U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 08 September 2004

In the Matter of:

DONALD B. CHURCH,
Claimant

v.

VIRGINIA POCAHONTAS CO.,
Employer

and

OLD REPUBLIC INSURANCE CO.,
Carrier

and

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

Case No.: 2003-BLA-231

Appearances:

Andrew Delph, Esq.
Wolfe, Williams & Rutherford
Norton, Virginia
For the Claimant

Mary Rich Maloy, Esq.
Jackson & Kelly PLLC
Charleston, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, Donald B. Church, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on November 4, 2003, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Director's Exhibits ("DX") 1-84 were admitted into evidence without objection. Due to an apparent clerical error, however, there were no exhibits labeled DX 15 or DX 30. Transcript ("Tr.") at 7-8; DX 59 at 6-7. No additional exhibits were offered. The Employer offered a pre-hearing report, and the Claimant and the Employer made their closing arguments orally at the hearing.

In reaching my decision, I have reviewed and considered the entire record pertaining to the duplicate claim, including all exhibits, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on July 26, 1974. He then returned to coal mine employment, and filed again on March 3, 1976. The claim was denied after a formal hearing held before Administrative Law Judge Frank J. Marcellino, in a Decision and Order dated October 19, 1984. DX 36-45. In that decision, Judge Marcellino found fifteen years of coal mine employment. The claim was adjudicated pursuant to 20 CFR Part 727, under which a miner was entitled to a presumption of total disability due to pneumoconiosis if he had 10 years of coal mine employment, and x-ray evidence of pneumoconiosis, qualifying pulmonary function or blood gas studies, or other medical evidence establishing the presence of a totally disabling respiratory or pulmonary impairment. Judge Marcellino found that the Claimant had invoked the presumption by chest x-ray, pulmonary function studies and other medical evidence, but that the Employer had rebutted it by showing that his disability was attributable to cigarette smoking rather than coal mine employment. The Claimant filed a timely appeal of the denial with the Benefits Review Board (the "Board") and on December 16, 1986, the Board affirmed the denial of benefits. DX 36-49. The Claimant did not pursue the claim further.

More than one year later, on July 8, 1998, the Claimant filed another claim. DX 1. The District Director of the Office of Workers' Compensation Programs ("OWCP") issued a Notice of Initial Finding, finding the Claimant entitled to benefits on November 30, 1998. DX 20. The Employer filed a timely controversion on December 11, 1998. DX 21. On March 30, 1999, the Director issued an Initial Determination, finding the Claimant entitled to benefits, DX 28, and on April 2, 1999, the Employer filed a request for a hearing. DX 31. This matter was referred to the Office of Administrative Law Judges on May 24, 1999. DX 37. On April 2, 2001, a formal hearing was held before Administrative Law Judge Thomas M. Burke. DX 59. Judge Burke

issued a Decision and Order on September 20, 2002, denying benefits. DX 63. In so doing, he found that the evidence did not show that the Claimant had pneumoconiosis caused by coal mine work, or that the Claimant was totally disabled due to pneumoconiosis. The Claimant filed a timely appeal with the Board. DX 64. While the appeal was pending, however, he then filed a Motion for Modification and Remand on December 23, 2002, DX 68, DX 71, which was granted by the Board on January 14, 2003. DX 70. On March 10, 2003, the Director issued a Proposed Decision and Order Denying Request for Modification, DX 73, and on July 1, 2003, this matter was again referred to the Office of Administrative Law Judges for a formal hearing. DX 84.

APPLICABLE STANDARDS

This claim relates to a request for modification of an adverse decision on a "duplicate" claim filed on July 8, 1998. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2004). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2004). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do not apply to pending cases, see 20 CFR § 725.2(c) (2004). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2004 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that he is entitled to benefits in connection with his current claim, the Claimant must demonstrate that there has been a change in conditions or a mistake in a determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004). I must consider all of the evidence pertaining to his duplicate claim to determine whether there has been a change in conditions or a mistake of fact by Judge Burke; new evidence is not required for me to reach a

determination that there has been a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

In this case, the Claimant has offered no new evidence in connection with his request for modification. For this reason, I have considered the evidence before Judge Burke to determine whether he made a mistake in a determination of fact. I find that he has not.

Because the underlying claim is a duplicate claim, in order to be entitled to benefits, the Claimant must also establish a material change in conditions since his previous claim was denied. 20 CFR § 725.309(d) (2000); see *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1363 (4th Cir. 1996). Judge Marcellino found that the Claimant was not entitled to benefits because the Employer established that his total respiratory disability was due to smoking, rather than pneumoconiosis arising out of coal mine employment. I construe his decision to mean that the Claimant established that he was totally disabled by a pulmonary or respiratory impairment, but failed to establish any other element of his claim. In the context of 20 CFR Part 718 and 20 CFR § 725.309 (2000), therefore, the Claimant may establish a change in conditions by showing any other element of his claim, i.e., that he has pneumoconiosis, caused by coal mine employment, which contributes to his pulmonary or respiratory disability. Because I find that he has established none of these elements, he has not established a change in conditions, and I need not address the medical evidence from his initial claim in this decision and order.

ISSUES

The issues contested by the Employer and/or the Director, are:

1. Whether the claim was timely filed.

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled

5. Whether his disability is due to pneumoconiosis.

6. Whether the evidence establishes a material change in conditions since denial of his first claim pursuant to 20 CFR § 725.309 (2000).

7. Whether the evidence establishes a change in conditions or a mistake in a determination of fact in a prior denial of his duplicate claim pursuant to 20 CFR § 725.310 (2000).

At the hearing, the Employer conceded 15 years of coal mine employment, and that the Claimant has a totally disabling respiratory impairment. The Employer also conceded that the Claimant has one dependent, his wife, and that his last coal mine employment was in 1975 with Virginia Pocahontas Company, absent contrary testimony. DX 84; Tr. 5-6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Church testified twice during the proceedings on his duplicate claim, at the hearing before Judge Burke in April 2001, DX 59, and at the hearing in November 2003. Mr. Church is married, and his wife, Leona, is his sole dependent. DX 1, Tr. 10. He was 66 years old at the time of the second hearing. Tr. at 16. He thought he worked in the coal mines about 19 years. In his decision on the initial claim, Judge Marcellino determined that the Claimant had established 15 years of coal mine employment, DX 36, a finding reaffirmed by Judge Burke, DX 63. No new evidence has been submitted on this issue, and I find no mistake in the prior determinations. I find that the Claimant had 15 years of coal mine employment.

Mr. Church said that all of his work was underground, and he did a bit of everything. Most of it was dusty work. Tr. 10-13. He stopped working because he became disabled. He has not been employed since he left the coal mines. Tr. 13. His last employer was Virginia Pocahontas Company, from 1970 to 1975. DX 59 at 21. His last coal mine employment was in Virginia. Tr. 7, DX 59 at 21. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Mr. Church said he has to use oxygen at night, and he was using it at the hearing. Tr. at 13. He could not remember the name of the doctor who prescribed it. At the previous hearing, in April 2001, he said he had been using it every night for two years. DX 59 at 36. He does not have a heart problem that he knows of. Tr. at 14. He used to smoke, not over a pack a day. He started at age 19 or 20, and quit about 17 years before the hearing [1986]. Tr. at 14-15. Although he had been scheduled for doctor examinations three times since his claim was last denied, he did not attend because he could not afford to go. Tr. at 15. He did not attend an examination scheduled by the Employer because he was sick. Tr. at 16, 17. His only income is from Social Security, and a miner's pension. Tr. at 16. Dr. Baxter at Grundy, Virginia, told him he was totally disabled by pneumoconiosis. Tr. at 17. Mr. Church was not asked when Dr. Baxter told him that, and there are no records or reports from Dr. Baxter in evidence in either claim. A question by counsel at the previous hearing suggested that Dr. Baxter told Mr. Church to get out of the mines in 1975. DX 59 at 38.

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

The purpose of the Regulation allowing the filing of duplicate claims is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). There is no

statute of limitations or time limit for filing a duplicate claim. 20 CFR § 725.309 (2000); *Andryka v. Rochester Pittsburgh Coal Co*., 14 B.L.R. 1-34 (1990). While there is a one-year time limit for filing a request for modification pursuant to 20 CFR § 725.310 (2000), the request for modification filed by the Claimant, was filed within the requisite time period. There is no limit to the number of times a party may seek modification. *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491 (4th Cir. 1999). The Employer has offered no evidence or argument in support of this issue. I find that the claim is timely.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in the duplicate claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). Any such readings are therefore included in the "negative" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and the registry of physicians' specialties maintained by the American Board of Medical Specialties.[1] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology.

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[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis
08/26/98	DX 13 Gaziano (B) 1/2	DX 12 Paranthaman (B) 0/1 DX 14 Navani (B, BCR) 0/1 DX 26 Wiot (B, BCR) DX 29 Spitz (B, BCR) DX 61 Meyer (B, BCR) DX 61 Wheeler (B, BCR) DX 61 Scott (B, BCR)
01/19/99	DX 25, DX 56 DePonte (B, BCR) 1/0	DX 29 Wiot (B, BCR) DX 33 Spitz (B, BCR) DX 39, DX 61 Meyer (B, BCR) DX 61 Scott (B, BCR) DX 61 Wheeler (B, BCR) DX 61 Kim (B, BCR) DX 61 Abramowitz (B, BCR) 0/1 DX 61 Binns (B, BCR) 0/1 DX 61 Gogineni (B, BCR) 0/1
02/09/99		DX 27 Castle (B) 0/1 DX 29 Wiot (B, BCR) DX 29 Spitz (B, BCR) DX 39, DX 61 Meyer (B, BCR) DX 61 Scott (B, BCR) DX 61 Wheeler (B, BCR) DX 61 Kim (B, BCR) DX 61 Abramowitz (B, BCR) 0/1 DX 61 Gogineni (B, BCR)
08/16/99	DX 41 Robinette (B) 1/1	DX 61 Wheeler (B, BCR) DX 61 Scott (B, BCR) DX 61 Abramowitz (B, BCR) 0/1 DX 61 Gogineni (B, BCR)
09/02/99		DX 61 McSharry (A) DX 61 Scott (B, BCR) DX 61 Wheeler (B, BCR) DX 61 Kim (B, BCR) DX 61 Abramowitz (B, BCR) DX 61 Gogineni (B, BCR) DX 61 Binns (B, BCR) 0/1
03/27/00	DX 56 Robinette (B) 1/1	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis
01/03/01	DX 51 Patel (B, BCR) 1/0	DX 61 Wheeler (B, BCR) DX 61 Scott (B, BCR) DX 61 Kim (B, BCR) DX 61 Gogineni (B, BCR) DX 61 Binns (B, BCR) 0/1 DX 61 Abramowitz (B, BCR) 0/1

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the duplicate claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 08/26/98 Paranthaman	61 72.5	.51 .81	1.91 3.05	27% 27%	21 33	Yes Yes	Very severe airway obstruction with significant response to bronchodilators
DX 27 02/09/99 Castle	62 70"[2]	.79 1.01	2.93 4.23	27% 24%	26 38	Yes Yes	Severe airway obstruction with significant improvement after bronchodilators. No restriction.

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 61 09/02/99 McSharry	62 72”	.84 1.28	3.40 4.92	25% 26%	28	Yes Yes	Severe obstructive lung disease with excellent bronchodilator response. No restrictive disease.
DX 51 01/03/01 Rasmussen	63 71”	.78 .96	2.79 3.73	28% 26%	22 33	Yes Yes	Very severe, partially reversible obstructive ventilatory impairment.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the duplicate claim. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 11	08/26/98	Paranthaman	48	74	No	Mild hypoxemia.
DX 27	02/09/99	Castle	52.8	69.4	Yes	Normal for patient’s age.

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recorded height of the miner from 70” to 72.5”, I have taken the average (71.4”) in determining whether the studies qualify to show disability under the regulations. All of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 61	09/02/99	McSharry	48	63	No	Hypercarbia and mild hypoxemia
DX 51	01/03/01	Rasmussen	49.0 47.0	58.0 60.0	Yes Yes	Moderate resting hypoxia.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). In this case, all of the pulmonary function studies, and all of the medical opinions, as well as some of the arterial blood gas studies, are in agreement that the Claimant is totally disabled. With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). The record contains the following medical opinions relating to the duplicate claim.

There are reports from six doctors who have examined or treated Mr. Church in evidence.

Emory H. Robinette, M.D., who is Board Certified in Internal Medicine and Pulmonary Diseases, and a B reader, saw Claimant on July 9, 1998 for a medical assessment of Claimant's pulmonary disease at the request of one of claimant's treating physicians, Dr. Sutherland. In a letter dated August 12, 1998, Dr. Robinette indicated that Claimant had evidence of some early interstitial fibrosis associated with emphysema and pleural parenchymal scarring with pulmonary function studies confirming a very severe obstructive ventilatory defect and marked air trapping. He further stated that Claimant was a candidate for possible lung volume reduction surgery versus a transplant candidate, in view of his age of 6l years. DX 8, DX 25.

S. K. Paranthaman, M.D. who is Board Certified in Internal Medicine and Pulmonary Disease, and a B reader, DX 10, examined Claimant at the request of the Department of Labor on

August 26, 1998. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Church worked in the mines for 18 years. He reported a smoking history of 1 pack per day for 15 years. The chest examination revealed marked increased anteroposterior diameter, hyper- resonant percussion, prolonged expiration and bilateral wheezing. Dr. Paranthaman classified the x-ray as 0/1. The pulmonary function test showed severe obstruction with significant response to bronchodilators. The arterial blood gas study revealed mild hypoxemia and mild carbon dioxide retention at rest. A note from Dr. Sutherland said that Mr. Church would be unable to perform an exercise study due to severe obstructive pulmonary disease and angina. Diffusion capacity was markedly reduced. Dr. Paranthaman diagnosed pulmonary emphysema and bronchospasm, and concluded that Claimant's respiratory impairment was severe and totally disabling. He stated that Claimant's emphysema was likely related to his 15 year cigarette smoking history. He said further, "If 18 years of coal mine employment in the underground is documented it could have aggravated the condition significantly. Bronchospasm is unrelated coal dust exposure." DX 9.

In a supplemental report dated November 6, 1998, Dr. Paranthaman reviewed records supplied by the Department of Labor and again indicated that Claimant had severe pulmonary emphysema with marked airway obstruction causing a severe respiratory impairment. He noted that one reader found x-ray evidence positive for pneumoconiosis, while two found it negative. He felt that cigarette smoking was more likely the primary cause of Claimant's respiratory condition but that his 15 years of coal mine employment and the positive chest x-ray reading would point to the fact that Claimant's respiratory condition could have been aggravated by coal dust exposure. He further concluded that Claimant would qualify for a diagnosis of coal workers' pneumoconiosis since the legal definition of coal workers' pneumoconiosis includes any respiratory condition that is significantly aggravated by coal dust exposure. DX 10.

James R. Castle M.D., who is Board Certified in Internal Medicine and Pulmonary Diseases, and a B reader, examined the Claimant on behalf of the Employer on February 9, 1999. He took occupational, social, family and medical histories, and conducted a physical examination, EKG, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Church worked in the mines for 18 years. He reported a smoking history of 33 pack years. The chest examination revealed an increased AP diameter, intercostal retractions with quiet breathing, some use of the accessory muscles with minimal exertion, markedly decreased breath sounds with prolongation of the expiratory phase, and bilateral expiratory wheezing. Dr. Castle read the x-ray as showing opacities in both lower zones, which he classified as 0/1, stating they did not indicate the presence or look like the findings of coal workers' pneumoconiosis. The pulmonary function studies were valid and showed evidence of very severe obstructive airway disease with significant response to bronchodilator therapy. There was evidence of mild gas trapping. The total lung capacity was normal, and there was not evidence of any restriction. Diffusing capacity was normal. These findings were consistent with a diagnosis of tobacco smoke induced asthmatic bronchitis. The arterial blood gas study was normal at rest. Mr. Church declined an exercise study. EKG indicated an old myocardial infarction. Dr. Castle concluded that there was no evidence of coal workers' pneumoconiosis. He diagnosed chronic asthmatic bronchitis, tobacco smoke induced, with a severe partially reversible airway obstruction; coronary artery disease; history of myocardial infarction; and angina pectoris, controlled. DX 27.

After reviewing other available medical records, Dr. Castle said Mr. Church had sufficient exposure to have developed coal workers' pneumoconiosis if he were a susceptible host. Tobacco abuse was also a risk factor for development of pulmonary disease. In addition, cardiovascular disease can also cause pulmonary symptoms. He said that Mr. Church had not demonstrated consistent physical findings indicating the presence of an interstitial pulmonary process such as would be expected with clinically significant coal workers' pneumoconiosis. The x-ray findings in the lower lung zones were consistent with tobacco abuse. Physiologic studies showed severe airway obstruction with significant response to bronchodilator therapy, no evidence of restriction, and normal diffusion, findings consistent with obstruction caused by smoking. Arterial blood gases were essentially normal at rest with a mild degree of hypercarbia. Coal workers pneumoconiosis may cause irreversible hypoxemia, but there was no fall in the pO_2 in Dr. Robinette's exercise study, and hypercarbia is a sign of damage from smoking, but not pneumoconiosis. Thus Dr. Castle still concluded that Mr. Church did not suffer from coal workers' pneumoconiosis, concluding that he was totally disabled as a result of tobacco smoke induced asthmatic bronchitis. He further stated that this disability was entirely unrelated to Claimant's coal mine employment and coal dust exposure. DX 27.

Roger J. McSharry, M.D., who is Board Certified in Internal Medicine, Pulmonary Diseases and Critical Care Medicine, and an A reader, also examined the Claimant on behalf of the Employer, on September 2, 1999. He took occupational, social, family and medical histories, and conducted a physical examination, EKG, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Church worked in the mines for 20 years. He reported a smoking history of one pack per day for 15 years. The chest was hyper inflated in AP diameter, and he heard bilateral wheezing. The EKG showed no significant abnormalities. Dr. McSharry said the x-ray showed hyperinflation without evidence of coal worker's pneumoconiosis, confirmed by Dr. Scott's B-reading as well. The pulmonary function test showed severe obstruction with excellent bronchodilator response. There was no evidence of restrictive lung disease. The arterial blood gas study revealed minimally reduced PO2 for his age, with evidence of chronic hypercarbia. Carboxyhemoglobin was normal. Dr. McSharry found that Claimant did not have pneumoconiosis, based on the absence of supporting evidence, particularly typical abnormalities on chest x-ray, irreversible obstructive disease, or restrictive lung disease. He did diagnose severe obstructive lung disease which he found to be suggestive of severe asthma and/or asthmatic bronchitis, which would prevent Mr. Church from performing his last coal mining work. Dr. McSharry testified to these opinions during a deposition which was taken on October 15, 1999. He testified that Claimant's asthma was not related to his coal mine dust exposure. DX 61.

Dr. Robinette examined claimant a second time on April 12, 2000. Since the first examination, Mr. Church reported progressive severe dyspnea on exertional activity, chronic cough and paroxysmal wheezing. He had not been hospitalized. He was using several medications for his breathing. Dr. Robinette reported a 20 year history of work in the mines, and a 35 to 40 pack year smoking history. On examination, Mr. Church was using accessory muscles of respiration, and his chest had an increased AP diameter. Breath wounds were diminished, poor air movement was noted, and bilateral wheezes were heard. There was marked prolongation of the expiratory phase, and rhonchi were present in both lung bases. Dr. Robinette classified an x-ray taken on March 27, 2000, as positive for pneumoconiosis, 1/1. Pulmonary

function studies showed decreased flow rates. Diffusion capacity was severely impaired. Blood gas studies revealed a normal pH, PCO2 and a reduction of the PO2. Test results were not in the record, but Dr. Robinette characterized them as being consistent with very severe obstructive lung disease with response to bronchodilators. There was evidence of moderate air trapping, reduction of diffusion capacity, hypercapnia and intercurrent hypoxemia. EKG was normal. He diagnosed coal workers' pneumoconiosis with a profusion abnormality of 1/1 with underlying emphysema; very severe chronic obstructive pulmonary disease with evidence of intercurrent hypoxemia, hypercapnia and profound impairment of the diffusion capacity; and history of hyperlipidemia. He also noted that there had been progressive deterioration of Claimant's lung function since 1998. Dr. Robinette concluded that Claimant was totally disabled from working on the basis of his lung disease alone and he stated that Mr. Church's pulmonary disease is at least partially attributable to his prior coal mine employment. DX 56.

Dr. D. L. Rasmussen examined Mr. Church at the request of his counsel on January 3, 2001. Dr. Rasmussen's qualifications are not in the record. He reported that Mr. Church began smoking at age 20 in 1957, smoking one pack a day, having quit in 1986. He recorded 18 years of coal mine employment. Mr. Church's AP chest diameter was increased, and chest expansion seemed diminished. Breath sounds were markedly reduced. There were no rales of rhonchi, and a few expiratory wheezes. There was marked prolonged expiratory phase and wheezing with forced respirations. Chest x-ray was interpreted by Dr. Patel to show pneumoconiosis, 1/0, affecting the middle and lower lung zones. Ventilatory function studies revealed very severe, partially reversible obstructive insufficiency. Maximum breathing capacity, total lung capacity and residual volume were markedly increased. Single breath carbon monoxide diffusing capacity was very markedly reduced. The arterial blood gas study revealed resting hypoxia and minimal hypercarbia. Exercise study was terminated after blood sampling because of severe respiratory distress. His oxygen uptake was 26% of his predicted maximum. Oxygen transfer was impaired. Dr. Rasmussen diagnosed pneumoconiosis and indicated that Claimant suffered from a totally disabling respiratory insufficiency which is a consequence of both his cigarette smoking and his coal mine dust exposure. He was emphatic that neither cause could be dismissed as a potent cause of Mr. Church's impaired function, citing a NIOSH report and other epidemiologic studies. He concluded that Claimant's coal mine dust exposure was a significant contributing factor to his disabling lung disease. DX 51.

The record includes an undated letter from another of Claimant's treating physicians, Harold E. Schultz, D.O., in which he reviewed a limited number of medical records, including a few positive x-ray readings, results of periodic pulmonary function testing, and evaluations by Dr. Robinette and Dr. Rasmussen. Dr. Schultz is an osteopath certified in family practice. He indicated that he had last evaluated Claimant on February 23, 2001, at which time he was "continuing to experience lung trouble and continued to be on a regimen of medication for the symptomology." He concluded, as Claimant's treating physician and upon review of medical records, that Mr. Church did suffer from coal workers' pneumoconiosis resulting from his exposure to coal mine dust during his coal mine employment. There are no treatment records from Dr. Schultz in the file, and no indication that he was shown any of the negative x-ray readings or medical opinions generated on behalf of the Department of Labor or the Employer. DX 55.

In addition to the foregoing reports, two of the Employer's examining doctors later submitted supplemental reports after reviewing additional records, and four other doctors provided two opinions each on behalf of the Employer, based on their review of records in 1999 and 2001.

In supplemental reports dated September 24, 1999, and February 23, 2001, Dr. Castle indicated that he had reviewed additional medical records relative to this claim, including x-ray and medical reports which found pneumoconiosis, as well as those which did not. He stated that the new records corroborated his original opinions given at the time of the February 2000 examination, which remained unchanged. Similarly, in a report dated February 20, 2001, Dr. McSharry also indicated that he reviewed additional records but his opinions remained the same. He specifically disagreed with Dr. Rasmussen's conclusion that the x-ray changes and pulmonary function test results from his examination supported a diagnosis of pneumoconiosis, as the positive x-ray report was more suggestive of asbestos related lung disease, and the pulmonary function study results were much more consistent with cigarette smoking-induced disease. DX 61.

Joseph J. Renn, III, M.D who is Board Certified in Internal Medicine and Pulmonary Disease reviewed medical records from 1998 and 1999 in a report dated September 19, 1999, and reviewed his own previous reports[3] and more recent records, including Dr. Rasmussen's report, plus one x-ray from 1974, to prepare a report dated February 9, 2001. He diagnosed chronic obstructive pulmonary disease secondary to chronic bronchitis and emphysema with a bronchospastic component which was partially reversible. He found no pneumoconiosis, but concluded that Claimant's moderate ventilatory impairment would disable him from coal mine employment. He found no relationship between Claimant's lung disease and his coal mine employment; rather, he found it to be consistent with an obstructive impairment due to cigarette smoking. His opinions remained unchanged. DX 61.

A. Dahhan, M.D. who is Board Certified in Internal Medicine and Pulmonary Disease, and a B reader, reviewed available records dating back to 1974 as indicated in his reports dated September 1, 1999, September 20, 1999, and February 9, 2001. He found insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis. He pointed in particular to the reversibility of the obstructive impairment, and the normal diffusing capacity. He diagnosed an obstructive pulmonary disability with significant reversibility after administration of bronchodilators which would totally disable claimant from coal mine employment. He concluded that Claimant's pulmonary disability did not result from coal dust exposure or occupational pneumoconiosis, but rather was caused by his previous smoking habit. He said hyperactive airway disease or asthmatic bronchitis also contributed to the disability. DX 61.

Bruce N. Stewart, M.D. provided consultation reports dated September 16, 1999, and February 26, 2001, based on his review of the available medical records dating back to 1974. He was deposed in October 1999. Dr. Stewart, who is Board Certified in Internal Medicine and Pulmonary Disease, and a B reader, found that claimant did not suffer from coal workers' pneumoconiosis, citing the results of physical examination and pulmonary function tests. He

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[3] Dr. Renn had also provided a report dated March 19, 1984, in connection with the Claimant's initial claim. DX 36-39.

diagnosed obstructive lung disease from asthma and cigarette smoking which would be totally disabling. He concluded that this impairment was not caused in whole or in part by coal workers' pneumoconiosis. At his deposition, he said that the 1998 and 1999 pulmonary function studies revealed that Mr. Church's lung volumes were relatively normal, but air flow was significantly obstructed, consistent with hyperinflation demonstrated on chest x-ray, and consistent with his patients with severe cigarette smoke-induced lung disease. He also said the normal diffusion studies were significant to his diagnosis. He agreed with counsel for the Employer that Dr. Robinette did not have benefit of many relevant studies when he gave his opinion. In Dr. Stewart's opinion, Mr. Church did not have either medical or legal pneumoconiosis. Rather, his disease was caused by smoking. Dr. Stewart saw nothing to change his opinion in the reports from Dr. Rasmussen's January 2001 examination of Mr. Church. DX 61.

Finally, Robert G. Loudon, M.D., Professor of Internal Medicine and Director of the Pulmonary Disease Division at the University of Cincinnati, also reviewed medical records back to 1974, as indicated in his reports dated September 26, 1999, and February 16, 2001. He found insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. He diagnosed a severe and disabling pulmonary or respiratory impairment, which he felt was the result of the miner's cigarette smoking habit, and possibly associated with an asthmatic tendency. He concluded that this disability was not caused in whole or in part by pneumoconiosis. In his more recent report, he considered Dr. Rasmussen's report at length. He said Mr. Church's clinical and physiological condition had deteriorated between 1999 and 2001. He agreed with Dr. Rasmussen that Mr. Church had severe and totally disabling respiratory insufficiency, but disagreed with Dr. Rasmussen's conclusion that coal dust exposure contributed to the disability. Dr. Loudon said that the progression of reversible airflow obstruction and emphysema reinforced his own opinion that cigarette smoking, not coal dust, was the cause of Mr. Church's disability, citing the preponderance of negative x-rays, along with the results of pulmonary function, arterial blood gas and diffusion capacity studies. DX 61.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

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

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

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This

definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

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

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

20 CFR § 718.201 (2004). In this case, Mr. Church's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Church has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Church filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that

later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the seven available x-rays in this case, five have been read by at least one reviewer to be positive for pneumoconiosis, and two only to be negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

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

20 CFR § 718.202(a)(1) (2004); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The x-ray taken on August 26, 1998, has been read as positive by Dr. Gaziano, a B reader, and negative by six dually qualified readers, and one B reader. I find this x-ray to be negative.

Similarly, the x-ray taken on January 19, 1999, has been read as positive by Dr. DePonte, who is dually qualified, but negative by nine dually qualified readers. I find this x-ray to be negative as well.

The x-ray taken February 9, 1999, has been read only as negative for pneumoconiosis. It, too, is negative.

The x-ray taken August 16, 1999, has been read as positive by Dr. Robinette, a B reader, but negative by four dually qualified readers. It is negative.

The x-ray taken September 2, 1999, has been read only as negative, and is therefore negative.

The x-ray taken March 27, 2000, has been read only as positive, and is therefore positive.

The x-ray taken January 3, 2001, has been read as positive by one dually qualified reader, Dr. Patel, and negative by six other dually qualified readers. I find this x-ray to be negative.

As I have found six of the seven x-rays to be negative, the weight of the x-ray evidence is negative, and therefore insufficient to establish the existence of pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). A medical opinion which is supported by more extensive documentation is entitled to greater weight than an opinion based on more limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299, 1-301 n. 1 (1984). A medical opinion better supported by the objective medical evidence of record is entitled to more weight. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n.1 (1986).

In this case, Dr. Robinette, Dr. Paranthaman, Dr. Rasmussen, and Dr. Schultz believe Mr. Church has or may have pneumoconiosis, while Dr. Castle, Dr. McSharry, Dr. Renn, Dr. Dahhan, Dr. Stewart and Dr. Loudon, do not. The conflicting medical opinions must be weighed to resolve the contrary conclusions. All of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions. At the outset, however, I note that Dr. Paranthaman's opinion was equivocal at best, as he said in both reports that the Claimant's respiratory condition "could" have been aggravated by coal dust exposure. Moreover, none of the other doctors who said Mr. Church had pneumoconiosis had the opportunity to review any of the negative evidence, and all apparently relied on positive x-ray evidence, while I have found the weight of x-ray evidence to be negative. By way of contrast, the doctors who concluded otherwise had much more complete information, positive and negative, available to them.

After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinions of Drs. Castle and McSharry. Both possess excellent credentials in the field of pulmonary disease. Both had the opportunity to examine the Claimant

as well as to review other medical evidence in the record. I find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by the physicians who concluded that the Claimant has pneumoconiosis. Drs. Castle and McSharry better explained how all of the evidence they developed and reviewed supported their conclusions.

I also find the opinions of Drs. Castle and McSharry to be in better accord both with the evidence underlying their opinions and the overall weight of the medical evidence of record. Further, additional credibility is lent to their finding of no pneumoconiosis by the detailed and reasoned opinions rendered by Drs. Renn, Dahhan, Stewart and Loudon. While none of the latter four examined the Claimant, each reviewed much or all of the medical evidence of record. In this case, their corroborating analyses lend substantial support to the opinions of Drs. Castle and McSharry.

In sum, I do not discredit any of the medical opinions of record. In resolving the conflict presented by the record, however, I find the opinions of Drs. Castle and McSharry, as supported by the conclusions of Drs. Renn, Dahhan, Stewart and Loudon, to merit greater probative weight. These credible and well reasoned medical opinions are convincing for purposes of establishing that the Claimant does not have either clinical or legal pneumoconiosis arising out of coal mine work. This evidence out weighs the contrary conclusions provided by Drs. Robinette, Paranthaman, Rasmussen and Schultz. I conclude, therefore, that the weight of the medical opinions of record fails to establish that the Claimant has pneumoconiosis as the Act requires for entitlement to benefits.

Neither the x-ray evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet his burden of showing that his exposure to coal dust contributed to his disabling respiratory disease. Thus he cannot show that he is entitled to benefits under the Act. For this reason, I conclude that Judge Burke did not make a mistake in a determination of fact when he denied the claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that there has been a change in conditions or a mistake in determination of fact in the decision on his duplicate claim, or that there has been a material change in conditions since the denial of his previous claim became final, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The request for modification filed by Donald B. Church on December 23, 2002, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2004), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.