U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue date: 28Dec2001

In the Matter of:	:	
	:	
ROY FULLER,	:	
Claimant,	:	
	:	Case No.: 97-BLA-1044
v.	:	
	:	
CLINCHFIELD COAL COMPANY	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,	:	
Party-In-Interest	:	

Lawrence L. Moise, III, Esquire
For the Claimant

Timothy W. Gresham, Esquire
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER -- REJECTION OF CLAIM

Statement of the Case

This case was remanded to this tribunal by unpublished decision and order of the Benefits Review Board dated February 29, 2000, vacating this tribunal's admission of the May 1994 report of Dr.

Robinette and its findings under 20 C.F.R §§718.204 and 718.304[1]. On remand, the Board directed this tribunal to re-examine the facts and circumstances surrounding Claimant's failure to submit Dr. Robinette's May 1994 report and to determine whether such evidence establishes that extraordinary circumstances exist for the report's not having been properly submitted during the pendency of Claimant's duplicate claim before Administrative Law Judge Brown. §§ 725.414(e)(1), §725.456(d);*see Doss v. Director, OWCP*, 53 F.3d 654, 19 B.L.R. 2-181 (4th Cir. 1995). The Benefits Review Board ordered this tribunal, after making such findings, to reconsider the medical evidence of record based upon its determination regarding the admissibility of Dr. Robinette's May 1994 report. In addition, the Board directed this tribunal to weigh all of the evidence submitted since the filing of Claimant's duplicate claim in determining whether Claimant has established a material change in conditions pursuant to §725.309(d), which, in this case, requires this tribunal to determine whether the evidence is sufficient to establish a totally disabling respiratory impairment pursuant to §718.204(b). If this tribunal finds the evidence is sufficient to satisfy §725.309, it must then consider entitlement on the merits pursuant to Part 718 based upon consideration of all the evidence of record. *Lisa Lee Mines v. Director, OWCP [Rutter II]*, 86 F.3d 1358, 20 B.L.R. 2-227 (4th Cir. 1996).

This proceeding involves a claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §901 *et seq*. (the Act), and the regulations promulgated thereunder. Since Claimant filed this application for benefits after March 31, 1980, Part 718 applies. This claim is governed by the law of the Fourth Circuit of the United States since Claimant was last employed in the coal industry in Virginia. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*).

Claimant, Roy Fuller, filed his initial claim for benefits under the Act on March 19, 1987 (D-82). On February 21, 1990, Administrative Law Judge Forbes denied benefits, finding that, although Claimant established the existence of pneumoconiosis, he did not establish total disability (D-82). Claimant did not appeal the denial, and it became final.

Claimant filed a duplicate claim on March 8, 1994 (D-1). On October 5, 1995, Administrative Law Judge Brown denied benefits, finding that Claimant did not establish total disability or the existence of complicated pneumoconiosis (D-41). At the hearing before Judge Brown, Claimant was represented by counsel, Carl McAfee, but offered no evidence, even though, for example, Dr. Robinette's examination report of May 8, 1994, was in existence (D-36 at 6, D-51). On October 25, 1995, Claimant, by his counsel at the hearing, filed a Notice of Appeal. Thereafter, Employer filed a timely motion to dismiss the appeal as abandoned or not in compliance with Board requirements (D-47). The Board issued an order to show cause on April 18, 1996 (D-48). Claimant's counsel advised Claimant that the appeal should be abandoned (D-49). On May 29, 1996, the Benefits Review Board dismissed the appeal because Claimant

---

[1] All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are denoted "D-"; Claimant's Exhibits are denoted "C-"; Employer's exhibits are denoted "E-",and citations to the hearing transcript are denoted "Tr."

did not file a Petition for Review or a brief (D-42, 50). Thereafter, Claimant, *pro se*, submitted additional medical evidence consisting of Dr. Robinette's May 6, 1994, examination report, which the Benefits Review Board, by order dated June 20, 1996, construed as a request for modification (D-52).

On March 4, 1997, the District Director granted modification and awarded benefits, finding that Claimant had complicated pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and he is totally disabled thereby (D-75). On March 17, 1997, Employer requested a formal hearing (D-78). On April 17, 1997, the District Director forwarded the claim to the Office of Administrative Law Judges (D-83).

A formal hearing was held in Abingdon, Virginia on October 8, 1997. All parties had representation and were afforded a full opportunity to present evidence and argument. This tribunal, admitted, as evidence of record on modification, evidence that pre-dates Judge Brown's October 5, 1995 denial of benefits, finding that Claimant established that extraordinary circumstances existed so as to excuse the late submission of the evidence consisting of Dr. Robinette's May 6, 1994 report (Tr. 54-57). The record was left open for Claimant's submission of an October 14, 1997 deposition of Dr. Robinette, which was received and admitted into evidence (C-2). In a decision and order dated July 6, 1998, this tribunal found the evidence sufficient to establish complicated pneumoconiosis pursuant to §718.304 and, thus, determined that this finding established both a change in conditions and a mistake in a determination of fact which entitled Claimant to modification and review of the record of the case on the merits. Additionally, this tribunal found the evidence sufficient to establish a totally disabling respiratory or pulmonary impairment of which pneumoconiosis was a contributing cause. Accordingly, this tribunal awarded benefits to commence March 1, 1994.

Employer appealed the Decision and Order on August 4, 1998. In an unpublished decision and order dated February 29, 2000, the Benefits Review Board vacated the decision and order awarding benefits, and remanded with instructions.

ISSUES

1. Whether the facts and circumstances surrounding Claimant's failure to submit Dr. Robinette's May 1994 report establish that extraordinary circumstances existed for the report's not having been properly submitted during the pendency of Claimant's duplicate claim before Judge Brown.

2. Whether, under §725.310, Claimant has established a change in conditions or mistake in a determination of fact in relation to Judge Brown's October 5, 1995, denial of Claimant's duplicate claim by showing that he is totally disabled or suffers from complicated pneumoconiosis.

3. If Claimant is totally disabled, whether such disability is due to coal workers' pneumoconiosis.

FINDINGS OF FACT

Background, Dependents, and Coal Mine Employment

Claimant, Roy Fuller, was born on February 19, 1936, and completed eight years of formal education (D-1). For the purpose of augmentation of benefits, Claimant has a dependent wife, Julia Conaway, to whom he was married on June 22, 1968 (D-1; Tr. 32). Claimant testified that his breathing problems have increased over the years (Tr. 38). He also testified that he is a diabetic, has a hernia and may have had tuberculosis (Tr. 38-41). Claimant smoked one half pack of cigarettes per day for twenty-five years, quitting in 1978 (D-10).

Claimant's Social Security and employment records establish twenty-three years of coal mine employment (D-2-7). Claimant stopped working in the coal mines on July 17, 1984, due to a back injury (Tr. 37-38). Claimant has not worked in any capacity since then (Tr. 31). During his tenure as a coal miner, Claimant worked in various capacities, including miner operator, roof bolter and belt cleaner, all underground and in contact with coal dust (D-36; Tr. 32-34). His last mining job that he held for more than a year was above ground as a janitor, cleaning the bath house and ensuring that the miners' headlamps were clean and functional (D-36; Tr. 51). Based on the above, this tribunal finds that Claimant has established twenty-three years of qualifying coal mine employment.

Medical Evidence[2]

X-ray Evidence[3]

Exh. No.	Date of X-ray	Date of Report	Physician/ Qualifications	Interpretation
D-27	2/9/79	12/16/87	Morgan B/R	-/-

[2] Judge Forbes's February 21, 1990, denial constitutes the previous denial relative to any material change in conditions relevant to Judge Brown's denial of the duplicate claim, which did not become final because of Claimant's timely request for modification. Judge Brown's denial on October 5, 1995, is the temporal point of reference for the change in conditions relevant to the request for modification. The scope of the requisite search of the record for mistake in a determination of fact relevant to the request for denial does not include a review of the underpinnings of Judge Forbes 1990 denial, which was final.

[3] "BCR" denotes that the doctor is a board-certified radiologist. "B" denotes that the doctor is a B-reader.

D-22	9/23/87	10/28/94	Scott B/R	-/-; questionable tb; focal scarring apices, probably tb unknown activity; cannot rule out cancer
D-22	9/23/87	10/28/94	Wheeler B/R	-/-; emphysema; tuberculosis; no evidence of silicosis or CWP
D-26[4]	9/23/87	12/2/94	Fino B	-/-; tuberculosis
E-1	8/22/88	10/18/88	Wheeler B/R	-/-; tuberculosis unknown activity both apices, probably healed; few small blebs in right apex; minimal discoid atelectasis or linear fibrosis in both costophrenic angles; no other abnormality
E-2	8/22/88	10/18/88	Scott B/R	0/1; r/q; tuberculosis; probable tb - unknown activity apices; discoid atelectasis and/or linear fibrosis bases; cannot rule out mass due to cancer right apex
D-22	8/26/92	10/28/94	Scott B/R	-/-; questioned tuberculosis; focal scarring both apices, probably due to healed tb, cannot rule out activity

[4] Dr. Fino prepared a report dated December 7, 1994, for which he reviewed the films dated September 23, 1987, August 26, 1992, December 2, 1993 and May 4, 1994 (D-26). In regard to those films, Dr. Fino stated the following:

> Review of the chest x-rays did show rounded opacities in both upper lung zones[,] but I felt that these were consistent with previous tuberculosis disease.
>
> I also noted changes on the chest x-ray over time. There are increased densities or infiltrate in the right upper lung zone on the 9/23/87 film. This progressed slightly and now was on the left hand side in the upper portion of the left lung on 8/26/92. It remained the same on the films dated 12/2/93 and 5/4/94.
>
> I do not feel that this represented coal workers' pneumoconiosis. I felt that all of the changes were consistent with tuberculosis.

D-22	8/26/92	10/28/94	Wheeler B/R	-/-; emphysema; coarse scars in both apices with possible few small calcified granulomata compatible with tb unknown activity, probably healed; no evidence of silicosis or CWP
D-26	8/26/92	12/2/94	Fino B	-/-; tuberculosis
D-22	12/2/93	10/28/94	Scott B/R	-/-; tuberculosis; focal scarring both apices, probably due to healed tb, cannot rule out activity
D-22	12/2/93	10/28/94	Wheeler B/R	-/-; tuberculosis; hyperinflation of lungs compatible with emphysema with areas of decreased lung markings
D-26	12/2/93	12/2/94	Fino B	-/-; tuberculosis
D-35	3/31/94	7/17/95	Castle B	0/1; s/t; tuberculosis; old granulomatous changes both apices
D-35	3/31/94	7/21/95	Scott B/R	-/-; tuberculosis; linear scarring and patchy infiltrates L>RT upper zone compatible with tb, unknown activity; masse both apices, possible granuloma ? cancer
D-35	3/31/94	7/21/95	Wheeler B/R	-/-; emphysema; tuberculosis; 2x4 cm mass lower right apex and ill defined mass or fibrosis left apex with infiltrates or fibrosis in LUL and few small nodules compatible with tb unknown activity; can't exclude tumor in either apex, probable emphysema with areas of decreased lung markings; suggest CT Scan
D-35	3/31/94	7/14/95	Hippensteel B	0/1; s/t; tuberculosis; bilateral apical densities compatible with old tb
D-12	5/4/94	7/7/94	N. Sargent B/R	0/1, s/t; emphysema; old tuberculosis; question smoking history; need to compare to old films

D-13	5/4/94	6/22/94	Gaziano B	1/1; q/q; Category A large opacities; cannot exclude tuberculosis or tumor; need old films for comparison
D-14	5/4/94	5/31/94	Hickey B/R	0/1; q/q; Category A large opacities; predominantly nodular interstitial lung disease; no evidence of cancer
D-22	5/4/94	10/28/94	Scott B/R	-/-; tuberculosis; focal scarring both apices probably due to healed tb; cannot rule out malignancy or tb
D-22	5/4/94	10/28/94	Wheeler B/R	-/-; emphysema; bullae; tuberculosis; no evidence of silicosis or CWP; suggest high resolution CT scan for addition lung detail and to demonstrate subtle calcifications in apical scars
D-26	5/4/94	12/2/94	Fino B	-/-; tuberculosis
D-27	12/29/94	12/29/94	D. Sargent B	4 cm mass in RUL; possible complicated CWP – more likely carcinoma
D-28	12/29/94	2/10/95	Scott B/R	0/1; q/s; probable healed tb with focal scars, calcified granulomata apices; hyperinflation in lungs compatible with emphysema
D-28	12/29/94	2/10/95	Wheeler B/R	0/1; t/q; bullae; emphysema; tuberculosis; coarse infiltrates in periphery LUL and masses in both apices compatible with tb unknown activity, probably healed judging from few small calcified granulomata; sparing central portion upper lobes and fact that irregular scars predominate is against pneumoconiosis
D-31	12/29/94	3/22/95	Fino B	-/-; changes consistent with previous tuberculosis; no changes consistent with a coal mine dust related pulmonary condition

D-32	12/29/94	4/6/95	Pendergrass B/R[5]	0/0; cancer; tuberculosis; 4 cm density right apex, 2+ cm density left apex, smaller poorly defined densities left upper mid lung zone; need to rule out both malignancy and reactivation TBC–check previous x-ray; ? re: two cardiac parenchymal scars at base of left lung; there are no significant small rounded or [irreg] opacities so I believe it unlikely we are dealing with large opacities of CWP
D-35	12/29/94	6/19/95	Stewart B	-/-; bilateral apical granulomatous changes consistent with old tb
D-58	5/24/95	7/26/ 96	Fino B	-/-; TB changes both upper lungs
D-58	5/24/95	7/3/96	Wheeler B/R	-/-; 4 cm mass right apex and 2.5 cm mass lower left apex compatible with inflammatory pseudotumors probably due to TB since there are a few small granulomata and tiny calcified granulomata in periphery upper lobes; suggest CT scan to see if masses are calcified which would indicate granulomatous disease; minimal emphysema; few tiny linear scars in both mid and upper lungs could be component of COPD or from healed infections
D-58	5/24/95	7/3/96	Scott B/R	-/-; questionable tb; linear fibrosis apices; calcified granuloma left apex; 3.5 cm mass right apex; 2.5 cm mass left apex - probably granulomatous, cannot rule out cancer

[5] The professional credentials of Dr. Pendergrass are not in evidence. However, this tribunal takes judicial notice that his relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org, and the List of NIOSH Approved Readers. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990).

D-58	8/29/95	7/3/96	Wheeler B/R	-/-; 4 cm mass lower right apex and 2 cm ill defined mass lower left apex compatible with inflammatory pseudotumors probably due to TB; suggest CT Scan to see if masses are calcified which would indicate granulomatous disease; minimal emphysema; few tiny linear scars in both mid and upper lungs could be component of COPD or from healed infections
D-58	8/29/95	7/3/96	Scott B/R	-/-; linear fibrosis apices; calcified granuloma left apex; 3.5 cm mass right apex; 2.5 cm mass left apex - probably granulomatous but cannot rule out cancer or active tb
E-4	8/29/95	7/26/96	Fino B	-/-; Tb changes both upper lungs
D-58	2/2/96	7/3/96	Wheeler B/R	-/-; 4 cm mass lower right apex and 2 cm ill defined mass lower left apex compatible with inflammatory pseudotumors probably due to TB; suggest CT Scan to see if masses are calcified which would indicate granulomatous disease; minimal emphysema; few tiny linear scars in both mid and upper lungs could be component of COPD or from healed infections
D-58	2/2/96	7/26/96	Fino B	-/-; TB changes both upper lungs
D-58	2/2/96	7/3/96	Scott B/R	-/-; linear fibrosis apices and calcified granuloma left apex compatible with healed tb; 3.5 cm mass right apex and 2.5 cm mass left apex and few smaller nodules - probable granulomatous disease; cannot rule out cancer or active tb

D-57	8/5/96	8/5/96	Epling[6]	-/-; conglomerate masses consistent with coalworkers' pneumoconiosis with progressive massive fibrosis; significant change since 3/31/94
D-57	8/5/96	7/16/96	Robinette B	1/2; q/t; hyperinflation; bilateral conglomerate masses consistent with progressive massive fibrosis superimposed on a background of chronic interstitial fibrosis; evidence of a category A mass in the upper lobes; pulmonary emphysema was present
D-62	8/5/96	8/29/96	Aycoth B/R	2/2; p/s; complicated pneumoconiosis category B; large 3cm right and 2cm left upper lobe masses; smaller scattered rounded and irregular density opacities measuring up to 1.5 mm in diameter throughout both lungs; while the noted upper lobe masses are believed to be associated with progressive massive fibrosis, on a single examination the possibility of malignancy cannot be excluded and suggest old comparison films and/or follow up films for evaluation

[6] The professional credentials of Dr. Epling are not in evidence. Dr. Epling's qualifications were not disclosed on the worldwide web, American Board of Medical Specialties, however she was listed as an A-reader on the List of NIOSH Approved Readers. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990).

D-62	8/5/96	8/29/96	Cappiello B/R	2/2; p/s; complicated pneumoconiosis category B; small rounded and irregular opacities throughout both lungs varying in size from a fraction of a mm up to approximately 1.5 mm in diameter; 3 cm mass in the right upper lobe as well as 2 cm mass in the left upper lobe; while the noted large masses are believed to be associated with complicated pneumoconiosis, neoplasm cannot be ruled out on a single study; old comparison films or follow-up films would be useful
D-62	8/5/96	8/20/96	Pathak B[7]	2/1; p/q; complicated pneumoconiosis category B; emphysema; bullae; minute soft rounded parenchymal opacities are seen scattered throughout all six lung zones with predominant opacities measuring between 1.5 and 3 mm; large opacities in both upper lobes consistent with conglomerate masses measuring approximately 3 cm in right upper lobe and 2 cm in left upper lobe; remote possibility of malignancy cannot be ruled out; comparison of old films could be great value
D-65	8/5/96	10/21/96	Navani B/R	1/1; p/q; category B large opacities; bullae
D-68	9/25/96	9/25/96	D. Sargent B	1/0; q/r; opacities suggestive of category B large opacities in both upper lobes

[7] Dr. Pathak's curriculum vitae indicates that he has the British equivalent of board-certification in radiology (D-62).

D-71	9/25/96	11/7/96	Scott B/R	-/-; bullae; tuberculosis; bullous emphysema right apex; 4 cm mass left apex, 3 cm mass left apex and few smaller nodules compatible with healed tb or other granulomatous disease; no small rounded opacities to suggest pneumoconiosis
D-71	9/25/96	11/7/96	Wheeler B/R	-/-; bullae; tuberculosis; 4 cm mass below right apex and 2-3 cm mass below left apex compatible with probable conglomerate tb with few small calcified granulomata in lateral subapical portion LUL and focal right upper lateral pleural fibrosis; minimal emphysema with few bullous blebs; no background nodules in upper lobes to suggest silicosis or CWP and masses subapical which is above usual location for large silicotic opacities
D-76	2/4/97	2/4/97	Epling	-/-; coalworkers' pneumoconiosis with progressive massive fibrosis; no significant change since 3/31/94
E-5	2/4/97	4/10/97	Wheeler B/R	-/-; tuberculosis; 4 cm mass in lower right apex and subapical portion RUL and ill defined 2 -2.5 cm mass in left lower apex and ill defined focal infiltrates or masses in posterolateral portion LUL and possibly in upper superior segment LLL compatible with tb unknown activity, probably healed; cant exclude tumor but favor granulomatous disease; tiny calcified granuloma mid portion RUL due to healed tb; possible emphysema
E-6	2/4/97	4/10/97	Scott B/R	-/-; tuberculosis; 4 cm mass right upper lobe posteriorly and smaller masses posterior left upper lung compatible with tb of unknown activity; cannot rule out neoplasm right apex; minimal left hemidiaphragm elevation

E-7	2/4/97	6/25/97	Fino B	-/-; granulomatous changes both upper zones
E-10	5/15/97	9/15/97	Wheeler B/R	-/-; emphysema; tuberculosis; 4 cm well defined mass subapical portion RUL and 3 cm mass subapical portion LUL compatible with conglomerate tb more likely than cancers but compare to prior films or get CT Scan to see if they contain calcification; few small linear and irregular scars in lateral periphery RUL more than LUL with possible few small calcified granulomata compatible with healed tb
E-11	5/15/97	9/12/97	Scott B/R	-/-; questionable cancer and emphysema; 4 cm mass right apex and 3 cm mass left apex; as there is no convincing background of small opacities, these are not likely to be large opacities; lung cancer and granulomatous disease are more likely possibilities; hyperinflated lungs

Pulmonary Function Studies[8]

Exh. No.	Date of Test	Age/ Height	Valid	FEV1	MVV	FVC	Ratio	Qualify
D-9	5/4/94	58/70	No[9]	2.33 2.80	62.7 83.1	5.07 5.94	46 47	No No
D-27	12/29/94	58/69	Yes	2.15 2.65	44	5.14 5.34	42 50	No No
D-35	3/31/94	58/70	Yes	2.22 2.66	42	5.15 5.53	43 48	No No
D-57	8/5/96	60/70	Yes	1.71 2.19		3.88 4.71	44 46	Yes No

8 A second set of entries on the same test relates to results after administration of bronchodilators.

9 The technician noted poor effort (D-9).

D-68	9/25/96	60/70	Yes	1.95 2.74	50	4.47 6.02	44 46	Yes No

Arterial Blood Gas Studies[10]

Exhibit No.	Test Date	PCO2	PO2	Qualify
D-11	5/4/94	37.6 37.8	74.8 78.0	No No
D-27	12/29/94	36.2	86.9	No
D-35	3/31/94	38.7	82.0	No
D-57	8/5/96	37	83	No
D-68	9/25/96	36	72	No

The pulmonary function studies and arterial blood gas tests performed in 1994 were before Judge Brown. Those performed in 1996 constitute new evidence relevant to the change in conditions.

Medical Reports and Opinions

Dr. Iosif, who is board-certified in internal medicine and the subspecialty of pulmonary diseases, examined Claimant on May 4, 1994. (D-10).[11] The examination included recordation of Claimant's employment and medical histories, a physical examination, a chest x-ray, a pulmonary function study, an arterial blood gas study, and an EKG. Dr. Iosif noted that Claimant's x-ray and previous x-rays showed "unquestionable evidence of simple and also complicated pneumoconiosis with the presence of bilateral fibrotic conglomerates in the apical zone which appear to be more confluent when comparing their appearance to previous films." Dr. Iosif found a moderate obstructive ventilatory impairment. Dr. Iosif attributed this respiratory impairment to coal dust exposure and not to smoking because Claimant was a light smoker and had quit the habit sixteen years prior to the examination. He further concluded that Claimant's respiratory impairment rendered him incapable of performing his last coal mine employment. Dr. Iosif's findings were before Judge Brown.

Dr. Robinette examined Claimant on July 17, 1996 (D-57; C-2 at 9-10). The examination included recordation of Claimant's employment and medical histories, a physical examination. Laboratory tests including a chest x-ray, a pulmonary function study, and an arterial blood gas study were performed

---

[10] A second set of entries on the same test relates to results during exercise.

[11] The professional credentials of Dr. Iosif are not in evidence. However, this tribunal takes judicial notice of the fact that Dr. Iosif is listed in the American Medical Association *Directory of Physicians in the United States*, 35th ed. (1996) and *The Official ABMS Directory of Board Certified Medical Specialists*, 27th ed. (1995) as board-certified in internal medicine and the subspecialty of pulmonary diseases. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

on August 5, 1996. Dr. Robinette read the x-ray as "1/2, predominant Q/T opacities with a Category A mass without significant progression of the radiographic abnormalities compared to 1994." He considered this lack of progression over two years to be inconsistent with diagnosis of a malignancy or an infectious agent such as tuberculosis. Based on Claimant's pulmonary function study, Dr. Robinette diagnosed "moderately severe obstructive lung disease with response to bronchodilator therapy." Dr. Robinette noted that Claimant's FEV1 function had deteriorated since his 1994 study. Although Dr. Robinette acknowledged that pneumoconiosis typically does not respond to bronchodilator therapy, he stated that "one would not anticipate such severe loss in FEV1 along [sic] due to other disorders." Finally, Dr. Robinette concluded that Claimant was totally disabled due to pneumoconiosis. Following an office visit and physical examination on February 4, 1997, Dr. Robinette reiterated his prior findings of coal workers' pneumoconiosis, progressive massive fibrosis, complicated coal workers' pneumoconiosis, and silicosis, based on laboratory data, pulmonary function studies confirming severe obstructive ventilatory defect (D-76).

Dr. Robinette was deposed on October 14, 1997. (C-2). Dr. Robinette summarized his findings based upon his examinations of Claimant. Dr. Robinette also discussed a bronchoscopy that he performed on Claimant on May 15, 1997, after Claimant expressed concern that he had cancer in his chest. Dr. Robinette explained that the purpose of the bronchoscopy was to determine the nature of the masses found upon radiographic examination of Claimant's lungs. He noted that the bronchoscopy revealed no malignancy or tuberculosis. He also noted that the bronchoscopy revealed a great deal of anthracotic pigment in Claimant's bronchial tubes. However, Dr. Robinette acknowledged that a bronchoscopy cannot establish the presence of complicated pneumoconiosis because it views too small an area of lung tissue. When asked if the large mass in Claimant's lung could represent healed tuberculosis rather than complicated pneumoconiosis, Dr. Robinette explained that it was improbable because Claimant would have been acutely ill if he had that much tuberculosis and that, in his experience, tuberculosis of that severity does not simply heal by itself. Finally, Dr. Robinette reiterated his earlier opinion that Claimant was totally disabled due to complicated pneumoconiosis.

Dr. Sargent, who is board-certified in internal medicine, and the subspecialties of pulmonary diseases and critical care medicine, examined Claimant on December 29, 1994. (D-27). The examination included recordation of Claimant's employment and medical histories, a physical examination, a chest x-ray, a pulmonary function study, an arterial blood gas study and a CT scan. The x-ray revealed biapical pulmonary masses, with one in the right lung measuring four centimeters. Dr. Sargent opined that the masses represented carcinoma or granulomatous disease or possibly complicated pneumoconiosis, if carcinoma were ruled out. He recommended further testing. He concluded that Claimant had an almost completely reversible obstructive pulmonary impairment without restriction and with normal diffusion capacity. He explained in detail why such an impairment was related to Claimant's history of smoking and asthma and not pneumoconiosis. He concluded that Claimant's impairment was not severe enough to prevent Claimant from performing his last coal mine employment. These findings were before Judge Brown. By letter dated January 23, 1995, Dr. Sargent noted that he had reviewed Claimant's December 29, 1994, CT scan in reaching these conclusions.

On June 6, 1995, Dr. Sargent was deposed. (D-34). Dr. Sargent discussed Claimant's medical condition. That transcript was before Judge Brown. Dr. Sargent stated that he examined Claimant in 1988 and in 1994. He reiterated his earlier opinion that he did not believe that the mass in Claimant's lung was complicated pneumoconiosis, but more likely indicated carcinoma or tuberculosis. He noted that the mass contained calcification which was consistent with tuberculosis. He also stated that the quick development of the mass was inconsistent with the manner in which complicated pneumoconiosis manifests itself. Finally, he explained that Claimant's pulmonary function studies were inconsistent with an impairment caused by pneumoconiosis and that Claimant's mild obstructive impairment was not totally disabling.

Dr. Sargent examined Claimant again on September 25, 1996. (D-68). The examination included recordation of Claimant's employment and medical histories, a physical examination, a chest x-ray, a pulmonary function study, an arterial blood gas study, and EKG and a CT scan. Dr. Sargent read the x-ray as positive (1/0) and noted that there were "opacities suggestive of category B large opacities in both upper lobes." The pulmonary function studies showed a mild ventilatory impairment that improved significantly after administration of bronchodilators. Dr. Sargent read the CT scan as "positive for bilateral apical nodular lesions consistent with conglomerate pneumoconiosis." However, Dr. Sargent did not make a definitive diagnosis of complicated pneumoconiosis. At one point, he stated that Claimant "probably" had pneumoconiosis. Elsewhere, he mentioned that Claimant "may well be suffering from complicated pneumoconiosis" and referred to the "likelihood of complicated pneumoconiosis." However, he also stated "that it is not possible at this point to absolutely exclude one or the other [tuberculosis or complicated pneumoconiosis] as potential causes of upper lobe infiltrates and nodules since coal workers' pneumoconiosis, especially complicated pneumoconiosis and tuberculosis often occur together." Concerning disability, Dr. Sargent noted that Claimant's "ventilatory impairment is really very mild" and, because it responded to bronchodilators, was not consistent with any impairment due to coal dust exposure. Nonetheless, and without further explanation, he stated that "because of the likelihood of complicated pneumoconiosis, [Claimant] would be considered disabled from doing any job that would require dust exposure."

By a letter dated December 23, 1996, Dr. Sargent noted that the masses in Claimant's lungs could represent healed tuberculosis (D-74). However, he stated that the only way to determine conclusively the nature of the masses would be to perform a biopsy.

By letter dated September 4, 1997, Dr. Sargent reviewed Dr. Robinette's bronchoscopy report (E-9). He criticized Dr. Robinette's findings, stating that a bronchoscopy that is not accompanied by a biopsy cannot be used to diagnose complicated pneumoconiosis and that the absence of tuberculosis or fungal organisms on bronchial washings does not exclude these two entities as a cause of upper lobe nodules. Dr. Sargent explained that, if tuberculosis is treated properly, the bacteria disappears from the lung, but the scarring remains. He further stated that the presence of anthracotic pigment in the bronchial tree does not establish complicated pneumoconiosis. Finally, he stated that it was "not possible to distinguish between complicated pneumoconiosis and previous tuberculosis infection as a cause of [Claimant's] chest x-ray changes."

By a report dated February 13, 1995, Dr. Wheeler, who is board-certified in radiology, reviewed Claimant's CT scan taken on December 29, 1994. (D-28). Dr. Wheeler noted several masses in excess of one centimeter, and that the scan revealed tuberculosis and chronic obstructive pulmonary disease, including forms of emphysema. He opined that the location of the masses revealed by the scan would be most unusual for pneumoconiosis or silicosis but were typical for tuberculosis. He cited the calcification in the masses and linear scarring, as opposed to rounded nodules, as supporting a diagnosis of healed tuberculosis.

Dr. Wheeler reviewed Claimant's CT scan taken on September 25, 1996 (D-71). Dr. Wheeler noted the large masses in Claimant's upper lobes and stated that there were no background nodules to suggest silicosis or pneumoconiosis. He further stated that the positions of the masses and the accompanying pleural involvement indicated that the masses were conglomerate tuberculosis, probably healed.

Dr. Wheeler gave a deposition on May 6, 1997, in which he discussed two CT-scans of Claimant and his chest x-rays (E-8). Dr. Wheeler noted that CT-scans taken in 1994 and 1996 revealed, *inter alia*, masses in Claimant's upper right and left lobes and linear scarring. He explained that the location of the masses and the presence of linear scarring, rather than nodules, were characteristic of tuberculosis and inconsistent with a diagnosis of silicosis or pneumoconiosis. Dr. Wheeler also noted that the lesions were calcified, indicating healed tuberculosis rather than pneumoconiosis. He further explained that nine out of ten people with tuberculosis self-cure and never realize that they had the disease.

Dr. Scott, who is board-certified in diagnostic radiology, reviewed the chest x-ray dated December 29, 1994 and Claimant's December 29, 1994, CT scan. (D-28). In a report dated February 10, 1995, he noted that there were "a few rounded radiodensities which could possibly be due to silicosis or coal workers' pneumoconiosis but they are sparse." However, he further noted that the "changes are most compatible with healed tuberculosis with focal scarring and calcified granuloma in both apices." In the x-ray report he noted, "Probable healed lungs compatible with emphysema."

Dr. Estes, who is a board-certified diagnostic radiologist and B-reader, reviewed Claimant's CT scan taken on September 25, 1996. (D-65).[12] He noted no significant changes in Claimant's lungs since the previous CT-scan in 1994. Dr. Estes noted numerous, small, nodular, interstitial lesions, primarily in the upper lobes. He also noted large masses in the upper-right and upper-left lobes, demonstrating peri-lesional cicatrization and marginal emphysematous changes. He concluded that the findings were fully consistent with conglomerate pneumoconiosis.

---

[12] The record does not contain the credentials of Dr. Estes. However, this tribunal takes judicial notice of the fact that Dr. Estes is listed in the AMA *Directory of Physicians in the United States*, 35th Edition (1996), and *The Official ABMS Directory of Board Certified Medical Specialists*, 27th Edition (1995), as board-certified in diagnostic radiology, and as a B-reader in the List of NIOSH Approved Readers at the time he examined the Claimant. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

Dr. Navani, who is board-certified in diagnostic radiology and a B-reader, reviewed Claimant's CT scan taken on September 25, 1996 (D-69). He noted innumerable, round, small micronodules in both lung fields and large confluent densities in the upper zones with irregular borders, representing progressive massive fibrosis. However, he noted that the "possibility of associated tuberculosis is not excluded." Finally, he diagnosed complicated pneumoconiosis. Dr. Navani also interpreted an August 5, 1996, chest x-ray as 1/1, p/q with large "B" opacities (D-66).

Dr. Fishman, who is a professor of radiology and oncology at the Johns Hopkins University School of Medicine, and is board certified in radiology and diagnostic radiology, reviewed Claimant's CT scan taken on September 25, 1996. (D-71). Dr. Fishman noted that the key findings were multiple, irregular masses in the upper zone bilaterally. He could not tell whether there was calcification present because only lung windows were submitted. He considered "the possibility of silicosis with large conglomerate masses" but noted that he did not see "a definite background of nodularity which is typically present in these cases." He also considered the possibility of tuberculosis with scarring and tethering. However, he made no definitive diagnosis.

Dr. Fino, who is board-certified in internal medicine and pulmonary diseases, examined Claimant's medical reports dating back to 1987 and prepared a report detailing his findings on December 7, 1994. (D-26). Dr. Fino reviewed the August 24, 1988 medical examination performed by Dr. Sargent, x-ray readings of the August 26, 1992, December 2, 1993, and May 4, 1994 films, and provided his own interpretations for the September 23, 1987, August 26, 1992, December 2, 1993, and May 4, 1994 films. Dr. Fino noted that several x-rays showed "rounded opacities in both upper lung zones" but concluded that they were representative of tuberculosis, not pneumoconiosis, because they were asymmetrical. Dr. Fino, therefore, concluded that Claimant did not have pneumoconiosis. He did not opine regarding disability.

By a report dated March 22, 1995, Dr. Fino stated that he had reviewed Claimant's medical records consisting of Dr. Sargent's medical evaluation performed on December 29, 1994 and the December 24, 1994 CT Scan. (D-31). Dr. Fino agreed with Dr. Sargent's finding of asthma based on Claimant's post-bronchodilator spirometry. He also noted that Claimant's father had tuberculosis and that Claimant had a positive skin test for tuberculosis. Dr. Fino stated that Claimant's x-rays and CT scan were consistent with previous tuberculosis and not pneumoconiosis. He opined that the large mass in Claimant's upper right lung might represent carcinoma, but was not complicated pneumoconiosis. Dr. Fino concluded that Claimant had a mild reversible obstructive impairment due to asthma and not coal dust exposure. He stated that Claimant did not have pneumoconiosis. He further opined that Claimant retained the pulmonary capacity to perform his last coal mine employment.

By a report dated July 20, 1995, Dr. Fino stated that he reviewed additional medical records consisting of Dr. Iosif's May 4, 1994 report and Dr. Sargent's June 6, 1995 deposition. (D-35). He reiterated his earlier conclusions and explained in detail why he thought the mass in Claimant's lung was consistent with tuberculosis and not complicated pneumoconiosis. Specifically, he noted that the "lesions that are present on CT Scan are not associated with distortion of the chest, hilar retraction, migration

toward the medial aspect of the chest, or sub-pleural emphysema," as would be expected with complicated pneumoconiosis.

In a report dated September 18, 1997, Dr. Fino reviewed Claimant's medical records dating back to 1988 and provided his opinions regarding Claimant's medical condition. (E-12). Dr. Fino reviewed the August 22 and September 13, 1988 pulmonary function studies, Dr. Robinette's May 6, 1994 evaluation[13], readings for the December 29, 1994 CT scan, readings of the May 24 and August 29, 1995 films, readings of the February 2, 1996 film, Dr. Robinette's medical evaluations of Claimant dated July 17 and September 12, 1996 and February 4, 1997, Dr. Sargent's September 30, 1996 report and December 23, 1996 letter, the May 6, 1997 deposition of Dr. Wheeler, and the report of Claimant's May 13, 1997 bronchoscopy. Dr. Fino noted that Claimant's pulmonary function studies indicated a reversible obstructive ventilatory defect, which, he explained, was inconsistent with the typically irreversible impairment caused by pneumoconiosis. Dr. Fino opined that Claimant might be suffering from asthma. He also stated that Claimant did not have the type of oxygen abnormality that would be consistent with complicated pneumoconiosis. Furthermore, he stated that the masses indicated by Claimant's CT scan were related to a previous tuberculosis infection. Concerning Claimant's bronchoscopy, Dr. Fino stated that it is not a proper technique for diagnosing complicated pneumoconiosis and that the presence of anthracotic pigment in the breathing tubes is not sufficient to diagnose either simple or complicated n pneumoconiosis. Finally, Dr. Fino opined that Claimant did not have pneumoconiosis and that his obstructive impairment was not disabling because it improved with bronchodilators.

---

[13] This report was ultimately not admitted into evidence pursuant to this decision and order.

CONCLUSIONS OF LAW AND DISCUSSION

Admissibility of Dr. Robinette's May 6, 1994 Report Under the Pre-Amended Regulations Pursuant to §§ 725.414(e) and 725.456(d)[14]

This tribunal admitted the May 6, 1994 report of Dr. Robinette (hereinafter, the "Report") (D-51) into the record at the October 8, 1997 hearing. Although it was established that Claimant and Claimant's former counsel, Carl McAfee, who represented him before Judge Brown, obtained the Report during the time the claim was pending before the District Director, but withheld it from the District Director and all other parties to the claim, this tribunal found that extraordinary circumstances existed such that the failure to timely submit the Report was excused and the evidence admitted. In its unpublished decision and order, the Benefits Review Board disagreed with this tribunal's findings under the applicable §§ 725.414(e) and 725.456(d), and accordingly vacated its findings pursuant to those regulations with instructions to examine the facts and circumstances surrounding Claimant's failure to submit the Report and to determine whether such evidence establishes that extraordinary circumstances exist for the report's not having been properly submitted during the pendency of Claimant's duplicate claim before Judge Brown. Based on a re-examination of the facts and circumstances surrounding Claimant's failure to timely submit the Report, since the relevant circumstances have not been elaborated, and in consideration of the applicable case law and regulations, this tribunal now finds that the Claimant has not established that extraordinary circumstances existed that would excuse Claimant's failure to submit the Report during the pendency of his claim before Judge Brown.

The applicable regulations set forth two specific exceptions to the mandatory exclusion of evidence which was not properly submitted to either the district director or the administrative law judge: 1) where admission of the evidence is requested by the Director or another party or 2) where there is a finding by the administrative law judge of extraordinary circumstances for the failure to submit the evidence at the

---

[14] Since this tribunal's July 6, 1998 Decision and Order –Award of Benefits and the Benefits Review Board's Decision and Order remanding this case, the Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969 were amended effective January 19, 2001. *See Nat'l Mining Ass'n v. Chao*, No. 00-CV03086 (D.D.C., August 9, 2001). Accordingly, §§ 725.414(e) and 725.456(d) were eliminated. The Department of Labor found that both sections were no longer necessary in light of amendments altering the adjudication of black lung benefits cases. 65 Fed. Reg. 79,991-2, 79,999 (December 20, 2000). In particular, the Department of Labor pointed out that these sections were originally intended to ensure that the district director's initial determination of the claimant's eligibility was based on all of the available evidence regarding the claimant's medical condition. *Id*. at 79,999. The Department of Labor then noted that the amended regulations significantly alter the adjudication of black lung claims, such that, "the district director will make his initial determination in reliance on a complete pulmonary evaluation performed by a highly qualified physician," thereby ensuring that the district director's initial determination is based on reliable evidence regarding the claimant's medical condition. *Id.* The amended regulations are not applicable to this tribunal's determination regarding the admissibility of Dr. Robinette's May 6, 1994 pursuant to the former §§725.414(e) and 725.456(d). §725.2(c).

appropriate time.[15] §§ 718.414(e)(1), 725.456(d); *see Shertzer v. McNally Pittsburg Manufacturing Co.*, BRB No. 97-1121 BLA (June 26, 1998) (unpublished) (citing *Wilkes v. F.& R Coal Co.*, 12 B.L.R. 1-1 (1988)). Here, neither the Director nor the Employer sought admission of the Report, and, therefore, the Claimant was required to establish that extraordinary circumstances existed for failing to submit the report in the prior duplicate claim.

In *Doss v. Director, OWCP*, 53 F.3d 654, 19 B.L.R. 2-181 (4th Cir. 1995), the Court of Appeals for the Fourth Circuit held that §§725.414(e) and 725.456(d) were to be read literally. Accordingly, the Court found the reasons offered by the claimant, *i.e.*, his failure to timely disclose the evidence did not result in surprise, his late disclosure of the evidence did not result in delay in resolution of the claim, and his failure to disclose the evidence was inadvertent, were insufficient to establish extraordinary circumstances to justify the failure to meet the regulations' requirements. *Doss v. Director, OWCP*, 53 F.3d 654, 658, 19 B.L.R. 2-181 (4th Cir. 1995).

During the October 8, 1997 hearing, this tribunal reviewed *Doss*, and Claimant testified regarding his knowledge of the circumstances surrounding the failure by his former attorney to submit the Report during the pendency of his previous claim. Lawrence L. Moise, Claimant's attorney in this claim, argued that extraordinary circumstances existed that prevented proper submission of the Report.[16] Claimant's testimony revealed that both he and Mr. McAfee, received a copy of the Report during the pendency of the duplicate claim (Tr. 49-50). However, Mr. McAfee did not submit the Report at the August 14, 1995 hearing before Judge Brown, despite Claimant's reliance on Mr. McAfee as his lawyer to submit the Report and handle his case for him while he "stuck back" (Tr. 52-53; D-36 at 6). Neither Mr. Moise nor Claimant was able to offer any reason as to why Mr. McAfee failed to submit the Report. However, the

---

[15] Section 725.414(e)(1), in pertinent part, states:

> Any documentary evidence obtained by a party during the time a claim is pending before a deputy commissioner, which is withheld from the deputy commissioner or any other party to the claim, shall not be admitted in any later proceedings held with respect to the claim in the absence of extraordinary circumstances, unless the admission of such evidence is requested by the Director or such other party.

Section 725.456(d) states:

> Documentary evidence which is obtained by any party during the time a claim is pending before the deputy commissioner and which is withheld by such party until the claim is forwarded to the Office of Administrative Law Judges shall, notwithstanding paragraph (b) of this section, not be admitted into the hearing record in the absence of extraordinary circumstances, unless such submission is requested by any other party to the claim (see §725.414(e)).

[16] Claimant's former attorney, Carl McAfee, did not appear at the hearing or provide any evidence regarding his failure to submit the Report.

crux of Mr. Moise's argument was that Mr. McAfee's inadvertent failure to submit the decidedly favorable Report amounted to malpractice, and that, he stated, "seems to...be a fairly extraordinary circumstance." (Tr. at 8-9). This tribunal, noting that the applicable standard was extraordinary circumstances, found that the Claimant had a right to rely on his attorney, finding that Claimant was not negligent or otherwise accountable for his failure to intervene at the hearing before Judge Brown when the Report was not offered (Tr. 55). The facts of this case are distinguishable from those in *Doss*, inasmuch as the actions in this case, in the judgment of this tribunal, amount to gross negligence, and not mere inadvertence or negligence as evidenced in *Doss* (Tr. 56). Therefore, the Report was admitted, based on a finding that Mr. McAfee's actions amounted to gross negligence, and, that such negligence, without a plausible reason for withholding the Report, amounted to malpractice which would be *per se* an extraordinary circumstance (Tr. 57).

Based on review of the evidence relating to the existence of extraordinary circumstances and upon re-examination of *Doss*, this tribunal now finds that admission of the Report cannot be justified on the instant record. Claimant was unable on remand to provide any reason as to why Mr. McAfee failed to submit the Report in the prior claim. Because the Benefits Review Board has declared the probative value of the evidence in question not to be relevant in determining whether extraordinary circumstances exist pursuant to the regulations, this tribunal cannot find, based on the favorable nature of the Report, that Mr. McAfee's unexplained failure to submit the Report amounted to gross negligence, and therefore, established extraordinary circumstances.[17] *See* §§ 725.414(e)(1) and 725.456(d). Additionally, the general rule is that a client is bound by the actions of his attorney, and such actions are imputed to the client as the actions of his freely chosen attorney/agent, apparently without regard to the level of education or sophistication of the client. *See Link v. Wabash Railroad Co.,* 370 U.S. 630 (1962); *see also Paik v. First*, 67 F.3d 308 (9th Cir. 1995). As pointed out by the Benefits Review Board, the fact that it might have been Claimant's former attorney's negligence which resulted in the Report's not being submitted for inclusion in the record, does not justify a finding of extraordinary circumstances because Claimant, however realistically, would have a separate action for negligence against his former attorney in another forum. Decision and Order at 6-7. Therefore, without any evidence in the record establishing any other reason besides Mr. McAfee's apparent negligence in failing to submit the report on behalf of the Claimant, this case becomes indistinguishable from *Doss*, and, accordingly, the Report must be excluded from the record.

At his October 14, 1997 deposition, Dr. Robinette summarized his findings from his March 17, 1994 examination of the Claimant, which formed the basis for the now excluded May 6, 1994 report (C-2 at 6-9). As admitting such testimony into the record, while excluding the actual report upon which it is based, would render meaningless the exclusionary rules of §§ 725.414(e) and 725.456(d), those portions of Dr. Robinette's deposition based on or regarding his findings as set out in the May 6, 1994 report (D-

---

[17] What would qualify as extraordinary circumstances is not well defined. However, the probative value of favorable evidence would appear to vary inversely with the reasonableness of a failure to submit such evidence in a timely manner.

51) are deemed to be stricken from the record and do not affect this tribunal's consideration of the claim.[18]

Modification of a Duplicate Claim

The instant claim involves a request for modification of the denial of Claimant's duplicate claim. Section 725.310(a) provides that "[u]pon his or her own initiative, or upon the request of any party on grounds of a change in conditions or because of a mistake in determination of fact, the deputy commissioner may, at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits." Claimant filed a timely request for modification within one year of the denial of his duplicate claim.

Where modification is sought based on an alleged change in conditions, new evidence must be submitted and the administrative law judge must conduct an independent assessment of the newly submitted evidence, in conjunction with the evidence previously submitted, to determine whether the weight of the evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision. *Napier v. Director, OWCP*, 17 BLR 1-111(1993); *see also Kovac v. BCNR Mining Corp.*, 14 BLR 1-156 (1990), *modified on recon.*, 16 BLR 1-71 (1992).

Where modification is sought based upon a mistake of fact, new evidence is not a prerequisite; and the adjudicator may resolve the issue based upon wholly new evidence, cumulative evidence, or further reflection on the evidence initially submitted. *See Kovac v. BCNR Mining Corp.*, 14 BLR 1-156 (1990), *modified on recon.*, 16 BLR 1-71 (1992); *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). A "mistake in determination of fact" may be based upon an allegation "that the ultimate fact – disability due to pneumoconiosis – was mistakenly decided." *Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993). The record does not reveal whether Claimant is alleging a mistake of fact or a change in conditions in his modification request. However, because the modification provisions should be broadly construed, this tribunal has reviewed the record *de novo* in determining whether Claimant has demonstrated a mistake of fact or change in conditions under §725.310 in relation to the October 5, 1995, denial of his duplicate claim. *See O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971).

A duplicate claim is to be denied on the same grounds as the previous denial unless there has been a material change in conditions. §725.309(d). To prove a material change in conditions, a claimant must prove, under all the favorable and unfavorable medical evidence of his condition after the previous denial, at least one of the elements previously adjudicated against him. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 20 BLR 2-227 (4th Cir. 1996)(*en banc*). Since the instant claim involves a request for modification of a denial of a duplicate claim, it requires a *de novo* review of the medical evidence, including newly submitted evidence, relevant to Claimant's medical condition after the previous denial, which, in this

---

[18] The excluded testimony is primarily found at pages six through nine of C-2.

case, was issued by Judge Forbes on February 21, 1990. *See Jessee v. Director, OWCP*, 5 F. 3d 723, 18 BLR 2-26 (4th Cir. 1993). The denial was based on the finding that Claimant suffered from pneumoconiosis but did not establish total disability (D-23). Accordingly, this tribunal has reviewed all of the evidence of record of Claimant's medical condition after the 1990 denial in assessing whether he has established total disability and, if so, whether that disability is due to pneumoconiosis as defined in §718.201, so that he is entitled to benefits.

Complicated Pneumoconiosis

In its Decision and Order - Award of Benefits, this tribunal found that Claimant established the existence of complicated pneumoconiosis by a preponderance of the evidence. Decision and Order - Award of Benefits at 10-12. This finding of complicated pneumoconiosis established both a change in conditions and a mistake in a determination of fact which both equated a material change in conditions and entitled Claimant to a modification and review of the claim on the merits. *Id.* at 12. In finding complicated pneumoconiosis, this tribunal found persuasive the numerous x-rays indisputably yielding large opacities of the size qualifying under §718.304(a), the corroborative opinions of Drs. Navani and Estes based primarily on review of the September 25, 1996 CT scan, and the opinions of the treating physician, Dr. Robinette, and the examining physician, Dr. Iosif. *Id.* at 11-12. The Benefits Review Board vacated this tribunal's findings under §718.304, and directed it to reconsider the medical evidence of record based upon its determination regarding the admissibility of Dr. Robinette's May 1994 report.[19] Decision and Order at 7. The Benefits Review Board admonished this tribunal to evaluate the relevant evidence in each category within §718.304, and then weigh together those categories prior to invoking the irrebuttable presumption at §718.304. The Benefits Review Board also suggested that this tribunal address Employer's contentions regarding the existence of inconsistencies within the different reports submitted by Dr. Robinette. *Id.* at fn. 4.

Section 718.304 provides an irrebuttable presumption of total disability due to pneumoconiosis if the miner is suffering from a chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1,7,11 (1996);

---

[19] This tribunal's findings under §718.304 did not significantly rely on Dr. Robinette's May 1994 report for support. As one of Claimant's treating physicians since that May 6, 1994 examination, Dr. Robinette provided reports from examinations performed on July 16, 1996 and February 4, 1997, and was deposed on October 14, 1997 (D-57, 76; C-2). These later reports were based on extensive evaluation of the Claimant and were persuasive in regard to the positive findings of complicated pneumoconiosis therein. However, in considering all the evidence of record, this tribunal found most persuasive Dr. Robinette's credentials as Regional Chest Clinic Physician for the State of Virginia for Tuberculosis Control, his continuous treatment of Claimant over a number of years, and his well-reasoned opinions and reliance on objective evidence, of which the bronchoscopy he performed on Claimant on May 15, 1997, a discussion of which appears in the transcript of the October 14, 1997 deposition, was most significant (C-2; Decision and Order - Award of Benefits at 11). However, as explained in the analysis, upon review of the evidence relating the existence of complicated pneumoconiosis, this tribunal now finds that its reliance on Dr. Robinette's reports and bronchoscopy above all the other evidence was inappropriate.

Eastern Associated Coal Corp. v. Director, OWCP, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three methods by which a Claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs, or c) when diagnosis by means other than those specified by (a) and (b), would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had diagnosis been made as therein described. Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis, but rather require the administrative law judge to first evaluate the evidence in each category, and then to weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*); *See also Dennis E. Keene v. G & A Coal Co.*, BRB No. 96-1689 BLA-A (September 27, 1996) (*unpublished*). Moreover, because clauses (a), (b) and (c) are intended to describe a single, objective condition, in applying the standards set forth in each prong, "one must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption." *Eastern Associated Coal Co. v. Director, OWCP*, 220 F.3d 250, 255 (4th Cir. 2000) (citing *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243 (4th Cir. 1999)). Since no biopsy or autopsy evidence is of record, this tribunal examined the x-ray evidence for complicated pneumoconiosis under part (a) and equivalent diagnostic evidence under part (c).

There is a consensus among the physicians of record that the post-1994 x-ray evidence reveals large masses of greater than one centimeter in Claimant's lungs. §718.304(a). These masses were also revealed in Claimant's post-1994 CT scans. 718.304(c). However, a majority of those physicians found that the masses are not lesions of complicated pneumoconiosis, but, instead, are masses of healed tuberculosis. Drs. Iosif, Robinette, Navani, and Pathak. concluded that the x-rays of record establish that Claimant has complicated pneumoconiosis. Dr. Navani also based his diagnosis on the September 25, 1996 CT scan of Claimant's lungs (D-69). Dr. Estes diagnosed conglomerate pneumoconiosis based on a high resolution CT scan which identified large lesions in the lung apices and no significant change in comparison with the 1994 CT scan (D-65). Drs. Aycoth and Cappiello both observed category B large opacities in the August 5, 1996 film. However, because they only interpreted the single film, both stated that they were unable to rule out other pathologies, and suggested the need for a comparison with other films (D-62).

Drs. Fino, Wheeler and Scott concluded that the masses revealed on x-ray were not indicative of complicated pneumoconiosis, and opined that the masses represented healed tuberculosis and/or granulomatous disease. Drs. Wheeler and Scott also stated that they were unable to rule out other pathologies such as cancer.

Dr. Sargent's most recent opinion was that he was unable to determine whether the masses were tuberculosis or complicated pneumoconiosis, and stated that the only way to determine conclusively the

nature of the masses would be to perform a biopsy (D-74). Dr. Fishman, who reviewed Claimant's CT scan taken on September 25, 1996, was also unable to make a definitive diagnosis (D-71).

While the radiographic evidence under §718.304(a) strongly favors this tribunal's finding complicated pneumoconiosis, because the preponderance of the evidence affirmatively establishes that the masses are more likely healed tuberculosis of an unknown origin, this tribunal must find that Claimant has failed to establish the existence of complicated pneumoconiosis under §718.304. *Eastern Associated Coal Co. v. Director, OWCP*, 220 F.3d 250, 256 (4th Cir. 2000) (The Fourth Circuit, after finding that the probative force of x-ray evidence displaying opacities greater than one centimeter is not reduced by less vivid or inconclusive evidence under one of the other prongs of §718.304, stated, "Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader.")

The objective evidence of record supports a finding that Claimant was infected with the tuberculosis pathogen and may have developed an active form of the associated disease. Claimant's medical history reveals an exposure history via his father; Claimant's father had tuberculosis and may have died from complications thereof (D-10; E-12). While Claimant denied ever having been diagnosed with tuberculosis, on January 13, 1989 he had a positive, 30 x30 mm, PPD skin test indicating the presence of tuberculosis germs (D-82). Previously, on August 26, 1988, Claimant's treating physician at that time, Dr. H.C. Scott, noted that Claimant informed him that the had been "spitting up blood for eight or nine years," a fact Claimant had not previously mentioned. *Id*. Dr. Iosif also noted in his May 4, 1994 report that Claimant reported a past history of blood streaks in his phlegm, although he had not observed this in the last two or three years (D-10).[20] Dr. Robinette, who had extensive experience with tuberculosis as Regional Chest Clinic Physician for the State of Virginia for Tuberculosis Control confirmed that people with active tuberculosis cough up blood (C-2 at 45). Therefore, it is possible, based on these opinions, that Claimant had active tuberculosis at some point in the 1980s.

The physicians who opined that the large masses in Claimant's lungs were healed tuberculosis and not complicated pneumoconiosis are highly credentialed and provided well-reasoned opinions. Consequently, this tribunal accords their opinions controlling weight as affirmative proof that the large opacities revealed in Claimant's x-rays are not what they seem to be because of an intervening pathology. *Eastern Associated Coal Co.* at 256. Dr. Fino practically reviewed the entire record for this claim and, therefore, he was able to form conclusions based on extensive medical data gathered over several years of Claimant's life. Dr. Fino determined that the opacities were healed tuberculosis based on their asymmetry, the lack of accompanying changes consistent with a fibrotic lung disease**,** the lack of a

---

[20] Evidence in Claimant's initial claim before Judge Forbes contains examination reports from Dr. Sargent, Abernathy, and Cardona wherein Claimant reported a history of hemoptysis, episodes of coughing up blood, dating as far back as 1978 (D-82).

background pattern for simple pneumoconiosis, and the lack of changes consistent with complicated pneumoconiosis revealed by CT scan. (D-26, 31, 35; E-12). Dr. Fino also supported his conclusion with evidence of Claimant's exposure history and positive skin test for tuberculosis. *Id.* Dr. Fino, as well as Dr. Sargent, did not find Dr. Robinette's bronchoscopy findings, indicating a lack of active tuberculosis or cancer and the presence of anthracotic pigment in the lining of major breathing tubes in the upper lobe, persuasive.[21] (E-9, 12; C-2 at 15). Both physicians agreed that a bronchoscopy cannot be used to diagnose complicated pneumoconiosis or the presence of healed tuberculosis. *Id.* Both physicians also agreed that the presence of anthracotic pigment in the breathing tubes is not sufficient to diagnose complicated pneumoconiosis (E-9, 12). Moreover, Dr Robinette concurred with Dr. Sargent, stating that bronchoscopies are not diagnostic and explaining that, with the specimens provided by bronchoscopy, "you're looking at a tiny specimen and you do four to six biopsies, but you're still looking at two millimeter to four millimeter pieces of tissue which can show you cell morphology but it does not – like cancer cells or granulomatous reaction, [but it does not] show you alveoli and does not show you coal macules and does not show you areas of progressive massive fibrosis which are microscopically much larger pictures that we see." (C-2 at 29-30).

Dr. Wheeler, who is a dually qualified board-certified radiologist and B-reader, reviewed Claimant's December 1994 and September 1996 CT scans, numerous x-rays dating as far back as 1987, and was deposed regarding his findings on May 6, 1997. Based on his review of the x-ray and CT scan evidence, Dr. Wheeler explained that the location of the masses in Claimant's upper right and left lobes and the presence of linear scarring, rather than nodules, were characteristic of tuberculosis and inconsistent with silicosis or pneumoconiosis (D-71; E-8). He also noted that the lesions were calcified, indicating healed tuberculosis rather than pneumoconiosis. *Id.* Dr. Wheeler stated that he did not need to know whether the Claimant had a history of tuberculosis to form an opinion regarding the pathology of the masses because Claimant's x-rays "are quite characteristic of tuberculosis," although a history of tuberculosis or family exposure would strengthen the diagnosis (E-8 at 19). Summarizing his opinion, Dr. Wheeler stated:

> I have an opinion that they [the greater-than-one-centimeter masses are] due to tuberculosis, and that's a very high order certainty. Over the last several years we've been able to get biopsies on lesions like this, and they've all been granulomatous disease. If they were central, there would be much more uncertainty, but if they had background nodules as opposed to linear scars, there'd also be a differential diagnosis, such as tuberculosis versus silicotuberculosis. But in this case there are no background nodules. There are background linear scars. The lesions are asymmetrical. They are peripheral, apical, superior segment, lower lobe.

---

[21] Bronchoscopies do not qualify under §718.304(b) as biopsies or under §718.304(c) as an alternative equivalent diagnostic tool because they cannot, in and of themselves, be used to identify lesions of complicated pneumoconiosis.

> All of these are very characteristic of tuberculosis and very uncharacteristic of silicosis. (E-8 at 19-20)

This tribunal does not find Dr. Robinette's arguments that Claimant could not have healed tuberculosis persuasive. Dr. Robinette relied heavily on the presumption that for Claimant to have developed active tuberculosis with large lesions in both upper lung zones, he would have had to become very ill and, in turn, spread the disease to many others. (C-2 at 18). Dr. Robinette also stated that if Claimant had been sick and infected numerous people, he would have seen that wave of illness in his capacity as a regional chest clinic physician for the state of Virginia for tuberculosis control. *Id.* However, the records indicate that Claimant tested positive for tuberculosis in January 1989 after experiencing symptoms associated with tuberculosis during the previous eight or nine years (D-82). Dr. Robinette did not begin his engagement with the state of Virginia until 1989 (C-2 at 3). Therefore, given that Claimant was not treated for active tuberculosis in 1989, and he was symptomatic for almost a decade prior to 1989, it seems likely that if Claimant had tuberculosis, he had it prior to Dr. Robinette's engagement.

Dr. Robinette disagreed with Dr. Wheeler's conclusions and statement that nine out of ten people with tuberculosis self heal, again arguing that Claimant should have been very ill, should have cultured tuberculosis if Claimant had active tuberculosis that evolved into the masses, and the literature supports a finding that coal miners are predisposed to tuberculosis (C-2 at 39). None of Dr. Robinette's arguments are persuasive because they are unsupported by objective evidence of record and are effectively refuted by the findings of Drs. Fino and Wheeler. Claimant never informed any physicians that he was very ill in the 1980s, but he did report symptoms of tuberculosis. Moreover, Dr. Wheeler explained that in his experience and in general, nine out of ten people with tuberculosis self-cure, and that the majority of people who have tuberculosis do not know they have ever had the infection (E-8 at 19). According to Dr. Robinette, the bronchoscopy could only diagnose active tuberculosis, not healed tuberculosis, and it appears that Claimant was never tested for active tuberculosis in the years prior to or since his 1989 skin test (C-2 at 30). Finally, none of the physicians unequivocally opined that Claimant had both healed tuberculosis and complicated pneumoconiosis, and Dr. Wheeler effectively ruled out the presence of a silicotuberculosis.

Upon weighing the evidence under §718.304(a) and (b), this tribunal finds the corroborative opinions of Drs. Fino and Wheeler that the greater than one centimeter masses in Claimant's lungs are not lesions of complicated pneumoconiosis, and are instead, lesions of healed tuberculosis most persuasive. These physicians provided well-reasoned, comprehensive opinions based on an extensive amount of x-ray and diagnostic evidence. Dr. Sargent's opinions were too equivocal to be relied upon, and the other physicians' opinions which were inconsistent were based upon less objective evidence and less detailed and persuasive reasoning. Accordingly, Claimant has failed to establish the existence of complicated pneumoconiosis and is not entitled to invoke the irrebuttable presumption of total disability due to pneumoconiosis. This finding does not establish a change in conditions or mistake in determination of fact.

Total Disability

In its prior decision, this tribunal found that Claimant was totally disabled, and that pneumoconiosis was a contributing cause of that disability based on Claimant's two most recent qualifying pre-bronchodilator pulmonary function studies and the opinions of Drs. Robinette, Iosif and Sargent. Decision and Order – Award of Benefits at 12-14. Additionally, based on its finding of total disability, this tribunal found that Claimant had established a change in conditions and a material change in conditions. *Id.* at 12. The Benefits Review Board vacated this tribunal's findings under §718.204, and directed it to reconsider the medical evidence of record based upon its determination regarding the admissibility of Dr. Robinette's May 1994 report. Decision and Order at 7.

Section 718.204(b) provides that the criteria for determining whether a miner is totally disabled are: (1) pulmonary function tests qualifying under applicable regulatory standards, (2) arterial blood gas studies qualifying under applicable regulatory standards, (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure, or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinion of a physician relying upon medically accepted techniques. §718.204(b). If there is contrary evidence in the record, all evidence must be weighed as a whole to determine whether there is proof by a preponderance of the evidence that the miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986). There is no evidence of cor pulmonale in the record.

Claimant's two most recent pulmonary function studies, which were performed in August and September 1996, and which, presumably, most accurately reflect his current condition, produced qualifying values before administration of bronchodilators (D-57, 68). However, those same studies produced non-qualifying results after administration of bronchodilators caused significant reversibility. Dr. Fino accurately calculated that after administration of bronchodilators, Claimant's August 1996 FVC and FEV1 increased by twenty-one and twenty-eight percent, respectively, while his September 1996 FVC and FEV1 increased by thirty-five and forty-one percent, respectively (E-12). This improvement is significant in that it militates against total disability under applicable regulatory standards. *See Phillips v. Jewell Ridge Coal Co.*, 825 F.2d 408, 10 B.L.R. 2-160 (4th Cir. 1987); *see also, Defore v. Alabama By-products Corp.*, 12 B.L.R. 1-27 (1988); *cf. Adkins v. Secretary, HHS*, 755 F.2d 931 (6th Cir. 1985). In addition, Drs. Fino and Sargent noted that such reversibility is consistent with disease processes other than pneumoconiosis, most notably, asthma–which they diagnosed based on the reversibility of Claimant's pulmonary function studies, the obstructive nature of Claimant's mild impairment, and consistent reports of wheezing [22] (D-27, 31, 34; E-12).[23] This tribunal finds Drs. Fino and Sargent's analysis persuasive in

---

[22] Claimant denied having problems with wheezing at the hearing for this case (Tr. 41). However, the record indicates that Claimant reported such problems to several physicians over the years, including Drs. Robinette, Sargent, and Abernathy(D-57; D-83).

[23] Dr. Sargent explained that asthma is defined as an obstructive ventilatory impairment that improves at least ten percent after the administration of bronchodilators (D-27).

light of the objective evidence of Claimant's significantly reversible ventilatory impairment, and therefore, that Claimant has failed to establish total disability pursuant to 718.204(b)(2)(i). None of Claimant's arterial blood gas studies yielded qualifying values, and accordingly, Claimant has also failed to establish that he is totally disabled under §718.204(b)(2)(ii).

Nor has Claimant established that he is totally disabled by evidence of reasoned medical opinion under §718.204(b)(2)(iv). Dr. Iosif diagnosed Claimant with a moderate obstructive ventilatory impairment based on spirometry, noting significant reversibility. (D-10). However, he also noted that the obstructive pattern was not corrected after bronchodilator administration. After discussing Claimant's past smoking history, finding it to be "very mild," Dr. Iosif stated, "I have to conclude that there is a respiratory impairment severe enough to prevent him from returning to his previous coal mine employment and that this impairment is due to the presence of simple as well as complicated pneumoconiosis which appears to be progressive." Dr. Iosif's opinion is unpersuasive because he failed to provide any reasoning for his determination that Claimant was totally disabled other than noting the presence of simple and complicated pneumoconiosis. He did not explain how he determined, or whether he considered, Claimant's moderate, reversible obstructive ventilatory impairment to be totally disabling in light of Claimant's last coal mine employment, nor did he link any of the objective evidence of this case to his finding that Claimant was totally disabled. Accordingly, Dr. Iosif's opinion is accorded little weight.

Dr. Robinette's opinion is also unpersuasive. Dr. Robinette believed that Claimant's last coal mine employment was as a belt line operator, a considerably more strenuous position than Claimant's real last coal mine employment as a janitor in the bath house (D-57). Consequently, Dr. Robinette qualified his opinion that Claimant was totally disabled, stating, "His [Claimant] pulmonary impairment is so severe that he would be unable to work as an underground coal miner, based on his pulmonary disease alone." (D-57). At his October 14, 1997 deposition, after being informed of Claimant's true last coal mine employment, Dr. Robinette stated that his opinion would not change because "there's certainly no way a man can do janitorial work where he has to do heavy work with his arms and lift things above his head, carry more than 20 pounds for more than 50 foot....One of the things we recognize is that working with your arms in terms of exertional activities such as painting or mopping the floor is one of the more demanding physiological test[s] that there are." (C-2 at 51). At his most recent hearing, Claimant attempted to establish that his last coal mine employment was that of a beltman, but eventually conceded that he worked in the bath house during his last three to four years of coal mine employment (Tr. 32-36). Claimant stated that he kept the bath house clean, keeping the lights up and the floors clean by sweeping and scrubbing (Tr. 36). Claimant never stated on the record before this tribunal that he was required to lift items overhead or lift twenty-pound items and carry them any distance. His description of this janitorial position indicated that it required mild exertion at best. Accordingly, because Dr. Fino did not have an accurate understanding of Claimant's last coal mine employment and based his determination of disability on that misconception, his opinion is entitled to little weight. *Bobick v. Saginaw Mining Co.*, 13 B.L.R. 1-52 (1988).

Moreover, despite finding that Claimant's obstructive lung disease was moderately severe, Dr. Robinette found that it improved significantly with administration of bronchodilators. Dr. Robinette made no attempt to resolve or explain the significant reversibility in light of his finding of total disability. Instead, he assumed Claimant was totally disabled and focused his analysis of the reversible impairment on the etiology of the impairment, stating that pneumoconiosis typically does not respond to bronchodilator therapy, but that one "would not anticipate such severe loss in FEV1 [along] due to other disorders." (D-57). Accordingly, this tribunal finds that Dr. Robinette failed to account for the objective evidence of the significant reversibility of Claimant's obstructive ventilatory impairment, and accordingly, his opinion is entitled to less weight because it is unreasoned. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987).

This tribunal also notes that in his July 16, 1996 report, Dr. Robinette explained that he previously found that Claimant would be unable to work in a dusty environment as a consequence of his radiographic abnormalities consistent with complicated pneumoconiosis and progressive massive fibrosis. (D-57). As this tribunal has determined that Claimant did not have complicated pneumoconiosis, and the report upon which Dr. Robinette's previous diagnosis was based was not admitted to the record, this tribunal accords that associated finding of total disability unpersuasive.

Dr. Sargent's opinions cannot provide a reliable basis for concluding that Claimant was totally disabled. Dr. Sargent opined that Claimant's mild obstructive ventilatory impairment was not totally disabling (D-34). He also opined that if Claimant had complicated pneumoconiosis, he would be considered disabled from doing any job that would require dust exposure (D-68). Dr. Sargent was unable to provide an unequivocal opinion as to whether Claimant had complicated pneumoconiosis. Accordingly, because Dr. Sargent's determination that Claimant was totally disabled was qualified dependent upon a finding of complicated pneumoconiosis, which he could not make, and because this tribunal found that Claimant did not suffer from complicated pneumoconiosis, Dr. Sargent's opinion cannot support a finding that Claimant is totally disabled.

Dr. Fino's opinion is also unsupportive of a finding of total disability. Dr. Fino reviewed much of the medical evidence of this case and consistently opined that Claimant was neither partially nor totally disabled from employment. Dr. Fino based his opinion, in part, on review of objective evidence consisting of Claimant's pulmonary function studies dating back to 1988 evidencing that Claimant's obstructive impairment, which the doctor categorized as mild, was reversible and significantly improved by administration of bronchodilators (D-31; E-12). In his July 20, 1995 report, Dr. Fino stated:

> From a purely physiologic standpoint, it is my opinion that this man's respiratory capacity, based on pulmonary function studies and blood gas studies, would present only a mild reversible pulmonary impairment. It would not prohibit this man from working either as a bath house attendant or a belt cleaner in low coal. (D-35).

Accordingly, because Dr. Fino provided a well reasoned opinion based on the objective testing performed on Claimant for over a decade and because he both understood and considered Claimant's last coal mine employment, as well as other possible employment positions, this tribunal finds his opinion persuasive. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Therefore, Claimant has not established by a preponderance of the evidence that he is totally disabled pursuant to §718.204(b)(2)(iv), and has not established a change in conditions or a mistake in a determination of fact.

Total Disability Due to Pneumoconiosis

To establish entitlement, a claimant must prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. A miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.*

In this case, the preponderance of the evidence did not establish that Claimant is totally disabled. Therefore, the issue of whether the Claimant is totally disabled due to pneumoconiosis is moot.

Attorney's Fee

The award of an attorney's fee under the Act will be approved only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services of an attorney rendered to the Claimant in pursuit of this claim.

ORDER

The claim of Roy Fuller for benefits under the Act is denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.