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: 04 November 2002

BOBBY G. YATES,
Claimant

Case No: 2000-BLA-97

v.

CALICO COAL COMPANY,
Employer

and

INTERNATIONAL BUSINESS AND MERCANTILE
REASSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-In-Interest

Appearances:

Bobby S. Belcher, Jr., Esq.
Wolfe, Farmer, Williams & Rutherford
Norton, Virginia
For the Claimant

Russell Vern Presley, II, Esq.
Lucy G. Williams, Esq.
Street Law Firm, LLP
Grundy, Virginia
For the Employer/Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. (the "Act"). The Act and implementing regulations, 20 CFR parts 410, 718,

725 and 727 (the "Regulations"), provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death (for claims filed prior to January 1, 1982). The Act and Regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2002). In this case, the Claimant, Bobby G. Yates, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on January 16, 2001, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure, 29 CFR Part 18 (2002). At the hearing, Director's Exhibits ("DX") 1-39 and Employer's Exhibits ("EX") 1-17 were admitted into evidence without objection. Claimant's Exhibits ("CX") 1-3 were admitted over the employer's objection. *See* the employer's Motion to Strike filed January 16, 2001, and Transcript ("Tr.") at 7-16, 35-36. The record was held open after the hearing to allow the parties to submit additional evidence and argument. I hereby admit EX 18, received from the employer on February 16, 2002, as well as a reading of a December 14, 2000 x-ray by Dr. DePonte, as CX 4.[1] The claimant's Closing Argument was received on April 3, 2002. The Brief on Behalf of Alleged Responsible Operator was received on April 19, 2002. The post-hearing proceedings in this claim are set forth more fully below.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

PROCEDURAL HISTORY

The claimant filed his first claim for benefits under the Act on July 6, 1994. He alleged thirty-four years and seven months of coal mine employment, last on June 8, 1991, when Dr. J.P. Sutherland told him to leave the coal mines because of his lung condition. Following a formal hearing, Judge Sheldon R. Lipson issued a Decision and Order Denying Benefits on October 30,

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[1]The claimant did not offer Dr. DePonte's reading of the December 14, 2000 x-ray into evidence at the hearing, perhaps forgetting that he had sent it to this office under cover letter of December 22, 2000. *See* Tr. at 12. However, since the employer had the x-ray reread post-hearing by Dr. Fino, I am sua sponte admitting Dr. DePonte's reading into the record as well.

1996. After determining the responsible operator and length of coal mine employment, Judge Lipson found that the evidence did not establish pneumoconiosis by any of the means available under §718.202(a). Accordingly, benefits were denied without reaching the issue of total disability. DX 37-67.

The claimant appealed that denial to the Benefits Review Board ("the Board"), which affirmed the denial by Decision and Order of November 21, 1997. In affirming the determination that the claimant did not establish pneumoconiosis by the medical opinion evidence, the Board stated that:

> Although Drs. Kennedy and Sutherland diagnosed the presence of pneumoconiosis, the administrative law judge properly found that neither physician explained how he reached this determination nor noted diagnostic studies leading to the diagnosis. Thus, the administrative law judge properly rejected their opinions as unreasoned. In addition, the administrative law judge correctly found that Dr. Stewart's initial finding of the presence of pneumoconiosis could not sustain claimant's burden of proof given the physician's subsequent report casting doubt on the original diagnosis. *See Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988); *Clark, supra; Fields, supra.* Finally, we note that the administrative law judge did not err in crediting the opinion of Dr. Fino, that claimant does not suffer from pneumoconiosis, over the contrary opinion of Dr. Forehand in view of the record evidence of Dr. Fino's qualifications, see Employer's Exhibit 4, and the fact that Dr. Forehand's credentials are not listed in the record. Thus, we hold that the administrative law judge acted within his discretion in deferring to the physician with superior qualifications. *See Scott v. Mason Coal Co.*, 14 BLR 1-37 (1990)(*en banc*), *rev'd on other grounds*, 60 F.3d 1138, 19 BLR 2-257 (4th Cir. 1995); *McMath v. Director, OWCP*, 12 BLR 1-6 (1988); *Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988); *Martinez v. Clayton Coal Co.*, 10 BLR 1-24 (1987).

DX 37-76.

The instant duplicate claim was filed on April 8, 1999. DX 1. The employer was notified of the claim, and subsequently controverted based on both its liability and the claimant's eligibility. DX 14, 15, 18, 22, 24. The District Director, Office of Workers' Compensation Programs ("OWCP") awarded benefits on September 17, 1999. DX 27. As the employer declined to voluntarily commence the payment of benefits, interim payments have been made by the Black Lung Disability Trust Fund. DX 32. The employer timely requested a formal hearing, and the claim was forwarded to the Office of Administrative Law Judges ("OALJ") on November 1, 1999. DX 26, 29, 30, 31, 38, 39. The employer’s motion for summary decision dated April 30, 1999, DX 18, was denied by Judge Edward T. Miller on December 3, 1999, and the motion having been twice renewed, was also denied by Judge Richard A. Morgan on July 7, 2000, and again by me on November 15, 2000.

Following several continuances, a hearing was held on January 16, 2001. The record was left open until June 18, 2001 to allow submission of responsive evidence and closing arguments. In the meantime, the revised regulations under the Black Lung Benefits Act became effective on January 19, 2001. The United States District Court for the District of Columbia, however, issued a Preliminary Injunction Order dated February 9, 2001, staying any cases affected by the revised regulations. By Order dated March 16, 2001, I requested briefs on whether or not the revised regulations applied to this claim. Briefs were submitted by the employer and the claimant. After the District Court stay was lifted, *see National Mining Ass'n v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001), I issued an Order on August 31, 2001 directing the parties to submit a status report relative to instant case, and by Order of November 14, 2001, I reinstituted the timeline for submission of any responsive evidence and written closing argument as initially set out at the hearing.

ISSUES

The following issues remain for resolution:

1. Whether the claim was timely filed;

2. The number of the claimant's dependents, if any;

3. The length of the claimant's coal mine employment;

4. Whether Calico is the responsible operator for this claim;

5. Whether the claimant has pneumoconiosis as defined by the Act and regulations;

6. Whether the claimant's pneumoconiosis, if any, arose out of coal mine employment;

7. Whether the claimant is totally disabled;

8. Whether the claimant's disability, if any, is due to pneumoconiosis; and

9. Whether the evidence establishes a material change in conditions within the meaning of 20 CFR § 725.309(d) (2000).

The employer has also raised several issues for appellate purposes. Those issues were noted and reserved in the record. Tr. 5-7; DX 38.

APPLICABLE STANDARDS

This claim relates to a "duplicate" claim filed on April 8, 1999. Because the claim at issue was filed after April 1, 1980, the Regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2002).

Parts 718 (standards for award of benefits) and 725 (procedures) of the Regulations have undergone extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2002). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2002). On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the “old” rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the “new” rules will be cited to the 2002 edition.

Because this proceeding relates to a duplicate claim, pursuant to 20 CFR § 725.309 (2000), in order to establish that he is entitled to benefits, Mr. Yates must demonstrate that there has been a “material change in conditions” since the denial of his previous claim such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. The courts of appeals have developed divergent standards to determine whether "a material change in conditions" has occurred. Because the claimant last worked as a coal miner in the state of Virginia, the law as interpreted by the United States Court of Appeals for the Fourth Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989). In order to establish entitlement to benefits under Part 718, Mr. Yates must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2002). I must consider the new evidence and determine whether the claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

The claimant's previous claim was denied for failure to establish pneumoconiosis. The issue of total disability was not reached. In order to establish a material change in conditions, the claimant must show by the newly developed evidence that he now has pneumoconiosis or that he now is totally disabled. For the reasons stated below, I have concluded that both elements have been established.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The claimant, Bobby G. Yates, was fifty-nine years old at the time of the hearing, and has an eighth grade education. He has one dependent, his wife. Tr. 17-18, 29; DX 1. He said he worked thirty-three and a half years in the mines. His last employer was Baldwin Coal Company for six or eight months; before that he worked for Calico. Tr. at 18. His last job was as a buggy man, pulling coal from the face, and general inside work, including dragging 50- to 80-pound bags of rock dust to spread on top of coal dust, and cleaning belt line or other places when the miner was not working. Tr. at 19-22; DX 3. He could not go back and do that job because of his energy and his breathing. Tr. at 23. He started having trouble with his breathing in 1990, when Dr. Sutherland pulled him out of the mines on account of his lungs. Tr. at 24. He never worked anywhere else after he came out of the mines. Tr. at 25. At the time of the hearing, he said he could walk on level ground at his own pace for about 200 feet before he would have to rest for five or ten minutes, but he could not walk up hill. Tr. at 25-26. He can operate a riding mower, but he was last able to trim with a push mower in the early nineties. Tr. at 26, 33-34. Dr. Sutherland was still treating him at the time of the hearing. He prescribed an inhaler, cough syrup and Tessofolan pills four times per day. Tr. at 26-28. He had also been seen by Dr. Kennedy since his last heart attack in 1997, most recently in January 2000. Tr. at 28. On cross examination, he agreed his last day of work may have been June 8, 1991, and that he had had two heart attacks. Tr. at 29-30. He smoked cigarettes and a pipe for about forty-one years, having stopped when he had his last heart attack in 1997. Tr. at 31. He denied that he was still smoking when he saw Dr. Rasmussen or Dr. Hippensteel. Tr. at 32.

Timeliness of Claim

The purpose of the Regulation allowing the filing of duplicate claims is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). There is no statute of limitations or time limit for filing a duplicate claim. 20 CFR § 725.309 (2000); *Andryka v. Rochester Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990). The employer has not presented any argument as to why this duplicate claim is untimely. Therefore, I find that the claim was timely filed.

Dependents

Mr. Yates testified that he has one dependent, his wife. There is no evidence to the contrary. I find that he has one dependent, for purposes of augmentation of benefits.

Length of Coal Mine Employment

The claimant testified that he was a coal miner for thirty-three and one-half years. Tr. 18.

In the prior claim, Judge Lipson determined that the claimant had thirty and one-half years of coal mine employment. The employer did not appeal that determination. *See* DX 37-68 – DX 37-74. As the claimant appealed pro se, his appeal placed all issues before the Board. The Board, however, did not address the issue of length of coal mine employment. Nevertheless, the claimant, who now has counsel, has not argued any specific error in Judge Lipson's calculation, and I find none. The claimant has not had any subsequent coal mine employment. Therefore, the claimant's coal mine employment is determined to have lasted thirty and one-half years.

Responsible Operator

The Claimant testified and I find that he worked at Baldwin Coal Company for less than one year after he worked for Calico Coal Company. Tr. at 18; *see also* DX 16, 17, 37-50, 37-61, 37-63, 37-67. The Director found that the Claimant worked for Calico Coal Company from September 7, 1988, to March 5, 1990, and from June 30 to July 25, 1990, verified by Social Security records, W-2's and company records. DX 12, 15, 21, 37-3, 37-23, 37-67. Calico Coal Company was insured by International Business and Mercantile Reassurance Company during the relevant time period. There is no evidence that the employer or carrier is unable to assume liability in the event the Claimant is found to be eligible for benefits. Calico Coal did not present any argument as to why it is not the responsible operator. I find that Calico Coal Company is the responsible operator in this case pursuant to 20 CFR §§ 725.491, 492 and 493 (2000). Judge Lipson reached the same conclusion. DX 37-67.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations performed before January 19, 2001, are found at 20 CFR § 718.102 (2000) and Appendix A of Part 718. The following table summarizes the x-ray findings available in connection with the current claim. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists. Film quality codes are 1, Good; 2, Acceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis; 3, Poor, with some technical defect but still acceptable for classification purposes; and 4 or U/R, Unacceptable. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large

opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis."

Exhibit Number	Date of X-ray	Reading Physician Name and Qualifications	Film Quality	Interpretation or Impression
DX 28	8/4/97	Patel		Chronic changes (portable film). No indication reading made for the presence or absence of pneumoconiosis.
CX 2	8/4/97	DePonte/BCR, B	2	2/2, p/q, all six zones.
EX 1	8/4/97	Wheeler/BCR, B	2	No parenchymal or pleural abnormalities consistent with CWP. Minimal interlobular effusion minor fissure and minimal pulmonary vascular congestion with interstitial edema in lower lungs compatible with CHF with ECG leads in place. Cannot rule out subtle interstitial fibrosis in bases but favor pulmonary vascular congestion. No silicosis or CWP.
EX 1	8/4/97	Scott/BCR, B	2	No parenchymal or pleural abnormalities consistent with CWP. Increased lower lung markings could be minimal non-specific linear fibrosis or due to overlying soft tissue.
EX 2	8/4/97	Castle/B	3	No parenchymal or pleural abnormalities consistent with CWP. ? CHF. Co.
EX 2	8/4/97	Hippensteel/B	2	Completely negative.
EX 9	8/4/97	Fino/B	1	No parenchymal or pleural abnormalities consistent with CWP. Changes in the mid and lower lung zones which are consistent with increased markings. Not CWP.
DX 28	7/30/98	Foster		Heart at upper limits to mildly enlarged without any overt failure. Chronic lung changes present. No real interval change from earlier study. No indication reading made for the presence or absence of pneumoconiosis.

Exhibit Number	Date of X-ray	Reading Physician Name and Qualifications	Film Quality	Interpretation or Impression
EX 14	7/30/98	Wheeler/BCR, B	2	No parenchymal or pleural abnormalities consistent with CWP. Probable few tiny scars and small nodules in upper RML compatible with granulomatous disease. Deep breath or emphysema. No silicosis or CWP.
EX 14	7/30/98	Scott/BCR, B	2	No parenchymal or pleural abnormalities consistent with CWP. Hyperinflation lungs: emphysema vs. deep breath. Probable granuloma RML.
EX 15	7/30/98	Fino/B	1	Completely negative.
DX 9	6/14/99	Patel/BCR, B	1	2/2, s, all six zones. Associated with bilateral pleural thickening. Mild hyperinflation (em) and generally thickened bronchovascular markings. RLZ calcified granuloma.
DX 10	6/14/99	Barrett/BCR, B	1	1/1, p/q, all six zones.
DX 36	6/14/99	Hippensteel/B	1	0/1, s/q, all zones but LUL. A few calcified granulomas.
DX 36	6/14/99	Castle/B	1	0/1, t/q, mid and lower zones. Calcified granulomas.
CX 1	11/18/99	DePonte/BCR, B	1	1/1, s/t, all six zones.
EX 3	11/18/99	Castle/B	3	Completely negative.
EX 3	11/18/99	Hippensteel/B	3	0/1, r/q, mid zones. ? small scattered calcified granulomas.

Exhibit Number	Date of X-ray	Reading Physician Name and Qualifications	Film Quality	Interpretation or Impression
EX 4	11/18/99	Wheeler/BCR, B	1	No parenchymal or pleural abnormalities consistent with CWP. Subtle interlobar effusion or fibrosis in minor fissure/check for recent CHF or inflammatory disease. Minimal increased markings in RL&ML lung compatible with subtle interstitial infiltrate or just pulmonary vascular prominence accentuated by overlying chest wall soft tissue. No evidence of silicosis or CWP.
EX 4	11/18/99	Scott/BCR, B	1	Slight thickening minor fissure. Few scars periphery LML & RM-LL. No evidence of silicosis/CWP.
EX 9	11/18/99	Fino/B	1	Changes in the mid and lower lung zones which are consistent with increased markings. Not CWP.
EX 9	2/14/00	Fino/B	1	No parenchymal or pleural abnormalities consistent with CWP. Changes in the mid and lower lung zones which are consistent with increased markings. Not CWP.
EX 10	2/14/00	Hippensteel/B	2	0/1, s/q, mid and lower zones. A few scattered calcified granulomas.
EX 11	2/14/00	Wheeler/BCR, B	2	No parenchymal or pleural abnormalities consistent with CWP. Possible subtle interlobar effusion or fibrosis minor fissure. Check for recent infection or CHF. Ill defined increased lower lung markings compatible with pulmonary vascular prominence accentuated by underexposure more likely than minimal interstitial fibrosis. No silicosis or CWP.
EX 11	2/14/00	Scott/BCR, B	2	Completely negative.
CX 4	12/14/00	DePonte/BCR, B	1	1/2, p/t, all six zones.

Exhibit Number	Date of X-ray	Reading Physician Name and Qualifications	Film Quality	Interpretation or Impression
EX 18	12/14/00	Fino/B	1	Clearly worse - the markings in the middle and lower lung zones have increased.
CX 3	12/18/00	Patel/BCR, B	1	1/2, p/s, all six zones. Em.
EX 18	5/4/01	Fino/B	1	No parenchymal or pleural abnormalities consistent with CWP. Clearly worse - the markings in the middle and lower lung zones have increased.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. The quality standards for pulmonary function studies performed before January 19, 2001, are found at 20 CFR § 718.103 (2000). The standards require that the studies be accompanied by two or three tracings of each test performed. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less.

Ex. No. Date	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC	MVV Pre-/ Post	Compre-hension/ Cooper-ation	Qualify
DX 5 6/14/99	57 64"	2.06 2.34	3.53 3.52	58% 66%	98 105	Good Good	No No
EX 10 2/14/00	58 64"	1.99 2.18	3.23 3.33	62% 65%	88		No No

Ex. No. Date	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC	MVV Pre-/ Post	Compre- hension/ Cooper- ation	Qualify
CX 3 12/18/00	59 64"	2.00 2.38	3.26 3.65	61% 62%	91 103		No No
EX 18 5/4/01	59 64"	1.77 1.91	3.27 3.14	54% 61%	84 81	Good Good	No No

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies performed before January 19, 2001, are found at 20 CFR § 718.105 (2000). The following chart summarizes the arterial blood gas studies available in connection with his current claim. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO_2 at rest exercise	PO_2 at rest exercise	Qualify
DX 7	6/14/99	Rasmussen	31 30	65 50	Yes
EX 10	2/14/00	Hippensteel	32.5	74.5	No
CX 3	12/18/00	Rasmussen	30	67	Yes
EX 18	5/4/01	Fino	33.5	59.3	Yes

Medical Records and Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability.

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2002). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2002). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2002). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2002). Quality standards for reports of physical examinations performed before January 19, 2001, are found at 20 CFR § 718.104 (2000). The record contains the following medical opinions submitted in connection with the current claim.[2]

The claimant was admitted to Buchanan General Hospital from August 4 to 5, 1997 due to chest pain. The attending physician, Dr. Clinton Sutherland, made diagnoses of acute non-Q-wave myocardial infarction, coronary artery disease with history of anterior wall myocardial infarction (1995), hypertension, and cigarette smoker. DX 28.

Dr. Donald L. Rasmussen examined the claimant on June 14, 1999 on behalf of the OWCP. He reviewed the claimant's histories, symptoms, and medications. The smoking history was one pack of cigarettes per day from 1957 through 1997. Examination revealed a few fine inspiratory crackles at both bases. An x-ray was positive for pneumoconiosis, 2/2. A pulmonary function study revealed a minimal, partially reversible obstructive ventilatory impairment. An arterial blood gas test showed a marked impairment in oxygen transfer. The SBDLCO and DL/VA were markedly reduced. An electrocardiogram revealed sinus bradycardia, small QII-III and AVF consistent with a previous inferior myocardial infarction, non-specific ST-T wave changes. Dr. Rasmussen diagnosed CWP based on the coal mine employment history and the x-ray changes of pneumoconiosis, due to coal mine dust exposure; COPD based on the chronic productive cough, airway obstruction, and decreased SBDC, due to coal mine dust exposure and cigarette smoking; and arteriosclerotic heart disease due to the myocardial infarctions in 1995 and 1997, due to non-occupational factors and cigarette smoking. He found the claimant to be totally disabled due to a very severe impairment in respiratory functions. Dr. Rasmussen stated that:

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[2]The medical evidence in the instant matter, except for Dr. Fino's last examination, was developed prior to January 19, 2001. Thus, the newly enacted § 718, subpart B does not apply to that evidence. Dr. Fino's examination is in compliance with the revised regulations.

> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coalworkers' pneumoconiosis which arose from his coal mine employment.
>
> The two risk factors for this patient's disabling respiratory insufficiency are his coal mine dust exposure and his cigarette smoking. His coal mine dust exposure is the more significant factor considering the pattern of impairment. The patient also may have some degree of airway reactivity, however, this is not a major factor in his disabling lung disease.

Dr. Rasmussen is board-certified in internal medicine. DX 6.

Dr. Peter G. Tuteur reviewed medical records on behalf of the employer and issued a report on February 10, 2000. Dr. Tuteur opined that:

> . . . [T]here is no convincing information to indicate the presence of clinically significant, physiologically significant, or radiographically significant coal workers' pneumoconiosis or any other coal mine dust-induced disease process. He clearly is clinically disabled. . . .
>
> . . . Clearly the history of progressive breathlessness is consistent with coal workers' pneumoconiosis. In fact, breathlessness is the quintessential clinical feature of coal workers' pneumoconiosis. Nevertheless, it is a highly nonspecific findings consistent with virtually any primary pulmonary or cardiac disorder. From a pulmonary standpoint though the breathlessness experienced by Mr. Yates is clearly present, the additional presence of cough, expectoration, wheezing and chest pain must be explained. These symptoms are not regular features of coal workers' pneumoconiosis. From a cardiac standpoint not only has he had two myocardial infarctions, but also has demonstrated at least focal left ventricular dysfunction. Yet this is insufficient to account for his marked widening of the A-aO2 gradient during exercise. In the face of the totality of available data pulmonary emboli, typically recurrent small pulmonary emboli, would be a consideration for the highest import. No clear cut data have been collected to aid in evaluation of this possibility. Obviously, both the chest pain and the orthopnea experienced is most consistent with and diagnostic of cardiac dysfunction.
>
> Physical examination of the chest waxes and wanes over time. At times the examination is normal. At other times focal or bibasalar crackles are reported. This waxing and waning nature of the chest examination findings are typical of either airways obstruction and/or congestive heart failure. In contrast, when coal workers' pneumoconiosis is sufficiently advanced to produce abnormalities on chest examination, one expects to find decreased lung expansion and/or the

presence of persistent late inspiratory crackling sounds. It is the persistence of these findings that reflect the irreversibility of the process. This is not the case here.

. . .

. . . Both in 1994 and 1999 resting arterial blood gas analysis revealed a low PO2 and a mildly elevated A-a gradient. These abnormalities substantially worsen during exercise. Not only is Dr. Rasmussen's study of June 14, 1999 internally validated, but comparison with the qualitative changes of the 1994 study further substantiates the validity of these findings. What is more difficult is ascribing this finding to a clinical process. Clearly this is a classic change associated with coal workers' pneumoconiosis. Yet there are no other data to support its presence clinically, physiologically, or even radiographically. That is not to say that it couldn't be present at the microscopic level. Yet, even if it were so, it is virtually unheard of that this profound degree of impairment of gas exchange during exercise could be present in the face of a normal radiograph and the absence of a restrictive ventilatory defect. Therefore one must begin to think of pulmonary vascular disease such as may occur with pulmonary hypertension and/or recurrent pulmonary emboli. Data to evaluate these possibilities are not present in the data base.

. . .

. . . [T]he overwhelming consensus indicates the absence of changes compatible with coal workers' pneumoconiosis. A few reviewers rate these radiographs as category I and one reviewer category II. Even if one were to assume that these minority opinions are valid, then the presence of coal workers' pneumoconiosis in this man would be of insufficient severity and profusion to produce the physiologic abnormalities seen here.

Dr. Tuteur further stated that:

No airways obstruction is identified. Even if chronic airways obstruction were confirmed and it was due to chronic obstructive pulmonary disease (and not congestive heart failure), with reasonable medical certainty this condition would not be caused by coal workers' pneumoconiosis. It is fully recognized that the inhalation of coal mine dust or the development of coal workers' pneumoconiosis may result in airways obstruction. Mr. Yates used tobacco regularly in the form of pipe smoking for decades. The inhalation of tobacco smoke results in the development of chronic obstructive pulmonary disease in approximately 15% of such smokers; among non-smoking coal miners, airways obstruction occurs in only one out of 350 so exposed miners. Thus, with reasonable medical certainty in this

> case, if airways obstruction were present, it would not be due to the chronic inhalation of coal mine dust or the development of coal workers' pneumoconiosis.

Dr. Tuteur related the total disability predominantly to advanced atherosclerotic coronary artery disease involving the claimant's left anterior descending coronary resulting in multiple myocardial infarctions and persistent symptomatology. He related the oxygen desaturation during exercise to "[a]lmost certainly" significant pulmonary vascular disease, either pulmonary hypertension or recurrent pulmonary emboli. EX 5. Dr. Tuteur is board-certified in internal and pulmonary medicine. EX 6.

Dr. Kirk E. Hippensteel examined the claimant on February 14, 2000 on behalf of the employer. Examination revealed good air movement. An x-ray was read as minimal increase in interstitial markings, 0/1, with a few scattered calcified granulomas. A pulmonary function study revealed mild airflow obstruction with improvement almost to normal post-bronchodilator. The lung volumes showed no restriction and mild air trapping. The diffusion was reduced, the MVV mildly decreased. The carboxyhemoglobin level was 2.4%, "consistent with a small amount of continued smoke exposure of less than a pack per day." The arterial blood gas test was normal at rest; exercise was contraindicated due to angina with excitement or exercise. An electrocardiogram showed a normal sinus rhythm with old anterior infarct and diffuse nonspecific ST-T wave changes. Dr. Hippensteel also reviewed additional medical records. He concluded that:

> [T]his man has developed no new findings of pulmonary impairment since his previous application in 1994. The additional data from Dr. Rasmussen shows no new findings compared with that from Dr. Stewart and Dr. Forehand in previous examinations in 1994 and 1995. This man's main medical problem appears to be from his heart which has caused two myocardial infarctions and significant left ventricular dysfunction. He does have a diffusion abnormality which is not clearly sorted out as to cause, but is shown on my examination not to cause gas exchange impairment at rest, and therefore he has no permanent resting gas exchange impairment. His exercise ability is certainly affected by his severe cardiac disease, which is a known cause for gas exchange impairment with exercise, just as much as diffusion problems from various lung diseases can be a cause. His diffusion impairment, as tested by other physicians, was not correlated with carboxyhemoglobin level, which does decrease diffusion level. The findings on this man's x-rays, in my opinion, do not make for a diagnosis of coal workers' pneumoconiosis, but show minor interstitial changes in his lower lung fields that does not look like coal workers' pneumoconiosis and does not have high enough profusion to be labeled as pneumoconiosis either. When assessing all of the facts in this case, I think it can be stated with a reasonable degree of medical certainty that this man does not have evidence of coal workers' pneumoconiosis and also does not have pulmonary impairment referable or consistent with causation from coal workers' pneumoconiosis or coal dust induced lung disease. I think this case

> shows that one needs to look at all the factors of illness that can impair exercise performance and gas exchange, which was not done by Dr. Rasmussen. Only through a complete survey of the medical problems can causation of impairment be assessed with any reasonable degree of medical certainty.

EX 10.

Dr. Gregory J. Fino, who is also board-certified in internal and pulmonary medicine, reviewed medical records and issued a report on behalf of the employer on February 16, 2000. He concluded that:

> From a functional standpoint, this man's pulmonary system is abnormal. He does not retain the physiologic capacity, from a respiratory standpoint, to perform all of the requirements of his last job. Three are two risk factors for this disability - coal mine dust exposure and smoking. In this instance, the clinical information is consistent with a smoking related disability. Even if industrial bronchitis due to coal mine employment contributed to the obstruction, the loss in the FEV_1 would be in the 200 cc range. If we gave back to him that amount of FEV_1, this man would still be disabled. This medical estimate of loss in FEV_1 in working miners was summarized in the 1995 NIOSH document. Although a statistical drop in the FEV_1 was noted in working miners, that drop was not clinically significant. This man would be as disabled had he never stepped foot in the mines.
>
> In addition, as discussed in my [November 1995] report, this man has a significant abnormality in both diffusion and in oxygen transfer. In this case, they are not consistent with a coal mine dust related condition. This man's clinical picture is one of a severe decrease in the diffusing capacity, a severe decrease in the pO2 with exercise, and the development of an obstructive abnormality with reversibility. The obstruction is consistent with smoking. However, the combination of the decrease in the diffusion, a drop in the pO2 and reversible obstruction suggests a vasculitis of the lungs such as Churg-Strauss arteritis - this is a condition unrelated to the inhalation of coal mine dust.
>
> Although this man has developed new reversible obstruction, he is as disabled now as he was in the mid-1990s.

EX 7, 8.

Dr. Hippensteel was deposed on July 17, 2000. He testified that he is board-certified in internal and pulmonary medicine. EX 16. Dr. Hippensteel stated that different conditions can look the same on x-rays, even pneumoconiosis and heart disease. EX 16 at p. 10. As for the carboxyhemoglobin level, the increase could have been due to significant secondhand exposure,

and in any event, it does not fully explain the desaturation. EX 16 at pp. 14-15, 32. Although Dr. Hippensteel stated that the claimant does not have a significant enough respiratory condition to keep him from working in the mines, he conceded that the evidence shows that the claimant desaturates with exercise and that there is no evidence to the contrary. EX 16 at p. 31. Dr. Hippensteel further conceded that Dr. Rasmussen exercised the claimant at a high enough level to make him desaturate, and that there was no indication of chest pain. EX 16 at p. 42.

Dr. Tuteur issued a supplemental report on July 21, 2000 following his review of additional medical records. He noted that "the chronic daily cough productive of white sputum, if not due to left ventricular dysfunction, is consistent with the diagnosis of chronic bronchitis, cigarette smoke-induced." He stated that:

> His [total] disability is in great part due to arteriosclerotic heart disease manifested by myocardial infarctions and resultant left ventricular dysfunction complicated by suboptimally controlled hypertension. His exercise intolerance is also related to the physiologic phenomenon of desaturation of oxygen during exercise reflecting some pulmonary vascular derangement. Differential diagnosis would include pulmonary hypertension (unlikely) secondary to left ventricular failure or recurrent pulmonary emboli. Record is still silent with respect to the potentially available data to make this differential.

EX 12.

Dr. Fino issued a supplemental report on July 25, 2000 after reviewing Dr. Hippensteel's examination report. His conclusions remained the same. He stated that the claimant "has a smoking related disease which would prevent him from returning to his last mining job." Additionally, "significant coronary artery disease is also a contributing factor to his overall disability." EX 13.

Dr. Rasmussen examined the claimant again on December 18, 2000 at the claimant's request. Examination revealed bilateral basilar crackles and a few expiratory wheezes. An x-ray was positive for pneumoconiosis, 1/0. A pulmonary function study revealed minimal, reversible obstructive insufficiency. The maximum breathing capacity was minimally reduced, improving to normal after bronchodilator therapy. The single breath carbon monoxide diffusing capacity was markedly reduced. There was minimal resting hypoxia, and marked hypoxia with exercise. Again, Dr. Rasmussen found the claimant to be totally disabled. His conclusions were as before, though he was more explicit in stating that "[h]is coal mine dust exposure is the most significant factor in view of the fact that he shows only mild ventilatory impairment, but marked impairment in oxygen transfer. This pattern is consistent with many symptomatic coal miners." CX 3.

Dr. Fino was deposed on January 11, 2001. EX 17. He stated that the claimant's marked reduction in oxygen tension with exercise alone makes him totally disabled. EX 17 at p. 17. He further testified that the claimant is totally disabled based on his spirometry results alone, as he

could not perform heavy labor. EX 17 at p. 28. He noted that the decrease in the FEV_1 (300 cc) over the past four or five years was significant, in this case going from being normal for the claimant's previous age to being abnormal for his current age. Only about 25 cc per year of the loss (approximately 125 cc in total) is attributable to aging. EX 17 at pp. 27-29. He stated that he does not believe that the claimant has asthma. EX 17 at p. 39. The Atenolol could account for the partial reversibility. EX 17 at p. 40.

Dr. Fino examined the claimant again on May 4, 2001. X-rays again were negative for pneumoconiosis. A pulmonary function study revealed moderate obstruction with no bronchodilator response. The TLC was normal. Air trapping was present. The diffusing capacity was reduced, as was the oxygen desaturation. The carboxyhemoglobin level was normal. The resting arterial blood gas showed moderate hypoxia. Dr. Fino also reviewed additional records. He concluded that:

> There has been a significant change in this man's lung function over the years.
>
> He reported to me that he stopped working in 1991. He had normal lung function in 1994 and in 1995. He did have a drop in his pO2 with exercise in 1994 and again in 1999.
>
> On 2/14/00, a mild obstructive abnormality was present. Currently, there is a moderate obstructive abnormality.
>
> His resting oxygenation was normal in 1994 and minimally abnormal in 1999. It was normal again in 2000, but in 2001 (at the time I evaluated this man) there was a moderate hypoxia.
>
> . . .
>
> When I previously reviewed the film dated 11/18/99 (in a report dated 5/23/00), I noted that the film was negative for pneumoconiosis but that there were changes in the middle and lower lung zones consistent with increased markings.
>
> In previous reports, I noted that this man had the beginning of an obstructive abnormality consistent with smoking. However, I also noted a drop in his diffusing capacity and a drop in his pO2 with exercise, which suggested to me that he could have an interstitial pulmonary process independent of coal mine dust inhalation - such as a vasculitis, or inflammation of the blood vessels in the lungs.
>
> The most recent examination of 5/4/01 again documents obstruction (a little worse than in 1999), moderate resting hypoxia and a significant decrease in

the diffusing capacity. The chest x-ray is clearly worse, as the markings in the middle in the lower lung zones have increased.

Again, I do not find evidence of a coal mine dust related pulmonary condition. However, I do find evidence of an interstitial pulmonary condition that has progressed since 1998. It was fairly stable between 1998 and 2000 but, by the chest x-ray, it is worse in 2001. This very well could be a vasculitis of the lungs or it could be diffuse interstitial pulmonary fibrosis. Both of these conditions are unrelated to the inhalation of coal mine dust.

It is my opinion that the obstruction is related to his smoking.

EX 18.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

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

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

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

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal

mine dust exposure.

20 CFR § 718.201 (2002). In this case, Mr. Yates's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

20 CFR § 718.202(a) (2002), provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Yates has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Yates filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); Stanford *v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, above at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984). I give the recent x-rays more weight than those previously considered, as the claimant's pulmonary condition has progressed (at least the obstruction, if not also the oxygen desaturation).

Based on numbers alone, the negative interpretations outweigh the positive findings of pneumoconiosis; however, an administrative law judge is not required to defer to the numerical

superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). *See also Tokaricik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984) (the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease). For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2002); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). I place no weight on the x-ray readings which were not made for the presence or absence of pneumoconiosis (Dr. Patel's reading of the August 4, 1997 x-ray, and Dr. Foster's reading of the July 30, 1998 x-ray).

Of the new x-rays, the August 4, 1997 x-ray was read as positive by one dually qualified physician and negative by two dually qualified physicians, as well as negative by three B-readers. As the equally qualified BCR/B readers found pneumoconiosis to be both present and absent, I find that the readings of this x-ray are in equipoise as to the existence of pneumoconiosis.

The July 30, 1998 x-ray was read negative by two dually qualified physicians and one B-reader. There are no positive readings. I therefore find this x-ray to be negative for pneumoconiosis.

The June 14, 1999 x-ray was read positive by two dually qualified physicians and negative by two B-readers. Giving greater weight to the readings by the BCR/B readers, I find this x-ray to be positive for pneumoconiosis.

The November 18, 1999 x-ray was read positive by one dually qualified physician and negative by two dually qualified physicians, as well as negative by three B-readers. As the equally qualified BCR/B readers found pneumoconiosis to be both present and absent, I find that the

readings of this x-ray are in equipoise as to the existence of pneumoconiosis.

The February 14, 2000 x-ray was read negative by two dually qualified physicians and negative by two B-readers. I therefore find this x-ray to be negative for pneumoconiosis.

The December 14, 2000 x-ray was read positive by one dually qualified physician and negative by one B-reader. Giving greater weight to the reading by the BCR/B reader, I find this x-ray to be positive for pneumoconiosis.

The December 18, 2000 x-ray was read positive by one dually qualified physician. I therefore find this x-ray to be positive for pneumoconiosis.

The May 4, 2001 x-ray was read negative by one B-reader. I therefore find this x-ray to be negative for pneumoconiosis.

As the readings of two of the x-rays are in equipoise, three are negative, and three are positive, I find that the x-ray evidence demonstrates neither the presence or absence of pneumoconiosis. Therefore, while the readings do not establish pneumoconiosis under § 718.202(a)(1), they do not disprove it either.

Under § 718.202(a)(4), a claimant may also establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reasoned medical opinions. This section further provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories.

An undocumented or unreasoned opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields, supra.* An opinion may be adequately documented if it is based on items such as physical examinations, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1987). Whether a medical report is sufficiently documented and reasoned is for the judge as the finder of fact to decide. *Clark, supra.*

Judge Lipson's findings as to the previously submitted medical opinions were summarized above. I note that in 1994, following examination, Dr. J. Randolph Forehand diagnosed CWP based on the history, x-ray, arterial blood gas test, and pulmonary function study; and chronic bronchitis due to cigarette smoking, based on the history, arterial blood gas test, and pulmonary function study. He found the claimant to be totally disabled due to the combined effects of

pneumoconiosis and bronchitis. Dr. Stewart diagnosed CWP by x-ray. Judge Lipson determined that Dr. Stewart's subsequent remarks, concerning how pulmonary vascular congestion can be mistaken for interstitial markings, cast doubt on his previous diagnosis of CWP. However, I find Dr. Stewart's remarks to be no different than Dr. Hippensteel's, and a reading of one condition is simply a valid disagreement with a reading for the other condition. That these conditions can be mistaken for each other renders the examination reports all the more important as the x-ray is only one factor the physicians consider in reaching a diagnosis. Dr. Stewart related the reduced diffusing capacity to a differential diagnosis of pulmonary hypertension or other pulmonary vascular disease, with smoking contributing. However, he still did not budge from his diagnosis of CWP.

After reviewing all of the opinions of record, and considering all of the differing views on the cause of the claimant's oxygen desaturation, reduced diffusing capacity, and obstruction, I find that the claimant has established that he has coal workers' pneumoconiosis.

To begin with, I find Dr. Rasmussen's opinion to be documented and well-reasoned. He performed a thorough examination of the claimant, including an exercise test. All of his diagnoses are supported by the objective studies, histories, and examination findings. He diagnosed CWP based on the history and positive x-ray. He diagnosed COPD based on the chronic cough, obstruction, decreased SBDC, and he related the COPD to coal dust exposure and cigarette smoking. Dr. Rasmussen also diagnosed arteriosclerotic heart disease based on the myocardial infarctions, and he stated the role of cigarette smoking in the cause of that diagnosis. Dr. Rasmussen recognized that the claimant may have some degree of airway reactivity; however, he stated that such was not a major factor in the claimant's disabling lung disease.

Dr. Rasmussen's opinion withstands the criticisms of Dr. Hippensteel. Although Dr. Rasmussen did not measure the claimant's carboxyhemoglobin level, the testimony on that issue indicates that even if the claimant had been smoking some (which the claimant denied at the hearing), that the increase in carboxyhemoglobin would not account for much of the oxygen desaturation and reduced diffusing capacity. Moreover, Dr. Fino measured the carboxyhemoglobin level on a subsequent examination and despite the normal value, the claimant had moderate hypoxia at rest. Secondly, Dr. Rasmussen exercised the claimant. And, as Dr. Hippensteel conceded at his deposition, no chest pain was noted despite the oxygen desaturation. In this regard, not only do I find Dr. Hippensteel's criticisms to be baseless, but I also find that Dr. Rasmussen was in a better position than Dr. Hippensteel to reach a conclusion on the claimant's cardiac and pulmonary conditions because he did exercise the claimant.

Part of Dr. Rasmussen's comprehensive examination was an EKG. There was no problem with the validity of any of the studies Dr. Rasmussen obtained. Dr. Rasmussen's diagnosis of CWP is medically reasonable, with him relating the changes to pneumoconiosis and not heart disease. Dr. Rasmussen also reached a diagnosis of legal pneumoconiosis, which he did not base on the x-ray reading, when he related the COPD to both cigarette smoking and coal dust exposure. Dr. Rasmussen's finding is this regard is consistent with the Department's findings on

coal dust exposure being a cause of COPD, upon its review of the medical literature. 65 Fed. Reg. 79,937 - 79,945 (2000).

Dr. Tuteur acknowledged that the claimant's breathlessness, which a non-specific symptom, was consistent with CWP. He further acknowledged that the oxygen desaturation is consistent with CWP, although he would not relate it to CWP due to the absence of radiographic CWP and restriction. I find the latter reason of Dr. Tuteur to be countered by the differing x-ray readings in this case, and also refuted by the Department's findings on CWP being able to cause obstruction even in the absence of radiographic findings. 65 Fed. Reg. 79,937 - 79,945 (2000). Thus, even a waxing and waning of certain symptoms, attributable to airflow obstruction, ties in with the diagnosis of legal pneumoconiosis.

Dr. Rasmussen's opinion does account for the presence of cough, expectoration, wheezing, and chest pain.

Dr. Tuteur related some of the oxygen desaturation to the claimant's heart condition. He opined that the remainder was due to another cause, but not CWP. Echoing Dr. Stewart, he stated that pulmonary vascular disease was a consideration. His reports also called for further data to aid in the evaluation of that possibility. He stated that there was "potentially available data to make this differential." The employer did not provide Dr. Tuteur, its expert, with any further data. Therefore, there apparently is not any. My impression is that if the claimant had pulmonary vascular disease causing oxygen desaturation, there would be treatment records. As such, I find that the absence of treatment records refutes the differential diagnosis of Drs. Tuteur and Stewart.

Dr. Fino's opinion on the cause of the obstruction is flawed, not only because his premises differ with that of the Department and Act, but also because of Dr. Fino's own statements in this case. Dr. Fino stated that industrial bronchitis could only possibly account for a 200 cc loss in FEV_1 in this case, and that the claimant would still be disabled even if given that 200 cc back. Yet at his deposition, Dr. Fino testified that a 300 cc loss in FEV_1 was significant even with 125 cc of that loss being due to aging (thus a 175 cc loss due to another cause), rendering the claimant disabled. These statements show a bias on the part of Dr. Fino in failing to attribute changes to coal dust exposure.

For these reasons, I give the opinion of Dr. Rasmussen the greatest weight. His opinion is documented, well-reasoned, comprehensive, and defensible. His opinion is consistent with the Act and Regulations. Dr. Rasmussen is a board-certified internist. I therefore find that the preponderance of the medical opinions demonstrate pneumoconiosis under §718.202(a)(4) (2002).

Weighing all of the evidence, both like and unlike, on the issue of pneumoconiosis, I find that the claimant has established that he has pneumoconiosis. The x-ray evidence confirms neither the presence nor absence of pneumoconiosis. Dr. Rasmussen's opinion, however, establishes that it is present.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the Regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2002). Mr. Yates was employed as a miner for over 30 years, and therefore is entitled to the presumption. The record does not show any other dust exposure. I conclude that his coal mine employment caused his pneumoconiosis.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2002), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2002). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2002). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2002); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Yates suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

Weighing the evidence, I find that the claimant has established that he is now totally disabled from a pulmonary or respiratory standpoint. While the pulmonary function studies did not produce qualifying values as determined by Appendix B to Part 718, four of the five arterial blood gas tests (including the exercise and the most recent ones) produced qualifying values as determined by Appendix C to Part 718.

Two of the three examining physicians, Drs. Rasmussen and Fino, found that the claimant was totally disabled considering both types of studies. Dr. Fino explained that the pulmonary function study results, despite the non-qualifying values, indicated that the claimant could not perform the heavy labor required in his last position. The other examining physician, Dr. Hippensteel, opined that the claimant was not totally disabled from a pulmonary standpoint, but on cross-examination, his reasoning did not hold up. Dr. Hippensteel conceded that he did not have any evidence to counter a finding of total disability. The evidence shows desaturation with exercise. And Dr. Hippensteel did not exercise the claimant. Dr. Rasmussen did, and there is no indication of any chest pain with the desaturation, thereby refuting Dr. Hippensteel's conclusion.

The one reviewing physician, Dr. Tuteur, was not clear on whether he found the claimant

to be totally disabled from a pulmonary or respiratory standpoint. He simply stated that the desaturation could be due to pulmonary vascular disease, either pulmonary hypertension or recurrent pulmonary emboli. He did not find an obstruction.

Thus, I find that the weight of the arterial blood gas tests and the weight of the medical opinion evidence demonstrate total disability under §§ 718.204(b)(2)(ii) and (iv). Weighing all of the evidence, both like and unlike, I find that the evidence establishes total disability. The opinions of Drs. Rasmussen and Fino are documented and well-reasoned on this issue, and show that all of the evidence supports a finding of total disability.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2002); *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).

The Benefit Review Board has held that §718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co.*, 917 F. 2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109 (4th Cir. 1995) the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed *arguendo*) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgement on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116.

Dr. Rasmussen stated that the claimant's "coal mine dust exposure is the most significant factor in view of the fact that he shows only mild ventilatory impairment, but marked impairment

in oxygen transfer. This pattern is consistent with many symptomatic coal miners." Back in 1994, Dr. Forehand related the claimant's disability to the combined effects of pneumoconiosis (due to coal dust exposure) and bronchitis (due to smoking). Dr. Stewart's and Dr. Tuteur's statements concerning pulmonary vascular disease as a possible cause of the oxygen desaturation and decreased diffusing capacity has been refuted. Any increase in the carboxyhemoglobin level has been shown not to be a cause. Dr. Rasmussen's exercise test refutes Dr. Hippensteel's statement of heart disease being a cause. Dr. Fino believes the claimant may have vasculitis of the lungs as a cause, however, Dr. Fino's opinion is not credible given his bias. Therefore, I find that the claimant has established that his total disability is due to pneumoconiosis. Accordingly, he is entitled to benefits under the Act.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 CFR § 725.503(b) (2002). The claimant filed his claim for benefits in April 1999. When he was examined by Dr. Rasmussen in June 1999, he was already totally disabled. I therefore find the claimant entitled to benefits from the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that there has been a material change in conditions since the denial of his previous claim, and that he is totally disabled due to pneumoconiosis. He is therefore entitled to benefits under the Act.

ATTORNEY FEES

The Regulations address attorney’s fees at 20 CFR §§ 725.362, 365 and 366 (2002). Claimant’s attorney has not yet filed an application for attorney’s fees. Claimant’s attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by Bobby G. Yates on April 8, 1999, is hereby GRANTED. The employer, Calico Coal Company, is hereby ORDERED to pay the following:

1. To the claimant, Bobby Yates, all benefits to which he is entitled under the Act, augmented by reason of his one dependent, commencing April 1, 1999.

2. To the claimant, all medical and hospitalization benefits to which he is entitled, commencing April 1, 1999.

3. To the Secretary of Labor, reimbursement for any payment the Secretary has made to the claimant under the Act. The employer may deduct such amounts, as appropriate, from the amounts the employer is ordered to pay under paragraph 1 and 2 above.

4. To the Secretary of Labor or to the claimant, as appropriate, interest computed in accordance with the provisions of the Act or regulations.

A

Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2002), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.