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Issue Date: 29 June 2004

In the Matter of:

JAMES E. HARRIS,
Claimant,

CASE NO: 2002 BLA 5251

v.

OLD BEN COAL COMPANY,
Employer,

and

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

Appearances:

Sandra K. Fogel, Esquire
For the Claimant

Gary B. Nelson, Esquire
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

Statement of the Case

This proceeding involves a subsequent claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. 901 *et seq*. ("the Act") and the regulations promulgated thereunder.[1] Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies. §718.2.

[1] The Department of Labor's amendment of the regulations implementing the Federal Coal Mine Health and Safety Act of 1969 became effective on January 19, 2001, and was published at 65 Fed. Reg. 80,045-80, 107 (2000)(codified at 20 C.F.R. Parts 718, 722, 725, and 726 (2003)). Citations to the regulations, unless otherwise indicated, refer to the amended regulations. The Director's exhibits are denoted "D-"; Claimant's exhibit, "C-"; Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr."

Because the Claimant was last employed in coal mine work in the state of Illinois, the law of the United States Court of Appeals for the Seventh Circuit controls. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Procedural History

James E. Harris (the "Claimant") filed his initial claim for benefits under the Act on August 20, 1985. (D-1) The District Director denied benefits to Claimant on December 16, 1985, because Claimant had not proved that he had pneumoconiosis, that it was caused by coal mining, and that he was totally disabled by the disease. (D-1) Claimant took no further action, so that the denial has become final, and the case is considered administratively closed.

Claimant filed a subsequent claim for benefits on May 23, 2001. (D-2) In a Proposed Decision and Order dated May 23, 2002, the Director awarded benefits. (D-30). Old Ben Coal Company (the "Employer") controverted the award and requested a hearing before an administrative law judge on May 28, 2002. (D-31) A hearing took place before this tribunal on October 30, 2003, in Murphysboro, Illinois.

Issues

1. What evidence is properly admitted into the record of this case pursuant to 20 CFR §725.107 and §725.414?
2. Whether, under §725.309(d), Claimant has shown that one of the applicable conditions of entitlement previously decided against him has changed since the previous denial of benefits on March 9, 1995, by establishing that he has pneumoconiosis, that it was caused by coal mining, that he is totally disabled by a respiratory or pulmonary impairment, or that he is totally disabled by pneumoconiosis?
3. If so, whether Claimant has established the elements of entitlement to benefits under Part 718?

FINDINGS OF FACT

Background

Claimant was born on March 5, 1924, and completed the ninth grade of education (D-2). Claimant and the Employer stipulated to a twenty-nine year coal mine employment history, which is supported by the Claimant's Social Security and Employment records. (Tr. 7, D-1, 5) Claimant last worked in the coal mining industry for Employer as a battery barn attendant. (Tr. 21, D-1, 4) Claimant's first wife died in 1988. (D-2) Claimant married his second wife, Betty Harris, on October 13, 1989. (Tr. 20, D-2, 6) They were currently married and living together at the time of the hearing. (Tr. 19, 20, D-2)

Evidence

Director's exhibits one through thirty-five and Claimant's exhibits one through six were admitted into evidence at the hearing. (Tr. 6, 17) Employer submitted exhibits one through

nineteen, including an addendum to exhibit one, to be admitted into the record. (Tr. 55) Claimant objected to Employer's listing of Dr. Renn's review of CT scans in Employer's exhibit one as independent interpretations of CT scans, stating that Dr. Renn only reviewed records of other physicians' interpretations of the CT scans, but did not personally look at the CT scans. Employer contended that Dr. Renn's report stated that he interpreted the CT films. Ruling on the objection was deferred. (Tr. 62-64) Employer argued in its post-hearing memorandum that Dr. Renn simply relied upon the CT scan readings by radiologists who were the initial readers of the CT films, before making his own conclusions. In addition, Employer stated that the CT scan readings of Dr. Wiot and Dr. Spitz were not prepared at the time of Dr. Renn's report, so Dr. Renn could not have relied on them in writing his opinion. While it is clear that Dr. Renn did not rely on the CT scan interpretations of Dr. Spitz and Dr. Wiot, because their interpretations were written after Dr. Renn wrote his report, it is clear that Dr. Renn was reviewing Dr. Marmo's August 8, 2001 CT scan interpretation and Dr. Tuteur's February 19, 2002 interpretation, both written before Dr. Renn's July 9, 2002 report, as he quotes Dr. Marmo's and Dr. Tuteur's interpretations almost word for word. Dr. Renn did not state that he himself interpreted the CT scans, and, in context, including Employer's Addendum to exhibit one, it is clear that Dr. Renn was simply reviewing medical records, and this tribunal so finds. (E-1, p. 5) Therefore, Dr. Renn's review of the CT scan readings are not considered original readings and are not probative as independent CT scan readings. However, Employer's exhibit one has been admitted into evidence, but does not qualify as a CT scan reading. Employer's listing of the CT scans as evidence in the Evidence Summary form is deemed nonprejudicial in this instance.

Claimant objected to Employer's exhibits two through seven as excessive x-ray readings and the objection was sustained. (Tr. 64, 67) Employer's exhibits eight through ten were admitted into evidence. Claimant also objected to Employer's exhibit eleven through fourteen, as excessive x-ray and CT scan evidence. (Tr. 68-83) This tribunal sustained the objection to the x-ray evidence, and deferred the ruling on the objection to CT scan evidence subject to briefing and closing arguments. (Tr. 83-84) Claimant argued in its post-hearing memorandum that only the actual radiology record describing the results of a CT scan test is admissible under the regulations, and subsequent readings are not allowed. Neither §718.107 nor §725.414, place a limit on "other medical evidence" either explicitly or implicitly. Section 724.414(a)(2)(ii) and (a)(3)(ii) limits rebuttal evidence to one physician's assessment of each piece of evidence submitted under §718.107, but that is not in issue here because Employer did not submit the CT scan readings as rebuttal evidence. Therefore, Claimant's objection to the CT scan evidence is overruled, and the portions of exhibits eleven through fourteen comprised of CT scan evidence are admitted into evidence.

The consideration of x-ray interpretations in violation of regulatory strictures taint the opinions of the physicians who considered these x-ray interpretations in their opinions. (Tr. 65-73) Dr. Cohen reviewed one negative x-ray reading that was not admitted into evidence, Dr. Renn reviewed four negative x-ray readings that were not admitted into evidence. Dr. Repsher reviewed six negative x-ray readings that were not admitted into evidence Section 724.414(a)(2)(i) requires that any chest x-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions referred to in a medical report must be admissible under the regulations. While referred to in the opinions in violation of the regulations, the reference to the excluded x-ray interpretations in Dr. Cohen's opinion is

inconsequential, because he did not rely on the negative x-ray reading, finding that Claimant had pneumoconiosis. The reviews of the excluded x-ray readings by Dr. Renn and Dr. Repsher are also in violation of §724.414, but because those doctors relied on the negative x-ray readings in opining that Claimant did not have pneumoconiosis, their opinions will be deemed tainted and given less weight, rather than excluded, because no sanction is specified for such violations, and in this instance the opinions are deemed to retain some probative value. Employer's request to redact the opinions has been refused, as untimely, and without justification. Employer knew of the evidentiary limitations before the evidence was submitted. Employer also suggests exclusion of all three medical reports. This tribunal has declined that action, having concluded that each report can be weighed with due regard to the breach of regulatory limitations and impairment of the report's credibility by the doctor's impermissible consideration of certain evidence in this instance.

Employer withdrew submission of pages two through nine of Employer's exhibit fifteen. (Tr. 58) Employer's exhibit sixteen was not admitted, so that Employer could review it subject to its materiality and relevance. (Tr. 60) Employer resubmitted Employer's exhibit sixteen with its closing argument in timely fashion, and it has been admitted into the record. While the admissibility of Employer's exhibit eighteen, Dr. Tuteur's deposition, was discussed at the hearing, neither party objected to its admission into evidence. Because depositions are considered extensions of medical reports under §725.414(c), Dr. Tuteur's deposition has been admitted into the record.

Medical Evidence Developed Subsequent to the Closing of the Record on Which the Prior Denial was Based

X-Rays[2]

Exhibit No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
D-9, E-15-17	4/10/01	Ailinani	R[3]	Not Noted	No reading[4]

[2] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read as completely negative for pneumoconiosis. There are two readings of a single x-ray in the record prior to the last denial of benefits. Dated October 17, 1985, it was read as 0/1, s/t by Dr. Pitman, a board-certified radiologist and B-reader, and ½, s, by Dr. Sloan, a board-eligible radiologist. (D-1)

[3] Dr. Ailinani's credentials are not disclosed by the record, and this tribunal has taken judicial notice of those qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org, and the List of NIOSH Approved B Readers, found, *inter alia*, at http://www.oalj.dol.gov/libbla.htm. *See Maddaleni v. Pittsburg & Midway Coal mining Co.*, 14 B.L.R. 1-135 (1990).

[4] This x-ray reading was part of Claimant's treatment records. Dr. Ailinani noted that Claimant had Chronic Obstructive Pulmonary Disease (COPD), interstitial infiltrates of both lower lungs consistent with interstitial fibrosis. This x-ray does not conform to the regulatory standards of §718.102 because no notation was made with regard to the existence of pneumoconiosis.

Exhibit No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
D-17	4/10/01	Gaziano	B	1	Read for quality only
D-25	4/10/01	Wiot	R/B	1	0/0[5]
D-14, 15	7/27/01	Whitehead	R/B	1	3/2, s/t, Size A large opacities[6]
C-1	7/27/01	Alexander	R/B	2	2/3, p/s, Size A large opacities[7]
C-2	7/27/01	Cappiello	R/B	2	2/3, s/p, Size A large opacities[8]
D-16	7/27/01	Sargent	R/B	1	Read for quality only
D-24	7/27/01	Wiot	R/B	1	0/0[9]
E-19	2/19/02	Wiot	R/B	1	0/0[10]
C-3, 3A	2/19/02	Ahmed	R/B	Not Noted	Not read[11]

[5] Dr. Wiot opined that there was no evidence of coal workers' pneumoconiosis. He opined that Claimant has severe bibasilar interstitial fibrosis not related to coal dust exposure. There were bullous changes in the right upper and right mid lung field, and also within the left upper lung field.

[6] Dr. Whitehead noted severe COPD with emphysematous bullae in the upper lung fields. There was severe interstitial fibrosis in the bases with associated honeycombing. There was an approximately 10 by 18 mm. nodular density in the right mid lung field, which Dr. Whitehead opined could be related to the pattern of fibrosis.

[7] Prominent emphysematous changes and large bullae were present in both upper zones and in the right mid zone. Small round and irregular opacities were present bilaterally in the remaining three lung zones. Some "q" opacities were also present. The predominantly lower lung zone distribution was atypical, but probably was the result of the extensive upper zone emphysema. Areas of coalescence were present in both lower zones. An 18 by 9 mm. opacity was present. Dr. Alexander opined that it was complicated CWP, but that it could have been early lung cancer.

[8] There was hyperinflation of the lungs with changes of underlying chronic obstructive pulmonary disease (COPD), and there were emphysematous bullae in both upper lobes, larger and more prominent in the right upper lobe. There were cystic lucencies in the lower four lung zones, probably representing honeycombing. There were many small rounded and irregular parenchymal opacities in the four lower lung zones. There were coalescent opacities in both lower lung zones. There was a speculated "1+ cm." nodule in the right mid lung zone, which may have represented a neoplasm or a developing large opacity of complicated pneumoconiosis. Early carcinoma right lung could not be excluded.

[9] Claimant had significant bibasilar interstitial fibrosis, not related to coal dust exposure. In addition, there was emphysematous change within the upper lung fields, with bullae formation. There was an ill defined density overlying the fourth rib anteriorly on the right that was not related to coal dust exposure.

[10] Showed extensive bullous and emphysematous changes involving both lung fields. The distribution and character of the interstitial disease is not that of CWP. The most likely etiology would be interstitial pulmonary fibrosis, as there are no pleural plaques to suggest a past history of asbestos exposure.

[11] Dr. Ahmed opined that the film was digital and according to NIOSH standards, he was unable to interpret the film, because the ILO system does not permit the classification of digital films for pneumoconiosis.

Pulmonary Function Studies[12]

Exh. No	Test Date	Age/ Ht	Doctor	Co-op./ Undst./ Conf.?	FEV1	FVC	MVV	Qualify
D-9 E-16, 17	4/16/01	77/ 68”	Sanjabi	Good/ Good/ Yes	2.39 2.34	4.05 3.81	- -	No[13] No
D-12	7/27/01	77/ 67”	Houser	Good/ Good/ Yes	2.25 2.24	3.93 3.95	- -	No[14] No
D-28	2/19/02	77/ 67.5”	Tuteur	Good/ Good/ Yes	2.60 2.67	3.82 3.85	101 -	No No

Arterial Blood Gas Studies[15]

Exh. No.	Test Date	Physician	Conform?	pCO2	pO2	Qualifying
D-9 E-16, 17	4/16/01	Sanjabi	No[16]	33	71.2	No[17]
D-11	7/27/01	Houser	Yes	34.3	64.5	Yes[18]
D-28	2/19/02	Tuteur	No[19]	32.4 30.5	73 54	No Yes

[12] The second set of values indicates post-bronchodilator studies. Because the heights range between 67” and 68”, this tribunal averaged the numbers and used 67.5” as the height of Claimant. A pulmonary function study performed on October 17, 1985, when Claimant was age 61, and 70” tall, by Dr. Sanjabi, with good cooperation and understanding noted, produced nonqualifying values of FEV1, 3.00; FVC, 4.98; MVV, 90. (D-1)

[13] These results are part of Claimant’s treatment records.

[14] Dr. Katzman, who is board-certified in internal medicine, opined that the vents were acceptable.

[15] The second set of values, when present, relates to exercise test results. Dr. Sanjabi’s arterial blood gas studies performed on October 17, 1985, produced nonqualifying values for pCO2 and pO2, at rest of 31 and 77, and after exercise of 31 and 80, respectively. (D-1)

[16] No altitude or barometric pressure recorded.

[17] These results are part of Claimant’s treatment records.

[18] Dr. Katzman opined that the test is technically acceptable.

[19] No altitude or barometric pressure recorded.

CT Scans[20]

Exh. No.	Test Date	Physician/ Qualifications	Interpretation
D-9, E-15-17, C-6	4/27/01	Gatla/ R[21]	Bilateral interstitial changes in the mid and lower lung zones suggestive of interstitial pulmonary fibrosis. Severe changes of COPD with multiple bullae, especially in the upper lobes. No evidence of pneumothorax. There were discreet densities in the upper lobes with speculated margins, one in the right upper lobe slightly posteriorly 2 cm x 1cm in size. There were two discreet speculated densities in the left upper lobe 1 to 1.5 cm. in sizes. Large opacities may be due to chronic scarring and fibrosis, but discreet mass lesions could not be totally excluded.[22]
D-9, E-17	8/8/01	Marmo/ R	Evidence of severe COPD, especially in the mid and lower lung zones suggestive of pulmonary fibrosis. Evidence of emphysematous changes in the lungs with multiple bullae in both lungs, especially the upper lobes. There were discreet nodular areas in the right and left upper lobes, which probably represent areas of scarring rather than discreet masses.[23]
D-28	2/19/02	Tuteur/ I/P	Extensive changes of emphysema with large bullae in the upper lobes and changes of pulmonary fibrosis in both lower lobes. Multiple speculated nodules in both upper lobes concerning for multiple metachronous primary lung carcinomas.[24]

[20] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R"; board-certified in internal medicine, "I"; and board-certified in pulmonary disease, "P".
[21] This tribunal has taken judicial notice of Dr. Gatla's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org, and the List of NIOSH Approved B Readers, found, *inter alia*, at http://www.oalj.dol.gov/libbla.htm.
[22] These readings are part of Claimant's treatment records.
[23] These readings are part of Claimant's treatment records.
[24] While this reading was not selected by either party as part of its permitted evidentiary submissions, it was submitted with the Director's evidence without objection, and is considered because there is no applicable limitation on the admission of such CT scan evidence.

Exh. No.	Test Date	Physician/ Qualifications	Interpretation
D-28	2/19/02	Sagel/ R/B[25]	Noted far advanced bullous centrilobular emphysema. Dr. Sagel opined that there may be some minimal associated interstitial fibrosis at the lung bases but this also almost certainly was simply related to lung architectural distortion from the advanced emphysema. There were three irregular, somewhat spiculated nodular opacities noted, located within the posterior segment of the right upper lobe, the anterior segment of the right upper lobe, and the apical posterior segment of the left upper lobe. Dr. Sagel opined that these most likely represent scarring and architectural distortion related to advanced emphysema, but it was possible that one or more represents a primary bronchogenic carcinoma. In the background, there were a few small nodular opacities, which conceivably could relate to CWP, but even if present, they were miniscule in comparison to the advanced emphysematous changes.
E-11, 19	2/19/02	Wiot/ R/B	No evidence of CWP. There was extensive bullous change present involving both lung fields, with generalized emphysema. There was peripheral interstitial fibrosis, which was linear in nature and had all the characteristics of interstitial pulmonary fibrosis.
E-12	2/19/02	Spitz/ R/B	There was decreased vascularity in the upper lobes and to some degree in the middle portion of the lungs. There were bullae in the upper and middle lobes. There were linear strands noted bilaterally. There were small irregular opacities at the lung bases and to some degree in the left mid lung. There was no pleural disease. The CT scan confirmed the finding of emphysema with changes of interstitial fibrosis. There was no evidence of CWP.[26]

[25] This tribunal has taken judicial notice of Dr. Sagel's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org, and the List of NIOSH Approved B Readers, found, *inter alia*, at http://www.oalj.dol.gov/libbla.htm.

[26] This CT scan reading was not selected by Employer on its evidentiary form. However, Employer referred to the reading in its closing argument, and it has been admitted into evidence.

Exh. No.	Test Date	Physician/ Qualifications	Interpretation
C-5, C-5A	2/19/02	Cohen/ B	Many scattered small opacities ranging in size from 1.5 to 3 mm. The opacities are upper lobe in predominance. There were two large opacities noted in the left upper lobe which were 1 by 1.5 and 1 by 1.1 cm in diameter respectively. There was also a large opacity on the right side which measured 1 by 1.2 cm in diameter. There was a significant amount of emphysema and traction bronchiectasis noted in both upper lobes. Consistent with both simple and complicated CWP.

Medical Reports and Opinions

Dr. William Houser[27]

In connection with a medical report dated July 27, 2001, Dr. Houser, who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant. Dr. Houser recorded that Claimant had a thirty-two year coal mine employment history, that Claimant smoked one-half pack of cigarettes a day from the age of sixteen to the age of sixty-two. Dr. Houser declared that the reading by Dr. Whitehead of an x-ray dated July 27, 2001, disclosed S and T opacities in all lung fields, category 3/2 pneumoconiosis, honeycombing, emphysema bullae, and a lung nodule. (D-14, 15) Dr. Houser opined that pulmonary function tests showed a mild airway obstruction, and that an arterial blood gas study disclosed that Claimant had mild hypoxemia. Dr. Houser opined that a CT scan dated July 27, 2001, apparently not in evidence, disclosed bullous emphysema, interstitial fibrosis, and three nodular densities, which increased the likelihood of progressive massive fibrosis "versus" malignant tumor. Dr. Houser diagnosed Claimant with coal workers' pneumoconiosis (CWP), category 3/2, based on Claimant's coal mine employment, chest radiographic findings and rales on physical examination; progressive massive fibrosis, based on a chest radiograph and CT scan findings; bullous emphysema based on a chest x-ray and CT scan; and hypertension, based on "history" and Claimant's treatment at the time of the examination. Dr. Houser opined that Claimant's CWP and progressive massive fibrosis were caused by Claimant's coal mine employment, and his bullous emphysema was caused by cigarette smoking and exposure to coal and rock dust arising from coal mine employment. Dr. Houser opined that Claimant's airway obstruction and hypoxemia were secondary to his CWP, fibrosis, and emphysema. Dr. Houser concluded that Claimant was physically unable to perform his previous employment as a coal miner, that CWP and fibrosis made a "significant" contribution to Claimant's impairment, and that the emphysema made a "major" contribution with associated airway obstruction. Dr. Houser opined that the gas exchange abnormalities were probably secondary to multiple factors. (D-10)

[27] This tribunal has taken judicial notice of Dr. Houser's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org.

Dr. Peter Tuteur

In connection with a medical report dated February 21, 2002, Dr Tuteur, who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant and reviewed specified medical evidence, including a nonconforming x-ray interpretation that was not admitted into the evidentiary record. Dr. Tuteur noted that Claimant had a thirty-two year history of coal mine employment, ending in 1986, with work in the battery barn. He opined that Claimant "was exposed to sufficient amounts of coal mine dust and produced coal workers pneumoconiosis in a susceptible host." Dr. Tuteur recorded that Claimant smoked cigarettes from 1939 to 1986, "always less than one pack a day, and most often at a rate of one-quarter pack per day."

Dr. Tuteur declared that, heterogeneously throughout Claimant's chest, there were late inspiratory crackling sounds predominantly at the left, lower, anterior chest, both medially and laterally, and some in the right lower chest. Dr. Tuteur's assessment of a CT scan of the thorax dated February 19, 2002, prepared at his request two days before his examination, described one large bulla in the right upper lung field and paraseptal emphysema throughout. The remainder of the lung had increased density consistent with interstitial pulmonary fibrosis with some nodular quality and some honeycombing, but no conglomerate nodules or pleural changes. His assessment in the report made no reference to opacity measurements. However the addendum CT report described lymphadenopathy measuring 1.2 x 1.9 cm., a second node measuring 1.3 x 1.2 cm., subcarinal nodes measuring 1.7 x 2.7 cm., and multiple spiculated nodules throughout both upper lobes, possibly primary lung cancer, the largest of which measured 1.4 cm. x 9 mm. on the left side, and 1.2 cm. x .8 cm. on the right side. Pulmonary function studies demonstrated essentially normal spirometry with a little bit of swelling at low lung volumes and normal lung volumes. There was mild impairment of gas exchange at rest, which worsened during exercise. Dr. Tuteur opined that Claimant's carboxyhemoglobin reading was consistent with his current nonsmoking status.

Dr. Tuteur concluded that Claimant did have "some emphysema of insufficient magnitude to produce significant airflow obstruction." He also concluded that Claimant had "extensive interstitial pulmonary fibrosis consistent with the diagnosis of coal workers pneumoconiosis resulting in no net ventilatory changes, but significant impairment of gas exchange at rest that worsens during exercise[.] This fully accounts for his breathlessness." Dr. Tuteur opined that alternative possible causes for Claimant'se interstitial process are chronic gastroesophageal reflux, but that there was no convincing historical data to implicate recurrent aspiration to account for the interstitial process. (D-28)

In a deposition taken on January 7, 2003, Dr. Tuteur opined that the most significant evidence indicating the presence of CWP was the CT scan of Claimant's thorax. He also opined that the extensive bullous and paraseptal emphysema in Claimant's upper and mid lung fields were caused by cigarette smoking and were not related to the inhalation of coal mine dust. Dr. Tuteur opined that in the lower lung fields, Claimant had an interstitial pulmonary process associated with multiple nodular densities that ranged up to about 1.4 centimeters in greatest dimension, "which is most consistent within this setting [of a] radiographic manifestation of coal workers' pneumoconiosis of the simple type." Dr. Tuteur explained that he gave more weight to

Claimant's exposure to coal dust as the cause of Claimant's interstitial fibrosis in the lower lung fields, than to occasional aspiration caused by eating spicy foods. He also allowed that the findings on Claimant's chest x-ray and CT scan could possibly be idiopathic pulmonary fibrosis.

An examination of Claimant's chest revealed no restriction to lung expansion or restrictive abnormality, despite the interstitial process in the lower lung fields. Surprisingly, there was no substantial obstruction despite the extensive emphysema. Dr. Tuteur opined that Claimant's extensive emphysema involving destruction of up to two thirds of his lungs and approximately forty percent of lung function, was the "overwhelming" factor that contributed to his exercise intolerance reflected in tests disclosing unequivocally abnormal diffusing capacity and diminished pO2 blood gases during exercise, and aggravated by pulmonary hypertension. But he did not completely rule out CWP as a contributing factor.

Dr. Tuteur categorically opined that there was no evidence of progressive massive fibrosis or complicated CWP, because CT scans which he personally reviewed and the others in the data set did not show any A opacities or progressive massive fibrosis. Dr. Tuteur opined that Claimant was totally and permanently disabled from returning to work as a coal miner or work requiring similar effort and that the disability was caused by age and desaturation with exercise. Dr. Tuteur opined that in addition to other pulmonary diseases there was "clear-cut radiographic evidence of an interstitial process" with nodular densities which in this claimant is at least in part due to simple CWP in the lower lung fields, which is atypical, because the upper lung fields were "destroyed." However, he opined categorically that the CWP did not contribute to the total disability, because if it did, it would have exerted substantial additional impairment to pulmonary function on the already demonstrated impairment of the emphysema. (E-18)

Dr. Robert A.C. Cohen

In connection with a medical report dated July 25, 2003, Dr. Cohen, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, reviewed specified medical records. Dr. Cohen noted that Claimant worked as an underground coal miner for approximately twenty-nine years, stopping in 1986, last working as a battery attendant performing some heavy manual labor. Dr. Cohen noted that Claimant started smoking cigarettes in 1939 and quit in 1986, averaging one-fourth to one-half pack of cigarettes per day, for an eleven to twenty-three pack year history.

Dr. Cohen opined that Claimant had pneumoconiosis. He based this finding in part on Claimant's coal mine employment history, forty percent taking place before modern dust control regulations were in effect. In addition, pulmonary function testing performed over the two years previous to the report demonstrated a mild obstructive defect with severe diffusion impairment that is consistent with Claimant's exposure to coal dust and his tobacco smoking history. Dr. Cohen opined that cardiopulmonary exercise testing revealed mild hypoxemia at rest and a significant worsening of his hypoxemia with exercise, which was "quite consistent" with the interstitial lung disease of CWP, as well as emphysema caused both by coal mine dust and tobacco smoke.

Dr. Cohen declared that Claimant's x-ray and CT evidence was positive for interstitial lung disease, simple CWP, with a few conflicting reports. Dr. Cohen opined that the category 2 and category 3 readings of a 2001 study would be "perfectly" consistent with both the category 1 and nearly category 1 readings of the earlier 1985 study, and that it was not possible that the disease would have been missing on subsequent films given CWP's irreversible nature. Dr. Cohen opined that the significant amount of emphysematous changes makes it difficult for some reviewers to appreciate the CWP because the x-ray is susceptible to the superimposition of images and because emphysema tends to obscure CWP abnormalities. Dr. Cohen opined that Claimant had quite advanced disease with significant fibrosis, which was why the abnormalities could have been confused with idiopathic pulmonary fibrosis. Dr. Cohen declared that even if the sum of the x-ray and CT evidence were judged as negative for simple CWP, it would not change his opinion that Claimant had substantial historical, physical, and physiological evidence of CWP. Dr. Cohen opined that there was also CT scan evidence that was positive for complicated pneumoconiosis, although there were conflicting reports, and he found the small and large opacities to be quite clear and distinct on the CT scan. Dr. Cohen opined that there was no other occupational exposure that could have caused Claimant's CWP or obstructive lung disease.

Dr. Cohen noted that the American Thoracic Society and the European Respiratory Society define idiopathic pulmonary fibrosis (IPF), as a specific form of chronic fibrosing interstitial pneumonia, limited to the lung and associated with the histologic appearance of usual interstitial pneumonia (UIP) on surgical lung biopsy. A definite diagnosis of IPF in the presence of a surgical biopsy showing UIP requires: 1) exclusion of other known causes of interstitial lung disease such as drug toxicities, environmental exposures, and connective tissue diseases; 2) abnormal pulmonary function tests with restriction and/or impaired gas exchange with rest or exercise or decreased diffusion capacity; and 3) abnormal x-ray or CT scan. Dr. Cohen declared that where there is no surgical lung biopsy, the diagnosis remains uncertain.

Dr. Cohen opined that Claimant's interstitial lung disease had taken an "insidious and gradually progressive course," which is consistent with CWP, but it is not consistent with IPF which "commonly has a much more aggressive and severe course." Dr. Cohen declared, "Importantly, the necessary lung biopsy to make a diagnosis of IPF was not performed." Dr. Cohen opined that the x-ray and CT scan findings described in Claimant are seen in a wide variety of lung conditions, including occupational dust exposure, and are not diagnostic of IPF. Dr. Cohen declared that it is well known that lung scarring which appears quite similar to IPF can result from exposure to coal mine dust and silica dust, which is why it is mandatory to exclude such exposures when making the diagnosis. Dr. Cohen noted that, according to the American Thoracic Society's standards, there is no basis for an IPF diagnosis of unknown etiology where there are clear and convincing historical, clinical, pathologic, and radiographic findings specific for coal dust induced lung disease, which, he opined, was true for Claimant's case.

Dr. Cohen opined that the data from the pulmonary function testing confirmed that Claimant had a mild obstructive defect, severe diffusion impairment, and severe gas exchange abnormalities with exercise, and that the impairment "definitely" precluded Claimant from engaging in physical exertion required of his coal mine employment. Dr. Cohen declared that Clamant had no cardiac limitation to exercise or any significant cardiac disease on any of his

evaluations. Dr. Cohen opined that Claimant's exposure to coal dust was a significant contributing cause of his pulmonary disability, with tobacco smoke as the other contributing factor to the impairments. Dr. Cohen opined that Claimant would not be able to perform the physical labor required by his last coal mining job due to his pulmonary impairment. Dr. Cohen cited specific medical articles in opining that coal dust causes not only restrictive, but also obstructive pattern lung disease, regardless of whether the restrictive type is present, and he opined that Claimant had an obstructive lung disease caused by exposure to coal mine dust. Dr. Cohen declared that Claimant's coughing, sputum production, and shortness of breath are respiratory symptoms related to either the duration of exposure or cumulative exposure to respirable coal mine dust. (C-4)

Dr. Lawrence Repsher

In connection with a medical report dated December 9, 2002, Dr. Repsher, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, reviewed specified medical records. Dr. Repsher noted that Claimant worked as a coal miner for thirty-two years, thirty years underground, last working as a battery attendant in the battery barn. Dr. Repsher recorded that Claimant's smoking history varied widely from as little as two to three cigarettes per day for twenty years, quitting in 1986, to as much as one-half pack per day from the age of sixteen to sixty-two, or twenty-eight pack years.

Dr. Repsher opined that Claimant did not have CWP or any other pulmonary or respiratory condition, either caused by or aggravated by his coal mine employment. Dr. Repsher opined that Claimant had very mild COPD, which was due solely to his long cigarette smoking habit and was not due to any measurable extent to the inhalation of coal mine dust. Dr. Repsher found no chest x-ray evidence of CWP. He opined that Claimant's chest x-ray abnormalities were linear opacities involving the lower lung zone, which is opposite of what one would expect as the effect of inhalation of coal mine dust on chest x-ray. Dr. Repsher declared that these findings were classic for changes associated with respiratory bronchiolitis, a "purely cigarette smoking caused disease." Dr. Repsher opined that Claimant had bullous emphysema, which is not seen in simple CWP.

Pulmonary function tests showed only very mild obstructive impairment that would not be anticipated to be associated with shortness of breath. Dr. Repsher declared that, although Claimant had qualifying arterial blood gases with exercise in February 2002, the results were not caused by inhalation of coal mine dust, and they could be fully explained by his cigarette smoking induced COPD and emphysema. Dr. Repsher opined that although coal mine dust may cause airway obstruction, the degree of airways obstruction in Claimant was so small that it could not be measured, and the existence of such obstruction could be "ascertained only by comparing a large group of dust exposed coal miners with an equally large group of nondust exposed workers in another industry. Dr. Repsher declared that one could show "in a statistical sense" that there was COPD, but one could not show this to any extent clinically, because the "recommended FEV1" attributable to the inhalation of coal mine dust was so small "that it would be anticipated to be substantially less than the anticipated day to day and test to test variation." Dr. Repsher opined that Claimant's pulmonary function test values would be exactly the same, even if he had never set foot in a coal mine. Dr. Repsher concluded that Claimant did

not have a totally disabling pulmonary or respiratory impairment, but that, given his age and his mild to moderate COPD, he probably could not do his usual work as a coal miner. Dr. Repsher opined that the disability was due in no way to CWP or any other coal mine dust induced disease. (E-9)

Dr. Joseph J. Renn

In connection with a medical report dated July 9, 2002, Dr. Renn, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, reviewed specified medical records. Dr. Renn noted that Claimant worked as a coal miner from 1955 until his retirement in 1986, last working as a battery barn attendant, performing some heavy manual labor. Dr. Renn recorded that Claimant had three to twenty-three pack years of smoking cigarettes and that he stopped smoking in 1986. Dr. Renn opined that Claimant had bullous and centrilobular emphysema "owing" to tobacco smoking; an old pulmonary granulomatous disease; possible carcinoma of the lung; normal static and dynamic ventilatory function with an isolated diffusion abnormality; and that he did not have pneumoconiosis. Dr. Renn opined that none of the diagnoses were either caused by, or contributed to, by Claimant's exposure to coal mine dust. Dr. Renn opined that Claimant was totally and permanently impaired by tobacco smoke-induced bullous and centrilobular emphysema, to the extent that he would be unable to perform his last known coal mining job or any similar work. (E-1)

Hospitalization Records and Treatment Notes

In connection with treatment notes dated from April 10, 2001 to August 21, 2001, Dr. Sanjabi noted that Claimant had less than twenty pack years of smoking and that he stopped smoking in 1986. Dr. Sanjabi recorded that Claimant had over twenty-seven years of coal mine employment, all of it underground. Dr. Sanjabi noted that an unidentified chest x-ray showed significant abnormalities in the lower lobes, which, he opined, demonstrated changes consistent with CWP. Dr. Sanjabi also opined that an unidentified pulmonary function test showed that Claimant had COPD. Dr. Sanjabi opined that an unidentified CT scan showed the presence of significant bleb formation and emphysematous lung destruction, especially on the right side. (D-9, E-16, 17)

In treatment notes dated from May 29, 1998 to April 9, 2001, it was noted that Claimant was at times treated for breathing difficulty. It was noted that Claimant used to smoke, but had stopped. Lungs were observed as clear with no rales, crepitation, or wheezing. (E-16)

CONCLUSIONS OF LAW AND DISCUSSION

Subsequent Claim

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For the purposes of the Act, pneumoconiosis, commonly known as black lung, means a chronic dust disease of the lung, and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A

disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201. In order to obtain federal black lung benefits, a claimant must prove by a preponderance of the evidence that: (1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary impairment; and (4) pneumoconiosis contributed to the total disability. 20 C.F.R. §725.202(d)(2)(2001); §718.204.

Material Change in Conditions or Change in Applicable Conditions of Entitlement

Since the instant claim was filed more than one year after the denial of Claimant's previous claim, it is considered a subsequent claim under the Act. §725.309(d). Under the amended regulations, a subsequent claim shall be denied on the grounds of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. §725.309(d). In essence, the amended regulations codified the holding of the Fourth Circuit in *Lisa Lee Mines* that, to establish a material change in conditions, which is deemed to be equivalent to a change of the applicable conditions of entitlement, a claimant must prove at least one of the elements previously adjudicated against him, based on newly submitted probative medical evidence of his condition not available at the time of the prior claim. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 20 B.L.R. 2-227 (4th Cir. 1996)(*en banc*). The previous denial was based on the finding that Claimant had not established that he had pneumoconiosis, that it arose out of his coal mine employment, that he was totally disabled by a pulmonary or respiratory impairment, or that the disability was caused by pneumoconiosis. Therefore, in order to establish entitlement, Claimant must establish that one of these conditions has changed since the date of the denial of the prior claim.

Total Disability

This tribunal has reviewed the medical evidence to determine whether a material change of conditions or a change in applicable conditions of entitlement has occurred. To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

Under §718.204(b)(2)(i), both pre-and post-bronchodilator pulmonary function studies must be weighed when reviewing relevant evidence. *See Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). The fact-finder must determine the reliability of a study based upon its conformity

to the applicable quality standards, and must consider the medical opinions of record regarding reliability of a particular study. *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). The record indicates that the Claimant underwent three pulmonary function studies in connection with the pending claim. All of the studies conform to the standards for pulmonary function studies required under §718.103. None of the studies produced qualifying results. Therefore, the preponderance of the pulmonary function study evidence does not establish total disability pursuant to §718.204(b)(2)(i).

Three blood gas studies were performed on Claimant. One study conforms to the standards for arterial blood gas studies required under §718.105, while the other two, for the most part, are in conformity with the regulations. The test dated April, 2001, did not produce a qualifying result, the July, 2001, test produced a qualifying result, and the February, 2002, test produced a qualifying result during the exercise portion of the study. The April, 2001, study did not have an exercise portion of the study. Because the February, 2002, study contained an exercise portion of the study, which was qualifying, and is therefore the most complete examination, and because the July, 2001 study produced a qualifying result, the preponderance of the arterial blood gas study evidence establishes that Claimant was disabled pursuant to §718.204(b)(2)(ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, Claimant has not proved total disability pursuant to §718.204(b)(2)(iii).

Drs. Houser, Cohen, and Renn opined that Claimant was totally disabled by a pulmonary or respiratory disease. In an equivocal statement, Dr. Repsher opined that Claimant did not have a totally disabling pulmonary or respiratory impairment, but went on to say that given his age and mild to moderate COPD, Claimant could not do his usual coal mine work, and this does not rebut the fact of total disability found by Drs. Renn, Cohen and Houser. Dr. Tuteur did not specifically opine on Claimant's disability, but did opine that Claimant did have an airflow obstruction and a significant impairment of gas exchange at rest that worsened during exercise, reflecting desaturation and related exercise intolerance, which is consistent with pertinent findings of Dr. Houser, Dr. Cohen, and Dr. Renn. No medical opinions were submitted that would rebut a finding of total disability. Because a preponderance of the medical opinions and arterial blood gas study evidence establish that Claimant is totally disabled by a respiratory or pulmonary impairment as required under §718.204(b)(2)(iv), he has proved a material change in conditions or change in one of the applicable conditions of entitlement.

Review of All Evidence

When a claimant demonstrates a material change in conditions or change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, are binding on any party in the adjudication of the subsequent claim. §725.309(d)(4). Therefore, the subsequent claim is considered a new and viable claim to be reviewed *de novo* and Claimant must prove four elements to receive benefits: (1) the existence of pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause to his total respiratory disability.

Existence of Pneumoconiosis

The definition of pneumoconiosis includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis. See §718.201. Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§718.304, 718.305, and 718.306; or (4) the finding by a physician of pneumoconiosis as defined in §718.201 which is based upon objective evidence and a reasoned medical opinion. Since the claim was filed after January 1, 1982, and since this is not a survivor's claim, the presumptions set forth in §§718.305 and 718.306 are inapplicable. There is no evidence of biopsy performed on Claimant.

Pneumoconiosis may be established by a preponderance of the evidence pursuant to §718.202(a)(1), (a)(2), or (a)(4). *See Jones v. Badger Coal Co.*, 21 B.L.R. 1-103 (1998) (*en banc*) (It was proper for the administrative law judge to separately evaluate the x-ray evidence at §718.202(a)(1) and find no evidence of pneumoconiosis, but to find that the medical opinion evidence at §718.202(a)(4) did support a finding of the disease.) However, all evidence relevant to the existence of pneumoconiosis must be considered and weighed. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986).

The record contains nine interpretations of four chest x-rays. Four readings were positive for pneumoconiosis, four were negative, and one did not include a reading. Three positive and four negative readings were made by dually qualified board-certified radiologists and B-readers. One positive reading was performed by a board-eligible radiologist only. The x-ray reading that did not include a reading on pneumoconiosis did not conform to the regulations. Because no notation was made with regard to the existence of pneumoconiosis, the reading is not considered probative and is given little weight. One positive reading and one negative reading were made in 1985, which includes the reading by the board-eligible radiologist, and because they were taken nineteen years ago, and because pneumoconiosis is a progressive incurable disease, they are not given as much weight as the most current x-rays, taken in 2001 and 2002. The film taken February 19, 2002, is digital and according to Dr. Ahmed, a board-certified radiologist and B-reader, the ILO system does not permit the classification of digital films for pneumoconiosis. Similarly, Dr. Wiot's reading of the February 19, 2002, digital x-ray is given little weight. In his negative readings of the April 10, 2001, and July 27, 2001, x-rays, Dr. Wiot opined that there were bullae and emphysematous change in the upper lung fields, and his observation of interstitial pulmonary fibrosis is not necessarily wholly inconsistent with the opinions of physicians who read the x-rays as positive for pneumoconiosis, as none of the doctors read the x-rays as completely negative of any opacities. Because the most recent and the majority of the x-rays were interpreted as positive for pneumoconiosis, the radiographic evidence establishes that the Claimant has pneumoconiosis under §718.202(a)(1).

The record contains seven interpretations of three CT scans. One interpretation was positive for pneumoconiosis, two were negative for pneumoconiosis, one noted the possibility of pneumoconiosis, and three did not refer to the existence of pneumoconiosis. Five readings noted the existence of either nodular densities or opacities in the upper lung lobes. Dr. Spitz noted that there were bullae in the upper and middle lobes, and that there were small irregular opacities at

the lung bases and to some degree in the left mid lung, but did not comment on the size of the opacities in the lower lung or the bullae. Dr. Wiot did not directly observe the existence of nodules in the upper lung lobes, but he did find fibrosis, extensive bullous change, and generalized emphysema. Dr. Spitz and Dr. Wiot, who are dually qualified B-readers and board-certified radiologists, opined that Claimant did not have pneumoconiosis. While Dr. Spitz and Dr. Wiot might be better qualified to review CT scans than four of the physicians who read the CT scans, which include two board-certified radiologists, one B-reader, and one unqualified reader, the failure by Dr. Spitz and Dr. Wiot to note opacities in the upper lobes that were observed by three physicians in x-ray readings and five physicians in CT scan readings, suggests that their readings are incomplete, so that their readings are not given as much weight as the readings of the other physicians. It also does not appear that certification as a B-reader has any bearing on qualifications to interpret CT scans. Therefore, because Dr. Cohen opined that Claimant had pneumoconiosis, which is supported by Dr. Sagel's finding, and is not inconsistent with the findings of Drs. Gatla, Marmo, and Tuteur, and because the opinions of Drs. Spitz and Wiot are questionable, Claimant has proved by a preponderance of the CT scan evidence that Claimant has pneumoconiosis.

In a well reasoned medical opinion that was supported by the medical evidence he cited, Dr. Cohen opined that Claimant had pneumoconiosis, based upon a review of Claimant's extensive medical data. Dr. Cohen's opinion is consistent with the well reasoned reports of Dr. Houser, Dr. Tuteur, and Dr. Sanjabi, all of whom examined Claimant and found that Claimant had pneumoconiosis. The opinions of Drs. Cohen, Tuteur, Houser, and Sanjabi are clear and adequately explain their findings.[28] Drs. Renn and Repsher opined that Claimant did not have pneumoconiosis. Dr. Renn relied on four negative x-rays that were not admitted into the record and Dr. Repsher relied on six negative x-rays that were not admitted into the record. In addition, the opinions of Drs. Renn and Repsher that Claimant does not have pneumoconiosis are contrary to this tribunal's findings that the x-ray evidence supports a finding of pneumoconiosis. Therefore, Dr. Renn's and Dr. Repsher's opinions are not well reasoned, are not convincingly supported by the medical evidence, and their opinions are given little weight. While Dr. Cohen reviewed a negative x-ray reading that was not admitted into the record, it is apparent that he did not rely on the reading, because it was negative. He opined that Claimant had pneumoconiosis, and his review of the negative x-ray does not affect the weight of his opinion. Drs. Houser, Tuteur, Cohen, Repsher and Renn are board-certified in internal medicine and the subspecialty of pulmonary disease. The qualifications of Dr. Sanjabi are unknown. Because the qualifications of Drs. Houser, Tuteur, Cohen, Repsher, and Renn are virtually equal, no one opinion is given more weight on the basis of medical qualifications. The opinion of Dr. Sanjabi is given less weight because of his lesser qualifications. Therefore, Claimant has proved by a preponderance of the evidence that Claimant has pneumoconiosis under §718.202(a)(4).

Applicability of the Presumption Set Forth at §718.304

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled by, or that the miner's death was due to, pneumoconiosis if the miner is suffering or suffered from a chronic dust disease of the lungs of an advanced degree frequently referred to as

[28] While Dr. Tuteur included a review of an x-ray that was not admitted into the record in his opinion, as stated in his deposition, he relied on a CT scan that he read in finding that Claimant had pneumoconiosis.

complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three methods by which a claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs; or c) when diagnosis by means other than those specified by (a) and (b) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had diagnosis been made as therein described. Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Benefits Review Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis. Rather, the Board requires that the administrative law judge first evaluate the evidence in each category, and then weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

The Court in *Scarbro* stated that "the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they appear to be perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader." *Scarbro* at 256. The relevant objective evidence of complicated pneumoconiosis in the instant record pertains to the interpretations of x-rays under prong (a) of §718.304, and the interpretations of CT scans under prong (c) of §718.304.

X-ray Evidence under §718.304(a)

Three physicians read Claimant's July 27, 2001, x-ray, the most recent x-ray, as positive for complicated pneumoconiosis. All three physicians are dually qualified board-certified radiologists and B-readers.[29] Dr. Whitehead, Dr. Alexander, and Dr. Cappiello observed a one centimeter opacity in the right mid lung field. Dr. Wiot is the only physician to read the July 27, 2001, x-ray as negative for complicated pneumoconiosis. Dr. Wiot opined that there was an "ill defined density" that was not related to coal dust exposure in Claimant's lung. Employer claimed that Dr. Wiot's opinion should be given more weight because he reviewed several x-rays. Employer also claimed that Dr. Wiot is a C-reader. But, while Dr. Wiot noted extensive bullous and emphysematous changes involving both lung fields that he opined were not related to CWP, he gave no reason why he believed that the ill-defined density was not a large opacity or related to coal dust exposure. His failure to observe the opacities that were observed by three other physicians suggests that his review is incorrect or incomplete. Consequently, his opinion is given less weight. Thus, Claimant has proved by the x-ray evidence that he has complicated pneumoconiosis.

[29] While Dr. Wiot read a more recent x-ray dated February 19, 2002, as negative for pneumoconiosis, the x-ray was a digital film, which, according to Dr. Ahmed and uncontested by Employer, the ILO system does not permit to be read for pneumoconiosis.

Other Evidence under §718.304(c)

The entire record contains seven interpretations of three CT Scan readings. Dr. Gatla opined that the April 27, 2001, CT Scan showed a two by one centimeter large opacity in the right upper lobe, and two small densities in the left upper lobe, one to one and a half centimeters in size. Dr. Marmo read the August 8, 2001, CT scan as showing discreet nodular areas in the right and left upper lobes. Dr. Sagel, Cohen, and Tuteur all noted nodules in both upper lobes in the February 19, 2002, CT scan, but did not give measurements. However, Dr. Tuteur noted that there was a 1.4 centimeter opacity in the lower lung lobes, which he diagnosed as simple pneumoconiosis, but which under the regulations would qualify as complicated pneumoconiosis, because the opacity was over one centimeter. Dr. Cohen noted that there was a one by one centimeter opacity in the right lobe, and two large opacities in the left upper lobes, which were one by one and one by one and a half centimeters in diameter. Dr. Spitz noted that there were nodules in the lower lung zones, with a few in the mid lung zones, but did not note any in the upper lung zones. Dr. Wiot did not opine that that there were nodules present in either lung.

While Dr. Wiot and Dr. Spitz are dually qualified B-readers and board-certified radiologists, their opinions are contrary to those of five other physicians, including one dually qualified B-reader and board-certified radiologist, two board-certified radiologists, one B-reader, and one reader without established qualifications, and so are given little weight. While Dr. Cohen is a B-reader and his qualifications in reading CT scans are unknown, his opinion that there were large opacities in Claimant's lungs that were consistent with complicated CWP, is supported by the findings of other apparently more qualified physicians. In an equivocal finding, Dr. Sagel opined that the opacities were emphysematous or could be cancer. Dr. Tuteur's opinion, that the nodules were "concerning for multiple metachronous primary lung carcinomas," suggests uncertainty or equivocation, but because he found a 1.4 centimeter opacity in the lower lung, this tribunal finds his opinion tends to establish the existence of complicated pneumoconiosis under the applicable regulatory criteria, even thugh Dr. Tuteur is a pulmonary specialist, but not a B-reader or a board-certified radiologist, and though he has not explicitly indicated through his resume or testimony that he has particular expertise in reading CT scans. Dr. Gatla and Dr. Marmo did not give a specific etiology for the nodules, but noted bullae and emphysematous changes.

Equivalency Determination

All of the physicians who examined the x-rays and CT scans, with the exception of Drs. Spitz and Wiot, noted that there was a nodule in Claimant's right upper lobe. All of the physicians who examined the Claimant's CT scans, with the exception of Drs. Spitz and Wiot, noted nodules in the Claimant's left upper lobes as well. The physicians who opined on the size of the nodules upon viewing the CT scan, noted that the nodules were one centimeter and over, which is the size of the opacities noted by the physicians who read the x-rays. As previously noted, evidence of complicated pneumoconiosis established by x-ray reading "can lose force only if other evidence affirmatively shows that the opacities are not there or are not what the seem to be, perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader." *Easter Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000).

The majority of the physicians who read the x-rays opined that Claimant had complicated pneumoconiosis, and the physicians who read Claimant's CT scans did not prove that the complicated pneumoconiosis was incorrectly diagnosed. No physicians opined that the sizes of the opacities found in the CT scans would be any different size on the x-rays. The findings under prong (c) do not appear to be inconsistent with the findings under prong (a), and it may reasonably be inferred that the nodules noted in the CT scan and x-rays were similar in size. There is no evidence to the contrary that would establish that the nodules seen on the CT scans would have been seen as smaller on x-ray. There is no CT scan evidence that the size A opacities noted on the x-rays were not of equivalent size in both mediums. It may be inferred that Dr. Tuteur's declaration that, despite Dr. Whitehead's finding of a large A opacity, there was no evidence of progressive massive fibrosis or complicated coal workers' pneumoconiosis, referred to the typical clinical manifestations of the disease rather than the legal manifestations governed by §718.304. Thus, equivalency is inferentially established.

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established twenty-nine years of coal mine employment. Drs. Whitehead, Alexander, and Cappiello opined that the opacities observed on Claimant's x-rays were caused by pneumoconiosis. Dr. Wiot opined that the emphysematous changes and bullae he observed in x-rays were not caused by pneumoconiosis, but did not give a reason for his finding. His failure to observe the large opacities that were noted by three other physicians of comparable qualifications brings his opinion into doubt, and it is therefore given less weight.

Dr. Wiot opined that the emphysematous changes and bullae he observed in a CT scan reading were not caused by pneumoconiosis, but did not give a reason for his finding, so that his opinion is given less weight. Dr. Spitz opined in his CT scan reading that Claimant did not have CWP, but he did not give a reasoned opinion for his conclusion, so that his opinion is given less weight. In a well reasoned opinion supported by specified medical evidence, Dr. Cohen attributed the opacities in Claimant's lungs, viewed on the CT scan, to simple and complicated pneumoconiosis. Although Dr. Tuteur opined that nodules he observed on a CT scan could be caused by carcinoma, he noted that there were greater than one centimeter nodules in Claimant's lower lobe caused by coal mine employment, which by inference qualify as opacities, and which would be evidence of legal complicated pneumoconiosis,. Because Dr. Tuteur only stated that Claimant had simple pneumoconiosis, his opinion apparently did not take account of the regulatory, as opposed to the clinical, definition of complicated pneumoconiosis, which refers to opacities larger than one centimeter. However, the opinion is probative of the existence of pneumoconiosis arising out of coal mine employment. In his CT scan interpretation Dr. Sagel noted the overwhelming emphysematous abnormality and only a slight possibility of CWP, with the inferential nexus with coal mine employment, as well as that the large nodules probably related to the emphysema or possibly bronchogenic carcinoma.

In a well reasoned and well documented report, Dr Cohen opined that Claimant's CWP was caused by coal mine dust exposure. His opinion is supported by the opinions of Drs. Houser and Tuteur. Dr. Repsher and Dr. Renn opined that the opacities in Claimant's lungs were caused solely by cigarette smoking. However, in making this finding they relied on x-rays that were not admitted into the record. In addition, they found no pneumoconiosis, contrary to the finding of this tribunal and a majority of other doctors, so that their poorly reasoned opinions are effectively discredited. Employer has not marshaled sufficient evidence to rebut the presumption that Claimant's pneumoconiosis was caused by coal mine employment. Consequently, Claimant has established the requisite causal relationship between his pneumoconiosis and coal mine employment under §718.203(b).

Total Disability under §718.304

Because Claimant is entitled to the irrebuttable presumption that he is totally disabled by pneumoconiosis under §718.304, it is not necessary to establish total disability by a respiratory impairment under step three. Notwithstanding the finding of complicated CWP, Claimant has established that he is totally disabled due to a pulmonary or respiratory impairment under the evidence submitted with the duplicate claim. In the only medical opinion given prior to the previous denial, dated October 22, 1985, Dr. Sanjabi did not opine on Claimant's disability. Therefore, there is nothing in the past evidence that would prevent this tribunal from concluding that Claimant has established that he is totally disabled by a respiratory impairment by a preponderance of the evidence under §718.204(b)(2)(iv) as discussed, and this is consistent with the finding that Claimant is totally disabled under §718.304.

Total Disability Due to Pneumoconiosis

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

Claimant has proved that he has complicated pneumoconiosis, and under §718.304, he is entitled to the irrebuttable presumption that he is totally disabled by pneumoconiosis. Notwithstanding the finding of complicated CWP, Claimant has proved by a preponderance of the evidence that he is totally disabled by pneumoconiosis, based on the opinions of the physicians who examined him or reviewed his medical records. This is consistent with the conclusion that Claimant is totally disabled by complicated pneumoconiosis under §718.304. In a well reasoned and well documented report, Dr. Cohen opined that Claimant was totally disabled by pneumoconiosis, because of severe diffusion impairment and gas exchange abnormalities with exercise caused in part by Claimant's response to his long exposure to coal mine dust.. His opinion is supported by the well reasoned opinion of Dr. Houser. While Dr. Tuteur did not opine explicitly as to the extent of Claimant's disability, he noted that Claimant

did have a significant impairment at gas exchange at rest that worsened during exercise, a finding not inconsistent with, and partially corroborative of, Dr. Cohen's finding.

Because Dr. Renn and Dr. Repsher opined that Claimant did not have CWP, which is contrary to this tribunal's finding based on a preponderance of the evidence, their opinions are effectively discredited. *Amax Coal Co. V. Director, OWCP [Chubb]*, 312 F.3d 882 (7th Cir. 2002)(The administrative law judge properly discounted physician's opinion that pneumoconiosis did not contribute to the miner's total disability because the physician's opinion was based on a finding that the miner did not suffer from the disease, contrary to the administrative law judge's findings, which were supported by substantial evidence). Dr. Repsher's opinion that Claimant was not totally disabled, but that "given his age and his mild to moderate COPD, he probably could not do his usual work as a coal miner," was somewhat equivocal, but, in effect, establishes total disability with a significant pulmonary component. In finding that Claimant did not have pneumoconiosis, Dr. Repsher relied on x-rays that were not admitted into the record, as well as concluded that Claimant did not have pneumoconiosis or any other pulmonary or respiratory condition related to coal mine dust. Dr. Renn also opined that Claimant's total disability was not caused by coal mine employment. He also relied on x-rays that were not admitted into the record in making his finding, and opined that Claimant did not have pneumoconiosis, Since both of these negative opinions are discredited, Claimant has proved by a preponderance of the evidence that he is totally disabled due to pneumoconiosis.

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Date of Onset

Section 725.503(b) of the act provides that benefits are payable to a miner who is entitled to payment of benefits beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Where the evidence does not establish the month of onset, benefits shall be payable to such miner from the month in which the claim was filed, and "[i]n any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." §§725.309(d)(5), 725.503(b) Dr. Houser first opined that Claimant was disabled due to pneumoconiosis on July 27, 2001. There is no evidence of earlier onset. Therefore, July 27, 2001, is deemed to be the onset date which establishes entitlement to payment of benefits as of July 1, 2001.

Attorney's Fees

Claimant's counsel may file an application for approval of an attorney's fee with this tribunal within thirty days of the date of this decision in accordance with §§725.365 and 725.366. A service sheet must accompany any fee application, showing that service of the application has been made upon all parties including Claimant. Objections to the application may be filed within twenty days following receipt of such a fee application. The Act prohibits charging any fee to the Claimant for representation in relation to prosecution of a black lung claim in the absence of prior approval in accordance with the applicable regulations

ORDER

The claim of James E. Harris for benefits under the Act is granted. Respondent Employer shall pay Claimant the black lung benefits to which he is entitled commencing as of July 1, 2001.

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Edward Terhune Miller
Administrative Law Judge

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