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Issue Date: 05 April 2007

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In the Matter of:

I.A., widow of
E.A., deceased,
Claimant,

v. **Case No. 2004-BLA-6730**

CRESCENT INDUSTRIES, INC./
OLD REPUBLIC INSURANCE CO.,
Employer/Carrier, and

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

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Appearances:

Randy Clark, Esq., Clark & Johnson, Pikeville, KY
For the Claimant

Lois A. Kitts, Esq., Baird & Baird, PSC, Pikeville, KY
For the Employer/Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by I.A. ("Claimant") on June 10, 2002, based upon the death of her husband, deceased miner E.A. ("Miner"). The putative responsible operator is Crescent Industries Inc. ("Employer") which is insured through Old Republic Insurance Co. ("Carrier"). Benefits are being paid by the Black Lung Disability Trust Fund.[1]

[1] The term "Employer" will encompass both the Insurance Carrier and the Employer.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also applicable, as this claim was filed after January 19, 2001.[2] 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[3] The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant filed this survivor's claim for benefits on June 10, 2002, following Miner's death on January 30, 2002. (DX 2). The District Director issued a Schedule for the Submission of Additional Evidence on June 12, 2003, stating that Employer was the proper responsible operator but Claimant would not be entitled to benefits. (DX 19-3). On May 14, 2004, the District Director issued a Proposed Decision and Order denying Claimant benefits. (DX 45). The Director once again determined that Employer was the Responsible Operator and that Claimant would not be entitled to benefits. (DX 45-8). Although the Director found that Miner had pneumoconiosis which arose from his coal mine employment, he did not believe that Miner's pneumoconiosis caused, contributed to, or hastened his death. *Id*. Claimant filed a notice of appeal on June 10, 2004. (DX 49).

A hearing was held before the undersigned in Pikeville, Kentucky on October 13, 2005. Claimant was the only witness to testify. (Tr. at 8-15). Director's Exhibits 1 through 55 ("DX 1" through "DX 55") were admitted into evidence. (Tr. at 5-6). I also admitted Employer's Exhibits 1 through 6 ("EX 1" through "EX 6"). (Tr. at 18). Although I had received a copy of Employer's Exhibit 4, the deposition transcript of Dr. David Rosenberg, Claimant had not. (Tr. at 17-18). I asked Employer's counsel to provide a copy to Claimant. (Tr. at 18). I allowed the parties 60 days to submit written closing briefs, but allowed them to extend the time by stipulation. (Tr. at 19). I also announced that I was not keeping the record open for any reason. *Id.* Claimant filed her closing brief on December 13, 2005; Employer filed its closing brief on December 19, 2005.

By way of cover letter dated October 26, 2004, a copy of the deposition transcript of Dr. Raphael Caffrey, exactly identical to the one submitted at the hearing as Employer's Exhibit 5, was submitted to this office. However, this copy also contained copies of his Curriculum Vitae and the report he prepared on May 15, 2004. The copy submitted at the hearing listed Dr. Caffrey's C.V. and his report as exhibits, but did not actually include them. (EX 5 at 3). However, this put Claimant on notice as to their existence. I will therefore substitute the

[2] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[3] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

deposition of Dr. Caffrey submitted at the hearing with the copy submitted to this office. **SO ORDERED.**

Issues/Stipulations

The contested issues before me are whether Miner had pneumoconiosis, whether pneumoconiosis arose from coal mine employment, whether Miner's death was due to pneumoconiosis, whether Employer is the proper responsible operator, whether Employer had secured the payment of benefits, and other issues listed for appellate purposes. (Tr. at 6-7; DX 53).

At the hearing, Employer withdrew its contentions that the claim was not timely, that Miner was not a miner, that Miner did not have post 1969 employment, and that Claimant was not an eligible survivor of Miner. (Tr. at 6; Tr. at 15). Employer did not withdraw any of the other issues. Employer and Claimant stipulated that Miner had 17 years of coal mine employment. (Tr. at 6).

Employment History/Background

Claimant testified that she married Miner in 1955, and remained married to him until the time of his death. (Tr. at 9). As of the hearing, Claimant had not remarried. *Id*. Claimant and Miner had one daughter, who was an adult at the time of the hearing. (DX 15-6). Their daughter was not disabled or drawing social security from Miner's estate. (DX 15-7). Claimant testified that Miner worked for Employer from 1977 to 1981. (DX 14-5). He worked there as a foreman. (DX 15-5). However, Claimant also testified that she believed the last coal mining company he worked at was H & B Coal Company in 1986, although she did not know how long he worked there. (DX 15-5).

Claimant also testified at great lengths about Miner's breathing problems. She testified that although Miner had smoked at one point in his life, he had quit roughly 35 years prior to his death. (DX 14). Claimant testified that during the last years of Miner's life, he was hardly able to walk without running out of breath quickly. (Tr. at 10). He also had trouble sleeping, and had to sleep on his right side with two pillows. (Tr. at 11-12). Claimant estimated that Miner had been using inhalers for the last 10 years of his life. (Tr. at 11). He was also on breathing medication. *Id*.

Miner was admitted to Pikeville United Methodist Hospital of Kentucky, Inc. on January 12, 2002. (DX 13-89). He was admitted with what was initially believed to be an ischemic bowel and possibly an ischemic liver. (DX 13-90). Several surgical procedures were performed on Miner, but he ultimately suffered multisystem organ failure secondary to sepsis. (DX 13-91). Miner subsequently passed away on or about January 30, 2002.[4] (DX 8). His death certificate, prepared by Dr. Greg Stephens, M.D., listed his sole cause of death as mesenteric ischemia. *Id.*

[4] According to the terminal hospital records, the Miner died on January 31, 2002 but the death certificate lists January 30, 2002. *Compare* DX 13 *with* DX 8.

Medical Evidence

The medical evidence of record is discussed in greater detail *infra* where appropriate. Briefly summarized, the medical evidence is as follows. Director submitted the autopsy report of Dr. James Dennis, M.D., for the autopsy performed on January 31, 2002; Claimant also relied upon that report. (DX 10). Director also submitted various treatment records, most of which concerned Miner's treatment at Pikeville United in January 2002. (DX 13, DX 14). These records also covered treatment Miner received from Drs. E.D. Roberts and Harvey Page. Employer submitted the deposition transcript and report of Dr. Raphael Caffrey, M.D., as its autopsy evidence. (EX 5). For its medical opinion evidence, Employer submitted (1) the deposition transcript of Dr. Richard L. Naeye, M.D., as well as his report and an addendum to the report (EX 1, EX 2) and (2) the deposition transcript and report of Dr. David Rosenberg, M.D. (EX 3, EX 4). This evidence is in compliance with the evidentiary limitations.

DISCUSSION AND ANALYSIS

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), citing 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id.*, citing 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id.*, citing 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id.,* citing 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id.,* citing 20 C.F.R. §725.456(b)(1).

The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra.* First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; see 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. Third, the Board held that state claim medical evidence is properly excluded if it contains testing that exceeds the evidentiary limitations at § 725.414. In so holding, the Board noted that such records did not fall within the exceptions for hospitalization or treatment records or for evidence from prior federal black lung claims. *Dempsey* at 5.

In *Webber v. Peabody Coal Co,* 23 B.L.R. 1-__, BRB No. 05-0335 BLA (Jan. 27, 2006) (en banc), the Board changed the position that it took in *Dempsey* with respect to CT scan evidence and adopted the Director's position that "the use of singular phrasing in 20 C.F.R. § 718.107" requires "only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence."

As the Board noted in *Dempsey*, the regulations specifically allow evidence from a prior claim to be considered in connection with a later claim, so that a determination may be made whether there has been a material change in conditions since the time of the prior claim. 20 C.F.R. §725.309(d)(1). However, there is no such provision applicable to survivor's claims that would allow consideration of the evidence developed in the miner's claims, absent a finding of good cause. Consistent with the above limitations and the Board's decision in *Dempsey*, other administrative law judges have generally excluded evidence developed in connection with a miner's claim from consideration in a surviving spouse's claim to the extent that the limitations have been exceeded, unless the case involves a consolidated miner's claim and survivor's claim. However, in *Keener v. Peerless Eagle Co.,* BRB No. 05-1008 BLA (BRB Jan. 30, 2007) (en banc), the Board held that even if the cases are consolidated, there should be separate records for a miner's claim and a survivor's claim.

Responsible Operator

Miner's social security earning records show that Employer employed him from 1977 through 1981. (DX 5, DX 6). However, his records also show that Miner was employed with H & B Coal Co., Inc. in 1986. (DX 5-2). H & B and Employer were both identified as responsible operators by Director. (DX 16, DX 21). However, the Director ultimately determined H & B was not the putative responsible operator and relieved it of further liability with no discussion. (DX 32).[5] At the hearing, Employer continued to contest its designation as responsible operator. (Tr. at 7). It also continued to contest whether it had secured the payment of benefits through insurance. *Id*.

[5] While the record is not clear as to why H & B was dismissed, it appears Miner may have not been employed for more than 4 or 5 months with this responsible operator. *See* (DX 20-1).

Under 20 C.F.R. §725.495(c)(1) and (2), the designated responsible operator bears the burden of proving that it does not possess sufficient assets to pay an award of benefits or that it was not the potentially liable operator which most recently employed the miner. Although Employer contests its designation, it advanced no arguments at the hearing, in its closing brief, or elsewhere that would prove it lacked the financial capability to pay benefits, that it did not otherwise satisfy the statutory and regulatory criteria, or that Miner was employed at another responsible operator within the meaning of Section 725.494 for the required period subsequent to his employment with Employer. Therefore, I find that Employer is the proper responsible operator in this matter.

Medical Issues

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

In order to prevail in a survivor's claim, a claimant must establish that the miner had pneumoconiosis arising out of his coal mine employment which caused, contributed to, or hastened his death. 20 C.F.R. §718.205.

If complicated pneumoconiosis is established, all of the above elements of a claim are presumptively established under the irrebuttable presumption set forth in 30 U.S.C. § 921(c)(3) and 20 C.F.R. §718.304. Claimant has submitted evidence that suggests that Miner may have suffered from complicated pneumoconiosis. Therefore, I must begin by determining whether Claimant has established Miner had complicated pneumoconiosis.

Complicated Pneumoconiosis

If a claimant can establish complicated pneumoconiosis (also known as "massive pulmonary fibrosis"), under the criteria set forth in 30 U.S.C. § 921(c)(3) and 20 C.F.R. §718.304, she is entitled to an irrebuttable presumption of death due to pneumoconiosis. *See generally Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976) (upholding constitutionality of presumption). Pursuant to §718.304, a claimant may be entitled to the irrebuttable presumption of death due to pneumoconiosis, under paragraph (a), based upon a chest x-ray finding of one or more large opacities (*i.e.,* greater than 1 centimeter in diameter) which would be classified as Category A, B, or C under the applicable classification requirements (such as ILO and UICC); under paragraph (b), based upon a biopsy or autopsy yielding "massive lesions in the lung"; or, under paragraph (c), based upon a condition which "when diagnosed by means other than those specified in paragraphs (a) and (b) . . . could reasonably be expected to yield the results described in paragraph (a) or (b) . . . had diagnosis been made as therein described: *provided, however,* that any diagnosis made under this paragraph shall accord with acceptable medical procedures." 20 C.F.R. §718.304.[6]

[6] Both the statute and the regulations implementing the statute employ virtually the same language. *See* 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304.

These clauses are intended to describe a single, objective condition, and subsection (a) provides an objective standard against which the other subsections can be measured. *See Eastern Associated Coal Corporation v. Director, OWCP [Scarbro]***,** 220 F.3d 250, 255-57 (4th Cir. 2000). The statutory definition of complicated pneumoconiosis need not be congruent with a medical or pathological diagnosis. *Id.* at 257. *See also Double B Mining, Inc. v. Blankenship,* 177 F.3d 240 (4th Cir. 1999) (declining to adopt blanket 2 centimeter rule for pathology findings and instead requiring an equivalency determination to be made); *Handy v. Director, OWCP,* 16 B.L.R. 1-73 (1990) (finding that an x-ray report indicating the absence of small or large opacities consistent with pneumoconiosis, but noting the presence of a 1.0 centimeter lesion in the right lung, was legally insufficient to establish the existence of complicated pneumoconiosis because section 718.304(a) requires a finding of one or more large opacities greater than one centimeter in diameter.) An equivalency determination must be made regardless of whether there is x-ray or pathological evidence of record. *Braenovich v. Cannelton Industries, Inc.*, 22 B.L.R. 1-237 (2003). In *Braenovich*, the Board upheld the administrative law judge's finding of complicated pneumoconiosis based upon his equivalency determination that a 1.5 centimeter lesion on autopsy would produce an opacity of equivalent size on x-ray even though he found both the x-ray evidence and the autopsy evidence to be insufficient to establish complicated pneumoconiosis, because "'[e]vidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict.'"[7] *Id., citing Scarbro.*

While the section does not specifically require that a diagnosis of pneumoconiosis be associated with the lesions found, that requirement has been read into the regulation by the Benefits Review Board. In *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*), the Board stated that, because section 718.304 offered no opportunity for rebuttal, failure by an administrative law judge to consider all relevant evidence at the invocation stage could constitute a violation of an opposing party's due process rights. The Board held that:

> . . . the administrative law judge shall first determine whether the evidence in each category tends to establish the existence of complicated pneumoconiosis, and then must weigh together the evidence at subsections (a), (b) and (c) before determining whether invocation of the irrebuttable presumption pursuant to Section 718.304 has been established.

The Board noted that CT scans fit under subsection (c). *Id.* In *Braenovich, supra,* the Board indicated that under the Fourth Circuit's mandate in *Blankenship, supra***,** "the administrative law judge is bound to perform equivalency determinations to make certain that, regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption."

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[7] The majority of the Board in *Braenovich* determined that the administrative law judge's determination properly fit under subsection (c) of section 718.304 but the dissent maintained that it should have been considered autopsy or biopsy evidence under subsection (b). Thus, neither the majority nor the dissent applied the *Melnick* requirement of weighing the evidence under all three paragraphs together. The conflict arose in view of the assertion by some of the experts that there is a two-centimeter requirement for a pathological diagnosis of pneumoconiosis whereas there was also evidence that lesions on biopsy would result in approximately equivalent opacities on x-ray.

It is in the context of this precedent that I will consider the evidence of record under section 718.304.

Subsection (a): X-ray evidence. Neither Claimant nor Employer submitted x-ray evidence as part of their respective case-in-chiefs, and the only x-ray evidence consists of twenty-eight readings contained in Miner's treatment records. (*See* DX 13-7, 13-74, 13-75, 13-77, 13-78, 13-81, 13-82, 13-87, 13-256, 13-257, 13-260 through 13-263, 13-265 through 13-268, 13-271 through 13-275, and 13-277 through 13-281). However, I note that none of these x-rays discuss an opacity measuring greater than 1.0 cm. in diameter as required under Section 718.304(a). Additionally, they do not appear to comply with the requirements set forth at 20 C.F.R. §718.102. Even assuming, arguendo, that I considered these readings, none of them mention an opacity greater than 1.0 cm. in diameter or include a diagnosis of complicated pneumoconiosis or progressive massive fibrosis.

Subsection (b): Autopsy and Biopsy Evidence. Under 20 C.F.R. §718.304(b), complicated pneumoconiosis may be proved through autopsy or biopsy evidence showing "massive lesions" in the lung. Although there is no biopsy evidence of record, an autopsy was performed after Miner's death.

According to the death certificate, Miner died on January 30, 2002. (DX 8). Dr. James A. Dennis, M.D, a pathologist, performed an autopsy on Miner on January 31, 2002. (DX 10). Dr. Dennis' autopsy report is confined to a gross and microscopic description of Miner's respiratory and cardiovascular systems only. *Id*. The autopsy report was printed on March 8, 2002. (DX 10-3).

Dr. Dennis provided a detailed description of his gross findings for Miner's respiratory and cardiovascular systems. With respect to Miner's respiratory system, Dr. Dennis discussed gross findings in Miner's left and right lung. (DX 10-1). Dr. Dennis observed black pigment clusters ranging from 0.1 to 0.5 cms. in diameter in Miner's left lung. *Id*. He also found black macules in the mid-portion of this lung ranging from 0.3 to 0.5 cms. *Id*. He also noted the presence of thromboembolic change and post antimortem clots. *Id*. With respect to the Miner's right lung, Dr. Dennis found black pigment deposition forming macules ranging from 0.5 to 1.5 cms. *Id*. He also found dense nodules in the pulmonary parenchyma. *Id*. He also found black pigment deposition in a section of the lymph node of the hilum. *Id*. Dr. Dennis noted the presence of a post mortem clot. *Id.* Dr. Dennis also detailed his gross findings of Miner's cardiovascular system. He found left ventricular hypertrophy. (DX 10-2).

Dr. Dennis next described the microscopic findings he obtained through his autopsy of Miner's respiratory system from fourteen different sections (labeled "Section 1A" through "Section 1N") and of his cardiovascular system from four different sections (labeled "Section 1O" through "Section 1R.") (DX 10-2). In Section 1A, Dr. Dennis found pigment macules on the pleural surface varying in size from 0.5 to 1 cm in diameter. *Id*. He also noted the presence of fibrous tissue proliferation. *Id*. Dr. Dennis found some minimal black pigment deposition in Section 1B. *Id*. In Section 1C, Dr. Dennis found macrophages filled with black pigment that had birefringents compatible with silica particles. *Id*. Section 1E showed more black pigment

deposition and nodules scattered throughout the parenchyma. *Id*. Section 1F showed congestion and pulmonary edema. *Id*. In Section 1G, Dr. Dennis found emphysematous changes and fibrosis. *Id*. He stated the fibrosis measured greater than 1.5 cm. in diameter. *Id*. In Section 1H, he found fibrous connective tissue of silica particles measuring 0.5 cm. in diameter. *Id*. Emphysematous changes were also present in Section 1I. *Id*. Black pigment clusters were spotted in Section 1J. *Id*. He also found black pigmentation in the pleural surface. *Id*. Thromboembolic disease was also present in several other sections Dr. Dennis examined. *Id*.

Dr. Dennis also briefly outlined his microscopic findings of Miner's cardiovascular system. *Id*. He found no presence of myocardial infarction or acute infarction. *Id*. He did find a large coronary artery with calcification in the wall. *Id*.

Dr. Dennis' pathological diagnosis of Miner's respiratory system was as follows:

> 1. Pulmonary congestion and edema, focal with pulmonary emboli and thromboembolic disease with focal areas of hemorrhagic infarction secondary to pulmonary embolus and thrombus formation (antemortem).
> 2. Pulmonary congestion and edema, focal.
> 3. Anthracosilicosis, mild coal workers' pneumoconiosis with focal areas of fibrosis and nodule formation compatible with marked degree of silica exposure and fibrosis with emphysema.
> 4. Features suggestive of early fibrosis of the progressive variety (1 nodule greater than 1 cm diameter with fibrosis immediately subjacent to the pleura).
> 5. Marked black pigment deposition with silica particles noted in hilar lymph nodes and also in the interstitium with interstitial fibrosis, mild, and features suggestive of cor pulmonale.

(DX 10-3). With respect to Miner's cardiovascular system, Dr. Dennis listed the following pathological diagnosis:

> 1. Cor pulmonale (evidenced by the presence of the fact that the pulmonary artery is greater in diameter than the aorta, section taken at the same level, pulmonary artery measures 4 cms and the aorta 3 cms).
> 2. Left ventricular hypertrophy.
> 3. Coronary artery disease, mild with no evidence of acute myocardial infarction demonstrated.

Id.

After making the above diagnosis, Dr. Dennis stated his belief that Miner died "a pulmonary death with thromboembolic disease complicating his status." *Id*. He found the presence of "black lung disease", anthracosilicosis, fibrosis, and macule formation with extension greater than 1 cm in diameter in focal areas. *Id*. Dr. Dennis believed this demonstrated the presence of simple coal workers' pneumoconiosis and that his diagnosis of cor

pulmonale indicated "significant pulmonary disease." *Id*. He also believed this evidence supported a finding of early progressive fibrosis and noted the presence of a macule greater than 1 cm. *Id*. Although he diagnosed simple coal workers' pneumoconiosis, Dr. Dennis made no specific mention of complicated coal workers' pneumoconiosis (apart from the reference to early progressive fibrosis.)

Dr. Dennis' autopsy and accompanying slides were reviewed by Dr. P. Raphael Caffrey, M.D., who is board-certified in anatomical and clinical pathology, for Employer. (EX 5). He prepared a report based on his findings on May 15, 2004. (EX 5, Exhibit 2). He also elaborated on his findings in a deposition taken on October 1, 2004. (EX 5).

Dr. Caffrey reviewed 18 autopsy slides taken from Miner's lungs, Miner's death certificate, a copy of Dr. Dennis' autopsy report, and Miner's work history. (EX 5 at 6-7). Dr. Caffrey concluded that the slides taken by Dr. Dennis were of sufficient quality to allow him to reach an opinion. (EX 5 at 8-9). After reviewing the above evidence, Dr. Caffrey determined that the slides presented to him showed that Miner was suffering from simple coal workers' pneumoconiosis. (E.g., EX 5 at 17; EX 5, Exhibit 2).

Examining the specific slides of lung tissue taken by Dr. Dennis, Dr. Caffrey pointed out differences between what Dr. Dennis described in his report and what Dr. Caffrey observed. In the slide taken by Dr. Dennis that described macules measuring 0.5 to 1 cm. on the pleural surface of the lungs, i.e., slide 1A, Dr. Caffrey stated he could not see the presence of any such lesions. (EX 5 at 18). In slide G, Dr. Dennis described a nodule of fibrotic connective tissue measuring 1.5 cm. in diameter; however, Dr. Caffrey said that he could not find anything matching this description in slide F and he found no nodules in slide G.[8] (DX 10; EX 5 at 18 and Attachment 2). He also could not find the presence of any nodules measuring greater than 1 cm. in diameter, or any nodules for that matter, in the slides he reviewed. (EX 5 at 18-19). However, he did report seeing the presence of anthracotic pigment. (EX 5 at 14).

Dr. Caffrey also provided a final diagnosis based on the information he reviewed. His diagnosis was as follows:

I. Respiratory System
   a. Recent thromboemboli (ante mortem) with hemorrhagic infarction greatest in the right lung
   b. Centrilobular emphysema, moderate
   c. Simple coal workers' pneumoconiosis, very minimal
   d. Pulmonary congestion
   e. Mild to moderate amount of anthracotic pigment identified in hilar lymph nodes with one micronodule

II. Cardiovascular System
   a. Cardiomegaly-466 grams

[8] Although at his deposition, Dr. Caffrey erroneously attributed Dr. Dennis' finding to slide F, in the report annexed to the deposition transcript he correctly attributed them to slide G and stated that he found no nodules whatsoever on slide G. (EX 5, Exhibit 2).

b. Mild to moderate coronary artery atherosclerosis

(EX 5, Exhibit 2).

The above evidence conflicts on whether or not Miner had complicated pneumoconiosis; thus, I must determine whose opinion should be attributed greater weight. To begin with, I note that although both Drs. Dennis and Caffrey are pathologists, the record establishes that only Dr. Caffrey is board-certified in anatomical and clinical pathology. (EX 9). Dr. Dennis' Curriculum Vitae, or any statement setting forth his qualifications, is not of record. As such, Dr. Caffrey's findings are entitled to greater weight because the evidence establishes him to be a highly qualified pathologist while there is no evidence supporting that conclusion with respect to Dr. Dennis.[9]

While Dr. Dennis found one nodule measuring greater than 1 cm and pigment macules measuring up to 1 cm in diameter, Dr. Caffrey reported that the slides he reviewed did not support either of these findings. Dr. Caffrey said that none of the slides he reviewed from Miner's autopsy showed any nodules, much less one measuring greater than 1 cm. Since I have decided to attribute greater weight to Dr. Caffrey's findings, I do not find the autopsy evidence establishes the presence of an opacity greater than 1 cm. Even were I to find the evidence demonstrated the pathological presence of a fibrotic nodule greater than 1 cm. in diameter, in accordance with Sixth Circuit jurisprudence, this would still not be enough to diagnose complicated pneumoconiosis without radiographic evidence or a diagnosis of a "massive lesion." *See Gray v. SLC Coal Co.*, 176 F.3d 382, 390 (6th Cir. 1999). This case has neither. Furthermore, there is no basis for making an equivalency determination as the issue was not addressed by the reviewing physicians.

Given all of the above, I find that the autopsy evidence does not establish that Miner was suffering from complicated pneumoconiosis.

Subsection (c): Other Evidence. Several items constituting other evidence were submitted. Employer submitted the opinions of Drs. Naeye and Rosenberg. Claimant submitted Miner's death certificate and his treatment records from treating physicians spanning several years. This evidence is discussed in greater detail below.

(1) **Medical Opinions.** As part of its case-in-chief, Employer submitted the medical opinions of two physicians.

Dr. Richard L. Naeye, M.D., who is a pathologist board-certified in pathological and anatomical pathology, produced two reports for Employer: one on August 24, 2002, and an addendum on August 24, 2005. (EX 1, EX 2). He also elaborated on his findings in a deposition conducted by Employer on September 19, 2005. (EX 2). Dr. Naeye stated that he reviewed the medical records associated with Miner's death, Dr. Dennis' autopsy report, the slides from Dr.

[9] I do note that Dr. Caffrey testified that he believed simple pneumoconiosis is not disabling. (EX 5 at 23). As this statement contradicts the Act, his opinion may lose some probative force with respect to related matters. However, it does not undermine his superior qualifications.

Dennis' autopsy, and Miner's death certificate. (EX 1). Dr. Naeye did not explain what specific medical records associated with Miner's death he reviewed.

Dr. Naeye opined that the autopsy slides he examined did not show evidence of complicated coal workers' pneumoconiosis. (EX 2 at 16, EX 1). According to Dr. Naeye, the information he reviewed did not meet the "widely accepted" view that lesions in the lung need to measure 2.0 cm. or greater to classify as complicated pneumoconiosis.[10] (EX 1). Dr. Naeye also stated that many lesions measuring 2 cm. and "a whole bunch of other requirements" had to be present before a diagnosis of complicated pneumoconiosis could be made. (EX 2 at 16). Analyzing Dr. Dennis' slides, Dr. Naeye found anthracotic macules measuring between 0.1 and 0.2 mm. (EX 2 at 9). He also found a "very small amount of fibrosis." (EX 2 at 11). He testified that both emphysema and ruptured alveolar walls could cause the appearance of interstitial fibrosis, and opined that this is "probably" what happened with Miner. (EX 2 at 14). Nevertheless, he did find that Miner was suffering from simple coal workers' pneumoconiosis. *Id*.

Employer also had an opinion prepared by Dr. David Rosenberg, M.D., who is board-certified in pulmonary disease and internal and occupational medicine, and is also a B-reader, on August 29, 2005. (EX 3, 4). He also gave a deposition on October 7, 2005. (EX 4). Dr. Rosenberg is not a pathologist, and as such, did not review the slides obtained from Miner's autopsy. (EX 3). In preparing his report, Dr. Rosenberg reviewed medical reports from Pikeville Methodist Hospital, records from Dr. E.D. Roberts, and Dr. Caffrey's report and deposition. (EX 4).

Like Drs. Naeye, Dennis, and Caffrey, Dr. Rosenberg concluded that Miner was suffering from simple coal workers' pneumoconiosis. (EX 3, EX 4 at 24). He based this conclusion on the findings set forth in Dr. Dennis' autopsy and Dr. Caffrey's report and deposition. Analyzing Dr. Dennis' conclusions, Dr. Rosenberg stated that there could be no such thing as a coal macule greater than 1 cm. because it is a deposition of coal dust in around the coal macule.[11] (EX 4 at 22). He concluded that the x-rays he reviewed from Miner's treatment records did not show complicated workers' pneumoconiosis. (EX 4 at 23-24). Dr. Rosenberg also stated that if Miner had complicated pneumoconiosis:

> [T]there should have been a description microscopically of coal macules in and around the terminal bronchioles, there should've been micronodules and macronodules described in multiple areas in the same location; and then there should've been descriptions that there is coalescence of the micronodular opacities in certain areas and they come together to form large opacities. There should've been

[10] As noted above, the regulatory definition does not need to comport with the medical definition of complicated pneumoconiosis.

[11] Dr. Rosenberg stated: " – the description of a 'coal macule' greater than a centimeter, there is no such thing. Coal macule is a deposition of coal dust in and around the coal macule. It's not associated with fibrotic tissue. It can be associated with focal emphysema. So the terminology of a coal macule greater than one centimeter makes no sense. . ." It is unclear what Dr. Rosenberg was actually saying as his discussion on this point was confusing and contradictory, as well as inconsistent with the other medical opinions.

> descriptions of retractions of hilar structures because of distortion of the normal lung arc protection-you know-by the CWP that's being described.

(EX 4 at 25). Dr. Rosenberg also examined several pulmonary function test and arterial blood gas results in Miner's file, which he believed did not show disability due to complicated pneumoconiosis. (EX 3). Dr. Rosenberg based the above requirements for a finding of complicated pneumoconiosis on his experience interpreting reports and correlating the data with x-rays and clinical reports. *Id*. He also gave great weight to Dr. Caffrey's findings. (*See* EX 3).

Dr. Rosenberg's opinion is entitled to less weight for two reasons. First, Dr. Rosenberg, as noted above, is not a pathologist. Nevertheless, his conclusions are based largely on what was observed by other pathologists in this case and from his own personal experience. Second, his discussion of the definition of "coal macule" is confusing and contradictory, as discussed above, and is not consistent with the better-reasoned opinions of the other reviewing physicians.

Dr. Rosenberg also partially based his findings on x-ray readings from Miner's treatment records. He reviewed the following readings:

1. Undated film from Dr. Poulos showing Miner's lungs as negative
2. A February 2, 1994, reading by Dr. West finding no evidence of coal workers' pneumoconiosis
3. A March 26, 1997, film read by Dr. Poulos showing chronic bibasilar interstitial disease
4. A February 26, 1997, film read by Dr. Poulos showing a patchy infiltrate in the right mid lung zone
5. A March 6, 1997, film by Dr. Poulos showing a slight decrease in the infiltrate with the question of a right hilar mass
6. June 8, 1998, and January 7, 2000, readings by Dr. Halbert interpreted as normal.

(EX 3). In addition to reviewing these reports, Dr. Rosenberg also reviewed a CT Scan report of Dr. Poulos from May 1, 1997, which stated there was no infiltration, volume loss or abnormalities of the pleura, but some bullae in the lower lung zones. *Id*. The report also said that the periphery of the lung fields was clear. *Id*. None of the above x-ray readings contain the reading physicians' qualifications. Additionally, they do not appear to be in ILO compliance as required by 20 C.F.R. §718.102. Regardless, none of these readings mention the presence of opacities greater than 1 cm. in diameter.

Claimant provided no medical opinions disputing the findings of Drs. Naeye or Rosenberg. Dr. Dennis' autopsy report, which I have already determined does not prove Miner had complicated pneumoconiosis, is essentially the only evidence challenging the opinions of Drs. Naeye and Rosenberg and supporting Claimant's position. Therefore, despite the fact that I have accorded less weight to Dr. Rosenberg's findings, I nevertheless conclude that the medical opinion evidence establishes that Miner was not suffering from complicated pneumoconiosis at the time of his death.

(2) **CT Scans.** CT Scans were submitted in Claimant's treatment records. The first CT Scan was Dr. Poulos' interpretation of the CT scan of the chest with and without intravenous contrast made on May 1, 1997. (DX 13-83). That interpretation noted the presence of bullae in the medial aspect of the right lower lobe and posterior segment of the left lower lobe as well as of a few "small nonspecific nodes" in the mediastinum that measured less than 1.5 cm. in size. *Id.* Under "Impression", the interpretation stated:

> IMPRESSION: CT scan of the chest shows no evidence of areas of infiltration, regions of volume loss or pleural abnormalities involving either lung. There is no specific adenopathy noted in the mediastinum or hilar regions. Small bulli are seen in both lower lung zones as described. There is a question of possible gallstones present on the upper abdominal images which were also obtained. Ultrasound would be helpful for further assessment.

Id. The findings of this CT Scan did not mention coal worker's pneumoconiosis or silicosis and provides no evidence of complicated pneumoconiosis or progressive massive fibrosis.

There were also four other CT Scans submitted. These CT Scans are as follows:

1. A scan of Miner's liver dated January 2, 2002, and interpreted by Dr. William Kendall (DX 13-258);
2. A scan of Miner's pelvis dated January 2, 2002, also interpreted by Dr. Kendall, *id.*;
3. A scan of Miner's abdomen dated January 21, 2002, interpreted by Dr. Poulos (DX 13-269); and
4. A scan of Miner's pelvis dated January 23, 2002, also interpreted by Dr. Poulos. *Id.*

None of these four scans concerned Miner's chest region. As such, they do not provide any evidence that Miner was suffering from complicated pneumoconiosis. I therefore conclude that the CT Scan evidence of record does not support a diagnosis of complicated pneumoconiosis.

(3) **Death Certificate**. Miner's death certificate, signed on February 15, 2002, lists mesenteric ischemia as Miner's cause of death. (DX 8). There is no mention of complicated pneumoconiosis or progressive massive fibrosis.

(4) **Treatment and Hospital Records**. Director submitted nearly 400 pages of Miner's treatment records. (*see* DX 12, DX 13).

The majority of Miner's records concern his treatment at Pikeville United Methodist Hospital of Kentucky, Inc. ("Pikeville"), from the time of his admission on January 12, 2002, until January 31, 2002. (DX 13-89 through DX 13-294). Upon admission, Miner was diagnosed with the following:

1. Acute abdomen secondary to ischemic bowel.
2. Supraventricular tachycardia.

3. Severe dehydration.
4. Steroid dependent chronic obstructive pulmonary disease.
5. Coronary artery disease.
6. Hypertension.

(DX 13-89). During his stay, Miner was treated by Drs. Malik, Ammisetty, Musgrave, and Bhagrath. *Id*. It was determined that Miner was suffering from an ischemic bowel, and was treated accordingly. Miner had three surgeries performed on his bowels in attempt to cure him. (DX 13-90). The surgeries ultimately proved unsuccessful, and Miner expired on or about January 31, 2002.[12] (DX 13-91).

Miner's records from Pikeville list the following final diagnoses:

1. Acute abdomen secondary to ischemic bowel.
2. Supraventricular tachycardia.
3. Severe dehydration.
4. Steroid dependent chronic obstructive pulmonary disease.
5. Coronary artery disease.
6. Hypertension.
7. Hypoklemia.
8. Hypoalbuminemia.
9. Protein calorie malnutrition.
10. Hypophosphatemia.
11. Consumptive coagulopathy.
12. Multisystem organ failure.
13. Infection of the catheter tip with Staphylococcus aureus and Candida albicans.
14. Portal vein thrombosis.
15. Right pleural effusion.
16. Congestive heart failure.
17. Bilateral basilar atelectasis.

(DX 13-89).

There were several other records concerning Miner's treatment prior to his admission into Pikeville. Records of Miner's treatment by Dr. E.D. Roberts are present from late 1999 to early 2000. (DX 13-7 through DX 13-59). These records seem to deal with chest pain that Miner was suffering from, and diagnose COPD. However, a good portion of these records are in illegible handwriting. (DX 13-23 through DX 13-59). Also present are records from Dr. Harvey Page, M.D., describing various inhaler medications prescribed to Miner. (DX 13-61 through DX 13-66).

Although the above records discuss COPD, they do not reveal any information that would permit a diagnosis of complicated pneumoconiosis. There is no mention of complicated pneumoconiosis, large opacities, or massive fibrosis. In summary, Miner's treatment records do not support a finding of complicated pneumoconiosis.

[12] As noted above, the death certificate indicates that the Miner died on January 30, 2002. (DX 8).

Section 718.304 as a whole. Having reviewed each of the categories of evidence under Section 718.304, I now examine all three categories of evidence together. *See Melnick, infra*. As I discussed in greater detail above, Claimant was unable to establish the existence of complicated pneumoconiosis in any of the three categories available to her under Section 718.304. She is also unable to do so under the section as a whole. I therefore conclude that Claimant has not established by a preponderance of the evidence that Miner was suffering from complicated pneumoconiosis.

Simple Pneumoconiosis

Having determined that Miner did not suffer from complicated pneumoconiosis, I now examine whether the evidence establishes that Miner suffered from simple pneumoconiosis. The regulations (both in their original form and as revised effective January 19, 2001) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 (or two other presumptions set forth in §718.305 and §718.306); or (4) a determination of the existence of pneumoconiosis as defined in §718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a) (1)-(4). Under section 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. The United States Court of Appeals for the Sixth Circuit has often approved of the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis. *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc).

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131 (1986).

In the recent amendments to the regulations, the definition of pneumoconiosis in section 718.201 has been amended to provide for "clinical" and "legal" pneumoconiosis and to acknowledge the latency and progressiveness of the disease. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconiosis, such as coal worker's pneumoconiosis or silicosis. Legal pneumoconiosis is defined as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." 20 C.F.R. §718.201(a). The regulation further indicates that a lung 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." 20 C.F.R. §718.201(b).

Because the evidence in this case on the issue of simple pneumoconiosis is the same evidence submitted on the issue of complicated pneumoconiosis, I will explore the evidence in further detail only when necessary.

X-ray evidence. As outlined above, neither party submitted x-ray readings as part of their case-in-chief. Director submitted medical treatment records that contained numerous x-ray readings of Miner. However, as I already discussed, it does not appear as if these readings met the required criteria for a finding or a non-finding of pneumoconiosis. The x-ray evidence does not establish whether or not Miner was suffering from simple pneumoconiosis.

Autopsy and Biopsy Evidence. A claimant may prove the existence of pneumoconiosis through autopsy or biopsy evidence. 20 C.F.R. §718.202(a)(2). The regulation makes clear that the mere presence of anthracotic pigmentation in itself is not enough to establish pneumoconiosis. *Id.*; *see also Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001) (en banc). The autopsy evidence is discussed in greater detail *supra.*

Both physicians who submitted autopsy reports agreed that Miner was at least suffering from simple coal workers' pneumoconiosis. (*See* DX 10-3, EX 5 at 21). In the "summary and discussion" portion of his autopsy report, Dr. Dennis diagnoses simple pneumoconiosis apparently due to the presence of anthacosilicosis, fibrosis, and macule formation with extension greater than 1 cm. diameter in focal areas. (DX 10-3). Under his pathological diagnosis, Dr. Dennis also noted "[a]nthracosilicosis, mild coal workers' pneumoconiosis with focal areas of fibrosis and nodule formation compatible with marked degree of silica exposure and fibrosis with emphysema." *Id*. The rest of his findings are discussed in greater detail *supra*.

Dr. Caffrey testified that he believed Claimant was suffering from "pathologic coal workers' pneumoconiosis," which he believed was very mild. (EX 5 at 17). Dr. Caffrey appears to base this diagnosis on the presence of lesions that had coal dust with reticulin and focal emphysema. (EX 5 at 14). Dr. Caffrey said this occupied less than 5% of the lung tissue on the slides he reviewed, so Miner's pneumoconiosis was of the simple variety. *Id*. Dr. Caffrey's findings are also discussed in greater detail *supra.*

Both of the above physicians concluded that Miner was suffering from simple coal workers' pneumoconiosis. Although I have already determined that Dr. Caffrey's findings are entitled more weight, the fact that both physicians found the presence of the same disease strongly indicates it was present. In fact, no autopsy evidence has been produced disputing that Miner was suffering from coal workers' pneumoconiosis. I also note that the experts rendering physician opinions have also diagnosed him with simple coal workers' pneumoconiosis. *See supra*. I therefore find that autopsy evidence presented demonstrates that Miner was suffering from simple coal workers' pneumoconiosis at the time of his death.

Complicated Pneumoconiosis and Other Presumptions. As I discussed in much greater detail *supra*, Claimant has not established that Miner suffered from complicated pneumoconiosis; therefore, the associated irrebuttable presumption regarding complicated pneumoconiosis does not apply. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable because

they do not apply to claims filed after January 1, 1982, or June 30, 1982, respectively. Therefore, Claimant has not established pneumoconiosis through section 718.202(a)(3).

Medical Opinions on Pneumoconiosis. Two physicians offered opinions on whether or not Miner had pneumoconiosis at the time of his death, in addition to the pathology opinions of Drs. Dennis and Caffrey discussed above. Dr. Naeye provided two medical statements and testified at a deposition regarding his findings. (EX 1, EX 2). Dr. Rosenberg also prepared a medical report and testified by way of deposition as well. (EX 3, EX 4).

Dr. Naeye determined that Miner was suffering from simple coal workers' pneumoconiosis. (DX 2 at 11, DX 2-Exhibit 2). In reviewing the slides from Dr. Dennis' autopsy, Dr. Naeye stated that he saw anthracotic macules. (DX 2 at 9). He also saw the presence of tiny birefringent crystals and small amounts of fibrosis, which he testified indicated simple coal workers' pneumoconiosis. (DX 2 at 9-11). He also found rims of focal emphysema round the deposits of black pigment found in Miner's lungs. (DX 2-Exhibit 2).

Dr. Rosenberg also concluded that Miner was suffering from simple coal workers' pneumoconiosis. (EX 4 at 22). Specifically, Dr. Rosenberg stated the evidence he reviewed did not show that Miner was suffering from clinical pneumoconiosis until the time of his death. (EX 3). The clinical evidence Dr. Rosenberg reviewed did not demonstrate to him any sort of pneumoconiosis. (EX 3). In particular, his review of the x-rays discussed *supra* was central to his conclusion. *Id.*; *see also* EX 4 at 23-24. However, Dr. Rosenberg did state it was clear Miner was suffering from simple coal workers' pneumoconiosis after reviewing the autopsy evidence. (EX 3). He also disagreed with Dr. Dennis' findings of complicated coal workers' pneumoconiosis. (EX 3; EX 4 at 24-25).

The medical opinions do not supports a finding of legal pneumoconiosis. Although Dr. Rosenberg also briefly discussed Miner's diagnosis of chronic obstructive pulmonary disease ("COPD") and asthma, he stated that neither one of these could be attributable to coal dust exposure. (EX 3). However, an extended discussion of this is not necessary as Claimant provided no evidence linking Miner's COPD or asthma to coal dust exposure. Likewise, Drs. Caffrey and Rosenberg believed Miner was suffering from centrilobular emphysema, although neither doctor attributed it to his coal dust exposure. (EX 4, EX 5 at 13-14). Once again, Claimant provided no evidence linking this disease to Miner's coal dust exposure.

Viewing the medical opinion evidence above, I find it establishes that Miner was suffering from simple coal workers' pneumoconiosis (clinical or medical pneumoconiosis).

Other Evidence of Pneumoconiosis. Director submitted the same treatment records discussed above.

Claimant first points to Dr. E.D. Roberts' handwritten notes which detail his treatment of Miner for COPD and CAD. (DX 13-23 through DX 13-59). The copy quality of these notes is rather poor, as is the handwriting. Thus, it is difficult to make out what is written in these notes. Regardless, there does not appear to be any discussion as to the cause of his COPD.

Similarly, Miner's treatment records concerning his admission prior to his death also mention COPD. *See, e.g.,* DX 13-89. Like Dr. Roberts' notes, however, they make no mention of a cause.

Claimant also relies upon notes from Dr. Harvey Page from July 11, 1975, through October 9, 1998. (DX 13-61 through 13-66). These notes detail various inhalers that were prescribed to Miner for breathing problems he suffered from. In 1975, Dr. Page detailed providing refills for allergy and asthma medication. (DX 13-66). In 1994, Dr. Page diagnosed Miner with COPD and acute bronchitis. (DX 13-65). The remainder of Dr. Page's notes details his treatment of Miner for COPD and shortness of breath. (DX 13-64 through DX 13-61). Although COPD is discussed, Dr. Page does not provide a thorough reasoning for his diagnosis nor does he discuss the etiology of the disease.

Finally, the Director submitted Miner's death certificate discussed *supra*. As I set forth above, there is no mention of any type of pneumoconiosis on Miner's death certificate. The only item listed under cause of death is mesenteric ischemia. (DX 8). This provides no basis for a diagnosis of clinical or legal pneumoconiosis.

After having reviewed all of the above evidence, I conclude that the treatment notes and death certificate, considered alone, do not sufficiently establish that Miner was suffering from simple coal workers' pneumoconiosis.

Conclusion. I find that the autopsy and medical opinion evidence both establish that Miner was suffering from simple coal workers' pneumoconiosis. Stated differently, each category of information is sufficient in itself to establish that Miner was suffering from simple coal workers' pneumoconiosis. A finding of pneumoconiosis may be predicated solely upon one category of information in the Sixth Circuit. *See Ferguson*, *supra*. However, even if I were to consider all of the sections together, I would reach the same result.

Casual Relationship with Coal Mine Employment

Having proved that Miner was suffering from simple coal workers' pneumoconiosis, Claimant must also prove that it arose from coal mine employment. Under 20 C.F.R. §718.203(b) if a claimant establishes that he has pneumoconiosis and also establishes at least 10 years of coal mine employment in one or more coal mines, he is entitled to a rebuttable presumption that his pneumoconiosis arose from coal mine employment. At the hearing, both parties stipulated that Miner worked 17 years of coal mine employment. (Tr. at 6). Since the stipulation establishes over 10 years of coal mine employment and, as discussed above, Claimant has established that the Miner suffered from coal worker's pneumoconiosis, Claimant is entitled to the above presumption. Employer presented no rebuttal evidence. I therefore find that Miner's pneumoconiosis arose from his coal mine employment.

Death Due to Pneumoconiosis

Apart from proving Miner suffered from pneumoconiosis that arose from his coal mine employment, Claimant must also prove Miner's death was due to pneumoconiosis in order to receive benefits.

Since this survivor's claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by 20 C.F.R. § 718.205(c). As amended, that subsection provides:

> (c) For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at § 718.304 [relating to complicated pneumoconiosis] is applicable.
>
> (4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.
>
> (5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

Twenty C.F.R. § 718.205(c) (2001). Subsection (5) was added when the regulations were amended. Under existing precedent in the Sixth Circuit (and elsewhere), consistent with new subsection (5), any condition that hastens a miner's death is a substantially contributing cause of death. *Griffith v. Director, OWCP,* 49 F.3d 184 (6th Cir. 1995); *see also Brown v. Rock Creek Mining Co.*, 996 F.2d 812 (6th Cir. 1993); *Piney Mountain Coal Co. v. Mays,* 176 F.3d 753, 757-62 (4th Cir. 1999). Thus, the standards are the same under the new and old regulations. *See Mills v. Director, OWCP,* 348 F.3d 133 (6th Cir. 2002) (applying hastening death standard post regulation adoption).

Claimant relies upon Dr. Dennis' autopsy report to establish that pneumoconiosis contributed to or hastened Miner's death. Of importance to this position is the portion of the summary and decision that states Miner died a "pulmonary death with thromboembolic disease complicating his status." (DX 10-3). Under Miner's respiratory diagnosis, Dr. Dennis noted that Miner had "pulmonary congestion and edema, focal with pulmonary emboli and thromboembolic disease with focal areas of hemorrhagic infarction secondary to pulmonary embolus and thrombus formation (antemortem)." *Id*. He also diagnosed Miner with cor pulmonale, which indicated to him that Miner was suffering from "significant pulmonary disease." *Id*. However, Dr. Dennis did not specifically address what, if any, contribution coal worker's pneumoconiosis made to the Miner's "pulmonary death." Moreover, as Dr. Dennis did not perform an autopsy of Miner's abdominal area, he did not discuss what possible impact anything that may have been present there would have upon his findings.

Dr. Rosenberg opined that Miner's cause of death was the mesenteric ischemia in his bowel. (EX 4 at 23). Like Dr. Dennis, he agreed that Miner's course was complicated by blood clots and vascular congestion present in his chest at the time of his death. (EX 4 at 21). However, Dr. Rosenberg said this was caused by Miner's ischemia and was secondary to his bowel problems. (EX 4 at 23). Dr. Rosenberg did not believe coal dust contributed to or hastened any of these conditions. *Id*. Dr. Rosenberg concluded that neither coal workers' pneumoconiosis nor coal dust exposure contributed to or hastened Miner's death. *Id*.

Dr. Caffrey did not believe that simple coal workers' pneumoconiosis contributed to or hastened Miner's death. (EX 5 at 22). He also opined that Miner's pneumoconiosis did not contribute to or hasten any sort of respiratory or pulmonary impairment that Miner had prior to his death. *Id*. Dr. Caffrey attributed the thromboemboli with hemorrhagic infarction in Miner's lung to the ischemia in Miner's bowels, and also said it had nothing to do with coal dust exposure. (EX 5 at 11-12). Further, he stated Miner's pulmonary congestion was related to his thromboemboli, and not coal dust exposure. (EX 5 at 16). He also discounted coal dust exposure as the cause of Miner's cardiomegaly and coronary atherosclerosis. (EX 5 at 16-17). Dr. Caffrey also noted that the death certificate made no mention of any pulmonary problems, which he took to mean that Miner did not have any pulmonary disability prior to his death. (EX 5 at 22).

Finally, Dr. Naeye also determined that Miner's death was the result of the "destruction of [his] small bowel." (DX 3 at 15). He stated that coal dust in no way contributed to or hastened Miner's death. *Id*. He did not believe that any of the findings he reviewed in the slides contradicted the cause of death stated on Miner's death certificate. (DX 3, Exhibit 1).

After reviewing all the evidence submitted by both parties concerning Miner's cause of death, it is clear that Miner's pneumoconiosis did not substantially contribute to or hasten his death. Claimant relies heavily upon Dr. Dennis' autopsy report; however, this reliance is misplaced. As I mentioned above, Dr. Dennis did not perform an autopsy of Miner's abdominal region. This is crucial because Dr. Dennis does not appear to have taken into consideration how Miner's ischemia may have affected his analysis of Miner's respiratory and cardiovascular systems. Drs. Rosenberg and Caffrey testified that many of the problems found in Miner's lungs at the time of his death were actually associated with his bowel problems. Thus, Dr. Dennis'

assertion that Miner died a "pulmonary death with thromboembolic disease complicating his status" loses significant weight in face of the fact that most of Miner's pulmonary problems and thromboembolic disease were the apparent result of something Dr. Dennis did not even consider.

With respect to Miner's pneumoconiosis, which I have already determined exists, Claimant submitted no evidence suggesting that it in any way contributed to or hastened his death. Dr. Dennis did not address whether or to what extent Miner's pneumoconiosis had a role in his "pulmonary death", and Employer's experts found it played no role whatsoever. Moreover, Dr. Caffrey testified that Miner's pneumoconiosis did not contribute to or hasten any sort of pulmonary or respiratory disability Miner had prior to his death.[13] Claimant simply did not provide any evidence demonstrating any pre-existing conditions were exacerbated by Miner's pneumoconiosis. Nor did Claimant provide any evidence demonstrating that pneumoconiosis shortened his life.

Based upon the above, Claimant has not met her burden of proving by a preponderance of the evidence that pneumoconiosis contributed to or hastened Miner's death.

Conclusion

Based on the evidence presented to me, I have determined that Miner was suffering from medical pneumoconiosis which arose from his coal mine employment. However, I do not find that his pneumoconiosis contributed to or hastened his death. Therefore, I deny Claimant's claim for benefits under the Act.

ORDER

IT IS HEREBY ORDERED that the claim of Claimant I. A. for black lung survivor's benefits be, and hereby is, **DENIED**.

A
PAMELA LAKES WOOD
Administrative Law Judge

Washington, DC

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. §§

[13] This statement does not have significant weight because Dr. Caffrey freely admitted he was unable to review Miner's clinical history. (EX 5, Exhibit 2). Thus, serious problems exist with Dr. Caffrey's statement that none of Miner's previous disabilities were exacerbated by his pneumoconiosis because Dr. Caffrey was not even fully aware of what those problems were. Regardless, Dr. Caffrey's opinion appears to be the only one of record dealing with this particular issue. Even if it were given no weight, the evidence submitted falls short of establishing that pneumoconiosis played any part in causing or hastening the Miner's death.

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 20013-7601. 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 H. Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, 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 C.F.R. § 725.479(a).