No. _____

In The
Supreme Court of the United States

PEGGY EDWARDS, *et al.*,

Petitioners,

v.

LOUISIANA WORKFORCE COMMISSION, *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The Louisiana Court Of Appeal For The First Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Under the Louisiana workers' compensation statute, workers injured on the job are entitled to appropriate employer-funded medical care, which is usually provided through an insurance carrier retained by the employer. If an insurance carrier does not pre-approve treatment requested or by the worker's medical provider, the worker's claim for payment is adjudicated by a state agency. Under the governing regulations, the insurance carrier in opposing a claim for payment may introduce any evidence it chooses to justify refusing to pay for the treatment at issue.

The question presented is:

> Does the Louisiana administrative system for adjudicating medical claims by injured workers violate due process
>
> > (1) by denying the claimant an opportunity, at the initial agency decision stage, to offer either evidence or argument in response to the carrier's evidence,
> >
> > (2) by requiring a claimant challenging an adverse initial agency decision to show by clear and convincing evidence that the decision was erroneous, and in many cases by forbidding the claimant to adduce responsive evidence at this stage as well.

PARTIES

The petitioners are Peggy Edwards, Darrell Cormier, Joan Savoy, Karin Frierson, John Faulknor, and Vanessa Arnold.*

The respondents are the Louisiana Workforce Commission, the Louisiana Office of Workers' Compensation, Christopher Rich, M.D., Wes Hataway, and Curt Eysink.

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* The plaintiffs below also included two attorneys who represent workers' compensation claimants (including Janice Herbert Barber), and three physicians who provide medical treatment to such claimants. The Court of Appeal held that under Louisiana law these plaintiffs did not have standing to maintain this action. App. 10a-11a. For that reason, they are not among the petitioners.

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Petitioners Peggy Edwards, *et al*., respectfully pray that this Court grant a writ of certiorari to review the judgment and opinion of the Louisiana Court of Appeal for the First Circuit, entered on October 19, 2018.

OPINIONS BELOW

The February 18, 2019 order of the Supreme Court of Louisiana denying review, which is reported at 264 So.3d 451, is set out at pp. 61a-62a of the Appendix. The October 19, 2018, opinion of the Louisiana Court of Appeal, which is reported at 266 So.3d 368, is set out at pp. 1a-48a of the Appendix. The March 30, 2017, Written Reasons for Judgment of the 19th Judicial District Court, which is not officially reported, is set out at pp. 49a-60a of the Appendix.

JURISDICTION

The order of the Supreme Court of Louisiana denying review was entered on February 18, 2019. On May 7, 2019, Justice Alito granted an application extending the time to file the petition to June 18, 2019.[1] This Court has jurisdiction pursuant to 28 U.S.C. § 1257(a).

[1] That order was granted sub nom. *Barber v. Louisiana Workforce Commission*, No. 18 A1146.

CONSTITUTIONAL PROVISION, STATUTE AND REGULATION INVOLVED

The constitutional provision, statute, and regulation involved are set out in the appendix.

INTRODUCTION

This case presents the due process issue which this Court expressly reserved in *American Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40 (1999). That case, as here, concerned injured workers who seek payment under a workers' compensation statute for medical benefits related to their job-related injuries. The workers in *Sullivan*, although challenging the constitutionality under the Due Process Clause of the state procedures for determining entitlement to payment, asserted only that they had a property interest in the payments themselves. This Court held that such plaintiffs did not have a property interest in the payments as such, because the plaintiffs had not yet established a legal right to them. 526 U.S. at 59–60. The Court expressly reserved the question of what process would be due if a worker asserted a property interest in the *claim* for payment, as opposed to in the payment itself. 526 U.S. at 61 n.13 (citing *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 430–31 (1982)).[2]

[2] "Respondents do not contend that they have a property interest in their claims for payment, as distinct from the payments themselves, such that the State, the argument goes, could not finally reject their claims without affording them appropriate

In *Sullivan*, under the state procedures in place when the action was commenced, workers asserting claims for medical reimbursement "were not permitted to submit materials" in support of such claims to the state decisionmaker. 526 U.S. at 46 n.3. The Third Circuit had held that this restriction violated the Due Process Clause, and the state then changed its procedure to permit workers to do so. *Sullivan v. Barnett*, 139 F.3d 158, 174–78 (3d Cir. 1998); 526 U.S. at 46 n.3. In separate opinions, Justice Stevens and Justice Ginsburg concluded that the original state procedure had denied workers due process. See 526 U.S. at 62 (Ginsburg, J., concurring in part and concurring in judgment) ("I do not doubt, however, that due process requires fair procedures for the adjudication of respondents' claims for workers' compensation benefits, including medical care") (citing *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428–31 (1982)), 62 n.* ("I agree with Justice Stevens that . . . Pennsylvania's original procedure was deficient"), 67 (Stevens, J., concurring in part and dissenting in part) ("the Court of Appeals correctly concluded that the original procedure was deficient because it did not give employees . . . an opportunity to provide relevant evidence and argument to the state actor vested with the initial decisional authority.").

The case presents the legal issue reserved in *Sullivan*. The plaintiffs here assert a property interest in

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procedural protections. Cf. *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 430–31 (1982). We therefore need not address this issue."

claims for payments for medical care under the state workers' compensation system,[3] and the court below correctly recognized that that property interest entitled them to due process in the resolution of such claims. App. 20a-21a. The plaintiffs contend that several features of the Louisiana system for adjudicating such claims deny them due process. The Louisiana administrative adjudicatory system at issue here limits the ability of workers' compensation claimants to offer evidence or argument in a manner more serious than the Pennsylvania system which the Third Circuit, and Justice Ginsburg, concluded in *Sullivan* was unconstitutional.

STATEMENT OF THE CASE

Legal Background

This case concerns the procedures established by Louisiana under its workers' compensation statute

[3] See App. 20a ("[i]n the instant case, plaintiffs asserted that they have a property interest in their claim for workers' compensation benefits, i.e., they have a property right in their claims ... ") (quoting *Logan* and citing n.13 in this Court's opinion in *Sullivan*); Complaint, ¶ 5 ("At all times relevant hereto, the Plaintiffs ... had property rights in their causes of action for workers compensation benefits, which property rights are protected by the Due Process Clause of the Fourteenth Amendment"), Memorandum in Support of Motion for Preliminary Injunction, 10 ("In a footnote [in *Sullivan*] the Court recognized that the Respondents had not asserted a property interest in 'claims for payment'.... That is precisely the argument made by plaintiffs here"); Original Brief on Behalf of Plaintiffs-Appellees, No. 2017-CA-0844, 9.

and regulations to adjudicate disputes regarding medical care for workers who have been injured on the job. Once there is a determination that an injury or illness was job-related, the employer's liability includes not only benefits for lost wages, but also payment for appropriate medical care. Most employers meet that obligation by purchasing insurance, although some are self-insured. For simplicity we refer to the entity paying for the medical care as the insurance carrier.

Under a statute enacted in 2011, injured workers[4] must usually obtain from the insurance carrier preauthorization of expenses for medical treatment (or costly diagnostic procedures).[5] If the carrier rejects a request, the injured worker can seek review of that rejection by state officials. Both the request for preauthorization, and any subsequent state review, are generally assessed in light of a Medical Treatment Schedule, authorized by the 2011 statute, and promulgated (with some subsequent modifications) in 2012. (The district court decision refers to this as the Medical Treatment Guidelines or "MTG"). The Schedule sets out the particular treatment or treatments that are authorized for specific medical conditions. Depending on the medical problem at issue, the Schedule might contemplate consideration of various types of tests or medical histories. "Each section of the medical treatment schedule contains specific recommendations for

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[4] Under the Louisiana system, the medical provider, not the claimant, must make the request.

[5] Pre-authorization is not required for treatment under $750, or for certain emergency treatment.

clinical evaluation, treatment and imaging/testing requirements." 40 La. Admin. Code Pt. I, § 2715(C)(2). The Schedule is complex, voluminous, and highly technical. The statute provides for a Medical Advisory Council to frame and update the Schedule, and specifies that experts from a variety of medical specialties be included. La. Rev. Stat. § 23:1203.1(F)(2). The central role in applying the Schedule is played by the Medical Director, who must be a physician, but who of necessity is not and could not be a specialist in most (or perhaps any) of the fields of medicine involved.

When a medical provider wishes to obtain authorization from the insurance carrier for a particular treatment, the provider must do so using a form provided by the state agency. The governing regulations specify what information the provider must provide with that form, including the worker's medical history, test results, physical findings, and improvements from prior treatment. 40 La. Admin. Code Pt. I, § 2715(C)(1). That information also includes the treatment plan recommended by the provider for which authorization is sought.

The Louisiana statute requires that the carrier notify the provider of its action on a request within five business days of receipt of the request. La. Rev. Stat. § 23:1203.1(J)(1). If the carrier denies the request, the claimant or provider has 15 calendar days to appeal to the Medical Director.[6] *Id.* Taking a somewhat different

[6] The appeal may also be heard by the associate medical director.

approach, the regulations provide that if the carrier fails to take any action for five business days, the carrier will be deemed to have denied the request, and the 15 days for appeal will begin to run automatically. 40 La. Admin. Code Pt. I, §§ 2715(E)(2)(a), 2715(H). That practice is referred to the decisions below as a "tacit denial." By simply failing to respond to an authorization request, and thus triggering the tacit denial provision, a carrier effectively avoids the requirement that an actual denial be accompanied by an explanation of the reasons for that denial. 40 La. Admin. Code Pt. I, §§ 2715(G)(1)(c), 2715(G)(3).

In reviewing a denial of a request for authorization, the Medical Director is limited to considering two types of information. The claimant (or provider) is required and authorized to submit only[7] the original request for authorization, and the information previously submitted to the carrier. 40 La. Admin. Code Pt. I, § 2715(J)(2)(b). The carrier, on the other hand, is free to provide the Medical Director with "any evidence it thinks pertinent to the decision regarding the request being denied." 40 La. Admin. Code Pt. I, § 2715(J)(5). In determining whether to approve or disapprove the requested treatment, the Medical Director is limited to considering the information originally submitted by the provider to the carrier, and "any medical evidence from the carrier." 40 La. Admin. Code Pt. I, § 2715(J)(5)(b). The effect of the limitation on what may be submitted

[7] The claimant or provider may provide additional evidence if, and only if, it is seeking a variance from the Schedule. 40 La. Admin. Code Pt. I, § 2715(J)(2)(d).

to or considered by the Medical Director is that the claimant may not respond in any way to the evidence submitted by the carrier, either by offering evidence of his or her own or by objecting to the carrier's evidence. For the claimant, the opportunity to be heard ends when his or her medical provider submits the request for authorization to the carrier, *before* the carrier indicates (usually by providing evidence to the Director opposing the claim) on what basis that request is being opposed.

The Director is required to decide two issues, "whether the request for authorization is medically necessary" and whether the request is "in accordance with the medical treatment schedule." *Id.* If either party disagrees with the decision of the Medical Director, it may file an administrative appeal. The appeal is heard by a workers' compensation judge,[8] who is required to hold a "hearing." 40 La. Admin. Code Pt. I, § 2715(K)(1). "Hearing" refers to a proceeding in which counsel for the parties may appear and offer oral argument. The agency interprets its regulation to bar either party from introducing any evidence at this hearing. R. 170, 453–54, 462–63. The workers' compensation judge may overturn the decision of the Medical Director only if the appellant shows "by clear and convincing evidence" that the decision was not in accordance with the statute. 40 La. Admin. Code Pt. I, § 2715(K)(1); La. Rev. Stat. § 23:1203.1(K).

Whether a claimant can offer evidence at the hearing before the workers' compensation judge has been

[8] That judge is sometimes referred to as an OWC (Office of Workers' Compensation) judge.

the subject of litigation independent of the instant case. Despite the agency's interpretation of its regulations, a decision in the First Circuit holds that claimants (and carriers) are allowed to adduce such evidence. *Thompson v. DHH-Office of Public Health*, 191 So.3d 593, 596 (La. Ct. App. 1st Cir. 2016). The relevant decision in the Second Circuit permits at least some such evidence, but it rests in part on a statute allowing parties in workers' compensation cases to call physicians as witnesses, and thus may not apply to testimony by claimants themselves. *Gilliam v. Brooks Heating & Air Conditioning*, 146 So.3d 734 (La. Ct. App. 2d Cir. 2014) (citing La. Rev. Stat. § 23:1124.1). In the Third Circuit, a workers' compensation judge may consider testimony or additional written statements by a physician where it would provide "expert testimony ... reasonably needed to assist [the judge] in the understanding of the ... M[edical] T[reatment] G[uidelines]," a rule which apparently would not apply to testimony by a claimant or to other physician testimony. *Spikes v. Louisiana Commerce & Trade Ass'n*, 161 So.3d 755, 761 (La. Ct. App. 3d Cir. 2014). Because there is no controlling appellate caselaw in the Fourth Circuit (which includes New Orleans), the agency's ban on testimony before a workers' compensation judge remains in full force. That would also be true in the Fifth Circuit, where the only tangentially relevant decision never discussed this legal issue.[9]

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[9] In *Wilson v. Broadmoor, LLC*, 169 So.3d 463 (La. Ct. App. 5th Cir. 2015), the claimant, in addition to introducing the records submitted to the Medical Director, may have offered some additional evidence before the workers' compensation judge. 169 So.3d at

Decisions by a workers' compensation judge are subject to review by a state Court of Appeal, but may be overturned only for manifest error or for clearly applying the wrong standard of review. *Gilliam v. Brooks Heating & Air Conditioning*, 146 So.3d 734, 743 (La. Ct. App. 2d Cir. 2014).

Proceedings Below

This action was commenced in 2013 in state court by six workers who had sustained on-the-job injuries, and whose medical conditions have required ongoing treatment, and are subject to the adjudicatory system. The plaintiffs asserted that their requests for treatment submitted by their medical provider had been denied by the relevant carrier, and that the Medical Director had refused to overturn those denials. The petition sought declaratory and injunctive relief on a variety of state and federal grounds. As relevant here, the petition asserted three claims under the Due Process Clause of the Fourteenth Amendment: (1) that injured workers could not present testimony or other evidence to the Medical Director, (2) that injured workers had no right to object to evidence submitted by the carrier to the Medical Director, and (3) that injured workers could not effectively challenge the Medical Director's decision under the clear and convincing evidence standard, especially if they had no right to submit evidence

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467. But the defendant did not appear at the hearing, and thus necessarily did not object. 169 So.3d at 465, and the court of appeal based its decision on "the evidence presented at trial [ ] which had been submitted to [the Medical Director]." *Id.* at 467.

to rebut the information or reasoning relied on by the Director.[10]

The case was ultimately tried in 2017. The plaintiffs again expressly asserted that the state's procedures violated the Due Process Clause.[11]

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[10] Petition for Declaratory and Injunctive Relief, pp. 5–6, R. 9-10:

> The new system ... for the administrative adjudication of injured workers' requests for medical treatment violates the due process clause of the Fourteenth Amendment.... These procedural due process violations include the following:
>
> > A. The injured worker's right to present evidence in support of his or his physician's request for medical treatment is greatly constricted and limited. There is no right to present testimony of either the injured worker, his treating physician or anybody else.
> >
> > B. There is no right to object to "evidence" submitted to the Medical Director by the employer or adjuster....
> >
> > * * *
>
> The right to appeal the Medical Director's decision only on a "cold record," which the injured worker has a very limited role in compiling, and subject to a "clear and convincing" evidence standard ... violates substantive due process.

[11] Plaintiffs' Proposed Findings of Fact and Conclusions of Law, R. 385-87:

> The Court concludes that the statute and regulations comprising the Medical Director review process and subsequent appeal to an OWCA administrative judge under a clear and convincing evidence standard violates the procedural Due Process clause[ ] of the Fourteenth Amendment....
>
> * * *

> There is no ... opportunity to be heard under the challenged system before the Medical Director denies the treating physician's recommendation for treatment of an injured worker....
>
> * * *
>
> The injured workers' right to appeal the Medical Director's determination to an OWCA judge is not a "meaningful" opportunity for a ... hearing. Such an appeal is confined to whatever administrative record the Medical Director chooses to provide; there is no opportunity to submit evidence to the OWCA judge; the OWCA judge cannot reserve ... a decision of the Medical Director unless the injured worker can somehow satisfy the unrealistic burden of showing by "clear and convincing evidence" that the Medical Director's decision is erroneous. The extremely limited opportunity to appeal does not satisfy the Fourteenth Amendment's requirements that the opportunity to be heard "must be granted at a meaningful time and in a meaningful manner," as required by.... *Mathews v. Eldridge*....

Plaintiffs' Proposed Findings of Fact and Conclusions of Law, R. 403-05:

> At the Medical Director level, injured workers have no opportunity to be heard, present evidence, [or] examine witnesses.... Their treating physicians are not allowed any opportunity to be heard by the Medical Director as to why the treatment he or she recommends is necessary or appropriate.
>
> * * *
>
> This court concludes that the present statutory and administrative system violates procedural due process for the following reasons:
>
> 1. There is no adequate procedural mechanism ... for the compilation of an administrative record....;
>
> 2. There is no adequate procedural mechanism for the injured worker ... to object to

The state district court concluded that "the statute and regulations comprising the Medical Director review process and subsequent appeal to the [workers' compensation] administrative judge under a clear and convincing standard violates the procedural Due Process clause[ ] of the Fourteenth Amendment...." App. 55a. The judge identified three distinct due process violations. First, at the Medical Director level, aside from the ability of the insurance carrier to "submit any information it desires for the Medical Director's consideration," "[t]here is no adequate procedural mechanism ... for the compilation of an administrative record." App. 54a. Second, "there is no adequate procedural mechanism for the injured worker to ... object to ... consideration [of the carrier's evidence] by the Medical Director before the Medical Director denies the treating physician's recommendation for treatment of an injured worker." *Id*. Third, "the injured workers' right to appeal the Medical Director's determination to [workers' compensation] judges is not a 'meaningful' opportunity for a post-deprivation hearing. Such an

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> ... consideration [of "evidence" submitted by the carrier] by the Medical Director;
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> 3. There is no right to a hearing at the Medical Director level;
>
> 4. There is no opportunity for the injured worker or his health care provider to be heard at the Medical Director level.
>
> There is a limited right to appeal to an OWC Judge.... A "clear and convincing" standard of review coupled with the fact that the appeal to the OWC Judge is limited to an on the record review exacerbates the due process problems in the Medical Director's review process.

appeal is confined to whatever administrative record the Medical Director chooses to provide; there is no opportunity to submit evidence to the [workers' compensation] judge; the [workers' compensation] judge cannot reverse or even modify a decision of the Medical Director unless the injured worker can somehow satisfy the unrealistic burden of showing by 'clear and convincing evidence' that the Medical Director's decision is erroneous." App. 56a.

On appeal, plaintiffs exhaustively briefed their due process claim. Original Brief on Behalf of Plaintiffs-Appellees, pp. 11–21 (section headed "The Medical Directory Adjudicatory System Does Not Provide Injured Workers with Due Process"). The court of appeal accurately summarized plaintiff three central due process claims:

> In seeking a permanent injunction of the foregoing statutory and regulatory provisions, plaintiffs asserted that these provisions are unconstitutional because they violate notions of procedural and substantive due process. In particular, plaintiffs asserted with regard to procedural due process that an injured worker is not provided an opportunity to be heard at any level, because: (1) there is no procedural mechanism for an injured worker to object to information or documents submitted by the employer or insurance carrier; (2) there is no opportunity at the medical director level for an injured worker to present evidence,

> examine witnesses, ... ; and (3) the appeal of a medical director's decision to the OWC judge is limited, as it is confined to the record and there is no right to call witnesses or submit evidence, making it impossible for an injured worker to meet his burden of establishing by "clear and convincing evidence" that the medical director's decision was not in accordance with the provisions of La. Rev. Stat. 23:1203.1.

App. 33a.

The court of appeal somewhat summarily rejected those federal constitutional claims:

> [W]e find that while the private interest affected by the statutory and regulatory provisions at issue is substantial, plaintiffs have failed to establish that the statutory and regulatory review system outlined above violates their right to procedural due process. As detailed above, the review process provides claimants with an opportunity to present their claim for review at multiple levels, including the right to a hearing before an OWC judge, where additional evidence may be submitted. Given the procedural protections afforded claimants, the risk of an erroneous deprivation is low. Therefore, we find that plaintiffs have failed to establish that the statutory and regulatory provisions detailing the process of appealing a denial of a request for authorization of treatment to the medical director and thereafter to [a workers' compensation]

> judge violates the procedural due process clauses of the federal and state constitutions.

App. 38a.

Plaintiffs submitted a timely petition for review to the Supreme Court of Louisiana. The petition again set out a detailed claim that the state's adjudicatory procedure violated the Due Process Clause. Application for Writ of Certiorari and/or Review, pp. 13–22 (section headed "The Court of Appeal's Decision is Erroneous in Its Holding that the Medical Director System Provides Sufficient Due Process to Injured Workers"). By a vote of 4-3, the narrowly divided state Supreme Court denied review. App. 61a-62a.

REASONS FOR GRANTING THE WRIT

The state of Louisiana has established, for the adjudication of medical treatment claims of injured workers, a system that violates in the most fundamental and unprecedented manner the due process rights of claimants. That system provides notice and opportunity to be heard, but in the wrong order; the only opportunity to be heard (by submitting materials to the insurance carrier) ends before the claimants learn on what basis their claims for treatment are being opposed by the carrier. The decision below, upholding that system, conflicts with decisions in the circuit courts of appeals, and in state courts of last resort, that have held unconstitutional far less egregious due process violations. The systemic violation at issue here affects 3,000

injured workers a year, who seek review of denials of medical care by insurance carriers.

I. THE DECISION OF THE COURT BELOW CONFLICTS WITH DECISIONS OF THE COURTS OF LAST RESORT OF SEVERAL STATES AND WITH DECISIONS OF SEVERAL COURTS OF APPEALS

The court below held that due process permits an adjudicatory process under which a claimant's ability to be heard—specifically, his or her ability to offer evidence—ends when a request for pre-approval of treatment is submitted, even though the claimant does not learn until later on what basis the insurance carrier is opposing payment for that treatment. That decision conflicts with decisions in several states and circuits that have held that the Due Process Clause is violated by substantially less serious limitations in the pre-opportunity-to-be-heard notice.

In *Royer v. State Dept. of Employment Security*, 118 N.H. 673 (1978), the state practice was to terminate an individual's unemployment compensation benefits based on an interview of the individual by a "certifying officer." The New Hampshire Supreme Court held that this violated due process; the interview constituted an opportunity to be heard, but the individual did not know until or even after the interview what issues were in question, and thus what information to provide. "[The] claimant receives no prior notice of any specific questions concerning claimant's continued entitlement

of benefits." 118 N.H. at 677. "The fundamental requisite of due process is the opportunity to be heard, and that opportunity is useless unless one is informed of the matter pending and the hearing is granted at a meaningful time and in a meaningful manner." *Id*. at 679. That constitutional problem was not solved by the availability of subsequent opportunities for the individual to provide information, because "[a]lthough [the agency] does afford the claimant a counter-interview and occasionally an interview with a certifying officer, claimants do not necessarily receive notice of a specific question that may have arisen concerning their continued receipt of benefits." *Id.*

In *Rojas v. Workforce Safety and Ins.*, 703 N.W.2d 299 (N.D. 2005), the North Dakota Supreme Court held that due process requires more than a notice that workers' compensation benefits might be terminated; a meaningful opportunity to be heard requires that the worker be given advance notice of the possible grounds on which benefits might be denied.

> [A] claimant's due process rights are violated if the [notice] does not adequately advise the claimant of the reason for the proposed termination and include a summary of the evidence relied upon.... Th[at] requirement ... is intended to provide the claimant with a meaningful opportunity to respond.... [A] claimant's due process rights are violated when he receives a notice that does not adequately set forth the [agency's] theories and evidence supporting termination because it

> deprives him of *the opportunity to meaningfully respond*....

703 N.W.2d at 303–04 (emphasis added); see *Stewart v. North Dakota Workers Compensation Bureau*, 599 N.W.2d 280, 284–85 (N.D. 1999) ("due process requires a summary of the evidence be provided to the [workers' compensation] claimant.... The ... procedure must include ... a summary of the evidence supporting the proposed termination, and a pretermination opportunity to respond in writing to the alleged grounds for termination. We have consistently reiterated that due process requires these ... protections, including a summary of the evidence."); *Beckler v. North Dakota Workers Compensation Bureau*, 418 N.W.2d 770, 775 (N.D. 1988) (due process violated because the state did not provide the worker with "a summary of the medical evidence supporting termination, and an opportunity to respond").

In *Auxier v. Woodward State Hospital-School*, 266 N.W.2d 139, 142–43 (Iowa 1976), the Iowa Supreme Court held due process requires that before termination of workers' compensation benefits, the worker must be told "the reason or reasons for the [proposed] termination" and given "the opportunity to submit any evidence or documents disputing or contradicting the reasons given for termination...." In *Mitchell v. State Workmen's Compensation Commissioner*, 163 W.Va. 107 (1979), the West Virginia Supreme Court concluded that due process requires that, prior to termination of workers' compensation benefits, the state must provide "[a] prior written notice to the claimant of the reason for the consideration of the termination

of his temporary total disability benefits [and] the claimant's right to furnish within a reasonable period relevant countervailing information...." 163 W.Va. at 120 (footnote omitted).

Gray Panthers v. Schweiker, 652 F.2d 146 (D.C. Cir. 1981), concerned the denial of claims for reimbursement of certain medical expenses under Medicare. Claimants were notified that their requests for reimbursement had been denied, and that they had a right to some review of that determination. The court of appeals concluded that the proffered opportunity for review was insufficient because the notice did not inform the claimant why the benefit at issue had been denied.

> [T]he notice accorded to the plaintiffs here ... does not give constitutionally adequate notice of why benefits are being denied.... [T]he reasons for claims denials given in the initial notice (can be) ... so unclear that it is virtually impossible for the average beneficiary to present a well-reasoned argument to the insurance company.... Unless a person is adequately informed of the reasons for denial of a legal interest, a hearing serves no purpose and resembles more a scene from Kafka than a constitutional process. Without notice of the specific reasons for denial, a claimant is reduced to guessing what evidence can or should be submitted in response and driven to responding to every possible argument

> against denial at the risk of missing the critical one altogether.

652 F.2d at 167–69. A subsequent panel decision, joined by then Judge Ginsburg, held that a new proposed form was still insufficient to satisfy due process. "The changes [in the form] ... do little to address the particular problems that this court identified in the old form. Specifically, the proposed form still fails to distinguish between unnecessary and unreasonable charges, or to explain the basis for a finding of unreasonableness." *Gray Panthers v. Schweiker*, 716 F.3d 23, 32 (D.C. Cir. 1983).

In *Mallette v. Arlington County Employees' Supplemental Retirement System*, 91 F.3d 630 (4th Cir. 1996), a claimant seeking long term disability benefits was notified that there would be a hearing, but only on the morning of the hearing was given an adverse report by the physician hired by the county. The Fourth Circuit held that it was not sufficient that, at the hearing, the claimant "had a chance to say anything she wanted to say." 91 F.3d at 641. Due process required that the claimant be told in advance of the basis on which the benefit might be denied; lacking that, she "did not receive notice 'reasonably calculated' to afford her a meaningful opportunity to present her side at the hearing." *Id.* "Mallette could not ... have prepared appropriate rebuttal evidence. The risk of an inaccurate and unfair deprivation mounts when decisionmaking is one-sided."

These state and federal decisions correctly conclude that due process requires that a claimant be given reasonable notice of the nature of the objections to his or her claim. A notice provided only after that opportunity to be heard has ended, the practice in this case, is no notice at all.

In *Sullivan v. Barnett*, *supra*, recognized the importance of permitting a claimant who does understand the issues to offer relevant evidence. The state workers' compensation system in that case permitted only claimants' medical provider, but not the claimants themselves, to provide information to the official determining whether to approve requested medical treatment of injured workers. The Third Circuit concluded (and Justice Ginsburg later agreed) that due process required that the claimants themselves, as well as their physicians, be provided an opportunity to be heard. "[W]e are hard-pressed to believe that the portrait of the employee's illness and treatment is complete without a statement or other input from the employee himself." 139 F.3d at 176. "[A]t a minimum the employee should be granted the opportunity to present additional evidence such as his/her testimony in writing as to the reasonableness and necessity of the disputed treatment, as this could significantly lessen the risk of erroneously depriving an employee of his/her medical benefits." 139 F.3d at 177. The Third Circuit decision that due process requires that claimants, not only their medical providers, be accorded an opportunity to provide evidence to a state's initial

decisionmaker is obviously inconsistent with the Louisiana decision upholding a system under which neither the claimant nor the medical provider is permitted to provide evidence to the Medical Director.

II. THE PALPABLE CONSTITUTIONAL ERROR OF THE COURT BELOW DENIES DUE PROCESS TO THOUSANDS OF INJURED WORKERS IN LOUISIANA

The claims of injured workers for reimbursement of medical expenses under the Louisiana workers' compensation statute are clearly a form of property protected by the Due Process Clause. "[A] cause of action is a species of property protected by the Fourteenth Amendment's Due Process Clause." *Logan v. Zimmerman Brush Co.*, 455 U.S. at 428 (citing *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950)). "The Court traditionally has held that the Due Process Clauses protect civil litigants who seek recourse in the courts, either as defendants hoping to protect their property or as plaintiffs attempting to redress grievances." 455 U.S. at 429. In this case, as in *Logan*, the "claimant has more than an abstract desire or interest in redressing his grievance: his right to redress is guaranteed by the State...." 455 U.S. at 431; see *Tulsa Professional Collection Services, Inc. v. Pope*, 485 U.S. 478, 485 (1988) ("Appellant's interest is an unsecured claim, a cause of action.... [S]uch an intangible interest is property protected by the Fourteenth Amendment."); *Richards v. Jefferson County, Alabama*, 517 U.S. 793, 804 (1996) ("[a] 'chose in action' ... [is] a property interest in

its own right"). The court below correctly recognized that injured workers have "a property interest in their claims for workers' compensation benefits for purposes of due process." App. 20a-21a.

As this Court has long reiterated, the fundamental requirement of due process is that an individual be accorded notice and an opportunity to be heard before a final deprivation of property. That principle has at times raised difficult questions about what form that opportunity must take (e.g., written submissions or oral testimony), and about the content and method of transmission of notice. But the principle at issue in this case is entirely clear, so obvious that it seems hitherto to have rarely if ever been questioned. The constitutionally required notice must be provided *before* the opportunity to be heard has ended.

If the opportunity to be heard is already closed, notice (no matter how detailed) is pointless; the individual is unable to act on the information in that notice, because the time for doing so expired before the notice was provided. An opportunity to be heard is useless if the individual does not (yet) know what issue or issues need to be addressed. The fundamental requirement of due process is the opportunity to be heard "at a meaningful time and in a meaningful manner." *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965). *Before* a claimant knows why a claim is being objected to is not a "meaningful time" to be heard. For due process purposes, providing notice only after the opportunity to be heard has ended is equivalent to the directive of

the Red Queen in *Alice in Wonderland*, "Sentence first—verdict afterwards."

Opportunity-to-be-heard first, notice afterwards, is precisely the system Louisiana has established for adjudicating the medical care claims of injured workers. At least with regard to the decision by the Medical Director, the only opportunity to be heard—to provide medical or other information or argument—occurs when a worker's medical provider submits to the insurance carrier a request for pre-authorization of the proposed treatment. At that point in time, neither the provider nor the worker can know whether the insurance carrier will deny the request, and if so on what basis.

If the insurance carrier denies the request, and the injured worker seeks review by the Medical Director, the carrier is authorized to provide the director with "any evidence it thinks pertinent to the decision regarding the request being denied." 40 La. Admin. Code Pt. I, § 2715(J)(5)(a). The insurance carrier is required to mail to the claimant a copy of that evidence, but no matter how expeditious the United States Postal Service may be, the letter will necessarily arrive after the point at which the claimant's medical provider has sent to the carrier the request for pre-authorization, and any supporting material, the only documentation that the claimant or provider is permitted to (later) give to the Medical Director.

A carrier which seeks to justify denying a request will usually adduce evidence intended to identify some

problem *not* solved by the material the provider has already submitted to the Medical Director. The carrier's evidence might, for example, assert there was some omission or error in the provider's information, or suggest that some other medical test should have been done. The regulatory scheme permits the carrier to consciously exploit the fact that the claimant is not permitted to provide the Medical Director with any response to the carrier's evidence. If the carrier's post-request submission to the Medical Director under § 2715(J)(5)(a) has a mistake of fact, or misconstrues the Medical Treatment Guidelines, if the carrier's medical analysis is unsound, or if some additional medical information would overcome the carrier's objections, the claimant has no way to provide that information to the Medical Director. And the carrier knows it.

Mathews v. Eldridge, 424 U.S. 319 (1976), considers three factors in assessing whether a government procedure for adjudicating a claim satisfies due process: the private interest affected by the action, the government's interest in the procedure, and the risk of an erroneous deprivation of the property in question. In this instance, the answer is indisputable.

Claimants seeking payment for job-related medical treatment have a compelling interest in the disposition of that request. The issue in this case is not, as in *Logan* or *Tulsa Collection*, simply money, but the health of the claimant. "[E]mployees' private interest in receiving ... medical benefits is a weighty and significant factor...." *Sullivan v. Barnett*, 139 F.3d at 175; see *id.* at 174 (loss of medical benefits resulted in

"longer periods of disability, unnecessary pain, and functional restriction"). If a request for treatment is rejected, the injured worker usually lacks the funds to pay himself for the medical care that the provider has concluded is a medical necessity. The injury itself will often have limited the victim's ability to work, and the physical injuries that give rise to workers' compensation claims are most often suffered by employees in less well-paid jobs. As a result, the injured worker whose claim was denied will simply have to endure the physical pain or incapacity that the treatment in question could have cured. In some instances, the lack of treatment will cause the worker's physical condition to deteriorate, or the worker may have to resort to some alternative (and likely less expensive) treatment which is all that the insurance carrier will fund, even if that treatment carries a risk of causing further injury.

It is difficult to imagine a significant government interest in hearing only one side of a dispute regarding that or any other claim. The court of appeal recounted that the state had an interest in "ensur[ing] health care services are delivered to injured workers in an efficient and timely manner while maintaining the welfare of the workers' compensation industry." App. 35a. The welfare of the state's workers' compensation industry would, in a sense, be enhanced if meritorious claims were rejected because of a one-sided adjudication process, but that assuredly is not the type of interest which *Mathews* had in mind.

As the Fourth Circuit correctly observed in *Mallette*, this sort of one-sided decision making creates a risk of error. 91 F.3d at 641. "No better instrument has been devised for arriving at truth than to give a person in jeopardy of serious loss notice of the case against him and opportunity to meet it." *Joint Anti-Facist Refugee Comm. v. McGrath*, 341 U.S. 123, 171–72 (1951). In *Sullivan v. Barnett*, the Third Circuit recognized that "the risk of erroneous deprivation is significant" if claimants seeking workers' compensation medical benefits are not permitted to provide to the decisionmaker at least written statements in support of their claims. 139 F.3d at 176. That risk of error is obviously greater if both the claimants and their medical providers are not permitted to do so. Everyone who has had to argue with an insurance company about a medical bill understands full well that insurers can be aggressive in seeking to avoid payments, and, at the least, can make expensive (to the insured) mistakes. The Louisiana system expressly and systematically denies the Medical Director information, made particularly relevant by the carrier's evidence, that is known to the claimant or his or her medical provider.

Mathews concluded that the medical nature of the dispute in that case was relevant to whether a quasi-judicial evidentiary hearing was needed to minimize error. But the Court rejected a due process challenge in *Mathews* only because the agency procedures actually gave the claimant repeated opportunities to respond in writing to the possible grounds for denying benefits.

> A further safeguard against mistake is the policy of allowing the disability recipient's representative full access to all information relied upon by the state agency. In addition, ... the agency informs the recipient of its tentative assessment, the reasons therefor, and provides a summary of the evidence that it considers most relevant. Opportunity is then afforded the recipient to submit additional evidence or arguments, enabling him to challenge directly the accuracy of information in his file as well as the correctness of the agency's tentative conclusions. These procedures, again as contrasted with those before the Court in *Goldberg* [*v. Kelly*, 397 U.S. 254 (1970)] enable the recipient to "mold" his argument to respond to the precise issues which the decisionmaker regards as crucial.

424 U.S. at 345–46. The Louisiana process for adjudicating claims for medical care lacks all of those safeguards.

The court of appeal's somewhat cursory assessment of this issue suggested that due process was satisfied because claimant had "an opportunity to present their claim for review at multiple levels." App. 35a. The mere fact that a claimant could "present [his or her] claim for review" to the Medical Director is palpably insufficient to satisfy due process, because claimants lack any meaningful opportunity to be heard regarding the issues raised in the insurance carrier's evidence. A claimant may seek further review by appealing the decision of the Medical Director to a workers'

compensation judge. But the judge does not decide the issue de novo,[12] but must uphold the Medical Director's decision unless the claimant can establish by "clear and convincing evidence" that the Director erred. La. Rev. Stat. § 23:1201.3(K). That evidentiary standard is an avowedly demanding one; its very purpose is to insulate erroneous decisions from reversal when their unsoundness is not especially obvious.[13] The limited nature of the permitted review assures that, in a significant number of cases, errors at the Medical Director level occasioned by the one-sided rule regarding evidence will go uncorrected.

In addition, in many instances claimants, at the hearing before the workers' compensation judge, are not permitted to offer evidence in response to evidence provided by the carrier to the Medical Director or to the reasoning of the Director. See pp. 8-9 *supra*. Obviously, it would be extremely difficult for a claimant to adduce clear and convincing evidence that the Medical Director erred if the claimant cannot adduce any evidence at all, other than what the medical provider gave

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[12] In *Sullivan*, the decision of the agency in question was subject to de novo review. 139 F.3d at 165.

[13] *Gilliam v. Brooks Heating & Air Conditioning*, 146 So.3d 734, 744 (La. Ct. App. 2d Cir. 2014) ("The 'clear and convincing' standard in a workers' compensation case is an intermediate standard falling somewhere between the ordinary preponderance of the evidence civil standard and the beyond a reasonable doubt criminal standard.... To prove a matter by 'clear and convincing evidence' means to demonstrate that the existence of the disputed fact is highly probable or much more probable than its nonexistence.").

to the insurance carrier before the claimant or provider knew what the carrier would object to. As one Louisiana appellate court noted, "limiting the claimant's evidence on appeal to the same evidence that was presented to the medical director ... may render [it] impossible for a claimant ... to meet the increased [clear and convincing evidence] burden of proof on the appeal [to the workers' compensation judge]." *Thompson v. DHH-Office of Public Health*, 191 So.3d 593, 597 (La. Ct. App. 1st Cir. 2016).

The unreliability of this procedure for adjudicating claims for medical benefits is starkly illustrated by two statistics. During the first four years of this system, the Medical Director approved only 21.9% of all requests for medical treatment. P. Ex. 6. At the time of trial, the Medical Director testified that she was then approving 70% of these requests for payment. App. 36a.

There is no possible benign account for this startling difference. Neither the regulations nor the Medical Treatment Schedule had been materially altered. Assuredly, the injured workers seeking medical care were not at the time of trial three times as sick as earlier claimants. The insurance carriers, whose decisions at one time where overwhelmingly upheld by the Medical Director, had not suddenly abandoned a prior practice of fairly evaluating treatment requests, and chosen instead to deliberately and systematically reject large numbers of meritorious requests for treatment. The hundreds of medical providers submitting requests for pre-payment to the carriers surely had

not, after years of failure, suddenly figured out on the eve of trial how to present those claims in a manner that, although groundlessly rejected by the carriers, would at last be persuasive to the Medical Director. Even the most credulous of baseball fans would know that something was wrong if a player's batting average jumped from .219 to .700.

What is demonstrated by this dramatic difference in the rate at which the Medical Directors have approved claims is that an adjudicatory system in which only one side can offer meaningful evidence and argument is a system in which the predilictions of the Director will often matter more than the merits of particular claims. If the individual who served as Medical Director at the time of trial was somehow getting the right result, then her predecessors must have improperly denied the claims of literally thousands of injured workers. If, in the first four years of the system, claims had been approved at the 70% rate, more than 4,000 unsuccessful claimants would have received the medical care they sought.[14] Unless the fundamental constitutional flaws in this system are corrected, the next Medical Director, uninhibited by the need to consider evidence or objections in response to the evidentiary submissions of insurance carriers, could revert to the earlier practice of approving only 22% of claims.

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[14] During this period the Medical Director received 8539 claims from individuals who had been denied treatment authorization by carriers. P. Ex. 6.

This palpable constitutional violation might not warrant review by this Court if it had occurred only in a single, isolated case. But the constitutional defect at issue here taints Louisiana's entire system for determining when and whether injured workers can obtain the medical care that state law mandates. Every year, approximately 3,000 injured workers, whose requests for authorization of medical treatment have been denied by insurance carriers, ask the Medical Director to review those adverse and painfully important decisions. It is intolerable that large numbers of working men and women who have suffered on-the-job accidents should continue to be denied the notice and opportunity to be heard that is accorded to all other litigants in the state and that is mandated by the Due Process Clause Fourteenth Amendment.

CONCLUSION

For the above reasons, a writ of certiorari should issue to review the judgment and opinion of the Louisiana Court of Appeal for the First Circuit.

Respectfully submitted,

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