case basis.

5. **20 CFR 725.601, 725.607 – Payments of Additional Compensation**

   a. **This revision does not require any procedural changes.**

      i. These regulations address the additional compensation a claimant may seek when a liable coal mine operator does not make timely benefit payments. The prior rules used two different phrases to describe these payments: "payments of additional compensation" and "payments in addition to compensation." For consistency, the final rule adopts the phrase "payments of additional compensation" throughout both regulations. This rule applies to all pending claims as well as those filed after the rule's effective date.

ii. Standard letters in CORS have been reviewed and updated to incorporate this change. Staff will review their locally stored letters to ensure that the wording is consistent with the regulatory change.

Disposition: This bulletin should be retained until the BLBA-PM has been updated.

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Distribution: All DCMWC Staff and Regional Directors