If Due Process Is a Big Tent, Why Do Some Feel Excluded from the Big Top

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Litigation of federal black lung claims has been altered by the revisions to the regulations governing the adjudication of claims. The procedures and types of evidence that can be considered have been changed, causing the claims process to resemble a three-ring circus. Parties are now specifically constrained to offer limited affirmative evidence, rebuttal evidence, or reply evidence in the event the opponent's rebuttal evidence tends to undermine the conclusion of a physician whose medical report was offered in the affirmative or rebuttal case. Trying to control all of the action under the three-ring big top is due process.

At its core, due process guarantees a meaningful hearing after proper notice before personal liberties or property are taken, providing equity and fair play.

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3 Lane Hollow Coal Co. v. Dir., OWCP, 137 F.3d 799, 808 (4th Cir. 1998) ("'Due process' is a big tent. It covers not only the procedural fundamentals at issue here but also certain substantive personal liberties and basic rules of justice... However in their essential character, these fair-play rules do not resemble the core components of due process, i.e., notice and the right to a hearing appropriate to the proposed deprivation at a meaningful time and place; instead, they are simply rules (albeit fundamental ones) of criminal law and practice... If the defendant has had a fair day in court and heard a reliable verdict, he has received all that due process guarantees him.") (footnote and citations omitted).
After several years of proposals, comments, and rule making, the United States Department of Labor (the “Department” or “DOL”) published new regulatory criteria for the adjudication of federal black lung claims. With an avowed goal to “level the playing field,” the Department expressed a preference for a bright line test that allows adjudication officers to resolve issues of eligibility based on the quality of the medical evidence developed by the parties rather than merely the quantity of evidence that parties with superior financial resources may be able to submit. The Department continues to believe that adjudications under these revised regulations will result in fairer, more reliable evaluations of black lung claims than the former system permitted.

Currently, in establishing their eligibility to benefits, claimants must confront the vastly superior economic resources of their adversaries: coal mine operators and their insurance carriers. Often, these parties generate medical evidence in such volume that it overwhelms the evidence supporting entitlement that claimants can procure. The proposed changes limiting evidentiary development attempt to make more equitable the adjudication of black lung claims and reduce the costs associated with these cases.

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4 The regulations published in 2000 traveled a long path before being proposed. In 1997, the Secretary of Labor issued a notice of proposed revisions to the rules governing the adjudication of claims under the Black Lung Benefits Act (“BLBA”). See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed. Reg. 3,338-3,435 (Jan. 22, 1997). Interested parties had until March 24, 1997 to file comments and that deadline was twice extended, until August 21, 1997. The Secretary received approximately 200 comments and held two public hearings on proposed rules, one in Charleston, West Virginia and a second in Washington, D.C. The Secretary also consulted the National Institute for Occupational Safety and Health (“NIOSH”), the federal agency charged with researching occupational health. On October 8, 1999, the Secretary issued another notice, announcing revisions to certain proposed regulations. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 64 Fed. Reg. 54,966-55,072 (Oct. 8, 1999). Interested parties were given until January 6, 2000 to file comments. After receiving more comments and testimony and consulting NIOSH and other sources, the Secretary promulgated a final rule which was to go into effect on January 19, 2001. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920-80,107 (Dec. 20, 2000).

5 Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed. Reg. at 3,372. The major changes proposed are procedural ones intended to level the playing field between the individual claimant and the employer or insurer by placing limits upon the amount of evidence which each party can submit.

6 Id. at 3,338.


Operating from this premise, the Department promulgated limits on the amounts and types of evidence parties can offer in the adjudication of black lung claims, the Department then defined a complete pulmonary evaluation to include a physician’s report of physical examination and pertinent medical, occupational, and social histories, a ventilatory study, chest X-ray, and arterial blood gas study. Thus, a party’s affirmative case can be wholly consumed in two complete pulmonary evaluations. The regulations further broadened the regulatory definition of pneumoconiosis, which is recognized as a latent and progressive disease that may first become detectable only after the cessation of coal mine dust exposure. The regulations also changed the procedures for identifying coal mine operators responsible for potential payment of benefits. Despite these changes, some still claim that coal miners are systematically discouraged from filing or pursuing claims brought under the Black Lung Benefits Act.

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9 In 20 C.F.R. § 725.414 (2000), the Department proposed that a party’s affirmative case be limited to chest X-ray interpretations, the results of two pulmonary function studies, two arterial blood gas studies, and two medical reports. In rebuttal, each party will be able to submit one piece of evidence analyzing each piece of evidence submitted by the opposing side. The Department also provided the parties with the opportunity to rehabilitate the evidence submitted in connection with their affirmative case that had been the subject of rebuttal. The parties could submit hospital records and any other treatment records relating to the miner’s respiratory or pulmonary condition without regard to the evidentiary limitations elsewhere in § 725.414. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. at 79,990.

10 See id. at 80,046.

11 Id. at 79,991.

12 20 C.F.R. § 718.201 provides the following definitions:

(1) Clinical pneumoconiosis. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matters in the lungs and fibrotic reaction of the lung tissue to that deposition caused by coal dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, and anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal pneumoconiosis. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.


The main criticisms of the federal black lung expenditure system "are that the claims process takes too long and helps too few." In 1997, less than 6% (419 of 6791) of claims for black lung benefits were granted.

This article seeks to highlight why the regulatory changes are not only unfair, denying a full or meaningful hearing to the parties, but were also unnecessary, and in the final analysis are much ado about nothing. In spite of the changes to the definition of coal workers' pneumoconiosis, the incidence of the disease continues to fall. Regulatory changes that seek to "level the playing field" by limiting the amount of evidence parties may offer, are a failed attempt which actually bulldoze the playing field leaving mazes, sand traps, or trenches for the unwary to negotiate. The draconian limits on evidence, which serve to complicate what had been a relatively routine hearing process before administrative law judges ("ALJ"), will now compel ALJs to identify different types of affirmative or rebuttal evidence and to rule if "good cause," a term left undefined, is shown to exceed the bright line limits proposed.

If unrepresented coal miners or their survivors previously felt excluded from the tent where black lung cases are decided, the new regulations and the changes enacted will surely accentuate feelings of exclusion. Pro se litigants will not likely feel the playing field has been leveled, but instead may feel they are prohibited from even entering the pitch where the due process tent is raised.

17 Id. at 178.
18 See Shedlock v. Bethlehem Mines Corp., 9 Black Lung Rep. 1-236 (1987); North American Coal Co. v. Miller, 870 F.2d 948 (3d Cir. 1989). Hearings have not always been straightforward. The twenty day rule (20 C.F.R. § 725.456) provided a source of great confusion and conflict until the Benefits Review Board explained that when presented with surprise evidence a response was proper.
21 See id.
22 Id. "Good cause" is an easier standard to meet than "extraordinary circumstances." Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,990 (Dec. 20, 2000). The "good cause" standard has a stated purpose to accommodate the differing circumstances of individual cases and to ensure that all parties are given due process. See id.
Concerns of whether the playing field on which the big tent is raised is level will be superfluous if no one applies to enter the tent.

I. BRIEF BACKGROUND OF THE PROGRAM

To understand the impact of the revised regulations, one must first understand where the federal black lung program has been. The federal black lung program was asked to handle a large number of claims from coal mine workers that had developed a chronic lung disease arising out of coal mine employment. The Black Lung Benefits Act, a federal workers' compensation program, was conceived in response to political pressures to address the problems caused by coal dust exposure, growing medical understanding of the effects of long-term exposure to coal mine dust, and the mine disaster that occurred in Farmington, West Virginia. The Federal Coal Mine Health and Safety Act of 1969 born of the disaster and legislative rush to respond, provided an initial disability program that was flawed from its inception. While coal workers' pneumoconiosis was described to affect a high percentage of American coal miners, in 1969 10% of active and 20% of inactive coal miners showed X-ray evidence of pneumoconiosis. From these active and retired coal miners, over one-half million federal black lung claims were filed.

In the first phase of the black lung program, coal mine operators were excluded from participation. The Department of Health, Education and Welfare ("HEW"), through the Social Security Administration ("SSA"), was charged with adjudicating claims arising out of coal workers' pneumoconiosis.

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24 In addition to coal miners, survivors of miners were also entitled to file claims.
27 The Federal Coal Mine Health and Safety Act of 1969 is roughly divided between the provisions at 30 U.S.C. § 801 et. seq., which impose mandatory regulations to protect the health and safety of coal miners, and the BLBA, 30 U.S.C. § 901 et. seq., which provides disability benefits to those suffering from coal mine dust induced lung diseases.
28 Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 6 n.1 (1976). The Congressional finding was less precise, stating "Congress finds and declares that there are a significant number of coal miners living today who are totally disabled due to pneumoconiosis arising out of employment in one or more of the Nation's coal mines; that there are a number of survivors of coal miners whose deaths were due to this disease; and that few States provide benefits for death or disability due to this disease to coal miners or their surviving dependents." 30 U.S.C. § 901(a) (2003).
29 Usery, 428 U.S. at 8 n.7.
If claims were approved, benefits were paid out of monies appropriated from general revenues. If claims were approved, benefits were paid out of monies appropriated from general revenues. These claims became known as "Part B" claims. SSA established a system that awarded lifetime disability benefits to a miner, or their survivors, usually based on mere evidence of pneumoconiosis. Claims filed on or after January 1, 1973, were to be filed by a claimant under the applicable state workers' compensation law if that law was approved by the Secretary of Labor. If no state law existed in the state in which the miner was employed, the claim was to be filed with and processed by the Secretary of Labor and paid by the miner's coal mine employer pursuant to criteria established by the Secretary of Labor. If no coal mine employer could be identified due to insolvency, bankruptcy, or similar events, the Secretary of Labor was authorized to pay approved claims from federal funds. Claims filed on or after January 1, 1973 were to be adjudicated pursuant to procedures incorporated from the Longshoremen's and Harbor Workers' Compensation Act, a federally administered and employer-financed workers' compensation law for employees engaged in certain maritime trades. The employer-financed portion of the program was set to expire on December 30, 1976. That expectation failed as claims are still being litigated twenty-six years later.

The black lung program, in the guise of a disability program, was more legitimately viewed as an entitlement or pension program for miners with more than ten years of coal mine work. The BLBA was initially premised on the erroneous belief that only 50,000 coal miners, primarily consisting of individuals no longer employed in the coal industry, were totally disabled by coal workers' pneumoconiosis. Under the Part B claims, initially administered by HEW and

33 For example, 20 C.F.R. § 410.414 provided for a presumption of total disability due to coal workers' pneumoconiosis with evidence of 15 years of coal mine employment and evidence of pneumoconiosis or a totally disabling chronic respiratory or pulmonary impairment.
34 These claims are known as "Part C" claims. The January 1, 1973 filing date was eventually moved back to June 30, 1973. 30 U.S.C. § 931 (1976).
36 See id. § 934. These federal funds are known as the Black Lung Disability Trust Fund. 20 C.F.R. §§ 725.101(a)(8), 725.496-.497. It is an estimated $7.3 billion in debt. 2002 OWCP ANN. REP. TO CONGRESS FY 2001, at 16.
paid by the United States, 509,900 individuals had established eligibility of 556,200 claims filed.  

The initial criteria for determining if a miner was entitled to benefits bore no semblance to medical reality and did not rely on any competent system of assessment of pulmonary impairment. Coal workers' pneumoconiosis is an unusual disease process. While coal workers' pneumoconiosis can cause pulmonary impairment that is sometimes severe and disabling and can contribute to, if not cause, death, the radiographic evidence of coal workers' pneumoconiosis does not correlate well with the presence of pulmonary impairment. As chest X-rays do not provide an estimate of lung function, experience has shown that the correlation of chest X-ray findings with pulmonary function studies and blood gas studies is quite poor.

Simple pneumoconiosis, ordinarily identified by X-ray opacities of a limited extent, is generally regarded by physicians as seldom indicative of significant respiratory impairment. Simple coal workers' pneumoconiosis is a radiological or pathological diagnosis; there are no associated symptoms or signs. The most important clinical fact to remember about simple pneumoconiosis is that, if the patient is breathless, even in the presence of category 3 disease, another disease is responsible. In general, it can be stated that simple pneumoconiosis *per se* has no important effect on spirometric measures of lung function when prior dust exposure is taken into account.

In medico-legal practice, it may be necessary to give an opinion, on the balance of the probabilities, as to whether breathlessness and abnormal lung function in a patient has been caused by exposure to coal mine dust. There is abundant evidence that reductions in forced expiratory volume in one reading ("FEV₁") and forced vital capacity ("FVC") occur in relation to dust exposure and this deficit may on occasions be severe. However, most coal miners have smoked, and in such cases, the relative contributions of the two harmful substances are a matter for individual judgment, depending on the numbers of cigarettes smoked and an assessment of

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42 Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 8 n.7 (1976).


44 20 C.F.R. §§ 718.201(a)-1(a)(2) (2000). The legal definition of pneumoconiosis includes a chronic dust disease of the lung arising out of coal mine employment, recognized as "clinical pneumoconiosis," usually diagnosed by X-rays or histological tissue from autopsy or biopsy samples and "legal pneumoconiosis," including chronic obstructive pulmonary disease and industrial bronchitis.


likely cumulative exposure to dust underground.\textsuperscript{48} In most instances, evidence that the employer adhered to the national coal mine dust standards at the time of employment should constitute a reasonable defense.\textsuperscript{49} 

Coal workers' pneumoconiosis is broadly divided between progressive massive fibrosis\textsuperscript{50} and simple coal workers' pneumoconiosis.\textsuperscript{51} While other differences exist, the conditions are generally separated by the size of the lesions seen on chest X-rays or in histological samples. Initially, only those miners with progressive massive fibrosis, or complicated coal workers' pneumoconiosis, were to be compensated by the federal system.\textsuperscript{52} Compensation for simple pneumoconiosis (added by the conference committee) multiplied the potential liability in black lung claims and the number of potential applicants.\textsuperscript{53} The plan sought to phase out the federal system when state workers' compensation programs were approved to provide similar benefits. The hope proved unrealistic. Today, there has yet to be a state program that has been approved to replace the federal black lung program.

Revised criteria, known as the "interim presumption," were adopted in the 1978 amendments to the BLBA, permitting many thousands of denied claims to be reopened.\textsuperscript{54} The Department of Labor, now charged to run the black lung program, faced a huge backlog of claims. First, the interim presumption encouraged many individuals with marginal claims to seek benefits. Second, the backlog was compounded by the directive for Department of Labor to review those claims denied by Social Security Administration.\textsuperscript{55}

The new interim criteria only served to further extend the unrealistic medical criteria and the artificially elevated award rate. Reopened claims using the liberal interim medical criteria enjoyed a 46\% approval rate at Office of Workers' Compensation Programs.\textsuperscript{56} Miners with at least ten years of coal mine employment were presumed totally disabled due to pneumoconiosis if the benefits claimant had one of four types of evidence that showed either pneumoconio-

\textsuperscript{48} Id. at 391. 

\textsuperscript{49} Id. at 392. 

\textsuperscript{50} This is also referred to as complicated coal workers' pneumoconiosis. See Double B Mining Inc. v. Blankenship, 177 F.3d 240, 243 (4th Cir. 1999). 

\textsuperscript{51} For a more detailed discussion, see Lapp, supra note 46, at 729. See also Murchison, supra note 15, at 1045. 

\textsuperscript{52} See Murchison, supra note 15, at 1045. 

\textsuperscript{53} Perhaps this explains the ten-fold increase in Part B claims eventually awarded. See supra note 42 and accompanying text. 


\textsuperscript{55} 20 C.F.R. pt. 727. 

A benefits claimant with either chest X-ray evidence of pneumoconiosis, ventilatory studies showing abnormal results, arterial blood gas studies showing abnormal results, or a physician's opinion indicating that there existed a totally disabling pulmonary disease was entitled to the presumption of total disability due to pneumoconiosis. Once invoked, the burden of proof shifted to the party opposing entitlement, whether the Department of Labor or a coal mine operator, to prove that no disability existed, that the impairment did not arise out of coal mine employment, or that the claimant did not suffer from pneumoconiosis.

The illusion of entitlement was exacerbated by the interim criteria of Part 727. One method to establish the presumption of total disability due to pneumoconiosis was with ventilatory tests. Ventilatory function is dependent on several factors including height, race, gender, and age. The criteria contained at § 727.203(a)(2) failed to consider the effect of age on ventilatory function. Medical reality is that ventilatory function naturally declines with age as the lungs become less elastic. Failing to consider the aging effect afforded older applicants the presumption of total disability due to pneumoconiosis, premised on ventilatory function which may not have evidenced any pulmonary impairment much less a disabling ventilatory impairment.

After more than a decade of the flawed award system, casting the illusion of a retirement rather than a disability program, the permanent criteria went

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57 While the threshold to apply the interim presumption was not high, it was temporarily lowered in a decision from the United States Court of Appeals for the Fourth Circuit that allowed the presumption to be invoked with one piece of positive evidence. Stapleton v. Westmoreland Coal Co., 785 F.2d 424 (4th Cir. 1986) (en banc). The Supreme Court later reversed that determination in Mullins Coal Co. v. Director, OWCP, 484 U.S. 135 (1987), requiring all evidence to be analyzed before invoking the presumption under 20 C.F.R. §§ 727.203(a)(1)-(a)(4).


59 Id. §§ 727.203(b)(1)-(b)(4).

60 Id. §§ 727.203(a)(2).


62 20 C.F.R. § 727.203(a)(2) (regulation only considered the effect of height, limiting the changes to between 67 and 73 inches--lumping together any shorter than 67" with those 67" tall, and anyone taller than 73" included with those 73" tall).

63 For a male whose height is 180 cm (about 71 inches), the predicted values for FVC and FEV1 decline from 5.05 liters to 4.21 liters for FVC and from 4.60 liters to 3.27 liters for FEV1. R. J. Knudson, et al., The Maximal Expiratory Flow-Volume Curve: Normal Standards Variability, and Effect of Age, 113 AM. REV. RESPIRATORY DISEASE 587-600 (1976).

64 The Department of Labor's disability guidelines now reflect declines in both parameters, as FVC for a 70.9 inch tall male declines from 3.12 to 2.53 and the FEV1 declines from 2.68 to 1.99 from age 22 to age 70. 20 C.F.R. pt. 718, App. B.
into effect in 1982. These criteria, found at Part 718, were tied to realistic medical criteria and scientific results. The effect of age was considered in evaluating ventilatory function. The benefits claimant, as the proponent of the requested order to award benefits, shouldered the burden of proof to establish entitlement to benefits by a preponderance of the evidence. Predictably, award rates declined.

The decline in awarded claims was multi-factorial. Not only were claims harder to win because of the new medical criteria, but coal mine operators were defending an ever greater percentage of the claims filed. Whether for political considerations, attorney competence, or fiscal limitations, coal mine operators have been much more successful in defending claims before ALJs than the Department.

Another reason the number of awarded claims declined is that the dust standards put into place by the 1969 Federal Coal Mine Health and Safety Act were beginning to reduce the amount of dust, and, in turn, the frequency and severity of lung disease in coal miners. In a study of over 31,000 coal miners at 1,439 mines in twenty-three states conducted between October 1995 and September 2002, NIOSH found 862 cases of simple coal workers’ pneumoconiosis (2.85%) and sixty-two cases of progressive massive fibrosis (0.25%). The

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67 Congress required the Department of Labor, in conjunction with NIOSH, to develop permanent “criteria for all appropriate medical tests . . . which accurately reflect total disability in coal miners . . .” 30 U.S.C. § 402 (f)(1)(D). For Part 718 claims, the appendix includes qualifying tables for ventilatory function considering age, gender, and weight.
68 See Appendix B to 20 C.F.R. part 718 for ventilatory function tables.
69 See 20 C.F.R. §§ 718.201-.204 (1982).
70 The district level approval rate for claims filed after December 1981 was 5.0 percent as of the end of the 1994 fiscal year. Claimants fared little better if they pursued their applications beyond the district level by requesting hearings before the Office of Administrative Law Judges; the approval rate for such claims during the same period rose only to 7.6 percent. See 62 Fed. Reg. 3338 (Jan. 22, 1997).
71 Id.
72 NIOSH, U.S. DEP’T OF HEALTH & HUMAN SERV., CRITERIA FOR A RECOMMENDED STANDARD, OCCUPATIONAL EXPOSURE TO RESPIRABLE COAL MINE DUST 42 (1995) (results from successive cross-sectional surveys (or records) of these studies have shown general downward trends in the prevalence rates of simple coal workers’ pneumoconiosis among U.S. underground coal miners). Of the 1,206 miners with exposure after 1969, 18 of 1,206 had X-rays indicating simple coal workers’ pneumoconiosis category 1 and 3 had category 2 or greater. Id. at 46. At current exposure rates of 2mg/m³, estimates indicate that 7 of 1,000 workers will develop PMF and 65 of 1,000 will develop simple coal workers’ pneumoconiosis over a 40 year working lifetime. Id. at 57.
73 CTR. FOR DISEASE CONTROL, PNEUMOCONIOSIS PREVALENCE AMONG WORKING COAL MINERS EXAMINED IN FEDERAL CHEST RADIographs SURVEILLANCE PROGRAMS IN THE UNITED
social fabric of coal mining in the eastern United States had greatly changed. No longer were individuals working thirty, thirty-five, or forty years as coal miners. As a result of increased mechanization, the number of coal miners needed to achieve the same or even greater production per mine was reduced. Mining in anthracite or hard coal mines, where exposure was the most dangerous, had all but ended. Together with the change of focus in American coal mining shifting from eastern underground mines to western strip mines, the number of individuals at risk of developing coal workers' pneumoconiosis as a result of underground coal mining dropped precipitously during the 1970's and 80's. Finally, the mythical belief that cigarette smoking somehow helped a miner clear his lungs after working was finally dispelled, and with fewer smokers, coal miners were generally less prone to develop chronic obstructive lung disease due to cigarette smoking.

II. THE CHALLENGE TO THE REGULATIONS

The National Mining Association and other interested parties challenged the revisions to the regulations, seeking declaratory and injunctive relief in the United States District Court for the District of Columbia. The rules were challenged as: impermissibly retroactive; violating the BLBA or applicable provisions of the Longshore and Harbor Workers' Compensation Act; impermissibly shifting the burden of proof; running afoul of the rights to a full and fair hearing; arbitrary, capricious, and an abuse of discretion; and violating the due process guarantee of the Constitution because the rulemaking procedure was inadequate. The district court ultimately granted the Secretary of Labor's Motion for Summary Judgment, upholding the regulations in every respect. The district court upheld the regulations against various substantive challenges and also found the rules were not impermissibly retroactive because they applied to only newly filed claims or sought to clarify legal principles which were already in affect and did not change the substantive standards of entitlement.

75 Id. at 80,033.
76 Id. Low sulfur coal, found in the Power River Basin, is mined in large strip mines with labor productivity approximately three times as high as eastern underground coal mines. Id. at 80,034.
78 Nat'l Mining Ass'n v. Dep't of Labor, 292 F.3d 849, 855 (D.C. Cir. 2002) (per curiam).
79 Id. at 855.
80 See id.
tional Mining Association sought review before the United States Court of Appeals for the D.C. Circuit. The D.C. Circuit found it had jurisdiction to consider the claim as the district court had jurisdiction to consider the challenges to the regulations.\textsuperscript{81} The regulations were found to be not impermissibly retroactive,\textsuperscript{82} and the court rejected substantive challenges to the revised definition of pneumoconiosis,\textsuperscript{83} the change in condition rule,\textsuperscript{84} the treating physician rule,\textsuperscript{85} the hastening death rule,\textsuperscript{86} operator liability rules,\textsuperscript{87} the medical benefits rule,\textsuperscript{88} the total disability rule,\textsuperscript{89} evidence limitation rules,\textsuperscript{90} dependency rules,\textsuperscript{91} and the attorney fees rule.\textsuperscript{92} The circuit court found that the BLBA's expanded definition of benefits, which included any expenses related to the medical authorization, lacked specific statutory authorization necessary for the fee-shifting required and, therefore, was the one regulation which was invalid on its face.\textsuperscript{93}

\textsuperscript{81} Id. at 858-59.

\textsuperscript{82} As the D.C. Circuit explained:

The general legal principles governing retroactivity are relatively easy to state, although not as easy to apply. An agency may not promulgate retroactive rules absent express congressional authority. A provision operates retroactively when it "imparts rights a party possessed when he acted, increases a party's liability for past conduct, or imposes new duties with respect to transactions already completed." In the administrative context, a rule is retroactive if it takes away or impairs vested rights acquired under existing law or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.

See id. at 859 (citations omitted). Furthermore, changes to the treating physician rule and the definition of pneumoconiosis were found to codify judicial precedent and did not work a substantive change in the law. Id. at 861-62.

\textsuperscript{83} See Nat'l Mining Ass'n v. Dep't of Labor, 292 F.3d 849, 869 (D.C. Cir. 2002) (per curiam) (upholding 20 C.F.R. § 718.202 (2000)).

\textsuperscript{84} Id. at 870 (upholding 20 C.F.R. § 725.309 (2000)).

\textsuperscript{85} Id. (upholding 20 C.F.R. § 718.104(d) (2000)).

\textsuperscript{86} Id. at 871 (upholding 20 C.F.R. § 718.205(c)(5)).

\textsuperscript{87} Id. (upholding 20 C.F.R. §§ 725.407-725.408, 725.495 (2000)).

\textsuperscript{88} Id. at 873 (upholding 20 C.F.R. § 725.201(e) (2000)).

\textsuperscript{89} Id. (upholding 20 C.F.R. § 718.204 (2000)).

\textsuperscript{90} Id. at 874; 20 C.F.R. §§ 725.310(b), 725.414, 725.456, 725.457(d), and 725.458 (2000).

\textsuperscript{91} Id. (upholding 20 C.F.R. §§ 725.204, 725.213(c), 725.214, and 725.219(d) (2000)) (consideration was declined because NMA failed to raise it during the notice-and-comment period).

\textsuperscript{92} Id. at 875 (upholding 20 C.F.R. § 725.366(b) (2000)).

\textsuperscript{93} Nat'l Mining Ass'n v. Dep't of Labor, 292 F.3d 849, 875 (D.C. Cir. 2002).
The *en face* challenge to the regulation was unsuccessful. However, the application of the regulations to specific cases, or even an *en face* challenge, may produce different judgments in different circuits. Although the D.C. Circuit rejected the introduction of unlimited evidence, the regulations were found not to have inflexible limits on evidence. The revised rules did not set inflexible limits on evidence. The rules gave ALJs discretion to hear additional evidence for "good cause." The court re-emphasized the need that the evidentiary limitations allow, as a secretary explained, ALJs to focus their attention on the "quality of the medical evidence in the record."

### III. RESPONSIBLE OPERATOR IDENTIFICATION

The new regulations make substantial changes to the Department of Labor's policies and procedures for identifying and notifying coal mine operators' believed responsible for liability in a federal black lung claim. Previous regulations provided little guidance or mandatory deadlines for the identification of the responsible operator. These oversights led to prolonged, and probably needless, litigation on several occasions. While coal mine operators were required to respond within thirty days after receipt of the notification, the identification of the responsible operator would occur "at any time during the processing of the claim . . . after sufficient evidence has been made available to the deputy commissioner." While the District Director may initially identify one

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94 *Id.*  
95 *Id.* at 874.  
96 *Id.*  
97 *Id.* at 875.  
98 *Id.* at 874 (quoting Regulations Implementing Changes to the Federal Coal Mine Health and Safety Act of 1969, as amended, 64 Fed. Reg. 54,992, 54,994 (Oct. 8, 1999)).  
100 See *id.* §§ 725.412-.413 (1978).  
101 *See, e.g.*, Island Creek Coal Co. v. Holdman, 202 F.3d 873 (6th Cir. 2000) (twenty years to resolve a claim filed in 1980); Consolidation Coal Co. v. Borda, 171 F.3d 175 (4th Cir. 1999) (twenty-one years to resolve a claim filed in 1978); Lane Hollow Coal Co. v. Dir., OWCP, 137 F.3d 799 (4th Cir. 1998) (twenty-two years to resolve a claim filed in 1975); Venicassa v. Consolidation Coal Co., 137 F.3d 197 (3d Cir. 1998) (twelve years to resolve a claim filed in 1986). In *Venicassa*, the court noted:  

This case comes to us with a lengthy procedural history, due in large part to the long delay by the OWCP in processing Venicassa's claim and to the acknowledged error by the OWCP in designating the responsible coal mine operator. Unfortunately, the OWCP's failure to designate the proper responsible operator at the outset has exacerbated a problem all too familiar to us.  

90 *Id.* at 198 n.2.  
or more operators as potentially liable for the payment of benefits, under the revised regulations eventually one operator has to be selected before the claim is referred to the Office of Administrative Law Judges.\textsuperscript{103} Given the limitations on evidence,\textsuperscript{104} the identification of a single responsible operator was necessary to prevent multiple evaluations from being conducted by several potential responsible operators.\textsuperscript{105}

A coal mine operator is required to take two steps after receiving notification of its identification as the potential responsible operator. First, within thirty days of receipt of the operator notification, a response must be filed indicating the intent to accept or contest identification as the potentially liable operator.\textsuperscript{106} If the operator contests its identification, it must respond to five questions.\textsuperscript{107} The second step required the potentially responsible operator to submit documentary evidence in support of its position within ninety days of the date on which it receives the operator notification.\textsuperscript{108} Submission of any documentary evidence is mandatory.\textsuperscript{109} No documentary evidence relevant to the issue of the identification of the responsible operator may be admitted in any further proceedings unless it is submitted within the time limits set forth in the section.\textsuperscript{110} Any testimony with regard to the liability of a potentially responsible operator or designated responsible operator may not be offered unless the District Director is notified of the name and current address of any potential witness.\textsuperscript{111}

\textsuperscript{103} Id. § 725.410(a)(3) (2000) ("The schedule shall contain the district director's designation of a responsible operator liable for payment of benefits.").

\textsuperscript{104} See Id. § 725.414 (2000).

\textsuperscript{105} 20 C.F.R. § 725.414(a)(3)(i) permits "[t]he responsible operator designated pursuant to § 725.410" to "be entitled to obtain and submit" medical evidence.

\textsuperscript{106} Id. § 725.408(a)(1) (2000).

\textsuperscript{107} These questions are presented at 20 C.F.R. § 725.408(a)(2):

(i) That the named operator was an operator for any period after June 30, 1973;
(ii) That the operator employed the miner as a miner for a cumulative period of not less than one year;
(iii) That the miner was exposed to coal mine dust while working for the operator;
(iv) That the miner's employment with the operator included at least one working day after December 31, 1969; and
(v) That the operator is capable of assuming liability for the payment of benefits.

\textsuperscript{108} 20 C.F.R. § 725.408(b)(1). The Department has been agreeable to extend this deadline for good cause.

\textsuperscript{109} Id. § 725.408(b)(2).

\textsuperscript{110} Id. This section effectively forces parties to produce relevant documentary evidence or names of witnesses relevant to the responsible operator identification to allow OWCP to properly identify the operator responsible.

\textsuperscript{111} Id. § 725.414(c) (2000).
The Department conceded that the revisions placed additional burdens on coal mine operators not present under the prior regulations.\textsuperscript{112} It observed that under the previous regulations operators routinely filed "form" controversies and waited until the case was referred to the Office of Administrative Law Judges to develop their defenses.\textsuperscript{113} The announced intention to change such practice was in order to provide the District Director with sufficient information to allow him to identify the responsible operator.\textsuperscript{114} The regulations permit the District Director to refer a case to the Office of Administrative Law Judges ("OALJ") with no more than one operator as a party to the claim—the operator finally designated as the responsible operator.\textsuperscript{115} Once referred to OALJ, the consequences for any error in naming the responsible operator are placed on the District Director.\textsuperscript{116} If the District Director has not named the proper operator, the Department is barred from seeking revision by naming alternative operators and the case will have to be defended (and if awarded, paid) by the Black Lung Trust Fund.\textsuperscript{117}

Under the previous regulations it had become relatively clear that the burden of identifying what operator was responsible rested with the District Director.\textsuperscript{118} That has now been changed, dumping the initial responsibility on the operator identified by the Department from the miner's employment history.

\textsuperscript{112} Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,985 (Dec. 20, 2000). Interestingly enough, the revised regulations seem to eliminate the need for a responsible operator to respond to a denial of benefits, as the operator response provisions require only an operator's response to a finding of entitlement. 20 C.F.R. § 725.412 (2000). In revisions to the regulations concerning a proposed decision and order, the Department has eliminated the need for both claimants and operators to ask for a hearing, provided that such a request had already been made. See id. § 725.408 (2000).

\textsuperscript{113} Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. at 79,985. The Department first proposed limiting development of evidence (absent extraordinary circumstances) to submission to the Office of Workers' Compensation Programs. Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed. Reg. 3,338, 3,361-62 (Jan. 22, 1997). The Department eliminated the requirement that documentary evidence obtained while the claim is pending before OWCP and withheld until the claim is forwarded for a hearing could not be admitted unless extraordinary circumstances were found to exist. 20 C.F.R. § 725.456(d) (1983); Standards for Determining Coal Miner's Total Disability or Death Due to Pneumoconiosis; Claims for Benefits Under Part C of Title IV of the Federal Mine Safety and Health Act, as amended, 48 Fed. Reg. 24,272, 24,292 (May 31, 1983). Obviously, this change fails to streamline the decision making process and now works to reward those who hide potential evidence.


\textsuperscript{115} 20 C.F.R. § 725.407 (d) (2000).

\textsuperscript{116} Id.


\textsuperscript{118} See Director, OWCP v. Trace Fork Coal Co., 67 F.3d 503, 507 (4th Cir. 1995).
and after "an investigation" of the identity of the potentially responsible operator.119 Under the prior regulations, when the District Director erred in naming the responsible operator, miners or operators were able to convince various courts that due process was not satisfied and that the parties had not been given a meaningful hearing.120 Now when an error occurs, the operator is required to defend the claim.121

The regulations do alter the burden of proof by requiring the coal mine operator--not the benefits claimant as the party who has filed the claim seeking to have an award of benefits entered or the controlling administrative agency--to conduct discovery of an applicant's coal mine employment.122 Either through interrogatories or depositions of coal miners, the named operator is asked to determine if the employment history presented is correct and if the applicant's last coal mining employment actually occurred with the operator identified. Contrary to the comments, the changed regulation does interject additional complexity, burdens and expenses in cases involving multiple operators and puts unrepresented claimants in potentially perilous situations.123 The reality of defending operators under the new regulations is that depositions frequently must be taken of benefits claimants, or their survivors, to determine if the coal mine employment reported is correct, if the job duties were actually integral to the production and extraction of coal (meeting the definition of "miner"),124 whether their coal mine employment lasted for 125 working days or one calendar year125 with the named or other coal mine operator, and the potential loca-

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120 For some reason, it is typically the circuit courts of appeals that have addressed these grievances in the past. See Venicassa v. Consolidation Coal Co., 137 F.3d 197 (3d Cir. 1998); Lane Hollow Coal Co. v. Director, OWCP, 137 F.3d 799 (4th Cir. 1998). For a discussion of these cases, see William S. Mattingly, Black Lung Update: The Evolution of the Current Regulations and Proposed Revolution, 100 W.Va. L. Rev. 601, 627-30 (1998).

121 20 C.F.R. § 725.407(d).

122 The D.C. Circuit disagreed. Nat'l Mining Ass'n v. Dep't. of Labor, 292 F.3d 849, 871-72 (D.C. Cir. 2002). Believing the revised regulations shifted only the burden of production, not the burden of proof, which is prohibited under Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994), the new regulations were characterized as requiring nothing more than operators to submit evidence rebutting an assertion of liability. This holding may be changed when courts examine actual cases and not abstract possibilities, when asked to determine if the revisions are valid when applied.

123 The District Director denies any of these possibilities in the comments to the regulation. Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,985 (Dec. 20, 2000). In affirming the regulation the D.C. Circuit focused on the comments to 20 C.F.R. § 725.495(c), rather than the effect of the regulation. Nat'l Mining Ass'n, 292 F.3d at 872.


125 Id. § 725.101(a)(32).
tion of prior employers, or their corporate officers. The last inquiry is the most difficult and the crux of most of the responsible operator litigation. A prior operator is asked to determine if other coal mine operators still exist, or if assets are present. Even when more recent employment with coal mine operators can be identified and their corporate officers or corporate successors are identified, the Director has discretion whether to name the more recent operator, its successor, or the corporate officers, or opt to trace back in a miner's employment history and locate an operator that is compliant with the regulations, either insured or self-insured, and is able to defend the claim or to be responsible for payment of benefits should the claim be awarded.

Why a private coal mine operator rather than a government agency is in a better position to obtain employment history and to make a determination as to what operator should be responsible is unexplained. Such a procedure does provide administrative convenience of shifting at least the burden of production and more probably the burden of proof on the coal mine operator. The assertion that "clearly, however, operators and insurers are in a better position to ascertain these facts than is the Department of Labor" is nonsense.

The revised regulations again fail to address the conflict of government workers who labor for years in or around coal mines and are exposed to coal mine dust and yet identify a prior coal mine operator as the entity responsible for payment of black lung benefits. Under the doctrine of sovereign immunity, federal coal mine inspectors employed by the Mine Safety and Health Administration ("MSHA") are precluded from filing federal black lung claims against their federal employer.

The comments also seem to run counter to the D.C. Circuit’s reasoning for upholding the regulation. Nat'l Mining Ass'n v. Dep't. of Labor, 292 F.3d 849, 872 (D.C. Cir. 2002).

Consolidation Coal Co. v. Borda, 171 F.3d 175, 180 (4th Cir. 1999). Although employees can file Federal Employee Compensation Act claims, they are not under any requirement to exhaust remedies under this Act before seeking remedies under the Black Lung Benefits Act.

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126 Id. § 725.495(a)(1)-(a)(2) (2000).
127 Id. § 725.492 (2000).
129 The Department agrees that additional demands are placed on potentially liable operators, but that these are not "unreasonable." Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,985 (Dec. 20, 2000).
130 Id. The comments also seem to run counter to the D.C. Circuit’s reasoning for upholding the regulation. Nat'l Mining Ass'n v. Dep't. of Labor, 292 F.3d 849, 872 (D.C. Cir. 2002).
131 Consolidation Coal Co. v. Borda, 171 F.3d 175, 180 (4th Cir. 1999). Although employees can file Federal Employee Compensation Act claims, they are not under any requirement to exhaust remedies under this Act before seeking remedies under the Black Lung Benefits Act.
tem that foists liability upon former coal mine employers in spite of years of coal dust exposure while working for government agencies.

IV. TREATING PHYSICIAN

In a substantive change, it is now mandatory for the adjudication officer to give consideration to the relationship between a miner and any treating physician whose report is admitted as evidence.\(^\text{132}\)\(^\text{133}\) The treating physician relationship, according to the Department, may support a finding to accord "controlling weight" to the treating physician's opinion.\(^\text{133}\) The revision of the treating phy-

\(^{132}\) The D.C. Circuit found this rule neither retroactive, Nat'l Mining Ass'n, 292 F.3d at 861, nor mandatory because it does not relieve the benefits claimant of proving either pneumoconiosis or the credibility of the doctor's opinion. Id. at 870. The rule may not be used to automatically give controlling weight to a treating physician's opinion, for the court found the regulation to permit reliance on the treating physician's testimony only where the physician's opinion is credible and consistent with record evidence. Id. In practice, the rule may be applied differently and be invalid. Id.

\(^{133}\) The full text of 20 C.F.R. § 718.104(d) (2000) provides:

(d) **Treating physician.** In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

1. **Nature of relationship.** The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

2. **Duration of relationship.** The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

3. **Frequency of treatment.** The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

4. **Extent of treatment.** The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

5. In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the
physician regulation reveals a softening of the initial 1997 proposal by the Department of Labor. Originally, the "treating physician rule" began with the proposition that a "treating physician may be entitled to controlling weight" by the adjudication officer. When this rule was revised, the relationship between the treating physician and the benefits claimant became the mandatory focal point for the adjudicator's analysis. Nonetheless, only in "appropriate cases" may the relationship provide support for the decision to give greater weight to the treating physician's analysis. Even though "controlling weight" is given to the "treating physician," and both terms are left undefined, the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

The full text of the initial treating physician proposal 62 Fed. Reg. 3,375 provided:

(d) Treating physician. The medical opinion of a miner's treating physician may be entitled to controlling weight in determining whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis. The adjudication officer shall take into consideration the following factors in weighing the opinion of a treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) Whether controlling weight is given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.


Section 718.104(d) instructs that the adjudication officer "must give" consideration to the relationship between the miner and a treating physician.

What constitutes appropriate cases is left undefined.


"Controlling weight" and "treating physician"—both key components—are left undefined without any clear meaning.
treated physician must provide a reasoned and documented opinion before his conclusions can be accorded controlling weight. Status cannot cure deficiencies in testing and explanation that would be fatal flaws in reports from a non-treating physician. The adjudicator was cautioned to consider the treating physician's opinion on its own merits in the context of the remainder of the records to determine whether deference to the treating physician is appropriate. The "treating physician rule" as formulated fails to define what constitutes a treating physician. Whether such a treating relationship is established on one occasion or over a course of years goes unaddressed and will be left for practitioners and ALJs to iron out.

The revisions leave open the possibility, to the exclusion of other relevant evidence, that a treating physician's opinion may be given controlling weight when well reasoned. Thus, no longer may the preponderance of the evidence be needed to establish entitlement to benefits. The fear with such a rule is that instead of mandating production of all relevant evidence, a fact finder may now automatically defer to the treating physician's opinion based on the nature, duration, frequency, and extent of the physician's treatment. If quality of medical evidence is really one of the overriding reasons for the regulatory revisions, how a physician-patient relationship indicates "quality" medical evidence is both unexplained and illogical.

140 Id.
141 See id. § 718.202(a)(4) (requiring both sound medical judgment and reasoned medical opinion).
142 See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed. Reg. 3,338, 3,342 (proposed Jan. 22, 1997) (to be codified at 20 C.F.R. § 718.104(d)). Paragraph (d)(5) underscores the requirement that, status aside, the treating physician must provide a reasoned and documented opinion before his conclusions can be accorded controlling weight. Status cannot cure deficiencies in testing and explanation which would be fatal flaws in reports from a non-treating physician. Accordingly, this provision requires the adjudicator to consider the treating physician's opinion on its own merits and in the context of the remainder of the record to determine whether deference to the treating physician is appropriate. It is based on this understanding that the D.C. Circuit found the regulation valid. Nat'l Mining Ass'n v. Dep't. of Labor, 292 F.3d 849, 870-71 (D.C. Cir. 2002).
143 By regulatory fiat, the Department has tried to accomplish what it failed to do before the United States Supreme Court's decision in Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994). In Greenwich Collieries, the true doubt rule, which eventually shifts the burden of persuasion to the party opposing the benefits claim when evidence is evenly balanced, was held invalid. Advocates for claimants asked the Department to resurrect the rule, but the Department declined to implement a rule to resolve all reasonable doubt in favor of the benefits claimant. Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,926 (Dec. 20, 2000). Rather, the Department "has provided assistance to claimants in other ways" including, for example, the treating physician rule. Id.
144 30 U.S.C. § 923(b) requires consideration of all relevant evidence. To the extent it is not otherwise defined by ALJs or regulations, relevant evidence is "[e]vidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." FED. R. EVID. 401.
Frequency and extent of treatment are relevant factors in evaluating any physician’s assessment and diagnosis. Yet, both the Department and operators are arbitrarily limited in showing additional medical studies or evidence to examining physicians, risking the exclusion of part or perhaps the entirety of their opinions.\textsuperscript{145}

Some claim confusion has marred the black lung claims process and evaluation of the physician opinion evidence, particularly the weighing of the opinion of a miner’s treating physician against the opinions of other physicians of record.\textsuperscript{146} Some claim that in most cases the miner relies heavily on the probative strength of his treating physician’s diagnosis of disease, disability, and disability causation.\textsuperscript{147}

The role of the treating physician in the litigation of federal black lung claims is fraught with controversy and confusion. Some circuit courts indicate that the treating physician deserves special deference based on status.\textsuperscript{148} The treating physician has been described as knowing his patient as a human being rather than as a claim number, and as a doctor who develops opinions in an attempt to treat the patient rather than providing “an opinion for hire”.\textsuperscript{149}

\textsuperscript{145} See 20 C.F.R. § 725.457(d). Some may envision 20 C.F.R. § 725.457(d) as representing a “fruit of the poisonous tree” scenario for physicians that view “inadmissible” evidence as requiring exclusion of the opinion of a miner’s treating physician against the opinions of other physicians of record. This section provides: “A physician whose testimony is permitted under this section may testify as to any other medical evidence of record, but shall not be permitted to testify as to any medical evidence relevant to the miner’s condition that is not admissible.” \textit{Id}. The “fruit of the poisonous tree” doctrine deals with coerced confessions of an accused. See generally Gary D. Spivey, Annotation, “Fruit of the Poisonous Tree” Doctrine: Exclusionary Evidence Derived From Information Gained in Illegal Search, 43 A.L.R.3d 385 (2003). Evidence inappropriately obtained from an accused is to be excluded from the state’s case. See \textit{Mapp v. Ohio}, 367 U.S. 643 (1961). Different considerations are made when the testimony is not a putative defendant. See \textit{United States v. Ceccolini}, 435 U.S. 268 (1978). Such an exclusion of evidence, especially from an expert, runs counter to established practice in other areas. See \textit{Peabody Coal Co. v. Director, OWCP}, 165 F.3d 1126, 1128 (7th Cir. 1999).

\textsuperscript{146} \textit{Id}. After clerking for an ALJ and practicing in this area since 1985, it has been my experience that it is more infrequently the case that a treating physician’s opinion is not presented as evidence. The new regulation encourages a change in this long standing practice.

\textsuperscript{148} \textit{See Tussey v. Island Creek Coal Co.}, 982 F.2d 1036, 1042 (6th Cir. 1985) ("It is clearly established that opinions of treating physicians are entitled to greater weight than those of non-treating physicians."). No support was given for this "well established principle" but for two cases: one not involving a treating physician, \textit{Sexton v. Director, OWCP}, 752 F.2d 213, 215-16 (6th Cir. 1985), and the other an SSA disability claim, \textit{Collins v. Sec’y of HHS}, 734 F.2d 1177, 1179-80 (6th Cir. 1984). Neither case was precedent for the proposition suggested. In \textit{Lango v. Director, OWCP}, 104 F.3d 573, 577 (3d Cir. 1997), the Third Circuit suggested that the ALJ may permissibly require the treating physician to provide more than a conclusory statement before finding that pneumoconiosis contributed to the miner’s death. The new rule would require more than a conclusory statement.

\textsuperscript{149} Grizzle v. Pickands Mathur & Co., 994 F.2d 1093, 1101 (4th Cir. 1993) (Hall, J., dissenting).
The Sixth Circuit has helped to put an end to any uncertainty concerning the application of the treating physician rule. Despite a certain degree of lingering confusion among the courts of appeals, it has become overwhelmingly evident that the testimony of the "treating physician" receives no additional weight. Noting that the Supreme Court recently reversed a Ninth Circuit decision that afforded deference to treating physicians in the context of ERISA-related disability determinations, the Sixth Circuit observed that the unanimous Court "disapproved of the 'treating physician rule' with language that criticizes the principle itself rather than its operation in the ERISA context." The DOL's regulations were viewed as consistent with the Court's rejection of routine deference given to a treating physician, as the DOL intended the rule to force a careful and thorough assessment of the treating physician relationship. The rule seems clear as explained by the Sixth Circuit:

A simple principle is evident: in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade. For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

In the Sixth and Seventh Circuits, the status of a physician as the treating physician is irrelevant in determining the relative weight to be accorded to a medical opinion. There is no basis for preferring the opinion of a "treating physician" over a physician who evaluates a benefits claimant or reviews clinical testing and serial treatment records of a benefits claimant. The treating physician rule was first proposed by the Department of Labor in 1997. In the

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150 Eastover Mining Co. v. Williams, 338 F.3d 501 (6th Cir. 2003).
151 Id. at 509.
153 Eastover, 338 F.3d at 509.
154 Black & Decker Disability Plan, 538 U.S. at 832-33.
155 Eastover, 338 F.3d at 512.
156 Id. at 513 (citations omitted).
157 See id. at 509; Peabody Coal Co. v. McCandless, 255 F.3d 465 (7th Cir. 2001).
republished rule in 1999, DOL specifically requested the views of the medical community to aid in their crafting of the "treating physician rule."\textsuperscript{159}

Although the medical community did not support the rule, the drafters ignored their advice and counsel. The American College of Chest Physicians commented:

We agree that some opinions should be considered to carry more weight than others. Opinions that carry the most weight should be based on the competence of the physicians and the competence of the opinion that was written. Everything else (duration of the relationship between the doctor and the miner or the extent of treatment) is irrelevant. This is an important error in the proposed regulations which must be corrected in this amended version of the black lung regulations.\textsuperscript{160}

The occupational lung disorder committee of the American College of Occupation and Environmental Medicine also opposed the preference:

The treating physician, however, has an inherent conflict of interest in determining whether the coal mine or patient is totally disabled from pneumoconiosis due to coal mine dust exposure. By supporting their patient's claim for black lung benefits, the treating physician is helping to guarantee future reimbursement for medical services rendered by the treating physician for almost any type of pulmonary disorder in ensuing years based on the proposed amendments to the Black Lung Benefits Act. This represents a direct financial conflict of interests. The eligibility determination for black lung benefits should be done as an independent medical evaluation by physicians with extensive experience and training in occupational pulmonary disease. The treating physician's medical records and supportive documentation should be available for review by the independent medical examiners and taken under consideration in rendering their opinions. The treating physician's opinion can be counted as a pulmonary evaluation but should not be given equal and not controlling weight in determining whether a coal miner is totally disabled or died due to pneumoconiosis.\textsuperscript{161} In fact some data would suggest treating physicians might even use decep-


tion to assist patients in obtaining third party benefits, making a treating physician’s opinion inherently less reliable.\textsuperscript{162}

The purpose in assigning a treating physician extra or controlling weight presumes the treating physician will generally support the result that the coal miner desires, an award of benefits.\textsuperscript{163} The treating physician rule cannot become another method of creating a presumption of entitlement that was present under 727 cases or a thinly veiled attempt to rely on the discredited “true doubt” principle.\textsuperscript{164}

The preference for the relationship of a treating physician seems contrary to other portions of the regulations that specifically direct the adjudicator to look at the credentials of physicians offering opinions.\textsuperscript{165} Even if a board certified radiologist and NIOSH certified B-reader\textsuperscript{166} indicate that posterior-anterior chest X-rays or CT scans are negative for coal workers’ pneumoconiosis, the provisions of § 718.104(d) suggest the absurd proposition that a general medical practitioner’s diagnosis of coal workers’ pneumoconiosis--premised on seeing a miner frequently for several years and treating complaints of a pulmonary disease--may now be given controlling weight. This might occur even if the general medical practitioner believed there is X-ray evidence of coal workers’ pneumoconiosis, while the other evidence proved such a conclusion errant. There exists no rational basis for such a balancing of conflicting evidence. Surely, the quality of the evidence would not be taken into consideration in such a weighing based on status of the examiner. Such a fear may be unfounded, however, as the D.C. Circuit seems to only allow the regulation to pass muster if reliance on the treating physician is premised on a credible medical opinion consistent with record evidence.

The “treating physician rule” cannot be read to require controlling or determinative weight to be given a treating physician. Rather, the ALJ must consider enumerated factors when evaluating any physician’s opinion, irrespec-

\textsuperscript{162} See V. Freeman, et. al., Lying for Patients: Physician Deception of Third-Party Payers, 159 ARCHIVES OF ENVT. MED. 2263, 2263 (1999); K. Folley, Physician Advocacy and Doctor Deception, 48 FED. LAWYER 25, 25 (2001); Peabody Coal Co., 255 F.3d at 469 (noting that “[t]reating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views”).


\textsuperscript{165} See 20 C.F.R. § 718.202(a)(1) (“in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays”).

\textsuperscript{166} B-readers are physicians that have demonstrated proficiency in evaluating X-rays for pneumoconiosis and other diseases by passing a specially designed proficiency examination. See 20 C.F.R. § 718.202(a)(i)(ii)(E).
tive of whether that physician is labeled as the "treating" physician. When quality of the evidence is examined, ALJs have understood their task is to weigh the quality, not just the quantity of the evidence. In the end, the treating physician rule adds an additional hoop through which ALJs must pass but should not change the outcome of the case if quality of the opinion is the guiding consideration.

V. LIMITATIONS ON THE QUANTITY OF EVIDENCE

The Department has instituted bright line limitations on the quantity and types of documentary medical evidence that parties may submit in a federal black lung claim. In proposing this limitation, the Department acknowledged the concerns expressed by the U.S. Court of Appeals for the Sixth Circuit. The Department believed that the amount of allowable evidence needed to be limited. The Department’s cited reasons for the limitations included its assertion that the limitations represented a reasonable means of focusing the fact finder’s attention on the quality of the medical evidence in the record before him. The Department first proposed limiting development of evidence, absent extraordinary circumstances, to submission to the Office of Workers’ Compensation Programs. In this belief is the implicit assumption that ALJs were unable to control the size of the record or the nature of the evidence to be submitted. This impression, perched on anecdotal evidence, ignores the ALJ’s


168 See supra note 6 and accompanying text.

169 Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,989 (Dec. 20, 2000). In Woodward v. Director, OWCP, 991 F.2d 314, 321 n.2 (6th Cir. 1993), the Sixth Circuit, without any basis, noted that the superior financial resources of some parties allow the development of a greater quantity of evidence, which "skewed and directly undermined" the “truth seeking function of the administrative process.” Id. at 321.

170 Such a belief evidences displeasure from an inferior bureaucratic level with the results reached by the policy determinations of a superior level. Here an inferior level of the Department of Labor, primarily the Office of Workers’ Compensation Programs, sought to institute a two pronged attack to limit ALJs’ ability to consider evidence by: (1) preventing ALJs from receiving any evidence; and (2) trying to prevent changes in entitlement determinations when claims were referred to an ALJ.


173 In one case, a mine operator’s lawyer submitted eighty-nine separate X-ray readings from fourteen different experts. Nat’l Mining Ass’n. v. Dep’t of Labor, 292 F.3d 849, 874 (D.C. Cir. 2002). I was the mine operator’s lawyer who submitted those 89 X-rays. The experts, either radiologists or pulmonary specialists, read the available series of chest X-rays to respond to the claim.
power to exclude repetitive or cumulative evidence.\(^{174}\) The Administrative Procedure Act ("APA")\(^{175}\) grants ALJs broad discretion to exclude excessive evidence which lacks significant probative value, and by implication, to limit examinations, evaluations, and consultations by experts that are unduly repetitious and thus lacking in probative value.\(^{176}\)

A second purported reason for the limitations was to prevent a miner from undergoing more than five pulmonary evaluations for purposes of assessing entitlement to benefits.\(^{177}\) This could indeed be a reasonable reason to limit examinations. In light of the strenuous nature of pulmonary testing, including both pulmonary function and arterial blood gas tests, no claimant should have to undergo repeated evaluations simply to create a numerically superior evidentiary record for one side or the other. Instead, five evaluations should be sufficient in most cases to allow the fact-finder to assess the miner’s pulmonary condition. In the Department’s view, additional evaluations would have only marginal utility.\(^{178}\)

The Department acknowledges that due process requires a flexible procedure as the particular situation demands.\(^{179}\) Further, coal mine operators have a monetary interest in each claim involving an average payout of $175,000 for the lifetime of claimant.\(^{180}\) Claimants also have a financial interest in the bene-

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\(^{174}\) See Underwood v. Elkay Mining Co., 105 F.3d 946, 950 (4th Cir. 1997).


\(^{176}\) Underwood, 105 F.3d at 950.


\(^{178}\) See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 64 Fed. Reg. at 54,994. The Department’s own comments seem to speak with a forked tongue. It is the frequency, duration, and extent of a treating physician’s testing, see 20 C.F.R. § 718.104(d), which may cause controlling weight to be appropriately accorded to that medical opinion. Why an examining physician, who has reviewed studies of ventilation, blood gas transfer, diffusion, or radiological techniques that may be in excess of the limitations, and based on that review are afforded a better quality and understanding of a miner’s longitudinal medical presentation, must be excluded from consideration, see 20 C.F.R. §§ 724.414(a)(2)(i), 725.414(a)(3)(i), and 725.457, is wholly arbitrary, irrational, and conflicting with the premises underlying other portions of the regulatory revisions.


\(^{180}\) Id. Awards can be substantially greater if a spouse or disabled dependent child is involved
fits of an award and should be given the "opportunity to substantiate their claims without being overwhelmed by the superior economic resources of their adversaries." 181 The Department noted that as a general rule there was not "significant risk" 182 of erroneous deprivation of private interests if there are similar limitations on the quantity of evidence each party may develop. An additional safeguard was added to allow an ALJ to receive evidence in excess of limitations upon a showing of good cause. 183

Based on this rationale, the Department has limited a claimant or a responsible operator to two X-ray interpretations, two medical reports, two ventilatory studies, and two arterial blood gas studies. 184 Strangely enough, the Department opted to set no limitations on "other medical evidence." 185 According to the regulations, "other medical evidence" includes the "results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or the absence of pneumoconiosis, . . . [and] may be submitted in connection with a claim and shall be given appropriate consideration." 186 The party submitting the other medical tests bears the burden to demonstrate that the test or procedure is relevant to establishing or refuting a claimant's entitlement to benefits. 187 In addition to the

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182 Id. The significance of the risk is in the eye of the responsible party. The Department's final rule revising the Black Lung Regulations will increase premiums paid by coal mine industries to insure. The premium increase would result in additional annual costs to the industry ranging from $32,220,000 to $88,320,000 with a point estimate of $57,560,000. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 80,030, 80,045 (Dec. 20, 2000).

183 Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 64 Fed. Reg. 54,966, 54,994 (Oct. 8, 1999). Medical evidence in excess of the limitations contained in § 725.414 shall not be admitted. 20 C.F.R. § 725.456 (b)(1) (2000). A showing of "good cause" is necessary only in the event that a party seeks to convince the ALJ that the particular facts of the case justify the submission of additional medical evidence, either in the form of a documentary report or testimony. The Department believes that in the majority of cases, the quantity of medical evidence permitted by the regulations, even in the absence of a good cause showing, will provide a more than adequate evidentiary basis for an ALJ to determine the claimant's eligibility for benefits. 65 Fed. Reg. at 80,000.


185 Id. § 718.107 (2000).

186 Id.

187 Id. Thus, the re-readings of CT scans of the chest, lung volume studies, or carbon dioxide diffusion capacity studies are not included in the limitation on evidence. This again evidences the arbitrary formulation of the limitations, as these studies, frequently found in claims, can be useful in establishing or refuting a claimant's entitlement to benefits. The comments emphasize that § 718.107 evidence is to be received to permit any party to offer evidence relevant to resolving entitlement to benefits. See Regulations Implementing the Federal Coal Mine Health and Safety Regulation Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 64 Fed. Reg. 54,994 (Oct. 8, 1999). Medical evidence in excess of the limitations contained in § 725.414 shall not be admitted. 20 C.F.R. § 725.456 (b)(1) (2000). A showing of "good cause" is necessary only in the event that a party seeks to convince the ALJ that the particular facts of the case justify the submission of additional medical evidence, either in the form of a documentary report or testimony. The Department believes that in the majority of cases, the quantity of medical evidence permitted by the regulations, even in the absence of a good cause showing, will provide a more than adequate evidentiary basis for an ALJ to determine the claimant's eligibility for benefits. 65 Fed. Reg. at 80,000.
two medical reports offered by the claimant and the responsible operator, a fifth medical report, ventilatory study, X-ray interpretation, and pulmonary evaluation is included in every record as the Department is charged with administering a complete pulmonary evaluation to each coal miner.\footnote{188}{A complete pulmonary examination includes a report of physical examination, a pulmonary function study, a chest roentgenogram, and, unless medically contraindicated, a blood gas study. 20 C.F.R. § 725.406(a) (2000).}

While arguing that this would be an equal presentation of evidence, the coal mine operators are now playing on an uphill field with a two to three ratio in every case and possibly a treating physician's opinion. To those defending coal mine operators, the big tent of due process looks much smaller and less inviting. The miner selects the physician to perform the OWCP evaluation.\footnote{189}{The miner selects an approved physician from a list of all authorized physicians in the state of the miner's residence and all states contiguous to the state of the miner's residence. See id. Why the Department believed miners living in West Virginia needed to be able to travel as far west as Toledo, Ohio, as far east as Philadelphia, Pennsylvania, as far north as Erie, Pennsylvania, or as far south as Norfolk, Virginia to be evaluated is unknown.}

Claimants frequently select physicians they believe will be sympathetic to their interests.\footnote{190}{For example, many in West Virginia select Dr. D.L. Rasmussen to perform the OWCP examination. A huge backlog of claims resulted when Dr. Rasmussen, the predominate OWCP examiner in southern West Virginia, was unable to perform pulmonary evaluations for several months in 2002.}

Why two X-ray interpretations, two pulmonary function studies, two arterial blood gas studies, or two medical reports are deemed sufficient to present each side's case is unknown. The "two reports and you are out rule" seems to be a carry over from the bright line rule proposed for claims examiners in 1997.\footnote{191}{Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed Reg. 3,338, 3,375 (Jan. 22, 1997).}

While the D.C. Circuit found the regulatory limitations passed an \textit{en face} challenge,\footnote{192}{Nat'l Mining Ass'n v. Dep't of Labor, 292 F.3d 849, 874 (D.C. Cir. 2002).} the limitations may not pass muster when applied. An ALJ must consider additional evidence and rule if the evidence is relevant to determine if good cause is established. The failure to consider the relevance of this evidence is \textit{per se} error; otherwise, the limitations are transformed into absolute boundaries that cannot be expanded.

A party is allowed to submit two chest X-ray interpretations in its respective affirmative case.\footnote{193}{20 C.F.R. §§ 725.414(a)(2)(i), (a)(3)(i) (2000).} However, the regulations are unclear as to whether or not the physician who performs the pulmonary evaluation should also interpret the chest X-ray to offer a "complete pulmonary evaluation." The Department's definition of a complete pulmonary evaluation includes a B-reading of a

chest X-ray. Thus, an examining physician who does not interpret a chest X-ray, but defers to the interpretation of a board-certified radiologist/B-reader may not have offered "a complete pulmonary evaluation." The weight accorded to that opinion may be disputed. While two arterial blood gas studies are guaranteed for each affirmative case, frequently exercise studies include one or two resting arterial blood gas studies and one to three exercise arterial blood gas studies. If a total of four or five arterial blood gas studies accompany a physician's assessment, it may be suggested that the bright line limitations have been exceeded so as to bar the report of the physician or other arterial blood gas studies. Of course, such an argument is folly if quality of evidence is of paramount concern. Despite the contrary holding by the D.C. Circuit, the evidentiary limitations may be invalid as applied.

While the Department selected two as the number of ventilatory studies, arterial blood gas studies, medical reports, or X-rays to be submitted by a party in its affirmative case, only one "autopsy report" was deemed sufficient. The regulatory criteria provide no explanation for this inconsistency. Again, when applied in a particular case and not in a hypothetical situation, the regulatory bright line limitation appears to be wholly arbitrary and capricious. As the practice has evidenced in black lung cases, no competent pathologist is willing to interpret the meaning of the tissue findings on autopsy or biopsy samples when medical records chronicling a patient's clinical presentation are available. Whether using these records will transform that autopsy or biopsy report into a "medical report" is unknown.

Depositions may only be conducted of witnesses who have offered medical reports, or provided in lieu of a medical report. However, the regulations suggest that a party may offer the testimony of no more than two physicians. Additional depositions are not allowed unless the ALJ finds good cause under § 725.456(b)(1). The right to confront and cross-examine is fun-

194 Id. §§ 718.104(a)(5), 725.406(a) (2000).
195 See supra note 188.
196 See 20 C.F.R. § 725.414(a)(2)(i) (requiring that any "chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible" as part of a parties' case or as a record of hospitalization or treatment for respiratory or pulmonary disease under § 725.414(a)(4)).
199 A physician must offer a medical report. 20 C.F.R. § 725.457(c)(2) (2000). A party may offer the testimony of no more than two physicians under the provisions of this section unless the adjudication officer finds good cause. Id. § 725.414(c).
200 Id.
damental. The use of consultative medical reports in the context of Social Security disability claims has been found reliable if the claimant had the opportunity to subpoena physicians and cross-examine the reporting physicians.\textsuperscript{201} In black lung claims, the provisions of the APA specifically provide for cross-examination.\textsuperscript{202} Limiting a party to depose only two of the five examining physicians would eviscerate the right of cross-examination for a full and true disclosure of the facts. The Department does not agree that the rights of the parties to fully cross-examine adverse evidence is denied.\textsuperscript{203} To support this conclusion, the Department acknowledges the right of the parties' ability to cross-examine the authors of written medical reports.\textsuperscript{204} The Department’s regulations purportedly provide all parties with a full and fair opportunity to conduct cross-examination:

If the author of a report testifies at the hearing, the opposing party may clearly avail itself of the opportunity to conduct live cross-examination. In cases where the documentary medical evidence stands on its own, the opposing party may question the author of the report under the conditions determined by the administrative law judge.\textsuperscript{205}

The regulations leave open the question of whether a party can ever depose a radiologist who had the opportunity to interpret either chest X-rays or CT scans. Depositions are authorized for physicians who offer medical reports or in lieu of a medical report.\textsuperscript{206} Medical reports “shall consist of a physician’s written assessment of the miner’s respiratory or pulmonary condition.”\textsuperscript{207} A physician’s written assessment of a single objective test, such as a chest X-ray, is “not be considered a medical report.”\textsuperscript{208} By definition, a radiologist’s report of a single chest X-ray is not a medical report and the radiologist is “not allowed” to be deposed.\textsuperscript{209} It is unknown if the opinion of a radiologist who reads X-rays

\textsuperscript{201} Richardson v. Perales, 402 U.S. 389, 404-05 (1971).

\textsuperscript{202} 5 U.S.C. § 556(d) (2000) provides, in pertinent part, that “[a] party is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts.”


\textsuperscript{204} Id.

\textsuperscript{205} See id.; 20 C.F.R. § 725.459(b) (2000) (providing for fees for the cross-examination of those witnesses a proponent does not intend to call to appear at a hearing or deposition).

\textsuperscript{206} 20 C.F.R. § 725.457 (2000).

\textsuperscript{207} Id. § 725.414(a)(1) (2000).

\textsuperscript{208} Id.

\textsuperscript{209} Id. § 725.457(c).
and a CT scan becomes a “medical report” (interpreting other medical evidence) under § 718.107, which would allow a deposition. Again, the regulations that purport to simplify the process through quality evidence only muck up the picture.

Frequently, the interpretation of a single chest X-ray is not useful to a radiologist or pulmonary specialist when looking for progression and changes in an individual’s chest. A large mass on a single chest X-ray could be progressive massive fibrosis, complicated coal workers’ pneumoconiosis,210 or a non-occupationally induced lung cancer or tuberculosis. Without serial interpretations of X-rays ranging over several years, certain lung diseases cannot be determined. The two X-rays limitation in an affirmative case imposes an arbitrary limit that may prevent a party from presenting a “full and true disclosure of the facts.”211 In essence, the limitations require that a party ask a physician to render differential diagnoses including all possible diseases that the abnormality might represent, or risk the exclusion of an opinion that considers too much evidence. Such a differential diagnosis does not aid the fact finder to complete the truth-seeking function and determination. If the Department is truly concerned about truth-seeking—a concern that the Sixth Circuit echoed in Woodward—bright line limitations make little sense when the limitations work to exclude better medical analysis of a miner’s condition. While the bright line limitation may serve a purpose for the non-lawyer administrative staff at OWCP, the limits are not useful for ALJs trained as attorneys. The bright line limits were first devised to serve the OWCP’s receipt of all medical evidence, and envisioned no new medical evidence being received by ALJs absent extraordinary circumstances.212 As is the practice under Rule 703 of the Federal Rules of Evidence, an expert witness may base an opinion on materials that “need not be admissible, let alone admitted, in evidence, provided that they are the sort of thing on which a reasonable expert draws in formulating a professional opinion.”213

The limitations on evidence seem to be disingenuous when compared to the standards by which the adjudicators are now required to weigh the opinion of the treating physician. The frequency with which the treating physician sees a patient, the duration of the relationship, the types of testing, and the extent of treatment or examinations conducted determine whether a treating physician has obtained “superior and relevant information” concerning the miner’s condition.214 A treating physician may be able to interpret serial X-rays or ventilatory and blood gas studies conducted over the course of the last 20 years. These

210 The presence of complicated coal workers’ pneumoconiosis entitles a claimant to benefits. Id. § 718.304(a) (2000).
211 See supra note 202.
213 Peabody Coal Co. v. Dir., OWCP, 165 F.3d 1126, 1128 (7th Cir. 1999); FED. R. EVID. 703.
would far exceed the two tests or X-rays the other parties are limited to submit. Such treatment records will be received into the record if offered by either party.\textsuperscript{215} However, if these records are not received into the record, or not offered but merely reviewed by an expert, the regulations prohibit consideration of that expert’s opinion.\textsuperscript{216} One ALJ rejected a recent pulmonary evaluation authored by a physician because that physician reviewed evidence which was not received into the record.\textsuperscript{217} That evidence consisted of ventilatory studies and arterial blood gas studies conducted during hospitalizations or in association with prior state occupational pneumoconiosis claims.\textsuperscript{218} Again, such an action defies the avowed goal of offering better quality evidence.

The regulations fail to provide any limitations on other types of medical testing such as the more sensitive radiological tool of CT scans.\textsuperscript{219} It is permissible for parties to offer multiple interpretations of CT scans (under other evidence at § 718.107) yet be limited to only two interpretations of inferior chest X-rays. Again, such limitations do not serve the goal of proving the highest quality information to a fact finder, but instead serve only to limit and skew evidence and present more questions because of the artificial limitations on evidence. The more reasonable limitation that could have been imposed was on examinations, leaving it up to the ALJ to determine if other evidence was relevant or cumulative.

It is axiomatic that the standard of care in medicine requires that a physician consider as many facts as pertinent to understanding a patient’s condition. Serial studies of ventilatory function, chest X-rays, or other types of testing are relevant to be considered when evaluating a patient’s condition. For example, in asthmatics, serial ventilatory tests with and without bronchodilator medications help to diagnose and then manage the asthma. Similarly, experts evaluating a coal miner’s condition need to be able to consider these studies without regard to whether the treatment records are, or are not, part of the administrative record presented to an ALJ for consideration.

These evidentiary limitation regulations were born out of a bureaucratic power grab, premised on the notion that no medical evidence should be considered except evidence submitted to the District Director.\textsuperscript{220} The Office of Administrative Law Judges would have been prohibited from receiving any additional evidence to be considered absent extraordinary circumstances.\textsuperscript{221}

\textsuperscript{215} Id. § 725.414(a)(4) (2000).
\textsuperscript{216} Id. §§ 725.414, 725.456 (2000).
\textsuperscript{218} Id.
\textsuperscript{219} 20 C.F.R. § 718.107 (2000).
\textsuperscript{221} Id.
Department eventually retreated from the position that parties submit all of their documentary medical evidence to the District Director.\textsuperscript{222} In addition, the Department has offered the good cause exception, theoretically extending the bright line rule which its regulations mandate for receipt of evidence before the District Director.\textsuperscript{223} The Department's suggestion that the claimant should have to undergo no more than five pulmonary evaluations seems to have a reasonable basis. However, the Department has given no reasonable explanation why physicians could not review medical records, X-rays, or CT scans known to exist and render consultative reports.

\textbf{VI. CONCLUSION}

An Administrative Law Judge recently made the following observations:

After over 25 years of hearing "black lung" cases, this is my final decision. I have enjoyed participating in the evolution of the law and particularly in the interaction with the attorneys that have appeared before me.

The program has been less than successful. Following are several obvious observations and suggestions on how the adjudication aspects may be improved.

1. More reliable evidence must be forthcoming. The Department of Labor should be given the wherewithal to obtain credible, objective, expert medical evidence. Additionally and/or alternatively ALJs should be given and exercise the authority similar to U.S. District Judges to order specific additional medical evidence, particularly with respect to the presence or absence of clinical pneumoconiosis.

2. The Benefits Review Board should refrain from their propensity to remand cases based on flimsy reasons. An objective overseer might contend that the sole or primary reason for some of these remands is to keep their attorneys busy and/or the system churning. Requirement for basically \textit{de novo} review by the ALJ in such cases is often an unnecessary and unwanted burden.

\textsuperscript{223} Id.
3. The so-called "progressive" nature of pneumoconiosis has resulted in systematic abuse of the modification procedure, most often on behalf of Claimants. At a minimum, a limit on the times a Claimant may file should be enacted.

4. Employers’ financial capability far exceeds Claimant’s resulting in a lack of qualified attorneys who are willing to aggressively pursue meritorious claims. Unequal results exist between those cases defended by an Employer and those by the Trust Fund. A way should be found to reward Claimant’s attorneys who pursue meritorious claims.

5. Claims that have been previously decided should not, except under rare circumstances, be resurrected by a change in regulations. Courts and the Board should refrain from deciding old cases on new principles in the law.

In summary, the amount of claims paid exceed far, far beyond anyone’s imagination when the legislation was passed in 1969. (The law was intended to expire in 1981) Nevertheless, the bureaucracy as well as Employers’ attorneys have probably benefited more than Claimants. Claims paid are based not so much on merit, but the ability to marshal evidence and the wherewithal of the adversary. Examining physicians have become polarized thereby losing credibility.

On the other hand, it is interesting to contemplate as to what outcomes would have resulted had the law not been passed, and, almost certainly, a class action been instigated, by plaintiff matters.224

Several of this experienced ALJ’s observations have been addressed in the proposed revisions to the regulations. All affected parties seem to agree that the program has been less than successful. Benefits claimants want more claims awarded, and coal mine operators find the costs of the program to be excessive. The need for more reliable evidence was one of the reasons the Department sought revisions.225 The opening of the door for ALJs to develop evidence was specifically rejected as neither the APA nor the LHWCA gives an ALJ the right to demand the submission of more evidence for their decision making.226 When


225 One of the other goals was to change the law in various circuits where the Department had lost cases.

unpersuaded by the evidence, the ALJ must resolve the issue against the party that bears the burden of proof. The scope of review for the Benefits Review Board is always a source of controversy. Yet, more often than not the ALJ fails to explain why evidence is, or is not persuasive, as is required by the BLBA. The progressive nature of pneumoconiosis, now a part of the regulatory definition, is sure to be a focus of controversy in future claims. The Department has not defined pneumoconiosis as always or even typically latent and progressive, for such a definition could not have been supported by the administrative record. Indeed, the Department has acknowledged that the most common forms of pneumoconiosis are not latent and that progressive pneumoconiosis is rare by all accounts. Of course, the notion of progressivity as a basis for modification could be stopped if the timeliness provisions of the regulations are ever really enforced.

In a profile of beneficiaries for Part B claims, a total of approximately 67,000 beneficiaries were receiving total monthly case benefits of $39 million from the Social Security Administration in Part B claims. Part C claims have over 54,000 miners or widows receiving benefits, and of those over 13% are responsible operator cases. With each miner’s claim valued at approximately $175,000 per claim, the coal industry shoulders over $1 billion of liability in black lung benefits. On top of this existing debt, DOL estimates that the revised regulations would cost the coal industry between $33 and $88 million in additional insurance costs. With current studies showing that less than 1,000

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227 Id.
228 Inadequate analysis is not restricted to black lung cases. Sufficient analysis, omissions, or findings that amount to a striking non sequitur plague appellate courts in reviewing other areas of law. See Niam v. Ashcroft, 354 F.3d 652 (7th Cir. 2004).
229 “Pneumoconiosis is recognized as a latent and progressive disease.” 20 C.F.R. § 718.201(c) (2003).
230 Nat’l Mining Ass’n v. Dep’t of Labor, 292 F.3d 849, 869 (D.C. Cir. 2002).
231 Id. at 863.
232 Id.
233 20 C.F.R. § 725.308 (2000) provides three years after a medical determination of total disability due to pneumoconiosis was communicated to a miner for a claim to be filed. Hope that ALJs will enforce the three year rule was given new life by the Sixth Circuit in Tennessee Consolidated Coal Co. v. Kirk, 264 F.3d 602 (6th Cir. 2001). See also Furgerson v. Jericol Mining Inc., 22 Black Lung Rep. 1-216 (BRB 2002) (en banc); Abshire v. D & L Coal Co., 21 Black Lung Rep. 1-202 (BRB 2002) (en banc).
235 Id. at 25.
working miners out of over 31,000 evaluated have chest X-ray evidence of pneumoconiosis, the suggestion that the low-award rates are flawed cannot be supported. As radiographic evidence of pneumoconiosis does not equate to the existence of disability, much less significant or "total disability," fewer, not more, awards are justifiable. While the evidentiary limits will fuel action under the big top for the immediate future, the need for this program is ending. The Congressional concerns that gave birth to the program have borne the fruit of improved health and safety for American coal miners.

237 See supra notes 67-74.