U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 15 June 2006

Case No. 2004-BLA-06349

In the Matter of

PRICE HOSKINS,
Claimant

v.

SHAMROCK COAL COMPANY, INC.,
Employer

JAMES RIVER COAL COMPANY,
Carrier

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

Appearances:
Edmond Collett, Esq., for Claimant
John H. Baird, Esq., for Employer

Before:
ALAN L. BERGSTROM
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 et seq. Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment. 30 U.S.C. § 902(b). In this case the claimant alleges he is totally disabled by pneumoconiosis.

The claim was referred by the Director, Office of Workers' Compensation Programs to the Office of Administrative Law Judges for a formal hearing in accordance with the Act and the regulations issued thereunder. A formal hearing was held on January 31, 2006, before Administrative Law Judge Richard E. Huddleston (TR)[1].

The record was transmitted to the Office of Administrative Law Judges on June 2, 2004, and was admitted without objection as DX 1 through 33. Additionally, a letter from Counsel for the Director dated January 9, 2006, correcting the statement of issues was admitted as DX 34. The Claimant submitted two exhibits, identified as CX 1 and CX 2, which were admitted without objection (TR at 11, 15). The Employer submitted eleven exhibits, identified as EX 1 through EX 11, which were admitted without objection to content but subject to objection "if they exceed the number allowed by Regulations" (TR at 13, 14, 15). The record was held open for 60 days for submission of simultaneous briefs. The Claimant filed his brief on April 6, 2006. The Employer filed its brief on April 17, 2006.

Subsequently, Judge Richard E. Huddleston retired and the parties were directed to advise the District Chief Administrative Law Judge by June 1, 2006, whether they would "prefer to have a new hearing or a decision based on the present record." On May 12, 2006, the Claimant elected "that a decision be rendered based upon the present record." On May 30, 2006, the Director, OWCP reported "no objection to a decision on the record in this matter." The Employer has not responded to the order.

This case has been assigned to the undersigned Administrative Law Judge. The findings and conclusions which follow are entered after a complete review of the record, argument of the parties, applicable statutory provisions, regulations and pertinent precedent.

ISSUES

The following issues are disputed by the parties:[2]

1. Whether the claimant has/had pneumoconiosis as defined by the Act.

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

3. Whether the claimant is/was totally disabled.

4. Whether the claimant's disability or death is/was due to pneumoconiosis.

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[1] TR – Transcript; DX – Director Exhibit; CX – Claimant Exhibit; EX – Employer Exhibit.

[2] The contested issues were identified by the Director on DX 31. The Director, OWCP contested issue 9 (causation). At the hearing the Employer withdrew issues 1, 2, 3, 4, 11, 12, 13, and 18a. The issues listed here are those which remain in dispute.

DISCUSSION OF EVIDENCE

This matter arises from a claim for federal black lung benefits filed by Mr. Price Hoskins (Claimant) on February 25, 2003 (DX 2). The claimant stated on his application that he has worked 32 years in the coal mines and the parties agreed to a finding of 32 years coal mine employment (TR 7). The Claimant testified that 25 years of his work was as an underground coal miner at various repair, welder, electrician, roof bolter, foreman and laborer. The last several years were above ground in the rebuild shop and as a foreman over the haulage from the longwall to tipple. He last worked in March 1999 when he injured his back, arm and leg while setting a large pump at the mine.

The application was considered by the District Director, OWCP, who issued a proposed denial of benefits on February 25, 2004 (DX 23). The Claimant requested a formal hearing on March 3, 2004 (DX 24). The case was referred for hearing on June 2, 2004 (DX 31).

Because this claim was filed after January 19, 2001, it is considered under the amended regulations, which became effective on that date, at 20 C.F.R. Part 718 and Part 725.

Summary of Relevant Evidence

Testimony of Claimant

The Claimant testified that he has an 8th grade education and a GED without other vocational training. He has never been a smoker except maybe a cigarette as a kid. He has at least 32 years of coal mine employment with most of it under ground, probably 25 years underground. His underground work included welder, repairman, electrician, mine foreman, equipment operator, roof bolter, shuttle car operator and miner. He stated 90% of the repair and electrical work was at the face of the coal and he was exposed to coal dust except when he was in a ventilated space talking on the telephone or eating lunch. He testified that when employed on the surface he worked as an electrician and trouble shooter which still required underground work approximately 2/3 of the time. The remainder of the time he would be in the rebuild shop where he was exposed to some coal dust but mainly metal dust. He stated that he injured his back, neck, left arm and left leg in March 1999 and stopped work. He reported he had begun to have problems with breathing if he had to exert himself or rush on something. Since he quit work in March 1999, his breathing has continued to worsen; but he does not receive any medical treatment for breathing problems. He reported that presently he has trouble breathing while walking and climbing a flight of steps. At night. he smothers and gets up every two to three hours wheezing, coughing, and having trouble breathing. He reports a productive cough and trouble walking 100 yards if he has to walk fast and exert himself. He reported that even if he had no other problems except his breathing problem, "there's no way I could return to work" as a coal miner in a dusty environment. (TR 16 to 24)

On cross examination, the Claimant testified that he is 5'11" tall, weighs 220 pounds, and has one dependent. He reported that Dr. W.E. Becknell is his family doctor and was probably the first medical doctor to tell him he needed to see someone about his breathing. Dr. Becknell did not take any chest x-rays, and he has not been told by a doctor that he is unable to work

because of black lung. He reported that he was awarded disability insurance benefits from Social Security based on his March 1999 injury. He also receives State workers' compensation and retirement from Shamrock. He stated that the March 1999 injury occurred while trying to position a suspended pump for setting and that he has not been released back to work. Dr. J. Gilbert was consulted, and the recommendation was that he had surgical problems but should put off surgery as long as possible. He stated the condition has become worse since 1999. He testified that his last coal mine employment position was as coordinator, or foreman, over the haulage, the belts from the longwall to the tipple. It was his responsibility to see that the belt was run and maintained; he had 25 to 30 employees working under him. The position required a lot of walking and was in a lot of dust. He wore a furnished respirator all the time except when eating lunch or talking on the telephone. He testified that had he not injured his back, he would have continued to work as a coordinator as long as he could before his breathing got to where he could no longer work. (TR 24 to 31)

The claimant told Judge Huddleston that he had not filed any other federal black lung claims. (TR 31)

X-ray Reports

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 admitted in this case.

The existence of pneumoconiosis may be established by 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 be classified as round (p, q, or r) or irregular (s, t, or u), and may be evidence of "simple pneumoconiosis". Large opacities (greater than 1 centimeter) 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 and 0/1, does not establish evidence of pneumoconiosis. 20 CFR § 718.102(b).

For cases of conflicting chest x-ray reports, the regulations provide that "when 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). Greater weight may be accorded to x-ray interpretations by dually qualified physicians. *Sheckler v Clinchfield Coal Co.*, 7 B.L.R. 1-218, 1-131 (1984)

	Exhibit No.	Date of X-ray	Physician	Reading	Quality
OWCP	DX 8	6/24/2003	V. Simpao	1/1	1

Claimant's initial reliance (TR 9): no additional x-ray reports

Employer's rebuttal (TR 14):

EX 7	6/24/2003	A. Poulos (rereading)	negative	2

Employer's initial reliance (TR 14):

EX 1	9/15/2004	L. Repsher	0/0	2
EX 3	5/21/2003	A. Dahhan	0/0	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 most frequently performed tests measure the forced vital capacity (FVC), forced expiratory volume in one second (FEV1) and the maximum voluntary ventilation (MVV).

	Exhibit No.	Date of Study	Physician	FEV1	FVC	MVV
OWCP	DX 8	6/24/2003	V. Simpao	3.73 (100%)	5.04 (105%)	64

Claimant's initial reliance (TR 9): no additional pulmonary function studies

Employer's rebuttal (TR 14):

EX 5	6/24/2003	G. Fino (review)	no abnormality	no abnormality	invalid

Employer's initial reliance (TR 14):

EX 1	9/15/2004	L. Repsher	4.28 (97%)	3.34 (95%)	59 (48%)
EX 3	5/21/2003	A. Dahhan	invalid due to poor effort		

Arterial Blood Gases

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect in that ability 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 (PO2) and the percentage of carbon dioxide (PCO2) in the blood. The lower the level of oxygen (O2) compared to carbon dioxide (CO2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

	Exhibit No.	Date of Study	Physician	PCO2	PO2
OWCP	DX 8	6/24/2003	V. Simpao	41.8 (resting) WNL	90.3 (resting) WNL

Claimant's initial reliance (TR 9): no additional arterial blood gas studies

Employer's rebuttal (TR 14):

EX 5	6/24/2003	G. Fino (review)	normal	normal

Employer's initial reliance (TR 14);

EX 1	9/15/2004	L. Repsher	39.2	93.4
EX 3	5/21/2003	A. Dahhan	40.5 (resting)	85.8 (resting)

Other Medical Evidence

High resolution CT scans may be used to diagnose pneumoconiosis and other respiratory diseases. The regulations provide no guidance for the administration of CT scans or evaluation of CT scans. Accordingly, they must be weighed with other acceptable medical evidence under 20 CFR § 718.107. (see *Webber v Peabody Coal Co*., BRB No. 05-0335 BLA (Jan 27, 2006)(en banc, AAJ Boggs concurring))

Exhibit No.	Type	Date of Study	Physician	Comments
Employer's initial reliance (TR 14);				
EX 6	CT Scan - chest	9/15/2004	D. Halbert	normal

Medical Reports

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 pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative chest x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 CFR § 718.201. Thus, even if the chest x-ray evidence is negative, reasoned medical opinions supported by objective medical evidence, such as blood gas studies, pulmonary function tests, electrocardiograms, physical performance tests, and physical examination, and medical and work history may establish the existence of pneumoconiosis. [See 20 CFR §§ 718.202(a)(4) and 718.204(b)(2)(iv)] A determination of the existence of pneumoconiosis cannot be made solely on the basis of a living miner's statements or testimony 20 CFR § 718.202(c).

OWCP:

[DX 8] On June 24, 2003, V.S. Simpao, M.D., examined the Claimant. He recorded the claimant's limitations as, "I get short of breath walking 75 ft., I don't climb steps due to my back and leg. I don't lift weight due to my back and leg." Reported symptoms included 5 years of

productive cough with "2 tbsp" of black secretions every day, wheezing on exertion and while lying flat every day, 5 years being short of breath every day on exertion and at rest, 5 years of unrelated chest pain at times increased with exertion, 6 to 7 years of sleeping with two pillows, 5 to 6 years of waking up at night with shortness of breath, and 5 years of frequent colds each winter. Physical examination reported the claimant as 70" tall with a weight of 224 pounds and intact arterial pulses. The lungs had increased resonance in the upper chest and auxiliary areas, few crepitation, and occasional forced expiratory wheezes. The chest measured 43.5" on expiration and expanded to 44.5" on inhalation. His lips and nails were slightly cyanotic. The claimant walked with a cane for unsteady gait. Dr. Simpao summarized diagnostic testing as: chest x-ray of 6/24/03 – coal worker's pneumoconiosis category 1; ventilation studies 6/24/03 – FEV1/FVC ratio reduced; arterial blood gases 6/24/03 – normal; and EKG 6/24/03 – Q wave in lead III and non-specific ST changes. Dr. Simpao's diagnosis was coal worker's pneumoconiosis 1/1 based on the etiology of "multiple years of coal dust exposure is medically significant in his pulmonary impairment. Dr. Simpao classified the severity of the respiratory or pulmonary disease as "mild impairment".

On Form CM-933 reporting the results of the chest x-ray interpretation, Dr. Simpao reported that he is not a board certified radiologist, is not a board eligible radiologist, and is not a B-reader. In his vitea (CX 1), Dr. Simpao indicates that he was certified an A-reader in 1988 and lists his extensive medical experience as well as his Board Certification in Internal Medicine, Subspecialty in Pulmonary Disease. There is no indication that he had a valid recertification as an A-reader in June 2003.

Claimant's initial reliance (TR 9): no additional medical reports

Employer's initial reliance (TR 14):

[EX 1] On September 15, 2004, Dr. L. H. Repsher, M.D., examined the claimant. He recorded the claimant's history as a coal miner for 35 years with 30 years underground at the face and 5 to 6 years above ground. He last worked for Shamrock (James River) Coal Company as a haulage coordinator requiring shoveling of spilled coal. He retired because of back and leg injuries associated with lifting a heavy pump. Prior to work as a miner he worked 2 years as a logger. The claimant's complaints were reported as progressive dyspenea on exertion for the past 5 to 6 years, much worse over the past two months; chronic productive cough with copious gray phlegm; angina pain for which he carries no nitroglycerin; nightly post nasal drip; 2 to 3 pillow orthopenea for 5 years; spring seasonal allergies/rhinitis; and hypertension requiring medication for the past 2 years. Physical examination reported no acute distress, 70" height, 223 pound weight, borderline blood pressure of 140/80, and walk with a limp and cane. Neck, chest, heart examination were negative. Dr. Repsher summarized the diagnostic testing as: chest x-ray shows no evidence of coal workers pneumoconiosis with a rated 0/0 x-ray of quality 2 due to obesity, poor inspiration and some left basilar atelectasis; high resolution CT chest scan is normal study with no evidence of coal workers pneumoconiosis; pulmonary function test are entirely normal which would rule out any clinically significant interstitial lung disease; arterial blood gases are unequivocally normal; ECG suggests an old inferior myocardial infarction with ongoing ischemic changes; and markedly elevated glucose suggests frank diabetes mellitus. Dr. Repsher's impression was: no evidence of coal workers pneumoconiosis; no evidence of any

other pulmonary or respiratory disease or condition caused or aggravated by employment with exposure to coal mine dust; coronary artery disease with ongoing ischemia; poorly controlled borderline hypertension of unknown cause; obesity; new onset diabetes mellitus; and spring only seasonal allergies/rhinitis. [It is noted that the CT reported upon was performed on the examination date by Dr. D. Halbert at Dr. Repsher's request. Dr. Repsher's restatement of the CT findings is consistent with Dr. Halbert's interpretation of the CT scan. (EX 6)]

[EX 2] In his February 10, 2005, deposition, Dr. L.H. Repsher testified that he has been certified and five times recertified as a B-reader for chest x-rays; that coal workers medical pneumoconiosis is primarily a restrictive airway disease that may have some superimposed obstruction particularly when it becomes severe; and that legal pneumoconiosis could be anything but is predominantly considered to be chronic obstructive pulmonary disease. Dr. Repsher testified that rales are most commonly due to congestive heart failure and certain types of interstitial lug disease, but no coal workers pneumoconiosis; rhonchi are seen in chronic bronchitis; and, wheezes are seen in asthma. Dr. Repsher testified to the physical examination of the claimant essentially as stated above. He stated that the physical examination of the claimant's chest showed normal size, there were no areas of dullness to percussion, on auscultation the breath sounds were normal, there were no adventitious sounds such as rales, rhonchi or wheezes. Dr. Repsher opined that the claimant had neither medical or legal coal workers pneumoconiosis; had no evidence of chronic obstructive pulmonary disease; probably could not return to his previous job in and around the mining industry because of his other diseases including diabetes, uncontrolled hypertension and coronary artery disease with ongoing ischemia which suggests he is in danger of having another heart attack; and is not disabled nor impaired from a strictly lung function.

[EX 3] On May 21, 2003, Dr. A. Dahhan, M.D., examined the claimant. He recorded the claimant's history as outside mining work as a foreman and coordinator in the mining industry for 35 years, ending in 1999 after a back injury. He reported the claimant's complaints as occasional productive clear sputum, dyspenea on exertion such as a flight of steps, and frequent back pain. The physical exam revealed 124/80 blood pressure, regular pulse, 221 pound weight and 69" height. Examination of the chest showed good air entry to both lungs with no crepitation, rhonchi or wheeze. Cardiac examination showed regular rhythm with normal heart sounds. The extremities showed no clubbing or edema. Dr. Dahhan summarized the diagnostic test as: the ECG showed regular sinus rhythm with normal tracings; the arterial blood gases at rest showed normal values of PO2 of 85.8 and PCO2 of 40.5; the spirometry was invalid due to poor effort; and the chest x-ray showed clear lungs with no pleural or parenchymal abnormalities consistent with pneumoconiosis being present and an ILO classification of 0/0. The claimant declined to do an exercise arterial blood gas study. Dr. Dahhan opined that "based on my overall evaluation of Mr. Hoskins, he appears to have no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers pneumoconiosis.

[EX 4] In his December 19, 2003, deposition, Dr. A. Dahhan testified that he is board certified by the American Board of Internal Medicine, the American Board of Pulmonary Medicine, and the American College of Chest Physicians. He was certified as a B-reader in 1987 and has been recertified in 2001 through 2005. Dr. Dahhan testified to the physical examination

essentially as stated above. He testified that the chest x-ray taken as part of the examination was grade 1 quality, showed clear lungs with no opacities consistent with pneumoconiosis or other abnormalities, and was classified as 0/0. He reported that the spirometry was invalid because of demonstrated excessive hesitation and inconsistent effort. He opined that there is no evidence of coal dust induced lung disease and he retains the respiratory capacity to return to his previous job in and around the mining industry.

Review and Rebuttal evidence

The claimant did not submit review or rebuttal evidence.

Employer's review and rebuttal evidence:

[EX 5] On December 8, 2003, Dr. G.J. Fino reported he reviewed the pulmonary function study dated 6/24/2003 by Dr. Simpao (DX 8) and opined that the spirometry was normal. He reported that the FVC and FEV1 along with the FEV1/FVC ratio showed no abnormality; that there was no obstruction, restriction or ventilatory impairment; and that the MVV was invalid and underestimates the true lung function and should not be used as medical evidence of respiratory impairment; that the arterial blood gas study was normal. He opined that from a pulmonary standpoint there was no evidence of any respiratory impairment to prevent performance of pervious coal mining employment or similar work. It is specifically noted that Dr. Fino's curriculum vitae (EX 8) indicates that he is board certified in internal medicine with the subspecialty of pulmonary disease and was certified as a B-reader February 1, 1989, and has been recertified from 2/1/93 through 1/31/01.

[EX 7] On November 18, 2003, Dr. A. Poulos, M.D., reported his review of the 6/24/03 chest x-ray performed by Dr. Simpao. Dr. Poulos reported the chest x-ray as film quality 2 with overlaying right scapula, lungs fields as clear and bony thorax and diaphragm shadows within normal limits. His impression was negative chest with no evidence of pneumoconiosis. He reported himself as a B-reader and board certified radiologist.

Excluded Evidence

There was no objection by either the claimant or employer to the July 14, 2003, rereading by Dr. P. Barrett (DX 9) of the chest x-ray taken 6/24/2003 by Dr. Simpao. The rereading by Dr. P. Barrett was of the x-ray submitted as part of his OWCP examination and would be permissible under 20 CFR § 725.414(a)(2)(i) as one of two x-ray interpretations; but the claimant indicated at the hearing (TR 9) and in CX 2 that he relied upon the medical evidence in DX 8 only. It is noted that DX 9 tended to contradict the reading set forth in DX 8 as relied upon by the claimant. The employer is entitled to one rebuttal interpretation of each x-ray submitted in the claimant's affirmative case under 20 CFR § 725.414(a)(3)(ii). Here the employer elected to rely upon EX 7 as a rereading of the 6/24/03 chest x-ray taken by Dr. Simpao, accordingly, DX 9 is not admissible through the employer's case. Accordingly, DX 9 has not been considered in evaluating this case.

DISCUSSION OF LAW AND FACTS

The threshold issue is whether the claimant has established that he has pneumoconiosis as defined under the Act. If the claimant fails to establish that he does indeed suffer from clinical or legal pneumoconiosis, then the remaining three issues must, necessarily, be found not to be established.

For the purposes 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 the medical or "clinical" pneumoconiosis and the statutory or "legal" pneumoconiosis:

> "Clinical" pneumoconiosis consists of those diseases recognized by the medical community as pneumoconiosis; i.e., conditions characterized by the permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to said particulate deposition caused by dust exposure in coal mine employment. This definition includes coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, and silico-tuberculosis, arising out of coal mine employment.
>
> "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

For the purposes of these definitions, pneumoconiosis is recognized as a latent and progressive disease which may first become detectable after the cessation of coal mine dust exposure 20 CFR § 718.201. In the face of conflicting evidence, all the evidence must be weighed together in reaching a finding that the claimant has established that he has pneumoconiosis. As this claim is governed by the law of the Sixth Circuit, the claimant may establish the existence of pneumoconiosis under any of the alternative methods set forth in 20 CFR § 718.202(a). [see *Cornett v Benham Coal Co*., 227 F.3d 569, 575 (6th Cir. 2000); *Fergerson v Jericol Mining, Inc*., 22 B.L.R. 1-216 (2002)(en banc)]

In order to establish a finding of pneumoconiosis, the claimant has relied upon the June 24, 2003 x-ray, pulmonary function studies, and arterial blood gas study interpretations and medical examination by Dr. V. Simpao. Dr. Simpao self reports that he is not a board certified radiologist, is not a board eligible radiologist, is not a B-reader and was certified as an A-reader in 1988. The record identifies Dr. Simpao as a medical doctor with the Coal Miners' Respiratory Clinic, Greenville, Kentucky, who was authorized to complete the required OWCP evaluation under 20 CFR § 725.406(a). (see DX 8) He holds board certifications in internal medicine and internal medicine subspecialty pulmonary disease as well as extensive medical work in the pulmonary field (CX 1).

To rebut the June 24, 2003, chest x-ray interpretation of Dr. Simpao which reported small lung opacities present but few in number (1/1) on a quality 1 film, the Employer submitted Dr. A. Poulos' rereading of the June 24, 2003, x-ray. Dr. Poulos reported the film as being quality 2

with lung fields clear and no evidence of pneumoconiosis being present. Dr. Poulos self reports that he is a board certified radiologist and a B-reader. (see EX 7) Additionally, the Employer submitted additional chest x-rays, one on May 21, 2003 classified by Dr. Dahhan as a quality 1 film with no evidence of opacities consistent with pneumoconiosis (0/0), and another from September 15, 2004, classified by Dr. Repsher as a quality 2 film with no evidence of opacities consistent with pneumoconiosis (0/0). Dr. Dahhan was recertified a B-reader in 2001 and is board certified in internal medicine and pulmonary medicine. Dr. Repsher is a B-reader, with recertification in 2001, and Diplomate American Board of Internal Medicine and American Board of Internal Medicine Subspecialty Pulmonary Disease with numerous published articles, academic and hospital affiliations related to pulmonary disease. (see Ex 1, 2, 3, 4)

To rebut the June 24, 2003, pulmonary function test interpretation of Dr. Simpao which reported that the vital capacity and flow volume curves were normal but the FEV1/FVC ratio was reduced, the Employer submitted Dr. G. Fino's review of the June 24, 2003, pulmonary function test results. Dr. Fino reported the test as being a normal study with no abnormality in FEV1, FVC or the FEV1/FVC ratio. He opined that the MVV was invalid. Dr. Fino self reports being a Diplomate American Board of Internal Medicine and American Board of Internal Medicine Subspecialty Pulmonary Disease, with numerous published articles and hospital affiliations related to pulmonary disease. (see EX 5, 8)

There is no dispute among the physicians that the arterial blood gas studies provided by the Claimant on May 21, 2003, June 24, 2003, and September 15, 2004 were all within normal limits. Likewise, there is no dispute that the chest CT scan performed on September 15, 2004 was normal. (see DX 8, EX 1, 3, 5 and 6) No medical opinions relied upon the MVV results of the pulmonary function studies. Additionally, the medical reports of Dr. Simpao, Dr. Dahhan and Dr. Repsher are all consistent with the Claimant's testimony regarding education, non-smoking history, coal mine employment, coal dust exposure, and reported body habitus, complaints and symptoms.

In his June 24, 2003, chest x-ray interpretation, Dr. Simpao indicates the minimum level presence of opacities consistent with pneumoconiosis on a quality 1 film. This is one month after the May 21, 2003, chest x-ray interpretation of B-reader Dr. Dahhan indicating no evidence of lung opacities in a quality 1 film; and 15 months before the September 15, 2004, chest x-ray interpretation of B-reader Dr. Repsher indicating no evidence of pneumoconiosis in a quality 2 film. Additionally, a dually qualified Dr. Paulos reread the June 24, 2003, chest x-ray and found it to be a quality 2 film with no indication of pneumoconiosis. When this evidence if considered with the remaining objective evidence and medical opinions, the probative weight to be afforded Dr. Simpao's x-ray interpretation and opinion is materially lessened. Under the facts of this case, this Administrative Law Judge affords greater weight to the rereading of the June 24, 2003, chest x-ray by Dr. Poulos than to the initial reading of Dr. Simpao.

In light of the "within normal limits" testing of pulmonary function and blood gas studies as well as the imaging reports of chest studies and medical examination by Dr. Dahhan and Dr. Repsher, and not withstanding Dr. Simpao's notation regarding slight cyanotic presentation in the claimant's lips and nails, there is no credible medical evidence that links the claimant's

symptoms and complaints regarding breathing restrictions and occasional sputum production to pneumoconiosis or other respiratory disease from coal dust related mine employment.

CONCLUSIONS AND FINDINGS OF FACT

After deliberation on all the evidence of record, including the post-hearing briefs submitted by counsel, this Administrative Law Judge finds:

1. The claimant has failed to establish that he has pneumoconiosis as defined by the Act.

2. The claimant has failed to establish that he has pneumoconiosis arising out of coal mine employment.

3. The claimant has failed to establish he is totally disabled due to respiratory disease.

4. The claimant has failed to establish a disability due to pneumoconiosis.

ORDER

Based upon the application filed by the claimant on February 25, 2003, the claimant has not been disabled due to pneumoconiosis and is not entitled to benefits under Title IV of the Federal Coal Mine Health and Safety Act, as amended, at any time through the date of this decision.

Alan L. Bergstrom
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. § *725.458* and § *725.459.* The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 200 13-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-21 17, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 CFR § 725.479(a).