U.S. Department of Labor

Benefits Review Board
200 Constitution Ave. NW
Washington, DC 20210-0001

BRB No. 21-0063

LOUIS PEÑA GARCIA Claimant-Petitioner v. CALZADILLA CONSTRUCTION CORPORATION and IMS INSURANCE COMPANY OF PUERTO RICO Employer/Carrier-Respondents DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR Respondent	)	DATE ISSUED: 7/26/2022 DECISION and ORDER

Appeal of the Decision and Order Denying Reimbursement for Requested Medical Treatment of Stephen R. Henley, Administrative Law Judge, United States Department of Labor.

Emilio F. Soler, San Juan, Puerto Rico, for Claimant.

Manuel Porro-Vizcarra, San Juan, Puerto Rico, for Employer/Carrier.

William M. Bush (Seema Nanda, Solicitor of Labor; Barry H. Joyner, Associate Solicitor; Mark A. Reinhalter, Counsel for Longshore),

Washington, D.C., for the Director, Office of Workers' Compensation Programs, United States Department of Labor.

Before: BUZZARD, ROLFE and JONES, Administrative Appeals Judges.

ROLFE and JONES, Administrative Appeals Judges:

Claimant appeals Administrative Law Judge (ALJ) Stephen R. Henley's Decision and Order Denying Reimbursement for Requested Medical Treatment (2020-LHC-00796)[1] rendered on a claim filed pursuant to the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §901 *et seq.*, as extended by the Defense Base Act, 42 U.S.C. §1651 *et seq.* (Longshore Act). We must affirm the administrative law judge's findings of fact and conclusions of law if they are rational, supported by substantial evidence, and in accordance with applicable law. 33 U.S.C. §921(b)(3); *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

Claimant injured his back at work on May 16, 1994, resulting in permanent total disability. He filed a claim for his work-related injuries. On December 29, 1998, the district director ordered Employer to furnish Claimant medical care and treatment pursuant to Section 7 of the Longshore Act, 33 U.S.C. 33 U.S.C. §907; it has "generally complied." ALJ's Decision and Order dated September 15, 2020 (Decision and Order) at 1. On March 23, 2019, Dr. Michael Soler, a licensed physician in Puerto Rico, stated Claimant "has steadily responded well" for "over one year" to prescribed "edibles infused with a specific dosage of medical cannabis," which seemed to be "one of the only treatments that best works for the patient [] at night time due to its absorption and dose doubling effect." Decision and Order (D&O) at 2. Claimant sought, but Employer denied, reimbursement for "payment of medical cannabis-infused cookies and edibles" obtained as medical treatment, prompting him to request a hearing before the Office of Administrative Law Judges (OALJ).

Prior to any hearing, the ALJ directed the parties to show cause on "whether the Controlled Substance Act's [21 U.S.C. §801 *et seq.*, hereinafter referred to as CSA] current placement of marijuana in Schedule I entails that marijuana can never be reasonable and

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[1] The Longshore and Harbor Workers' Compensation Act does not directly apply to Puerto Rico. *See Garcia v. Friesecke*, 597 F.2d 284 (1st Cir.), *cert. denied*, 444 U.S. 940 (1979) (First Circuit has determined the Act was displaced by the local Puerto Rican compensation scheme); *Guerrido v. Alcoa Steamship Co.*, 234 F.2d 349 (1st Cir. 1956). Nevertheless, the ALJ's "LHC" rather than "LDA" case code designation is harmless error as it has no impact on our consideration of the issues presented.

necessary for purposes of Section 7 of the [Longshore Act], or otherwise renders an award of such medical benefits improper or unlawful." D&O at 2. Claimant and Employer-Carrier each responded, and the Director, Office of Workers' Compensation Programs (the Director), declined to respond.

In his decision dated September 15, 2020, the ALJ found because marijuana remains a controlled substance under federal law, it cannot constitute reasonable and necessary medical treatment under the federal Longshore Act. He therefore denied Claimant's request "for a finding that medical cannabis treatment is covered" under Section 7 of the Longshore Act.

On appeal, Claimant challenges the ALJ's denial of his request for reimbursement for the cost of medical marijuana. He asks the Benefits Review Board to remand the case to the ALJ for a formal hearing on the matter. Employer and the Director have each filed responses, urging affirmance of the ALJ's decision.

Claimant asserts the CSA and the Longshore Act "may be rendered compatible and not contradictory to adjudicate" his reimbursement claim, "as the medical marijuana items' reimbursement does not entail preemptively CSA criminal exposure." Claimant's Brief (Cl. Br.) at 7 (unpaginated). He states the CSA and Longshore Act may be compatible because Puerto Rico's laws, unlike those of the federal government, recognize that registered patients with a certified physician's prescription, like him, may buy "cannabis" products for personal use at approved dispensaries. *See generally* Puerto Rico Law 42-2017, Regulation 9038 (2017). He cites case law, from states with similar legalization provisions, which favors reimbursement of expenses for medical marijuana under state workers' compensation schemes despite the CSA Schedule I marijuana classification and the Supremacy Clause of the United States Constitution. He further contends "a harmonious interpretative approach" between Puerto Rico's law, the CSA, and the Longshore Act means the CSA's classification of marijuana is not preemptive of reimbursement, but instead may be considered as part of the "reasonableness" analysis required by Section 7 of the Longshore Act.

Employer contends the federal government's classification of marijuana in the CSA as a Schedule I substance preempts Puerto Rico's state law allowing for the prescription of medical marijuana. It maintains that as long as marijuana remains illegal under the CSA, marijuana-based treatments cannot be "reasonable and necessary" for any medical condition under the Longshore Act. Employer asserts state law is not persuasive legal authority because this case involves interpretations of federal, rather than state, statutes, and, regardless, there are also many contrary state workers' compensation decisions.

Because Congress has decided marijuana has "no currently accepted medical use," 21 U.S.C. §812(b)(1), the Director similarly avers it cannot be considered "reasonable and necessary" treatment for an injury covered by the Longshore Act. He maintains the CSA and the Longshore Act are both federal laws, and to the extent the CSA and the Puerto Rico Controlled Substance Act (PRCSA) conflict with one another, federal law prevails by virtue of the Supremacy Clause. Art. VI, cl. 2. He further contends the state cases have no persuasive value in this claim arising under federal law, and even if they did, they involve different core issues and are distinguishable.

Under Section 7 of the Longshore Act, an employer is liable for reasonable and necessary medical expenses related to a claimant's work injury. 33 U.S.C. §907(a); *Ingalls Shipbuilding, Inc. v. Director, OWCP, [Baker]*, 991 F.2d 163, 27 BRBS 14(CRT) (5th Cir. 1993); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184 (1988). A claimant must request authorization before receiving medical treatment to recover medical expenses. 33 U.S.C. §907(d); *Pozos v. Army & Air Force Exchange Service*, 31 BRBS 173 (1997). For a medical expense to be covered, it must be reasonable and necessary for treatment of the work-related injury. *See* 20 C.F.R. §702.402; *Davison v. Bender Shipbuilding & Repair Co., Inc.*, 30 BRBS 45. A claimant can establish a prima facie case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *See Romeike v. Kaiser Shipyards*, 22 BRBS 57 (1989). Section 702.401(a) provides medical treatment which is recognized as appropriate by the medical profession is covered. 20 C.F.R. §702.401(a); *R.C. [Carter] v. Caleb Brett, LLC*, 43 BRBS 75 (2009).

The CSA, 21 U.S.C. §801 *et seq.*, "places all substances which were in some manner regulated under existing federal law into one of five schedules."[2] The CSA describes the different schedules based on three factors: 1) Potential for abuse; 2) Accepted medical use in the U.S.; and 3) Safety and potential for addiction. 21 U.S.C. §812(b). In this regard, the CSA generally creates a "closed regulatory system" making it illegal "to manufacture, distribute, dispense, or possess any controlled substance except [as] authorized by the CSA." *Gonzales v. Raich*, 545 U.S. 1, 12 (2005); *see* 21 U.S.C. §§841, 844. Marijuana is classified as a Schedule I controlled substance so, under federal law, it "has no currently accepted medical use in treatment in the United States." *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 491 (2001) (holding there is no medical need defense for the manufacture and distribution of Schedule 1 controlled substances) (quoting 21 U.S.C. §812(b)(1)(B)); *see* 21 U.S.C. §812(c).

[2] https://www.dea.gov/drug-information/csa

Despite its federal classification, individual states, starting with California in 1996, *see* Proposition 215, Medical Marijuana Initiative (1996), began permitting the use of medical marijuana. As of May 18, 2021, "[a] total of 36 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands have approved comprehensive, publicly available medical marijuana/cannabis programs."[3] In 2015, Puerto Rico's governor signed an executive order to permit the use of medical marijuana. Executive Order 2015-10; Regulation 8766 (2016). In 2017, Puerto Rico classified "Cannabis" as a Schedule II drug, 24 L.P.R.A. §2623, under its PRCSA, 24 L.P.R.A. §2202. In reclassifying marijuana, Puerto Rico recognized, among other things, it "has a currently accepted medical use in the United States or a currently accepted medical use with severe restrictions." 24 L.P.R.A. §2202(b)(2)(B).

The question before the Board is whether the ALJ properly found marijuana is a controlled substance under federal law such that it cannot constitute "reasonable and necessary" medical treatment under Section 7 and is not compensable under the Longshore Act. Claimant's claim arises under a federal Act; thus, it was necessary for the ALJ to accept the CSA as binding federal law in discerning whether marijuana constitutes medical care "which is recognized as appropriate by the medical profession for the care and treatment of the injury." 20 C.F.R. §702.401(a). As the ALJ found, by virtue of the CSA's present classification of marijuana as a Schedule I substance, the federal government has explicitly recognized it has "no currently accepted medical use in treatment in the United States."[4] 21 U.S.C. §812(b)(1)(B).

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[3] https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx

[4] The "factors" determining placement of substances on the CSA Schedule involve whether the "medical profession" recognizes the appropriateness of the substance "for the care and treatment of the injury," 20 C.F.R. §702.401(a). *See* 21 U.S.C. §811(c)(2)-(6). Providing "information on the drug scheduling process," the Drug Enforcement Agency's (DEA) resource guide, "Drugs of Abuse" (Apr. 13, 2020) states:

> Although some states within the United States have allowed the use of marijuana for medicinal purpose, it is the U.S. Food and Drug Administration that has the federal authority to approve drugs for medicinal use in the U.S. To date, the FDA has not approved a marketing application for any marijuana product for any clinical indication. Consistent therewith, the FDA and DEA have concluded that *marijuana has no federally approved medical use for treatment in the U.S.* and thus it remains as a Schedule I controlled substance under federal law.

Drugs of Abuse/A DEA Resource Guide: 2020 Ed. at 90 (emphasis added).

It follows, as the ALJ found, marijuana is neither "reasonable" nor "necessary" treatment under Section 7 of the federal Longshore Act because it is not presently "recognized as appropriate" treatment by the federal government. The ALJ's application of the CSA categorization in addressing the compensability of medical marijuana under the Longshore Act in this case is rational. Consequently, we need not consider the applicability of the PRCSA classification of marijuana in resolving a federal question of law arising under a federal Act.[5]

The recent Congressional appropriations riders prohibiting federal interference with state legalization laws do not impact this inquiry. Originally enacted in 2014 and extended and reenacted in subsequent years, the riders prohibit the Department of Justice from using any of its funds to prevent "[s]tates from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113–235, §538 (2014). By their plain language, the riders forbid the use of DOJ funds to prosecute individuals acting in accordance with state law; they do not address the appropriateness of authorizing the use of marijuana as reasonable and necessary medical treatment under a federal act. *See generally Lewis v. American Gen. Media*, 355 P.3d 850 (N.M. Ct. App. 2015) (limiting discussion of reasonable necessity to sufficiency of the evidence and preemption discussion to enforcement).

The prospect of federal prosecution for marijuana crimes simply is not implicated by this case. The ALJ was not tasked with determining, nor did he consider, whether Employer's paying for medical marijuana would constitute a criminal act under the CSA. Rather, he looked at whether the CSA categorization of marijuana as a Class I substance prevents it from being considered a reasonable and necessary modality of care under the federal Longshore Act. For the purposes of administering federal law, there remains an unavoidable distinction between refraining from prosecuting people participating in state-authorized programs and requiring employers to pay for medical marijuana use under a federally administered program. The regulated behavior in this case is not a state system

[5] Even if the PRCSA were to apply, we would find it clearly preempted as conflicting with federal law. *See*, *e.g.*, *PLIVA, Inc. v. Mensing*, 564 U.S. 604, 617-18 (2011); *Commonwealth of Puerto Rico v. Franklin Cal. Tax-Free Trust*, 579 U.S. 115 (2016). Moreover, both the OALJ and Board are federal entities and as such, hold authority under the federal laws of the United States, which includes the CSA. While the federal government's enforcement of the CSA's prohibition of medical marijuana has been equivocal in recent years in states that have permitted the use of marijuana, it is up to Congress to change federal law with respect to marijuana's classification for the purposes of federal law -- and Congress has not done so.

that Congress has expressly exempted from federal prosecution in appropriations bills -- it is care administered under a federal act by a federal agency. And the riders plainly do not address, let alone alter, the CSA's characterization of marijuana as a Schedule I substance that, for the purposes *of federal law*, still -- whether reasonable or not -- plainly establishes it "has no currently accepted medical use in treatment in the United States."[6]

The ALJ reasonably looked exclusively to the CSA classification of marijuana in addressing the compensability of the treatment in this case arising under a federal workers' compensation program. Having correctly found marijuana remains a Schedule I controlled substance under federal law that "has no currently accepted medical use in treatment in the United States," the ALJ rationally found it cannot constitute reasonable and necessary medical treatment under Section 7(a) of the Longshore Act. We affirm the ALJ's denial of Claimant's request "for a finding that medical cannabis treatment is covered" under Section 7 of the Longshore Act as it is rational and in accordance with federal law as expressed in the CSA. 33 U.S.C. §907; 21 U.S.C. §812(b)(1)(B); *see James*, 700 F.3d at 397, 403-404.

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[6] Our affirmance of the ALJ's decision is based on plain language of binding federal law. 21 U.S.C. §812(b)(1)(B); 21 U.S.C. §812(c); *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 491 (2001). Neither the policy nor enforcement influences cited by the dissent are relevant to the determination of whether marijuana-based treatment is reasonable and necessary under a federal act. The categorical language that marijuana, as a Schedule I substance, has "no currently accepted medical use" ends the inquiry in the federal context regardless of any state cases, laws, or regulations that authorize marijuana for state medical purposes. From a practical standpoint, approving reimbursement for medical marijuana under state law would put in place inconsistent definitions as to whether it constitutes a reasonable and necessary medical treatment for different claimants depending on where they live. Such a patchwork outcome is untenable. The path to approving the use of medical marijuana under federal law is through further Congressional action. To that end, in July 2021, Senators Chuck Schumer, Cory Booker, and Ron Wyden released draft legislation entitled the Cannabis Administration and Opportunity Act which, among other things, would remove cannabis from the CSA. https://int.nyt.com/data/documenttools/the-cannabis-administration-and-opportunity-act/6ae57fc5bae6ada6/full.pdf. It remains in committee.

Accordingly, we affirm the ALJ's Decision and Order Denying Reimbursement for Requested Medical Treatment.

SO ORDERED.

JONATHAN ROLFE
Administrative Appeals Judge

MELISSA LIN JONES
Administrative Appeals Judge

BUZZARD, Administrative Appeals Judge, dissenting:

I respectfully dissent from the majority's decision to affirm the denial of Claimant's medical treatment. Federal law specifically allows states and territories to establish systems for physicians to recommend and patients to consume medical marijuana to treat medical conditions. The Board therefore has no basis to deem such medical treatment unreasonable or unnecessary under the Longshore Act as a matter of law.

Background

Puerto Rico is one of forty-two states and territories that have established highly regulated systems for the cultivation, production, distribution, and physician-recommended use of medical marijuana to treat patients suffering from a variety of serious health conditions[7] such as cancer, Parkinson's disease, epilepsy, chronic pain, and autism.[8]

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[7] These states and territories are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Guam, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Northern Mariana Islands, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, U.S. Virgin Islands, Utah, Vermont, Virginia, Washington, and West Virginia. *See* National Conference of State Legislators, *State Medical Cannabis Laws*, https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx (last visited May 3, 2022).

[8] *See*, *e.g.*, Pennsylvania Medical Marijuana Act, 35 P.S. §§10231.101-10231.2110.

See generally Puerto Rico Law 42-2017, Regulation 9038 (2017). Claimant, a resident of Puerto Rico, was recommended medical marijuana by Dr. Michael Soler, a licensed physician in Puerto Rico, to treat his severe chronic pain stemming from a permanent and totally disabling work injury he suffered in 1994. *See* Parties' Joint Motion Submitting Agreed Stipulated Facts, ¶¶1(a), 1(b), 1(f). Although Claimant had been prescribed other medications for his injuries since 1995, Dr. Soler first recommended medical marijuana in early 2018. *Id.* at ¶1(d); *see* Dr. Soler's March 23, 2019, Letter. Having observed Claimant "under close medical supervision," he stated Claimant "has steadily responded well and with no complications to edibles such as cookies infused with a specific dosage of medical [marijuana] for over one year." *See* Dr. Soler's March 23, 2019, Letter. Dr. Soler elaborated that medical marijuana "seems to be one of the only treatments that best works for [Claimant] at night time due to its absorption and dose doubling effect." *Id.*

Employer does not contest that it is liable for Claimant's medical treatment for his 1994 work injury, including medication for his chronic pain. *See* Parties' Joint Motion Submitting Agreed Stipulated Facts, ¶¶1(d), 1(e). Nor does it allege that Dr. Soler's recommending medical marijuana to treat Claimant's work-related chronic pain, and Claimant's consumption thereof, violates Puerto Rico law. *Id.*; *see* Employer's Brief at 2-3. The sole question before the Board is whether medical marijuana, lawfully recommended by a physician and lawfully consumed by a patient under State law, can ever constitute "reasonable and necessary" medical care under Section 7(a) of the Longshore Act, 33 U.S.C. §907(a), such that an employer may be liable for it.

The ALJ referred to this question as "deceptively simple," agreeing with Employer's argument that because the Controlled Substances Act (CSA), 21 U.S.C. §§801-971, categorizes marijuana as a Schedule I substance, it can never be a reasonable or necessary medical treatment under the Longshore Act. Decision and Order at 3. He elaborated:

> Medical professionals may disagree [on the therapeutic value of marijuana] but as long as it remains classified as a Schedule I controlled substance, marijuana has no accepted medical use under federal law and no accepted safety for use in medically supervised treatment. A drug that has no accepted medical use under federal law can never constitute reasonable and necessary medical treatment under the [Longshore Act]. In other words, if a drug has no accepted medical use under federal law, then a federal ALJ has no authority to compel an Employer or Carrier to pay costs associated with the use of that drug as part of a course of medical care and treatment under the

> [Longshore Act], even in those states that have authorized doctor-recommended use of marijuana.

Id.

As the ALJ's decision hinges solely on a question of law, the Board reviews it *de novo*. 33 U.S.C. §921(b)(3); *see generally Duck v. Fluid Crane & Constr. Co.*, 36 BRBS 120, 122 n.4 (2002); *Herrington v. Savannah Mach. & Shipyard Co.*, 17 BRBS 194, 196 (1985); *see also Island Creek Coal Co. v. Bryan*, 937 F.3d 738, 753 (6th Cir. 2019). For the following reasons, I would reverse his conclusion that medical marijuana, lawfully recommended and lawfully consumed under State law, is never a reasonable or necessary medical treatment payable by an employer under the Longshore Act.

At the outset, it must be noted that the CSA makes no reference to the Longshore Act, and the Longshore Act makes no reference to the CSA, medical marijuana, or any other specific medication. Instead, Section 7(a) of the Longshore Act requires employers to pay an injured employee's "medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the [employee's work] injury or the process of recovery may require." 33 U.S.C. 907(a). The statute's implementing regulations further define "medical care" in its broadest possible terms, as including several enumerated services, treatments, medicines, devices and "any other medical service or supply . . . which is recognized as appropriate by the medical profession for the care and treatment of the injury or disease." 20 C.F.R. §702.401.

The Board generally refers to these provisions as requiring an employer to pay all "reasonable and necessary" medical expenses. *See Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996). Although a claimant bears the burden of establishing that the treatment is reasonable and necessary, *id*., a qualified physician's opinion that a medical expense is necessary for treatment of a work-related injury, as was offered in this claim, establishes a *prima facie* case for compensable medical treatment. *J.R.* [*Rodriguez*] *v. Bollinger Shipyard, Inc.*, 42 BRBS 95, 98 (2008).

Employer points to no evidence undermining Claimant's *prima facie* case. Instead, it argues that the Board should hold that the definition of medical care under the Longshore Act is limited by the categorization of various substances under a separate federal law, the CSA. For the following reasons, Employer's argument must fail.

In 1970, Congress passed the CSA "to create a comprehensive drug enforcement regime." *Raich v. Gonzales*, 500 F.3d 850, 854 (9th Cir. 2007). It establishes five "schedules" of "controlled substances" based on "their potential for abuse, their accepted medical use in treatment, and the physical and psychological consequences of abuse of the

substance." 21 U.S.C. §§802(6), 812(b). Possession, distribution, manufacture, cultivation, sale, and transfer of controlled substances, and attempting or conspiring to do so, in violation of the law exposes individuals to significant criminal and civil penalties, asset forfeiture, and denial of federal benefits. *See*, *e.g.*, 21 U.S.C. §§841, 842, 843, 844, 844a, 853. Importantly, only the Department of Justice and in rare cases, local law enforcement officers, can enforce the CSA. 21 U.S.C. §§871(a), 878(a), 882(c).

Of relevance to this case, and the point on which Employer's argument hinges, the CSA categorizes marijuana alongside drugs such as heroin and lysergic acid diethylamide (LSD) as among the most harmful substances a person can consume. 21 U.S.C. §812, Schedule I(b)(10), (c)(9), (c)(10). Schedule I substances like these are defined as having "a high potential for abuse," "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use of the drug or other substance under medical supervision" – thus subjecting individuals who consume them, doctors who prescribe them, and pharmacists who dispense them to a variety of penalties under the CSA. 21 U.S.C. §812(b)(1).

Its lack of accepted medical use under the CSA explains why marijuana has, historically speaking, been unavailable by prescription, while other drugs, like opiates fentanyl, hydrocodone, and oxycodone, are available with a doctor's approval, despite their also having a high, and now well-documented, potential for abuse. 21 U.S.C. §812(b)(2), Schedule II(a), (b)(6); 21 U.S.C. §§829 (criteria for prescribing controlled substances under Schedules II, III, IV, and V), 844(a) (not unlawful to possess a controlled substance "pursuant to a valid prescription or order, from a practitioner, while acting in the course of his professional practice").

Viewed strictly through the lens of the CSA, Employer's argument is rather straightforward: because Congress concluded in 1970 that marijuana has no accepted medical use and cannot be safely consumed even under medical supervision, it similarly cannot constitute "appropriate" or "reasonable and necessary" medical care under the Longshore Act. The fundamental flaw in this analysis, however, is that the CSA is neither the only nor the most recent Congressional pronouncement on the matter.

In December 2014, Congress passed legislation, commonly referred to as an "appropriations rider," prohibiting the Department of Justice from using any of its funding "to prevent [thirty-three enumerated] States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of *medical marijuana*." Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113–235, §538 (2014) (emphasis added). The effect of this legislation is to prohibit the Department of Justice from enforcing the CSA against any individual or company – patients, doctors, producers, dispensers – lawfully participating in a State-regulated medical marijuana

system. *United States v. Bilodeau*, 24 F.4th 705, 713 (1st Cir. 2022) (Congress' limitation of the Department of Justice's funding prohibits the prosecution of persons whose conduct complies with State medical marijuana laws."); *United States v. McIntosh*, 833 F.3d 1163, 1176 (9th Cir. 2016) (The Department of Justice violates its funding limitation "by punishing individuals who are engaged in the conduct officially permitted by [State medical marijuana laws]."");[9] *see also Green Sol. Retail, Inc. v. United States*, 855 F.3d 1111, 1114 (10th Cir. 2017) ("Congress reinforced [the Department of Justice's decision to not prosecute individuals acting in accordance with State law] by defunding [its] prosecution of the exchange of medical marijuana where it is legal under state law."); *United States v. Trevino*, 7 F.4th 414, 422 (6th Cir. 2021), *cert. denied*, 142 S. Ct. 1161 (2022) (assuming without deciding that Congress' appropriations rider prohibits the Department of Justice from enforcing the CSA against persons complying with State medical marijuana laws).

By its very terms, this law conveys at least two critical developments in federal medical marijuana policy since passage of the CSA in 1970. First, in describing marijuana as "medical," Congress is acknowledging that marijuana can have an accepted medical purpose. *Bilodeau*, 24 F.4th at 712 ("[A]lthough neither the rider nor the CSA defines it, we assume that the term 'medical marijuana' means marijuana prescribed by a qualified medical care provider to treat a health condition."), *citing Medical,* Merriam-Webster Online Dictionary, http://www.merriam-webster.com/dictionary/medical (defining "medical" to mean "of, relating to, or concerned with physicians or the practice of medicine" or "requiring or devoted to medical treatment"). That the term "medical marijuana" was used to explain the specific controlled substance against which the Department of Justice cannot enforce the CSA simply confirms this straightforward interpretation. *McIntosh*, 833 F.3d 1163, 1175 (Fundamental canons of statutory construction dictate that the medical marijuana rider's "words be interpreted as taking their ordinary, contemporary, common meaning" and the law be read "with a view to its place

[9] The First and Ninth Circuits agree that the Department of Justice cannot enforce the CSA against individuals lawfully participating in State medical marijuana programs but disagree on the extent to which persons must comply with State law to be shielded from the CSA. The Ninth Circuit interprets the appropriations rider as requiring "strict compliance" while the First Circuit requires "less-than-strict compliance" so as not to "skew a potential participant's incentives against entering that market." *Bilodeau*, 24 F.4th at 714.

in the overall statutory scheme for marijuana regulation, namely the CSA and [State medical marijuana laws].").

Second, by prohibiting the Department of Justice from "preventing" States and territories from "implementing their own State [medical marijuana] laws," Congress is acknowledging States' authority to lawfully "authorize" the prescription of this specific substance as part of a patient's medical care, despite an otherwise broad prohibition on *any* use under the CSA, medical or recreational. *Bilodeau*, 24 F.4th at 713 (purpose of the appropriations rider is to "giv[e] practical effect to [State] medical marijuana laws"); *McIntosh*, 833 F.3d at 1176 (same, relying on three dictionary definitions for the "ordinary meaning" of the term "implement"). In the years since, Congress has continued to pass virtually identical legislation and regularly updates it to reflect a growing interest among States in making medical marijuana available as a lawful treatment option for their residents. Thus, what began as a prohibition on enforcing the CSA in thirty-three enumerated States now enables the lawful, regulated use of medical marijuana – and the distribution, possession, and cultivation necessary for such use – in fifty-two States and territories.[10] Consolidated Appropriations Act, 2022, Public L. No. 117-103, §531 (2022). Puerto Rico, whose laws are the subject of this appeal, was added to the list in 2015. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114–113, §542 (2015).

Thus, the question in this case is *not* whether Congress, with the passage of the CSA in 1970, prohibited use of marijuana for medical purposes. It did. The relevant question is whether Congress has since updated its legislative determination that the substance has "no currently accepted medical use in the United States." It has.[11]

In determining whether medical marijuana can be an "appropriate" treatment, and thus compensable under the Longshore Act, the Board is not free to "ignore the judgment

[10] The current list includes: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, as well as the District of Columbia, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Guam, and Puerto Rico.

[11] To be clear, Congress did not repeal the CSA's federal ban on medical marijuana. The appropriations rider made the ban unenforceable in States that have opted, under State law, to create regulated systems for its distribution and use. But the fact that medical

of Congress, deliberately expressed in legislation." *McIntosh*, 833 F.3d at 1172, *quoting U.S. v. Oakland Cannabis Buyers' Co-op.*, 532 U.S. 483, 497 (2001). "Congress, exercising its delegated powers, has decided the order of priorities in [this] area" by specifically enabling States and territories to establish systems for patients to lawfully use physician-recommended medical marijuana. *McIntosh*, 833 F.3d at 1172, *quoting Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 194 (1978). So long as this Congressional policy remains in effect, the Board is without basis to hold medical marijuana, lawfully recommended by a physician and lawfully consumed by a patient under a State or territory system, can never constitute appropriate medical care under the Longshore Act.[12]

Claimant, in turn, established a *prima facie* case for the compensability of his treatment under the Longshore Act with Dr. Soler's opinion that, after a year of close supervision, he "has steadily responded well and with no complications" to "cookies infused with a specific dosage of medical [marijuana]." *See* Dr. Soler's March 23, 2019, Letter. Regrettably, with today's decision, the Board unnecessarily denies Claimant "one

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marijuana remains illegal (albeit unenforceable) under the terms of the CSA does not change the fact that Congress now acknowledges marijuana can have a valid medical purpose and explicitly enables States and territories to authorize its use. Courts that cite the continued illegality of medical marijuana under the CSA have typically done so in the context of explaining why participating in a State's lawful medical marijuana system may have legal implications other than federal prosecution. This is particularly so when applying federal laws that, unlike the Longshore Act, have a specific statutory connection to the CSA itself. *See*, *e.g.*, *United States v. Nixon*, 839 F.3d 885, 887 (9th Cir. 2016) (appropriations rider did not prohibit district court's requirement that a convicted person refrain from medical marijuana use while on probation, because the judge "was statutorily required to prohibit use of federally controlled substances, including marijuana, as a condition of probation"); *Green Sol. Retail, Inc.*, 855 F.3d at 1114 (that federal prosecutors "will almost always overlook federal marijuana distribution crimes in Colorado" does not mean the "tax man" must turn a blind eye to the federal tax law that prohibits deductions "for trafficking in [Schedule I] controlled substances"), *quoting Feinberg v. C.I.R.*, 808 F.3d 813, 814 (10th Cir. 2015).

[12] While Congress could choose to appropriate funds to resume medical marijuana prosecutions at some point in the future, doing so would have broad ramifications given that dozens of States and territories now allow the use of medical marijuana and have established regulated systems for its cultivation, production, and distribution as part of a patient's medical care. Indeed, as explained above, Congress has continued to pass and expand the appropriations rider each year, with a growing number of States and territories electing to establish lawful medical marijuana systems as contemplated by the federal law.

of the only treatments that best works" to treat severe chronic pain from his decades-old work injury, *id*., despite Congress enabling States and territories to permit its use, and his territory, Puerto Rico, choosing to do so.

As the ALJ's and Board's decisions are inconsistent with the law, I dissent.

GREG J. BUZZARD
Administrative Appeals Judge