U.S. Department of Labor Office of Administrative Law Judges
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Date: November 29, 2000

Case No.: 2000-BLA-0359

In the Matter of:

HAROLD CALLOWAY,
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

and

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

APPEARANCES:[1]

Harry R. Hinton, Esq.
For the Claimant

Natalie Brown, Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Harold Calloway for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended (Act). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis,

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[1] The Director, Office of Workers' Compensation Programs, was not represented at the hearing.

or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

A formal hearing in this case was held in Madisonville, Kentucky on May 17, 2000. Each of the parties was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon my observation of the appearance and the demeanor of the witness who testified at the hearing, and upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. Statement of the Case

The Claimant, Harold Calloway, filed a second claim for benefits under the Act on December 9, 1998 (DX 1).[2] The Office of Workers' Compensation Programs (OWCP), on March 25, 1999, denied the claim (DX 9). The Claimant appealed by letter dated May 24, 1999 (DX 10). On November 24, 1999, the District Director issued a Proposed Decision and Order Memorandum of Conference allowing benefits (DX 27). The Employer appealed on January 5, 2000, and on January 24, 2000, the case was forwarded to the Office of Administrative Law Judges (DX 33, 36).

Mr. Calloway's first claim was filed on July 20, 1994 and was denied by OWCP on December 15, 1994 (DX 35, pp. 14, 56). No appeal was taken and the decision became final.

II. Issues

The controverted issues as listed on the Form CM-1025 are as follows:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

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[2] In this Decision and Order, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the transcript of the May 17, 2000 hearing.

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;
4. Whether the Miner's disability is due to pneumoconiosis; and,

5. Whether there has been a material change in conditions per § 725.309.

III. Findings Of Fact And Conclusions Of Law

The Claimant, Harold Calloway, was born on July 24, 1948 and was fifty-one years old at the time of the hearing (DX 1). He has one dependent for purposes of augmentation of benefits, his wife, Shirley Ann (Brimm) Calloway, whom he married on April 18, 1981 (DX 35, p. 40; Tr. 12).

The Claimant testified that he smoked at the rate of one-half pack of cigarettes per day from age thirty-three [1981] until 1999 (Tr. 17). He conceded, however, that he told Dr. Simpao that he smoked at the rate of one pack per day. The physicians of record note varying smoking histories. Drs. Morgan and Selby expressed doubt regarding the histories related to them by the Claimant. Drs. Simpao, Jarboe, and Repsher noted that the Claimant began smoking in 1973. Several physicians noted that the Claimant smoked at the rate of one pack per day. Dr. Selby, in his August 31, 1999 report, stated that although the Claimant initially told him that he quit smoking in January 1999, he later admitted to Dr. Selby that he smoked two cigarettes the evening prior to the examination. Based on the histories noted by the physicians of record, I find that the Claimant smoked at the rate of one pack per day commencing in 1973 and continued to smoke until at least August 1999, for a smoking history of approximately twenty-six pack years.

Coal Mine Employment

The parties stipulated to sixteen years of coal mine employment (Tr. 8). This is supported by the evidence, including the Claimant's Social Security earnings records (DX 4). I find that the Claimant has established sixteen years of coal mine employment.

Responsible Operator

Island Creek Coal Company has been designated as the Responsible Operator. This issue is undisputed by the parties.

Accordingly, I find that Island Creek Coal Company is properly designated as the Responsible Operator.

IV. Medical Evidence

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standards
1.	11/18/99	EX 5	Hargan	COPD	Not stated
2.	08/31/99	EX 3	Repsher B reader[3]	No pneumo.	Good
3.	08/31/99	DX 32	Morgan B reader	0/0	Good
4.	08/31/99	DX 30	Selby B reader	No pneumo.	Good
5.	07/02/99	DX 25	Sargent B reader Board cert.[4]	No pneumo.	Poor
6.	07/02/99	DX 24	Whitehead B reader Board cert.	1/0 p,p	Good
7.	07/02/99	DX 17	Houser	1/1	Not stated
8.	01/05/99	DX 8	Sargent B reader Board cert.	No pneumo.	Poor
9.	01/05/99	DX 7	Simpao	1/2 p,p	Good

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[3] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

[4] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association.

	Date	Exhibit	Doctor	Reading	Standards
10.	01/05/99	DX 7	Galuten	Minimal reticulo-nodular pattern present; may represent acute or chronic process	Not stated
11.	10/28/94	DX 18	Broudy B reader	0/1 t,s	Good
12.	10/06/94	DX 18	Jarboe B reader	0/1 t,p	Good
13.	09/09/94	DX 35	Pope B reader	0/1 q,q	Good
14.	09/09/94	DX 35	Sargent B reader Board cert.	No pneumo.	Poor
15.	03/01/94	DX 19	Bassali B reader Board cert.	1/2 q,t	Fair
16.	03/01/94	DX 18	Broudy B reader	No pneumo.	Poor
17.	03/01/94	DX 18	Jarboe B reader	0/0	Fair
18.	03/01/94	DX 19	Anderson	2/2, q,p	Good
19.	01/13/94	DX 19	Baker Board cert.	1/1 p,q	Good
20.	01/13/94	DX 18	Broudy B reader	No pneumo.	Good
21.	01/13/94	DX 18	Jarboe B reader	No pneumo.	Fair
22.	02/07/86	DX 18	Hatfield	Category 0	Not stated

Pulmonary Function Studies[5]

	Date	Exhibit	Doctor	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
1.	08/31/99	DX 30	Selby	51/73"	1.59	3.03	71	52%	Tracings
		Post-bronchodilator			1.77	3.49	65	51%	included
2.	07/02/99	DX 21	Houser	50/73"	1.59	3.47	88	46%	Tracings
		Post-bronchodilator			1.80	4.02	88	45%	included

Validation: Dr. N.K. Burki, who is Board certified in Internal Medicine and Pulmonology, found this study to be acceptable (DX 21).

[5] Because the physicians conducting pulmonary function studies noted varying heights, I must make a finding on the Claimant's height. *See Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983). Based on the height most frequently noted, I find the Claimant's height to be seventy-three inches.

	Date	Exhibit	Doctor	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
3.	01/05/99	DX 7	Simpao	50/72"	1.51	3.00	75	50%	Good effort, coop., & comp.; tracings included

Validation: Dr. Burki found this study to be acceptable (DX 7).

4.	10/28/94	DX 20	Broudy	46/73"	2.41	3.99	98	60%	Good effort; tracings included
		Post-bronchodilator			2.52	4.25	100	59%	

Validation: Dr. Burki found this study to be unacceptable because the paper speed was too slow (DX 20).

5.	10/06/94	DX 23	Jarboe	46/73"	1.99	3.79	100	53%	Good but variable effort; tracings included
		Post-bronchodilator			2.00	3.74	94	53%	

Validation: Dr. Burki found this study to be unacceptable because the paper speed was too slow (DX 23).

6.	09/09/94	DX 35	Pope	46/72"	2.18	3.70	103	59%	Tracings included
		Post-bronchodilator			2.14	3.88	107	55%	

Arterial Blood Gas Studies

	Date	Exhibit	Doctor	pCO_2	pO_2
1.	08/31/99	DX 30	Selby	42	71
2.	01/05/99	DX 7	Simpao	41.9	71
3.	09/09/94	DX 35	Pope	41.2	63.4

Narrative Medical Evidence

1. a. Dr. Thomas M. Jarboe, who is a B reader and a Board-certified Internist, issued a consultative report dated January 6, 2000 based on his review of numerous medical records dated between February 7, 1986 and August 31, 1999, including reports, x-ray interpretations, and objective studies performed by Drs. Hatfield, Pandit, Houser, Baker, Broudy, Anderson, Bassali, Broudy, Whitehead, and Selby. Dr. Jarboe found insufficient objective medical evidence to justify a diagnosis of pneumoconiosis based on x-ray and pulmonary function study evidence. He stated that the pulmonary function study results

show severe airway obstruction, consistent with emphysema. He attributed the obstructive impairment to cigarette smoking and not to coal dust exposure based on a finding of no restrictive impairment, a disproportionate reduction in FEV_1 (a finding characteristic of obstruction seen in cigarette smoking), because "it is rare for coal dust inhalation to cause this degree of airflow obstruction" and because the studies show a significant degree of emphysema. Dr. Jarboe concluded that the Claimant is totally and permanently disabled from a respiratory standpoint based on the August 31, 1999 pulmonary function study (EX 2, 7).

b. Dr. Jarboe examined the Claimant on October 6, 1994, at which time he reviewed the Claimant's symptoms (shortness of breath, cough, sputum), and his occupational (underground mining for twenty years), smoking (three-fourths pack per day since age twenty-five and continues to smoke less than one-half pack per day), and medical (knee surgery in 1989 and 1994; right shoulder surgery in 1993, high blood pressure since 1989) histories, and performed a physical examination and a pulmonary function study (mild restrictive and moderate obstructive defects), and interpreted an x-ray (0/1 t,p). Dr. Jarboe diagnosed chronic bronchitis with moderate airways obstruction due to cigarette smoking and essential hypertension based on history and examination. He does not believe that coal dust inhalation causes airways obstruction of the Claimant's magnitude or that the Claimant suffers from an occupational lung disease. He opined that the Claimant is not physically able from a pulmonary standpoint to perform the work of a miner based on pulmonary function testing (DX 18).

c. Dr. Jarboe was deposed on May 10, 2000, at which time he discussed his 1994 examination of the Claimant as well as his review of other medical records. Dr. Jarboe found no evidence of pneumoconiosis based on the x-ray evidence, including the August 31, 1999 x-ray. He found a mild restrictive defect and a moderate obstructive defect based on pulmonary function testing. He does not believe that the impairment is related to coal dust exposure based on the Claimant's pattern of pulmonary function abnormality. Dr. Jarboe opined that the impairment is due to cigarette smoking based on the pattern of functional abnormality, because pulmonary testing shows a reversible component of airways obstruction and because the Claimant has a significant degree of emphysema. Because the Claimant ceased working in the mines in 1992, Dr. Jarboe noted that any occupational disease that the Claimant suffered would have been present at the time of his 1994 examination (EX 8).

2. a. Dr. W.K.C. Morgan, a B reader and an Emeritus Professor of Medicine at the University of Ontario, issued a consultative report dated January 5, 2000 based on his review of numerous medical records dated between February 7, 1986 and December 31, 1999, including reports, x-ray interpretations, and results of objective studies performed by Drs. Houser, Baker, Broudy, Jarboe, Pandit, and Selby. Dr. Morgan opined that the Claimant suffers from moderate airways obstruction, compatible with emphysema and chronic bronchitis. This finding is based on pulmonary function testing. Dr. Morgan attributed the impairment to cigarette smoking. He did not find evidence of pneumoconiosis on x-ray and concluded that there is insufficient evidence to make a diagnosis of pneumoconiosis. Dr. Morgan opined that the Claimant is "totally and permanently disabled because of his inability to get around from the injuries he sustained while coal mining and because he now has at least moderate airways obstruction due to his cigarette smoking" (EX 1).

b. Dr. Morgan was deposed on March 24, 2000, at which time he reiterated much of what was stated in his written report. He noted that the Claimant worked in the mines for approximately nineteen years and smoked less than one pack of cigarettes per day for thirty years. He found no evidence of pneumoconiosis based on the August 31, 1999 x-ray. Dr. Morgan opined that the Claimant suffers from chronic obstructive lung disease based on the December 1999 pulmonary function study. He attributed the impairment to smoking and obesity [227 lbs.]. Dr. Morgan said the Claimant's carboxyhemoblobin level suggests that the Claimant smoked one full pack of cigarettes per day. The reduction in diffusion capacity is consistent with the presence of emphysema due to cigarette smoking. Dr. Morgan concluded that the Claimant's impairment is in no way attributable to coal dust exposure (EX 6).

3. a. Dr. Lawrence Repsher issued a consultative report dated January 4, 2000 based on his review of numerous medical records dated between March 9, 1992 and December 3, 1999. Dr. Repsher found no evidence of pneumoconiosis or occupational lung disease based on x-ray, pulmonary function and arterial blood gas studies. He stated that the Claimant suffers from multiple chronic orthopedic problems, none of which have affected the Claimant's respiratory function. He also stated that the Claimant suffers from significant COPD and emphysema, which are the causes of the Claimant's respiratory problems. He attributed all of the Claimant's pulmonary impairments to a "long, heavy, and continued" smoking history, noting that obstructive impairments are generally caused by smoking. Dr. Repsher opined that the Claimant "probably retains sufficient pulmonary function

to allow him to do moderate coal mine work" but he could not do sustained heavy coal mine labor. Dr. Repsher is a B reader and is Board certified in Internal Medicine, Pulmonology, and Critical Care. He is also the Medical Director for the Occupational and Environmental Lung Disease Program at Lutheran Medical Center in Wheat Ridge, Colorado, and is an Associate Clinical Professor of Medicine in the Division of Pulmonary Sciences at the University of Colorado (DX 32; EX 4).

b. Dr. Repsher was deposed on January 19, 2000, at which time he recounted what was stated in his written report. He stated that his findings were based on a twenty-year coal mine employment history, a smoking history of one-half pack to one pack per day since age twenty-five, and numerous objective studies performed by other physicians. Dr. Repsher noted that the Claimant has had multiple orthopedic injuries, resulting in retirement, and currently suffers from hypertension and mild sleep apnea. He stated that the Claimant's major medical problem is COPD, "which is at least moderately severe, associated with moderately severe emphysema." "And of course, his primary problem is obviously a severe addiction to cigarette smoking." He found no evidence of pneumoconiosis on x-ray or pulmonary function testing, but stated that he cannot "rule out that he may have some clinically insignificant microscopic evidence of coal workers' pneumoconiosis." Dr. Repsher stated, however, that even if he does have mild pneumoconiosis, "it has not produced any impairment." He stated that the Claimant suffers from a "pure" obstructive impairment based on pulmonary function testing. "The fact that he has a normal total lung capacity would rule out any clinically significant restrictive lung disease such as coal workers' pneumoconiosis" (EX 4).

4. a. Dr. Bruce C. Broudy, a B reader and Board-certified Internist and Pulmonologist, issued a consultative report dated December 29, 1999 based on his review of numerous medical records, including his own October 28, 1994 examination of the Claimant, as well as reports by Drs. Jarboe, Houser, and Selby. Dr. Broudy opined that the evidence does not support a finding of pneumoconiosis or any other respiratory impairment arising out of coal mine employment. He noted numerous negative x-ray readings in support of his opinion. Dr. Broudy also noted that an obstructive impairment such as the Claimant's is associated with cigarette smoking. He stated that the Claimant's pulmonary function study results are qualifying, thus, the Claimant is unable to perform the work of a miner. However, his impairment was not caused in whole or in part by pneumoconiosis (DX 31).

b. Dr. Broudy previously examined the Claimant on October 28, 1994, at which time he reviewed the Claimant's symptoms (breathing problems, wheezing, dyspnea on exertion), and occupational (twenty to twenty-one years underground mining), smoking (one pack per day for fourteen years until September 1994), and medical (knee surgery in 1989 and 1994, shoulder surgery in 1993) histories, and performed a physical examination, a pulmonary function study (moderately severe impairment, mostly obstructive but slightly restrictive), and interpreted an x-ray (0/1 t,s). Dr. Broudy diagnosed moderately severe chronic obstructive pulmonary disease and opined that the Claimant does not suffer from pneumoconiosis. He opined that the airways obstruction resulted from cigarette smoking and some predisposition to asthma or bronchospasm. "I do not believe that there has been any significant pulmonary disease or respiratory impairment which has arisen from this man's occupation as a coal worker" (DX 18).

5. a. The record contains several examination reports by Dr. Kuldeep R. Pandit dated between March 9, 1992 and November 18, 1999. On November 18, 1999, Dr. Pandit noted that the Claimant is "doing well," with only a mild occasional cough with sputum production and improved sleeping, breathing, and exercise tolerance. Dr. Pandit interpreted an x-ray as showing "clear lung fields." He stated his impression: "Chronic Obstructive Pulmonary Disease. Pulmonary status clinically improved and stable" (EX 5).

b. The record contains a report by Dr. Pandit regarding a sleep study which was performed on July 7, 1999. He interpreted an EKG as normal and stated his impression: (1) mild obstructive sleep apnea only in the supine position with significant desaturation in the supine position; (2) obnoxious snoring significantly so in the supine position; (3) obesity, weighing 218 pounds [73"]; and, (4) multifocal premature ventricular contractions. In a report dated July 19, 1999, Dr. Pandit reviewed the results of the sleep study and diagnosed: (1) Mild obstructive sleep apnea, only in the supine position. Obnoxious snoring with significant associated arousals; (2) Multifocal PVC's during sleep study; (3) COPD; (4) Smoker; and, (5) "Sinus problems ? allergies" (DX 22).

c. The earliest report of record by Dr. Pandit was issued on March 9, 1992, at which time he noted that the Claimant's shortness of breath and exercise tolerance significantly improved. He continues to have some minimal wheezing and productive cough. The Claimant smokes about one-half pack per day. Dr. Pandit performed a physical examination

and noted that pulmonary function studies performed on February 27, 1992 showed a mild obstructive impairment with reduction of diffusion capacity. He stated his impression: (1) Asthmatic bronchitis. Status significantly improved at present; and, (2) Uncontrolled hypertension. In a report dated October 2, 1995, Dr. Pandit noted that "pulmonary function studies have revealed mild to moderate obstructive impairment with insignificant bronchodilator response." Dr. Pandit noted on February 20, 1996 that the Claimant is doing well, with only occasional productive cough and no shortness of breath, wheezing, or leg pain/swelling. He noted that the Claimant smokes three-fourths of a pack of cigarettes per day. In his June 20, 1996 report, Dr. Pandit reviewed the Claimant's symptoms (cough, sputum, shortness of breath on mild exertion, wheezing) and noted that the Claimant smokes one-half pack per day "in spite of repeated advise for smoking cessation." Dr. Pandit stated his impression: "chronic obstructive pulmonary disease with moderately severe obstructive impairment. Smoker." Dr. Pandit examined the Claimant on September 30, 1996, at which time he noted the Claimant's symptoms (mild cough with sputum, exertional dyspnea) and that the Claimant smokes one-half pack per day. He stated that a chest x-ray revealed mild bronchiectic inflammation and no evidence of pneumonia. He stated his impression as "Chronic asthmatic bronchitis. Smoker. History of pulmonary embolism in the past." Dr. Pandit noted on May 5, 1998 and September 8, 1998 that the Claimant is feeling better and denies any cough or sputum production. He still gets short of breath with mild exertion. The Claimant has not smoked in two and one-half months.[6] Dr. Pandit stated on May 5, 1998 that a chest x-ray showed changes consistent with COPD. He diagnosed severe COPD. Dr. Pandit, on January 18, 1999, stated that an x-ray taken on January 5, 1999 was read as having minimal radiculonodular pattern in both lungs. He noted that the Claimant continues to smoke ten cigarettes per day and has a mild chronic cough with sputum and shortness of breath. Dr. Pandit stated that no x-rays were available to him for personal review. He found that the Claimant suffers from COPD. Dr. Pandit examined the Claimant on January 21, 1999, at which time he interpreted an x-ray (no evidence of pulmonary infiltrate) and performed a pulmonary function study (moderate obstructive impairment). He diagnosed severe COPD. Dr. Pandit examined the Claimant on June 11, 1999 for evaluation of a possible sleep-related breathing disorder. He noted that the Claimant wakes himself up snoring and chokes and gasps at night. He noted that the Claimant is a former heavy smoker and "has not been smoking lately" (DX 18).

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[6] That the Claimant has not smoked in "2 1/2 months" is noted in both the May and September 1998 reports.

6. a. Dr. Jeff W. Selby, who is a B reader and is Board certified in Internal Medicine, Pulmonology and Critical Care, issued a consultative report dated December 3, 1999, in which he reviewed medical records, including reports by Drs. Pandit and Broudy. Dr. Selby stated that his review of these records does not change his opinion that the Claimant has asthma, emphysema, and chronic obstructive pulmonary disease, none of which are attributable to coal dust exposure (DX 28, 30).

b. Dr. Selby examined the Claimant on August 31, 1999. He noted that the Claimant suffers shortness of breath and "black lung" and that the Claimant worked for twenty years in underground mining. The Claimant initially told Dr. Selby that he smoked one pack per day for twenty-one years until eight months ago; however, he later said that he had two cigarettes the prior evening. Dr. Selby performed a physical examination, a pulmonary function study (moderate obstructive defect), an arterial blood gas study, and interpreted an x-ray (negative). Dr. Selby opined that the Claimant does not have pneumoconiosis or any respiratory impairment as a result of his coal mine employment. He found a moderate to severe obstructive disease in the form of emphysema from the Claimant's "many years of past and continuing cigarette smoking, which he finally admitted to, and also as a result of bronchial asthma entering into the picture in the last 2–3 years." He attributed the emphysema to smoking and the asthma to genetic make-up and environmental influences, most likely from viral infections and not from coal mine employment (DX 28, 30).

c. In a deposition taken on May 11, 2000, Dr. Selby recounted what was stated in his earlier reports. He noted that the Claimant has related various smoking histories and that he doubted the smoking history which was related to him. Dr. Selby found no evidence of pneumoconiosis based on x-ray. He found moderate obstructive defect based on pulmonary function testing with a significant response to bronchodilator. He noted that respiratory impairment due to coal dust exposure is irreversible and would not respond to bronchodilation. Dr. Selby opined that the Claimant has a significant degree of emphysema from smoking and an element of asthma or bronchospasm that is at least partially reversible. Dr. Selby did not find the Claimant totally disabled at the time of his examination because much of the Claimant's spirometric abnormality appears to be reversible, particularly if the Claimant ceased smoking. He did not attribute any of the Claimants' impairment to coal dust exposure because of the lack of restrictive scarring on the lungs, x-ray abnormalities, or a significant drop in oxygen levels with exercise (EX 9).

7. Dr. William C. Houser examined the Claimant on July 2, 1999. Dr. Houser reviewed the Claimant's symptoms (awakens with respiratory distress, coughs, sputum, wheezing), smoking (less than one pack per day for thirty-five years and continues to smoke five cigarettes per day), and medical (right knee, right shoulder, and rib injuries in 1992, with subsequent surgeries in 1991 and 1993; hypertension; high blood pressure) histories, and performed a physical examination and a pulmonary function study, and interpreted an x-ray (1/1). Dr. Houser diagnosed: (1) coal workers' pneumoconiosis 1/1; (2) chronic obstructive pulmonary disease; and, (3) hypertension. He opined that the Claimant's condition is related to his work as a miner based on an approximate twenty-year coal mine employment history and x-ray. Dr. Houser noted that coal and rock dust exposure is a causative factor in the development of chronic obstructive pulmonary disease. He stated that exposure to coal and rock dust is a contributing factor to the Claimant's chronic obstructive pulmonary disease, and that cigarette smoking is "also likely to be a contributing factor." "The restrictive changes are probably secondary to coal workers' pneumoconiosis, category 1/1, obesity [73", 223 lbs.] could be a contributing factor." Dr. Houser concluded that the Claimant has a "Class III impairment, range 30–45%." He noted that the Claimant's former position required unloading 6,000 pounds of 50-lb. bags of rock dust two or three times per week. In terms of restrictions, Dr. Houser stated that the Claimant should avoid exposure to dust, smoke, and fumes, and opined that he is "physically unable to do light, medium or heavy work" (DX 17).

8. Dr. Valentino S. Simpao examined the Claimant on January 5, 1999, at which time he reviewed the Claimant's symptoms (dyspnea, cough, orthopnea, paroxysmal nocturnal dyspnea), and his occupational (coal mining from 1972 to 1992), smoking (one pack per day from 1973 to 1997), and medical (wheezing attacks, arthritis, high blood pressure, crushed knees/surgery, shoulder surgery in 1993) histories, and performed a physical examination, a pulmonary function study (moderate restrictive and severe obstructive disease), an arterial blood gas study (ventilatory perfusion mismatch), and interpreted an x-ray (1/2). Dr. Simpao diagnosed coal workers' pneumoconiosis 1/2. He noted that "multiple years of coal dust exposure is medically significant in his pulmonary impairment." Dr. Simpao stated that the degree of the Claimant's impairment is "moderate" and opined that the Claimant does not retain the respiratory capacity to perform the work of a miner or comparable employment. He based his findings on x-ray, arterial blood gas, and pulmonary function testing, along with symptomotology and physical examination findings (DX 7).

9. Dr. Robert N. Pope examined the Claimant on September 9, 1994, at which time he reviewed the Claimant's symptoms (sputum, wheezing, dyspnea, cough, paroxysmal nocturnal dyspnea), and his smoking (one-half pack to one pack per day since 1984), medical (chronic bronchitis, high blood pressure, shoulder and spine injury in 1992/surgery 1993, knee surgeries 1989 and 1994), and family (father died of heart attack) histories,[7] and performed a physical examination, a pulmonary function study (moderate obstruction), an arterial blood gas study (mild hypoxemia at rest), and interpreted an x-ray (0/1). Dr. Pope diagnosed chronic obstructive pulmonary disease secondary to cigarette smoking based on spirometry. He opined that the Claimant suffers from a "Class 2" respiratory impairment. Dr. Pope noted that the Claimant "appears to have significant disability related to immobility of right knee" (DX 35, p. 27).

V. Discussion And Applicable Law

In cases where a claimant files more than one claim, and the earlier claim is denied, the later claim must also be denied on the grounds of the earlier denial, unless there has been a material change in conditions or the later claim is a request for modification. The Claimant filed his first claim on July 20, 1994, and it was denied by OWCP on December 15, 1994. The Claimant's present claim was filed on December 9, 1998, not within one year of the prior denial, thus constituting this claim as a duplicate claim. Section 725.309 governs the review of duplicate claims. The United States Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), adopted the following standard for determining whether a miner has established a material change in conditions:

> . . . to assess whether a material change is established, the administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the administrative law judge must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

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[7] The examination report states that an employment history is attached, however, there is no attachment to Dr. Pope's report.

Id. at 997-98.

Applying the *Ross* standard, I must review the evidence submitted subsequent to the denial of the previous claim to determine whether the Claimant has proven at least one of the elements that was adjudicated against him. The previous claim was denied when OWCP found that the Claimant failed to establish the existence of pneumoconiosis and, therefore, any of the other issues necessary for entitlement. Thus, if the Claimant establishes this element with new evidence, he will have demonstrated a material change in condition. I will then review the entire record to determine entitlement to benefits.

Material Change

Because the Claimant filed this claim after March 31, 1980, it must be adjudicated under the regulations at 20 C.F.R. Part 718. To be entitled to benefits under this Part, a claimant must establish: (1) the existence of pneumoconiosis; (2) pneumoconiosis arising from coal mine employment; (3) total disability; and, (4) total disability due to pneumoconiosis. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989).

Section 718.202 provides four means by which a claimant may establish pneumoconiosis. Under § 718.202(a)(1), a claimant may prove that the miner has pneumoconiosis on the basis of x-ray evidence. The new evidence consists of ten interpretations of four x-rays. Seven of the newly submitted interpretations are negative for pneumoconiosis and three are positive. Two of the negative interpretations are by physicians who are both B readers and Board-certified Radiologists, three are by physicians who are B readers only, and two are by physicians who possess no special radiological qualifications. One of the positive interpretations is by a dually qualified physician and two are by physicians with no special radiological qualifications. Interpretations by B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *See Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); *Vance v. Eastern Associated Coal Corp.*, 8 B.L.R. 1-68 (1985). A doctor who is a B reader as well as a Board-certified Radiologist may be credited over a physician who is only a B reader. *See Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). Placing greater weight on the majority of negative interpretations by the most qualified readers, I find that the newly submitted x-ray evidence fails to establish the existence of pneumoconiosis.

Under § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy or autopsy results. This section is inapplicable in this case because the record does not contain biopsy or autopsy results. Additionally, § 718.202(a)(3) is not available because none of the presumptions of §§ 718.304, 718.305, and 718.306 apply to the facts of this case.

Section 718.202(a)(4) provides that a claimant may establish the existence of pneumoconiosis if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the Claimant suffers from pneumoconiosis as defined in § 718.201. Section 718.201 defines pneumoconiosis as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. It is within the Administrative Law Judge's discretion to determine whether a physician's conclusions are adequately supported by documentation. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46, 1-47 (1985). "An administrative law judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *King v. Consolidation Coal Co.*, 8 B.L.R. 1-262, 1-265 (1985).

The newly submitted narrative medical evidence contains the opinions of eight physicians. Drs. Jarboe, Morgan, Repsher, Broudy, and Selby found no evidence of pneumoconiosis, while Drs. Houser and Simpao diagnosed pneumoconiosis. Dr. Pandit diagnosed chronic obstructive pulmonary disease but did not relate it to coal dust exposure.

Dr. Jarboe issued a consultative report on January 6, 2000 based on his review of numerous medical documents, including his own October 6, 1994 examination report. He found insufficient objective medical evidence to justify a diagnosis of pneumoconiosis based on x-ray and pulmonary function study evidence. He found a severe obstructive impairment based on pulmonary function testing, which he attributed to cigarette smoking and not to coal dust exposure. At the May 10, 2000 deposition, Dr. Jarboe stated that there was also an element of a restrictive impairment on pulmonary function testing, but opined that the Claimant’s impairment is due to smoking based on the pattern of functional abnormality. He noted that pulmonary function testing shows a reversible component of airways obstruction, which is inconsistent with coal dust-induced lung disease. He said that any occupational disease suffered by the Claimant would have been present at the time of the 1994 examination, given that the Claimant ceased working in the mines in 1992. Dr. Jarboe concluded that the Claimant was not

physically able from a respiratory standpoint to perform the work of a miner based on pulmonary function testing. Dr. Jarboe is a highly qualified examining physician. His opinion is well reasoned, well documented, supported by the evidence, and is entitled to substantial weight.

Dr. Morgan issued a consultative report dated January 5, 2000 based on his review of numerous medical records. He concluded that there is insufficient objective evidence to justify a diagnosis of pneumoconiosis. Dr. Morgan found that the Claimant suffers from moderate airways obstruction, compatible with emphysema and chronic bronchitis, which he attributed to cigarette smoking. He opined that the Claimant is totally disabled due to orthopedic injuries and "because he now has at least moderate airways obstruction due to his cigarette smoking." At the March 24, 2000 deposition, Dr. Morgan discussed the Claimant's carboxyhemoblobin level, which he opined suggests continued smoking. He concluded that the Claimant's impairment is in no way attributable to coal dust exposure. Although Dr. Morgan did not physically examine the Claimant, he is a highly qualified physician whose opinion is based on records dated between February 1986 and December 1999. His opinion is well reasoned, well documented, supported by the evidence, and is entitled to substantial weight.

Dr. Repsher issued a consultative report on January 4, 2000 based on medical records dated between March 9, 1992 and December 3, 1999. He found no evidence of pneumoconiosis on x-ray, pulmonary function, and arterial blood gas testing. Dr. Repsher opined that the Claimant suffers from significant COPD and emphysema, which he attributed to the Claimant's "long, heavy, and continued" smoking history, noting that obstructive impairments are generally caused by smoking. He concluded that the Claimant "probably retains sufficient pulmonary function to allow him to do moderate coal mine work," but he could not do sustained heavy coal mine labor. At the January 19, 2000 deposition, Dr. Repsher stated that he found no evidence of pneumoconiosis on x-ray or objective testing, but could not "rule out that he may have some clinically insignificant evidence of coal workers' pneumoconiosis." He opined that even if the Claimant did suffer from pneumoconiosis, "it has not produced any impairment." Dr. Repsher explained that "the fact that he has a normal total lung capacity would rule out any clinically significant restrictive lung disease such as coal workers' pneumoconiosis." Dr. Repsher did not physically examine the Claimant; however, he is highly qualified and he reviewed numerous medical records in rendering his opinion. Although Dr. Repsher stated that he could not rule out some "clinically

insignificant microscopic" evidence of pneumoconiosis, he failed to diagnose the disease based on the objective evidence. I find Dr. Repsher's opinion to be reasoned, documented, supported by the evidence, and entitled to substantial weight.

Dr. Broudy issued a consultative report in December 1999 based on various medical records, including his own October 28, 1994 examination report. He opined that the evidence fails to support a diagnosis of pneumoconiosis based on x-ray evidence. Based on pulmonary function testing, Dr. Broudy diagnosed a moderately severe obstructive impairment which he attributed to cigarette smoking and some predisposition to asthma or bronchospasm. He stated that the impairment did not arise in whole or in part from pneumoconiosis. Dr. Broudy concluded that the Claimant is unable to perform the work of a miner. Dr. Broudy is a highly qualified examining physician. His opinion is well reasoned, well documented, supported by the evidence, and is entitled to substantial weight.

Dr. Selby examined the Claimant on August 31, 1999 and opined that the Claimant does not suffer from pneumoconiosis or any respiratory impairment arising out of coal mine employment. He found a moderate to severe obstructive disease in the form of emphysema due to the Claimant's "many years of past and continuing cigarette smoking" and to bronchial asthma. He attributed the asthma to environmental influences, most likely viral infections and not coal dust exposure. Dr. Selby issued a consultative report dated December 3, 1999 based on his review of various medical records, and stated that his review of these records did not change his opinion that the Claimant's respiratory impairments are unrelated to coal dust exposure. At the May 11, 2000 deposition, Dr. Selby stated that there was no evidence of pneumoconiosis on x-ray and that considering the Claimant's response to bronchodilation on pulmonary function testing, the Claimant's respiratory impairment is not due to coal dust exposure. He stated that he did not find the Claimant to be totally disabled because much of the impairment appears to be reversible, particularly if the Claimant ceases smoking. Dr. Selby is a highly qualified examining physician. His opinion with respect to the presence of pneumoconiosis is reasoned, documented, supported by the evidence, and is entitled to substantial weight.

Dr. Houser examined the Claimant on July 2, 1999, at which time he diagnosed pneumoconiosis 1/1, chronic obstructive pulmonary disease, and hypertension. He opined that the Claimant's respiratory condition was related to his work as a miner based on a twenty-year coal mine employment history and x-

ray evidence. He also noted the presence of restrictive changes on pulmonary function testing, which are probably secondary to coal workers' pneumoconiosis and obesity. Dr. Houser stated that coal dust exposure is a contributing factor to the chronic obstructive pulmonary disease and that cigarette smoking is "also likely to be a contributing factor." He noted that the Claimant's former position required heavy lifting and opined that the Claimant is "physically unable to do light, medium, or heavy work" and should avoid exposure to dust, smoke and fumes. Dr. Houser, who lacks any special radiological qualifications, gave the July 2, 1999 x-ray a 1/1 reading. This same x-ray was interpreted as negative by Dr. Sargent, a dually qualified physician, and was given a 1/0 reading by Dr. Whitehead, also a dually qualified physician. As stated, I have found the x-ray evidence negative for pneumoconiosis. History of coal dust exposure is an insufficient basis upon which to make a diagnosis of pneumoconiosis. Further, Dr. Houser noted that the Claimant smoked at the rate of less than one pack per day for thirty-five years. I have found that the Claimant smoked one pack of cigarettes per day for at least twenty-six years. Dr. Houser's credentials are not of record. Although Dr. Houser is an examining physician, I find his opinion with respect to the existence of pneumoconiosis to be unsupported by the x-ray evidence, less reasoned, and entitled to less weight than the opinions of Drs. Jarboe, Morgan, Repsher, Broudy, and Selby.

Dr. Simpao examined the Claimant on January 5, 1999 and diagnosed pneumoconiosis 1/2. He stated that "multiple years of coal dust exposure is medically significant in his pulmonary impairment." Dr. Simpao opined that the degree of the impairment is "moderate" and the Claimant does not retain the respiratory capacity to perform the work of a miner. He based his findings with respect to pneumoconiosis and total disability on x-ray, pulmonary function and arterial blood gas testing, symptomotology, and physical examination. The January 5, 1999 x-ray was interpreted as negative by Dr. Sargent, a dually qualified physician. Dr. Simpao lacks any special radiological qualifications. I have found the x-ray evidence to be negative for pneumoconiosis. Dr. Simpao noted that the Claimant ceased smoking in 1997, however, the evidence shows that the Miner continued to smoke until at least August 1999. Dr. Simpao is an examining physician. However, I find his opinion with respect to the presence of pneumoconiosis to be entitled to less weight than the better reasoned and better supported opinions of Drs. Jarboe, Morgan, Repsher, Selby, and Broudy.

The record contains several examination reports by Dr. Pandit dated between March 9, 1992 and November 18, 1999.

Although Dr. Pandit diagnosed COPD, he failed to relate that impairment to coal dust exposure. Accordingly, I find that his opinion fails to support a finding of pneumoconiosis.

Placing greater weight on the opinions of Drs. Jarboe, Morgan, Repsher, Selby, and Broudy for the reasons stated above, I find that the newly submitted evidence fails to support a finding of pneumoconiosis. Nonetheless, I will analyze the newly submitted evidence to determine if he has established the existence of a totally disabling respiratory impairment arising out of coal mine employment.

Section 718.204(c) contains the criteria for establishing total disability due to pneumoconiosis:

> (c) Criteria. In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4) or (5) of this section shall establish a miner's total disability.

Section 718.204(c)(1) permits a finding of total disability when the evidence includes pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 results are divided by the FVC test results.

As all of the newly submitted pulmonary function studies yielded qualifying values, I find that the pulmonary function study evidence supports a finding of total disability.[8]

Under § 718.204(c)(2), a claimant may establish total disability with arterial blood gas studies that result in values equal to or less than those contained in the tables. The record contains the results of two new arterial blood gas studies, neither of which produced qualifying values. I find that the arterial blood gas study evidence fails to support a finding of total disability.

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[8] Dr. Burki found the October 6, 1994 and October 28, 1994 studies to be invalid because the paper speed was too slow (DX 20, 23). The January 5, 1999 and July 2, 1999 studies, however, were found acceptable by Dr. Burki (DX 7, 21). The record contains no validation reports with respect to the August 31, 1999 study.

Section 718.204(c)(3) is inapplicable because there is no evidence of cor pulmonale with right-sided congestive heart failure. Section 718.204(c)(5) is inapplicable because this is not a death claim.

Section 718.204(c)(4) allows a claimant to establish total disability if a physician exercising reasoned medical judgment concludes that the claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful employment.

The newly submitted medical evidence contains the opinions of seven physicians with respect to the degree of the Claimant's impairment. Dr. Jarboe stated that the Claimant suffers from severe airway obstruction and a significant degree of emphysema and opined that he is totally and permanently disabled from a respiratory standpoint based on the August 31, 1999 pulmonary function study. Dr. Broudy opined that the Claimant is unable to perform the work of a miner based on qualifying pulmonary function study results. I have found the opinions of Drs. Jarboe and Broudy to be well reasoned, well documented, and supported by the objective evidence. Their opinions support a finding of total disability.

Dr. Morgan opined that the Claimant is "totally and permanently disabled because of his inability to get around from the injuries he sustained while coal mining and because he now has at least moderate airways obstruction due to his cigarette smoking." I have found Dr. Morgan's opinion to be well reasoned, well documented, and supported by the evidence. His opinion supports a finding that the Claimant is totally disabled from a respiratory standpoint.

Dr. Repsher found that the Claimant suffers from significant COPD and emphysema. He opined that the Claimant "probably retains sufficient pulmonary function to allow him to do moderate coal mine work," but he could not do sustained heavy coal mine labor. The Claimant testified that his last coal mine employment was as a motorman, a job which he performed eight to sixteen hours per day (Tr. 16). Dr. Houser noted that the Claimant's former position required heavy lifting. The Claimant unloaded up to 6,000 pounds of fifty-pound bags of rock dust an average of two or three times per week. Based on the evidence, I find that the Claimant's former position as a motorman required "sustained heavy coal mine labor" and that Dr. Repsher's opinion supports a finding that the Claimant is unable from a respiratory standpoint to perform such work.

Dr. Houser diagnosed pneumoconiosis, chronic obstructive pulmonary disease, and hypertension. He opined that the Claimant is "physically unable to do light, medium or heavy work." He noted that the Claimant's former position as a motorman required the lifting of fifty-pound bags of rock dust two or three times per week. Dr. Simpao found a moderate restrictive and obstructive lung disease based on pulmonary function testing. He opined that the degree of the impairment is moderate and that the Claimant does not retain the respiratory capacity to perform the work of a miner based on objective testing, symptomotology, and physical examination. The opinions of Drs. Houser and Simpao with respect to degree of impairment are reasoned, documented, and are supported by the objective medical evidence. I find that they support a finding of total disability.

Dr. Selby, in his August 31, 1999 examination report, found a moderate to severe obstructive impairment based on pulmonary function testing. He stated at the May 11, 2000 deposition, however, that he did not find the Claimant to be totally disabled at the time of the examination because much of the Claimant's spirometric abnormality appears to be reversible, particularly if the Claimant ceased smoking. As stated, all of the pulmonary function studies yielded qualifying values, including the study relied on by Dr. Selby. Whether the Claimant's impairment would improve if he ceases smoking is speculative and is unsupported by the existing objective medical evidence. His finding that the Claimant is not totally disabled is entitled to less weight.

Dr. Pandit diagnosed "COPD" based on numerous examinations and sometimes diagnosed "severe COPD" as recently as June 11, 1999. He most recently stated his impression as "Chronic Obstructive Pulmonary Disease. Pulmonary status clinically improved and stable." The degree of the Claimant's current condition cannot be ascertained from Dr. Pandit's opinion that the Claimant's condition has "improved." Moreover, as Dr. Pandit has never stated whether the Claimant retains the respiratory capacity to perform the requirements of his last coal mine employment, I find that his opinion is entitled to less weight on this issue.

Based on the newly submitted pulmonary function study evidence and the medical opinions of Drs. Jarboe, Broudy, Morgan, Repsher, Houser, and Simpao, I find that the Claimant has established that he is totally disabled from a respiratory standpoint. Therefore, he has established a material change in conditions. I will now review all of the evidence of record to determine entitlement to benefits.

The entire x-ray evidence of record consists of twenty-two interpretations of ten x-rays. Sixteen interpretations are negative and six are positive. Three negative interpretations are by dually qualified physicians, ten are by physicians who are B readers only, and three are by physicians lacking any special radiological quali-fications. Two positive interpretations are by dually qualified physicians, one is by a physician who is a Board-certified Radiolo-gist only, and three are by physicians who have no special qualifi-cations. As noted, interpretations by more highly qualified readers are entitled to greater weight. *See Aimone*, 8 B.L.R. 1-32; *Vance*, 8 B.L.R. 1-68; *Sheckler*, 7 B.L.R. 1-128. Further, more weight may be given to the most recent x-ray evidence. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*). The two most recent x-rays of record, taken on November 18, 1999 and August 31, 1999, were interpreted as negative by all the physicians who read them. The next most recent x-ray, taken on July 2, 1999, was inter-preted as negative by Dr. Sargent, a dually qualified physician, and positive by Drs. Whitehead and Houser. Dr. Whitehead, a dually qualified physician, gave this study a 1/0 reading, the minimum reading under the regulations which will support a finding of pneu-moconiosis. Dr. Houser lacks any special radiological qualifica-tions. The January 5, 1999 study was given negative interpretations by two physicians, including Dr. Sargent, and a positive reading by a physician lacking any special radiological qualifications. The remaining interpretations are of x-rays taken in 1994 or before.

Placing greater weight on the majority of negative interpretations of the most recent x-rays by the most qualified readers, I find that the x-ray evidence as a whole fails to establish the existence of pneumoconiosis.

Likewise, the medical opinion evidence dated prior to the December 15, 1994 denial fails to establish the existence of pneumo-coniosis. Dr. Pope examined the Claimant on September 9, 1994. He interpreted an x-ray as negative and failed to diagnose pneumoco-niosis. Dr. Pope diagnosed chronic obstructive pulmonary disease secondary to cigarette smoking based on spirometry. Because he failed to relate the obstructive impairment to coal dust exposure, I find that Dr. Pope’s opinion fails to establish the existence of pneumoconiosis. As discussed, Drs. Jarboe and Broudy examined the Claimant in 1994 and opined that he does not suffer from pneumoco-niosis. Dr. Pandit examined him several times beginning in 1992. He diagnosed COPD but failed to relate it to coal dust exposure. Accordingly, I find that the entire medical opinion evidence of record fails to establish the existence of pneumoconiosis.

The Claimant has failed to establish the existence of pneumoconiosis based on the evidence submitted both prior and subsequent to the previous denial. Therefore, his claim must fail. Assuming, *arguendo*, that pneumoconiosis was established, the Claimant would still not be entitled to benefits. Although I have found, based on the most recent pulmonary function study and medical opinion evidence, that he is totally disabled from a respiratory standpoint, giving greater weight to the opinions of Drs. Jarboe, Morgan, Repsher, Selby, and Broudy for the reasons stated above, I find that the Claimant's condition is due to cigarette smoking and not to coal mine employment pursuant to § 718.204.

VI. Entitlement

The Claimant, Harold Calloway, has failed to establish the existence of pneumoconiosis or that he is totally disabled by that condition and, therefore, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

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

VIII. ORDER

It is, therefore,

ORDERED that the claim of Harold Calloway for benefits under the Act is hereby DENIED.

ROBERT L. HILLYARD
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 thirty (30) 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 a Notice of Appeal must also be served upon Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.