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In the Matter of	:	
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GARY FOX,	:	
Claimant,	:	Date: Jan. 5, 20001
	:	
vs.	:	Case No. 2000-BLA-00598
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	:	
ELK RUN COAL COMPANY, INC.,	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS'	:	
COMPENSATION PROGRAMS	:	
Party-in-Interest.	:	
	:	
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Gary Fox, Pro Se

Mary Rich Maloy, Esq.  
For the Employer

BEFORE: EDWARD TERHUNE MILLER  
Administrative Law Judge

**DECISION AND ORDER - DENYING BENEFITS**

Statement of the Case

This proceeding involves a first claim for benefits under the Black Lung Benefits Act, as amended, § 30 U.S.C. 901 et seq. (hereinafter "the Act") and regulations promulgated thereunder.<sup>1</sup> The Act and regulations provide compensation and other benefits to coal miners who are totally disabled due to pneumoconiosis and their dependents. The Act and regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment, including any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. § 718.201.

The instant claim was filed by the Claimant, Gary Fox, on May 4, 1999 (DX 1). Elk Run Coal Company Inc. was notified of the claim on May 17, 1999, by a Department of Labor claims examiner (DX 22). On October 18, 1999, a claims examiner made an initial award (DX 23). The Employer controverted the initial award on October 19, 1999 (DX 26). The District Director determined that Mr. Fox was entitled to benefits on January 12, 2000 (DX 29). On January 24, 2000, the employer requested a hearing

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<sup>1</sup> All applicable regulations which are cited are included in Title 20 of the Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are indicated as "DX", Transcript of the Hearing is indicated as "TR", Claimant's Exhibits are indicated as "CX", and Employer's Exhibits are denoted "EX."

before the Office of Administrative Law Judges (DX 32). This matter was referred for hearing on March 10, 2000 (DX 34).

A formal hearing was held in Beckley, West Virginia on September 19, 2000, at which all parties were afforded a full opportunity to present evidence and argument. Director's Exhibits one (1) through thirty-five (35) and Employer's Exhibits one (1) through fourteen (14) were received into evidence without objection (TR 12, 35). Because the Claimant miner was last employed in the state of West Virginia, the law of the Fourth Circuit of the United States controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (*en banc*). Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies.

### ISSUES

1. Whether the miner has coal workers' pneumoconiosis?
2. Whether the pneumoconiosis arose out of coal mine employment?
3. Whether the miner is totally disabled?
4. Whether Claimant has proved that he is totally disabled due to pneumoconiosis?

The Employer also challenged the constitutionality of the Act and regulations by way of the controversion of other related issues. Such issues of constitutionality are beyond the jurisdiction of administrative agencies. *Oesterich v. Selective Service System Board No. 11*, 393 U.S. 233, 242 (1968); (Harlan, J., concurring); *Public Utilities Comm'n v. United States*, 355 U.S. 534, 539 (1958).

### FINDINGS OF FACT, DISCUSSION, AND CONCLUSIONS OF LAW

#### Background

The Claimant, Gary Fox, was born on July 25, 1950, and has a GED and two years of college (DX 1). He married Mary Lynn Fox on May 25, 1972, and she is his only dependent (TR 14). He first noticed difficulty breathing in 1983 and now experiences tightness in his chest, has to rest after walking, and has difficulty climbing stairs (TR 22-23). Claimant uses three inhalers to assist his breathing (Tr. 24). He also suffers from high blood pressure and arthritis and underwent the removal of a tumor on his lung a few years prior to the hearing (TR 24-25, 26). The Claimant testified that he smoked about six years between the 1971 and 1979 (TR 25-26).

#### Length of Coal Mine Employment

Claimant alleges twenty-six years of coal mine employment (DX 1). The Employer conceded nineteen years of qualifying coal mine employment (TR 10). Claimant testified that he is currently still employed as a coal miner and has been employed by Elk Run Coal Company for over seven years (TR 16, 18). Although he had been a roof bolter, for the past six months prior to the hearing he had been performing work that requires heavier lifting and causes just as much dust exposure (TR 17-18). He

previously worked for Itmann Coal Company from 1974 to 1986, and for Birchfield Mining from 1987 to 1993 (TR 19; DX 2). He has worked as a roof bolter for eighteen years, but was a continuous miner operator with Itmann (TR 19). His work requires him to lift fifty-pound bags of rock dust and to unload roof bolts and plates, weighing fifty to seventy-five pounds, by hand (TR 20).

Claimant testified that he began coal mining in September 1974, but was laid off twice for a total of eight months (TR. 27). A document from Itmann Coal Company verifies employment from September 3, 1974 to December 13, 1982 and from April 18, 1983 to December 13, 1986, for a total of eleven years and ten months (DX 8). Social Security Earnings records confirm fifty quarters or twelve and one-half years of employment with Itmann Coal Company from 1974 to 1986; twenty-eight quarters or seven years with Birchfield Mining Inc. from 1987 to 1993; and sixteen non-overlapping quarters or four non-overlapping years of coal mine employment with Elk Run Coal Company Inc. from 1993 through 1997 (DX 9). Thus, the Social Security records reveal twenty-three and one-half years of coal mine employment from 1974 through 1997. Claimant has also worked for Elk Run from 1998 through the date of the hearing, September 19, 2000, for an additional two years and nine months of coal mine employment. The document from Itmann Coal Company, the Social Security records, and the Claimant's testimony established 25 years and seven months of coal mine employment within the meaning of § 402(d) of the Act and § 725.202 of the regulations.

### Responsible Operator

Elk Run Coal Company, Inc., as the last qualified employer of the Claimant for at least one year, is the responsible operator liable for payment of any benefits which may be found to be due.

### Findings of Fact - Medical Evidence

#### Chest X-ray Evidence<sup>2</sup>

<u>Exh. No.</u>	<u>Date of X-ray</u>	<u>Date of Report</u>	<u>Physician/Qualifications</u>	<u>Diagnosis</u>
DX 30	8/27/74	8/28/74	Martin	Negative for pneumoconiosis
DX 30	3/24/87	3/24/87	Speiden/R	Normal chest x-ray
DX 30	3/7/89	3/8/89	Speiden/R	Normal chest x-ray

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<sup>2</sup> The following abbreviations are used in describing the qualifications of the physicians: B = B-Reader, R = Board-Certified Radiologist. Although the credentials of certain of these physicians are not in the record, judicial notice is taken of their qualifications according to the disclosure on the worldwide web, American Board of Medical Specialities Public Education Program, Verification of Certification Results, at [www.certifieddoctor.com](http://www.certifieddoctor.com) and the 2000 NIOSH B-reader list. See *Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

EX 11	9/2/98-1 <sup>3</sup>	8/14/00	Wheeler/B,R	Oval mass in right upper lobe compatible with conglomerate tuberculosis or tumor; cardiomegaly; probably minimal pulmonary vascular prominence rather than pulmonary vascular congestion or subtle interstitial infiltrates in mid and lower lungs; negative for pneumoconiosis
EX 11	9/2/98-1	8/15/00	Scott/B,R	Negative for pneumoconiosis; right upper lobe mass; cancer versus granulomatous moderate right pneumothorax; pulmonary vascular prominence versus minimal interstitial infiltrate
EX 12	9/2/98-1	8/21/00	Kim/B,R	Negative for pneumoconiosis; mass in right upper lung; moderate right pneumothorax; probable interstitial fibrosis in lower lung
EX 11	9/2/98-2	8/14/00	Wheeler/B,R	Negative for pneumoconiosis; moderate right pneumothorax; no obvious pulmonary vascular congestion or interstitial infiltrates in mid and lower lungs; borderline cardiomegaly
EX 11	9/2/98-2	8/15/00	Scott/B,R	No evidence of silicosis/coal workers' pneumoconiosis; mass in right upper lobe which is either cancer or granulomatous; moderate marked right pneumothorax increasing since earlier exam
EX 12	9/2/98-2	8/21/00	Kim/B,R	Negative for pneumoconiosis; mass in right upper lobe is probably cancer or granuloma; moderate right pneumothorax; increased interstitial markings in the lower lung suggestive of fibrosis
EX 13	9/2/98-2	8/3/00	Castle/B,P	1/1; q; 3x7 cm. right upper lung mass; pneumothorax rom needle biopsy
EX 30	9/7/98	9/7/98	Setliff/R	Stable right apical pneumothorax; underlying chronic lung disease and a known right lung mass
EX 30	9/25/98	9/25/98	Maloof/R	Subcutaneous emphysema; large pneumothorax in right hilum
EX 30	9/25/98 <sup>4</sup>	9/25/98	Maloof/R	Pneumothorax again noted

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<sup>3</sup>There were two x-rays taken on September 2, 1998. The first is indicated by the designation "9/2/98-1" and the second is designated "9/2/98-2."

<sup>4</sup>This x-ray was taken eight hours after the prior film of the same date.

EX 30	9/27/98	9/27/98	Maloof/R	Post-surgical change with right pneumothorax; prominent pulmonary vasculature in left lung
EX 30	9/28/98	9/28/98	Setliff/R	Probable partial left lower lobe atelectasis and/or consolidation, suggested by retrocardiac denseness; possible partial atelectasis; no congestive heart failure
EX 30	9/29/98	9/29/98	Maloof/R	Pulmonary vascular prominence; slight increase in left lower lobe atelectasis
EX 30	10/1/98	10/1/98	Maloof/R	Improving aeration of right lung; small apical pneumothorax
EX 30	10/2/98	10/2/98	Setliff/R	No right pneumothorax
EX 30	10/3/98	10/3/98	Maloof/R	No interval change in appearance compared with 10/2/98 exam
EX 30	10/4/98	10/4/98	Maloof/R	Tiny apical pneumothorax and right pleural effusion not changed from 10/3/98 study; underlying interstitial lung disease
DX 20	7/2/99	7/12/99	Patel/B,R	No progressive change since 5/28/99 x-ray; stable postoperative changes of right upper lung resection; bilateral upper zone, retractive lung infiltrates, likely representing postoperative/postradiation fibrosis; stable bilateral upper zone and left mid lung zone spiculated and non-spiculated densities, likely representing category B large opacities of complicated pneumoconiosis; recurrent lung neoplasia, or pulmonary metastasis, not clearly excluded; 1/1; p/s; 6 zones associated with bilateral upper zone.
DX 19	7/2/99	9/10/99	Ranavaya/B	1/2; q/p; 6 zones
DX 18	7/2/99	9/22/99	Gaziano/B	1/2; q/q; 3 zones; size A large opacities
EX 31	7/2/99	1/4/00	Castle/B,P	0/1; p/q; 4 zones; changes of previous lung surgery on right due to old granulomatous disease
EX 3	7/2/99	5/15/00	Wheeler/B,R	Few linear scars in upper and lower right lung and minimal right diaphragm elevation with focal pleural fibrosis tenting lateral dome; ill defined mass, infiltrate, or fibrosis in subapical portion; negative for pneumoconiosis

EX 3	7/2/99	5/15/00	Scott/B,R	Right chest surgery with partial lung resection; cannot rule out mass hilum or left apex mass; negative for pneumoconiosis
EX 6	7/2/99	6/2/00	Kim/B,R	Negative for pneumoconiosis; evidence of right thoracotomy; rule out small lung mass in both upper lobes
EX 7	7/2/99	6/30/00	Hippensteel/B,P	1/0; s/q; 2 zones but upper lobe changes are not typical for pneumoconiosis; upper lobe changes could represent radiation injury from lung cancer therapy or from old granulomatous disease
EX 8	7/2/99	7/25/00	Fino/B,P	No pleural and no parenchymal abnormalities consistent with an occupational pneumoconiosis; emphysema and evidence of previous right lung surgery
EX 8	1/19/00	4/25/00	Castle/B,P	1/1; q/q; 6 zones; changes do not appear to be those of complicated pneumoconiosis
EX 4	1/19/00	5/16/00	Wheeler/B,R	0/1; s/q; 2 zones; fibrosis or mass in subapical portion and lower left apex and 2.5 cm fibrosis or mass in right upper lung compatible with inflammatory disease or possible cancer
EX 4	1/19/00	5/16/00	Scott/B,R	Negative for pneumoconiosis; suggestive of either cancer or granulomatous
EX 5	1/19/00	5/9/00	Castle/B,P	Upper lung zone abnormalities unrelated to coal mining employment
EX 6	1/19/00	6/2/00	Kim/B,R	Negative for pneumoconiosis; focal densities seen in both upper lobes, probably old healed tuberculosis but unknown activity and small lung masses in both upper lobes cannot be totally excluded
EX 7	1/19/00	6/30/00	Hippensteel/B,P	1/0; s/q; 2 zones but upper lobe changes are not typical for pneumoconiosis; upper lobe changes could represent radiation injury from lung cancer therapy or from old granulomatous disease
EX 8	1/19/00	7/25/00	Fino/B,P	No pleural and no parenchymal abnormalities consistent with an occupational pneumoconiosis; emphysema and evidence of previous right lung surgery

Pulmonary Function Studies

<u>Exh. No.</u>	<u>Test Date</u>	<u>Doctor</u>	<u>Co-op/Undst/TR</u> <sup>5</sup>	<u>FEV1</u>	<u>FVC</u>	<u>MVV</u>	<u>Qual.</u> <sup>6</sup>	<u>Hgt.</u> <sup>7</sup>
DX 30	3/7/89	Illegible	Good/Good/Yes	4.75	6.90	—	No	73"
DX 30	5/19/93	Yates	Good/--/Yes 4.85	6.85	171.7		No	74"
DX 30	9/25/96	Illegible	Good/Good/Yes	4.16 4.33	6.34 6.16	— —	No No	72 ½"
EX 1	1/23/97	Illegible	--/Yes	4.22	6.23	163	No	73"
DX 30	7/3/97	Rasmussen	--/Yes	4.06	6.10	145	No	73"
DX 15	7/2/99	Rasmussen	--/Yes	3.21	5.60	105	No	73"
EX 2	1/19/00	Castle	--/Yes	3.18 3.29	6.33 6.08	— —	No No	72"

Arterial Blood Gas Studies

<u>Exh. No.</u>	<u>Test Date</u>	<u>Doctor</u>	<u>Condition</u>	<u>pCO2</u>	<u>pO2</u>	<u>Alt.</u>	<u>Qualify</u>
DX 17	7/2/99	Rasmussen	resting 37	76	0-2999	No	
			after exercise	38	72	0-2999	No
EX 8	1/19/00	Castle	resting	39.8	83.3	0-2999	No

Medical Reports/Opinions

On August 26, 1998, the Claimant was examined by Dr. Scott M. Killmer (DX 30). He considered symptoms of a chronic cough, several x-rays, a CT scan, a medical history, a history of smoking for six years before quitting 20 years prior to the hearing, 30 years of coal mine employment, and a physical examination. He diagnosed a right upper lobe chest mass consistent with lung cancer. Dr. Killmer is board-certified in surgery.

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<sup>5</sup>Conforming reports of pulmonary function studies must record the miner's level of cooperation and understanding of the procedures, and include three tracings of the maneuvers performed.

<sup>6</sup>Values listed are those values obtained pre-bronchodilator. However, the second line of the values shown for the September 25, 1996 and January 19, 2000 studies indicate post-bronchodilator studies.

<sup>7</sup>Because of the various heights noted by the examining physicians, the discrepancy is resolved by taking the average of the heights recorded. *See Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). In this case, the average is 72.9 inches.

Dr. Killmer attended the Claimant during a hospitalization from September 2, 1998 to September 3, 1998 (DX 30). Based on a physical examination, a medical history, and chest x-rays, he diagnosed a right pneumothorax and a right lung mass. During this hospitalization, a right lung mass was removed via a fine needle aspiration biopsy. Dr. S. Gerard Koh, whose credentials have not been established of record, performed a microscopic and macroscopic examination of the tissue and diagnosed an inflammatory pseudotumor and found no evidence of epithelial malignancy.

On September 12, 1998, the Claimant was seen in the emergency room of Raleigh General Hospital in Beckley, West Virginia by Dr. Jean Bernard Poirier (DX 30). The Claimant had presented with pain in the lower right part of his abdomen. Dr. Poirier considered a medical history, symptoms, and physically examined the Claimant. He diagnosed a right ureteral stone without complication.

Claimant was hospitalized at Raleigh General Hospital from September 25, 1998 to October 4, 1998 (DX 30). Dr. Killmer performed an exploratory right thoracotomy with a right upper lobectomy, followed by a right upper lung lobectomy and diagnosed a mesenchymal tumor in that lung lobe. The lung tissue was biopsied by Dr. Koh on September 29, 1998 (DX 30). Both a gross and microscopic examination revealed a benign mesenchymal lesion with no evidence of bronchogenic carcinoma; inflammatory pseudotumor; and moderate to marked sinus histiocytosis with anthracotic deposits.

Dr. D. L. Rasmussen examined the Claimant on July 2, 1999 (DX 16). The examination included taking medical, employment and smoking histories, conducting a physical examination, pulmonary function and arterial blood gas studies and an x-ray. Dr. Rasmussen diagnosed complicated coal workers' pneumoconiosis due to coal dust exposure and chronic bronchitis due to coal mine dust exposure. In his medical opinion, Claimant has only minimal loss of lung function and retains the pulmonary capacity to perform his current coal mine job as a roofbolter. Dr. Rasmussen is board-certified in internal medicine.

On May 9, 2000, Dr. James R. Castle, who is board-certified in internal medicine and pulmonary diseases, examined the Claimant (EX 2). Dr. Castle considered a medical history, twenty-six years of underground coal mine employment, currently as a roof bolter, a history of smoking one package of cigarettes per day for three to four years before quitting when he was twenty-four or twenty-five years old, and a review of the results of x-rays, an EKG, blood gas studies, and pulmonary function studies. Dr. Castle diagnosed coal workers' pneumoconiosis and mild airway obstruction, but no evidence of respiratory disability. Dr. Castle stressed that the miner's x-ray was abnormal, that the abnormality is unrelated to coal workers' pneumoconiosis, and that it should be followed up by Claimant's local physician. Dr. Castle also reviewed x-ray reports from x-rays dated August 27, 1974, March 24, 1987, March 7, 1989, September 7, 1998, and July 2, 1999; pulmonary function studies from March 7, 1989, May 19, 1993, and July 3, 1997; medical records and reports from Dr. Killmer, Dr. Rasmussen, and Raleigh General Hospital; and the pathology report of September 28, 1998. Based on this review, Dr. Castle concluded that Claimant possibly has evidence of simple pneumoconiosis, but does not have complicated pneumoconiosis. Dr. Castle explained that there was no evidence of complicated pneumoconiosis in 1998, but Dr. Rasmussen diagnosed complicated pneumoconiosis in 1999, and so the time frame makes it physically impossible for the changes on x-ray to be related to complicated pneumoconiosis. He further opined that the Claimant has a mild degree of airway obstruction which is not disabling.

Dr. Castle was deposed on August 30, 2000 (EX 13). At that time, he had also reviewed additional x-ray interpretations of the July 2, 1999, January 19, 2000, and September 2, 1998 x-rays, as well as the reports of Drs. Dahhan and Fino. Dr. Castle also read the September 2, 1998 x-ray himself. He reiterated that the miner does not have complicated pneumoconiosis, but rather, changes due to his lung surgery or granulomatous disease. He felt the changes on x-ray might be due to the pseudotumor which

was removed but that the changes were not representative of pneumoconiosis. Dr. Castle opined that, if Dr. Rasmussen had been aware of the biopsy results, he would not have diagnosed complicated pneumoconiosis. Finally, Dr. Castle opined that the reduction in pulmonary function between 1997 and 1999 was due to the partial lung removal.

Dr. Abdulkadar Dahhan reviewed medical records pertaining to the Claimant on August 3, 2000 (EX 9). Dr. Dahhan, who is board-certified in internal medicine and pulmonary disease, reviewed x-ray interpretations of x-rays dated August 27, 1974, April 14, 1983, March 24, 1987, March 7, 1989, September 7, 1998, July 2, 1999, and January 19, 2000; pulmonary function studies performed on March 7, 1989, May 19, 1993, September 25, 1996, and July 3, 1997; blood gas studies performed on July 2, 1999 and May 9, 2000; medical records and reports from Dr. Killmer, Dr. Rasmussen, Dr. Castle, and Raleigh General Hospital; and the pathology report of September 28, 1998. He also considered a smoking history of one pack per day between 1971 and 1979 and twenty-four years of coal mine employment. Dr. Dahhan found evidence sufficient to justify the diagnosis of simple coal workers' pneumoconiosis. He did not find complicated pneumoconiosis, based on the majority of x-ray readers, the pathology report, the lack of crackles or crepitation found on clinical examination, and the absence of a restrictive ventilatory defect on spirometry. Dr. Dahhan opined the Claimant is neither permanently nor totally disabled from a respiratory standpoint and retains the respiratory capacity to continue his coal mining job.

Dr. Gregory J. Fino, who is board-certified in internal medicine and pulmonary disease, reviewed specified medical records on August 16, 2000 (EX 10). He considered a medical history, symptoms, a 24-year history of coal mine employment, currently as a roof bolter, and a history of smoking one package of cigarettes per day for five to six years before termination in 1979. He reviewed the results of x-ray readings, arterial blood gas studies, pulmonary function studies, medical reports, hospital records, and the pathology reports. Dr. Fino concluded that the Claimant does not have even simple coal workers' pneumoconiosis. He found no evidence of any pulmonary impairment or pulmonary disability attributable to coal mine dust. He concluded, that from a respiratory standpoint Claimant is neither partially nor totally disabled from returning to his coal mining job. He opined that this would be true even if it were found that the Claimant suffers from pneumoconiosis.

Dr. Kirk E. Hippensteel reviewed specified medical evidence on August 22, 2000 (EX 12). He declared that the pathology report belies his prior reading of pneumoconiosis, that the pathology report was more probative evidence; and that, since that report revealed a benign pseudotumor unrelated to coal workers' pneumoconiosis, his opinion had changed. He did not find complicated pneumoconiosis, and opined that Mr. Fox has the pulmonary functional capacity to return to his last mining job, even if the Claimant were found to suffer from pneumoconiosis. Dr. Hippensteel is board-certified in internal medicine and pulmonary disease.

Dr. Paul S. Wheeler, who is a board-certified radiologist, was deposed on September 7 2000 (EX 14). He had read the x-rays dated September 2, 1998, July 2, 1999, and January 19, 2000. He found changes that could be pneumoconiosis but which he determined were not sufficient to qualify as simple pneumoconiosis. With respect to the September 2, 1998 x-rays, Dr. Wheeler noted a seven-by-four-centimeter oval mass on the right which was either tuberculosis or a tumor and a four-centimeter pneumothorax possibly due to a recent needle biopsy. After reviewing the September 1998 surgical biopsy results, Dr. Wheeler declared that the discovered pseudotumor was unrelated to coal mine employment. Dr. Wheeler suspected tuberculosis as the cause, based on its position and continued growth. He also opined that whatever caused the pseudotumor probably also caused the small opacities. Dr. Wheeler stated that complicated pneumoconiosis usually grows slowly, and usually does not progress without ongoing coal dust exposure, and that q and r nodules are usually present and coalesce to form the large opacities characteristic of complicated pneumoconiosis. While Claimant continues to be exposed to coal mine dust, none of the other factors associated with complicated pneumoconiosis have been identified.

Consequently, Dr. Wheeler expressed confidence that the Miner does not have complicated pneumoconiosis.

### Conclusions of Law and Discussion

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *See Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

### Existence of Pneumoconiosis

Section 718.202(a) provides four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§ 718.304, 718.305, and 718.306; or (4) the findings by a physician of pneumoconiosis as defined in § 718.201 which is based upon objective evidence and a reasoned medical opinion.

There are thirty-six x-ray readings in evidence based on fifteen different x-rays. Of the thirty-six readings, twenty-one are by either board-certified radiologists or B-readers, and fourteen are by board-certified radiologists who are also B-readers. Seven readings were positive for pneumoconiosis, while twenty-nine were negative.

The first three x-rays, dated August 27, 1974, March 24, 1987, and March 7, 1989, were interpreted either as negative for pneumoconiosis or normal. Two x-rays were taken on September 2, 1998. The first was read as negative for pneumoconiosis by Drs. Wheeler, Scott, and Kim, all of whom are both B-readers and board-certified radiologists. Claimant underwent a fine needle biopsy of the lung before the second x-ray of September 2, 1998. That second film was also interpreted by Drs. Wheeler, Scott, and Kim as negative for pneumoconiosis. Dr. Castle, a B-reader, interpreted this film as Category One pneumoconiosis. Based on the unanimous opinion of the dually-qualified readers, both September 2, 1998 x-rays are determined to be negative for pneumoconiosis. *See Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984).

None of the ten films taken between September 7, 1998 and October 4, 1998 established the existence of pneumoconiosis according to Drs. Setliff and Maloof, who are board-certified radiologists.

The July 2, 1999 x-ray was interpreted as positive by Drs. Patel, Ranavaya, Hippensteel, and Gaziano, who are B-readers. Dr. Patel is also a board-certified radiologist. Drs. Castle, Wheeler, Scott, Kim, and Fino interpreted this film negative for pneumoconiosis. After consideration of the pathology report, Dr. Hippensteel retracted his finding of pneumoconiosis. While each of the doctors diagnosing pneumoconiosis is a B-reader, Drs. Wheeler, Scott, and Kim are also board-certified radiologists. Based on a majority of the readings of the best qualified of these physicians, and Dr. Hippensteel's opinion after reviewing the pathology reports, this tribunal finds that this x-ray is not proof of pneumoconiosis.

Finally, the January 19, 2000 x-ray was interpreted as positive by Dr. Hippensteel, but, as previously noted, he changed his opinion after reading the pathology reports which revealed a pseudotumor. Likewise, Dr. Castle originally found the film positive for pneumoconiosis according to the ILO-U/C International Classification of Radiographs of the Pneumoconiosis form, but his May 9, 2000 letter to the Claimant opines that the abnormal opacities are unrelated to coal mine employment (EX 5).

Drs. Wheeler, Scott, Kim, and Fino read this x-ray as negative. Based on the superior credentials of Drs. Wheeler, Scott, and Kim, as supported by Dr. Fino's report and the later explanations of Dr. Castle and Dr. Hippensteel, this tribunal concludes that this x-ray is not proof of pneumoconiosis. Thus, the majority of the best-qualified readers found the x-rays negative for the disease despite the findings of lung abnormalities. *See Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-309 (1984). Consequently, the overall x-ray evidence does not point toward a finding of pneumoconiosis under § 718.202(a)(1).

Based on the fine needle aspiration biopsy of September 2, 1998, and surgical biopsy of September 28, 1998, pathologist S. Gerard Koh concluded that, the former procedure revealed an inflammatory pseudotumor with no evidence of malignancy or coal workers' pneumoconiosis, and that the latter procedure confirmed the prior diagnosis and uncovered a benign mesenchymal lesion and moderate to marked sinus histiocytosis with anthracotic deposits. In addition, the pathology reports convinced, Drs. Castle, Dahhan, Fino, Hippensteel, and Wheeler that the existence of the pseudotumor effectively ruled out the existence of pneumoconiosis. Because anthracotic pigmentation is not sufficient, by itself, to establish the existence of pneumoconiosis, and because of the unanimous opinions of the reviewing physicians, who are either board-certified pulmonary specialists or radiologists, this tribunal finds that the pathology evidence does not establish the existence of pneumoconiosis under § 718.202(a)(2).

Under § 718.202(a)(3) it may be rebuttably presumed that the miner has pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable for the reasons discussed below. Section 718.305 is not applicable because the claim was filed after January 1, 1982. Section 718.306 is not applicable because the miner is living.

Section 718.202(a)(4) provides that the existence of pneumoconiosis may be proved by reasoned, objectively based physicians' opinions. Drs. Rasmussen and Dahhan diagnosed pneumoconiosis. Drs. Killmer, Fino, and Hippensteel did not. Dr. Castle's diagnosis of pneumoconiosis was equivocal. Dr. Wheeler did not find pneumoconiosis, but his opinion is not reasoned because he did not consider the miner's smoking and coal mine employment histories, examine the Claimant, or review the reports of other physicians' examinations. *See Perry v. Director, OWCP*, 9 BLR 1-1 (1986).

Dr. Rasmussen's opinion is given less weight because he relied upon Dr. Patel's x-ray interpretation of category one pneumoconiosis, and complicated pneumoconiosis. That x-ray was reread as negative by three board-certified radiologists who are also B-readers. Moreover, Dr. Rasmussen had not reviewed either of the pathology reports from the September 1998 biopsies, as had Drs. Castle, Dahhan, Fino, and Hippensteel. Dr. Castle's equivocal opinion is also given little weight because of his inconsistent diagnosis of coal workers' pneumoconiosis. *See Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Dr. Dahhan's opinion is credible because it is based on a thorough review of all the evidence to date, because it is supported by some x-ray evidence, and because Dr. Dahhan is board-certified in internal and pulmonary medicine. *See Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990).

Dr. Killmer's opinion is persuasive because he was the miner's treating surgeon, who followed him through his hospitalizations, and because his opinion is well documented and supported by the pathology reports. *See Schaaf v. Matthews*, 574 F.2d 157, 160 (3d Cir. 1978). The opinions of Drs. Fino and Hippensteel are persuasive because they are well documented and based on comprehensive reviews of all the evidence of record. They are supported by the most probative evidence of record, *i.e.* the biopsy reports, and the preponderance of x-ray readings. Drs. Fino and Hippensteel are board-certified pulmonary specialists. Accordingly, this tribunal finds that the medical opinion evidence does not support a finding of the existence of pneumoconiosis under either § 718.202(a)(4), or in conjunction with the other evidence of record under § 718.202 overall. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4<sup>th</sup> Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.2d 22, 24-25, 21 BLR 2-104 (3d Cir. 1997).

### Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to § 718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established 25 years and seven months of coal mine employment. Thus, had he established the existence of pneumoconiosis, he would have also been entitled to the rebuttable presumption that his pneumoconiosis arose from his coal mine employment under the provisions of § 718.203(b). But the issue is moot.

### Disability Due to Pneumoconiosis

Section 718.304 provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he is suffering from a chronic dust disease of the lung which, when diagnosed by chest x-ray, yields one or more large opacities classified in Category A, B, or C, or when diagnosed by biopsy or autopsy, yields massive lesions in the lung. While the biopsies did not yield massive lesions in the lung, there is some evidence of large opacities by x-ray.

Dr. Patel found category B large opacities on the July 2, 1999 x-ray, and Dr. Gaziano interpreted this film as showing size A large opacities. In reliance on Dr. Patel's reading, Dr. Rasmussen diagnosed complicated pneumoconiosis. Dr. Patel is a board-certified radiologist and a B-reader; Dr. Gaziano is a B-reader. However, the other reviewing physicians, Drs. Ranavaya, Castle, Wheeler, Scott, Kim, Hippensteel, and Fino did not diagnose complicated pneumoconiosis based on the July 2, 1999 x-ray. Nor were large opacities seen on any of the other x-rays of record. Because all of these physicians are at least a B-readers, their consensus that there are no large opacities is convincing. More persuasive, however, are the pathology results which proved the large mass in the miner's right lung to be a pseudotumor and neither cancer nor complicated pneumoconiosis. This conclusion is bolstered by the well reasoned opinions, based on a thorough review of the medical evidence, including the pathology reports, of Drs. Castle, Dahhan, Fino, and Hippensteel, all of whom are board-certified pulmonary specialists. Dr. Rasmussen, on the other hand, did not have the advantage of the pathology reports in deriving his determination. Accordingly, Claimant is not entitled to the irrebuttable presumption that he is totally disabled due to pneumoconiosis pursuant to § 718.304.

Under Section 718.204(c) the criteria for determining whether a miner is totally disabled under the Act 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 opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-95 (1986).

In this case, there is no evidence to support a finding that the Claimant is totally disabled. All seven of the pulmonary function studies and both arterial blood gas studies produced values that exceed those set forth in the regulations at §§ 718.204(c)(1) and (c)(2), and in Appendix B to Part 718. There is no evidence of cor pulmonale with right-sided congestive heart failure. None of the physicians who either examined Claimant or reviewed the medical evidence of record found the Claimant to have a totally disabling respiratory impairment. Drs. Rasmussen, Dahhan, and Hippensteel opined that the Claimant

retains the pulmonary capacity to perform his last coal mine job. Drs. Castle and Fino stated that the miner was neither partially nor totally disabled from returning to his last coal mining job. These opinions are not contradicted and are well documented and reasoned and supported by the underlying objective medical evidence. The opinions of Drs. Castle, Dahhan, Hippensteel, and Fino are entitled to greater weight because of their credentials as pulmonary specialists.. Moreover, the Claimant continues to labor as a coal miner at his usual coal mine employment. There is no evidence of changed circumstances of employment indicative of his reduced ability to perform such work. Accordingly, total disability is not established by the medical opinions of record pursuant to § 718.204(c)(4), or the aggregate of the evidence considered under § 718.204(c). Consequently, total disability due to pneumoconiosis is not established under § 718.204(b), and benefits must be denied.

#### Attorney's Fees

The award of an attorney's fee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claim before this tribunal.

### **ORDER**

The claim of Gary Fox for black lung benefits under the Act is denied.

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EDWARD TERHUNE MILLER  
Administrative Law Judge

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