U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 March 2007

In the Matter of:

M.G., Case No.: 2004-BLA-06315
Claimant

v.

STERLING MINING COMPANY, INC.
Employer

OLD REPUBLIC INSURANCE COMPANY,
Carrier

and

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

Appearances:

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

Lucy Bowman, Esq.
Street Law Firm
Grundy, Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C.

§ 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on October 27, 2004, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") at 32. Director's Exhibits ("DX") 1-44 , Employer/Carrier's Exhibits ("EX") 1-4, and Claimant's Exhibits ("CX") 1-3 were admitted in their entirety into evidence. Tr. at 7, 11, and 13. The record was held open to allow the Employer/Carrier to submit a re-reading of an x-ray, and closing arguments. Tr. at 8-11, 17. By an order dated July 7, 2005, Employer/Carrier's Exhibit 5 was admitted to the record. The Claimant and the Employer/Carrier filed closing briefs. The Employer/Carrier argued in its closing brief that the claim is a subsequent claim that relates directly back to a transfer case, and the Black Lung Disability Trust Fund should be held responsible for payment of any benefits awarded. I issued an order to the Director, OWCP, to show cause why liability, if any, should not be transferred to the trust fund. The Director filed a brief in response to the show cause order. The Employer/Carrier did not reply. The record is now closed.

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

PROCEDURAL HISTORY

The Claimant filed his initial claim on June 6, 1975. DX 1.[1] On June 23, 1980, the District Director, OWCP, denied the claim finding no evidence that the Claimant's pneumoconiosis was due to coal mine employment and no evidence of total disability due to pneumoconiosis. The Claimant did not appeal this decision.

On September 9, 1981, the Claimant filed a duplicate claim. DX 2. This claim was finally denied by Administrative Law Judge Edith Barnett, who issued a Decision and Order Denying Benefits on December 22, 1994. Judge Barnett held that the Claimant had not shown a material change in conditions, because he failed to establish that his pneumoconiosis arose at least in part to his coal mine employment or that he was totally disabled due to pneumoconiosis. The Claimant did not appeal Judge Barnett's decision.

The Claimant filed his current claim May 7, 2003. DX 4. The District Director, OWCP, issued a proposed Decision and Order awarding benefits on January 26, 2004. DX 30. The Employer/Carrier requested a hearing in a letter dated February 18, 2004. DX 32. The Carrier also requested a hearing in a letter dated February 27, 2004. DX 36. The claim was referred to the Office of Administrative Law Judges on May 18, 2004. DX 42.

[1] The exhibits from the initial claim now appear in DX 1. In the duplicate claim filed on September 9, 1981 (now DX 2), they were designated as DX 32. Thus the numbered Director's exhibits in the duplicate claim skip from 31 to 33.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on May 7, 2003. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

ISSUES

The issues contested by the Employer/Carrier are:

1. Whether the claim was timely filed.

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

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

5. Whether he is totally disabled.

6. Whether his disability is due to pneumoconiosis.

7. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2006).

The Employer/Carrier stipulated to 8.68 years of coal mine employment with Consolidated Coal Company. DX 42; Tr. at 5-6. The Employer/Carrier also reserved its right to challenge the statute and regulations. DX 42; Tr. at 6-7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at two hearings, the first on May 16, 1994, and the second, on October 27, 2004. The Claimant is divorced, and claims no dependents for augmentation of benefits. Tr. 15-16.

The Claimant alleged that he worked in the mines from 1967 to 1975. The Director found, and the parties agreed, that the Claimant had 8.68 years of coal mine employment, DX 22,

Tr. at 5-6, 14, and I so find. *See also* DX 5. The Claimant last worked in 1975. He left the mines due to a back injury. His last coal mine employment was in Virginia. Tr. 16. Therefore, this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The reports of the Claimant's smoking history varied over the years, from one pack per day in earlier reports, to one-half pack per day in more recent reports. I find that the Claimant smoked one-half to one pack per day, for about 30 years, for a total of about 20-25 pack years.

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The purpose of the regulation allowing the filing of subsequent claims, 20 CFR § 725.309 (2006), is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). The Benefits Review Board has held that there is no statute of limitations or time limit for filing a subsequent claim. *Andryka v. Rochester Pittsburgh Coal Co*., 14 B.L.R. 1-34 (1990). This view is not universally accepted by the courts. *Compare Wyoming Fuel Co. v. Director, OWCP*, 90 F.3d 1502, 1507 (10th Cir. 1996) ("… a final finding by an … adjudicator that the claimant is not totally disabled due to pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations."); *Westmoreland Coal Co. v. Amick*, 2004 WL 2791653, *3 (4th Cir. 2004) (unpub.) (rejecting the Board's view, but agreeing with *Wyoming Fuel*); *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608 (6th Cir. 2001) ("The three-year limitations clock begins to tick *the first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and … may only be turned back if the miner returns to the mines after a denial of benefits.") (Emphasis in original). Applying the *Wyoming Fuel* standard to this case, there is no evidence in the file that the Claimant was told that he was totally disabled by pneumoconiosis between the time his previous claim was denied in 1994, and the time he filed his current claim. The Employer/Carrier has offered no evidence or argument on this issue. I find that the claim is timely.

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was denied by Judge Barnett on December 22, 1994, and the denial became final one year later. As will be discussed in more detail below, arterial blood gas studies and medical reports indicate that the Claimant now has a pulmonary or respiratory impairment which is totally disabling. This constitutes a material change in conditions. Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. Evidence admitted in the prior claims may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006). 20 CFR § 725.309(d)(1) (2006). Moreover, no findings

in the prior claims are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2006).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in the current claim. X-ray interpretations submitted by the parties in connection with the current claim were in accordance with the limitations contained in 20 CFR § 725.414 (2006).

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are therefore included in the "negative" column. Any x-ray interpretations which made no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who classified opacities observed on x-ray have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[2] Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

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[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM . Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07/18/03	CX 1 Alexander BCR/B ILO Classification 2/1 CX 3 Miller BCR/B ILO Classification 1/1 DX 19 Forehand B ILO Classification 1/0	EX 1 Wiot BCR/B	DX 20 Quality rereading by Dr. Navani, BCR/B
01/20/04		EX 1 Wiot BCR/B EX 3 Dahhan B	
02/18/04		CX 1 Patel BCR/B[3] EX 5 Wiot BCR/B	

X-ray interpretations from the prior claims appear on the following chart. X-ray interpretations which made no reference to pneumoconiosis, positive or negative, given in connection with medical treatment are listed in the "silent" column.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/22/73			DX 2 Carter Slight cardiac enlargement; otherwise nothing unusual.
12/21/77			DX 2 Cooper No abnormalities
02/20/76	DX 1 Navani BCR/B ILO Classification 1/0		
10/10/80		DX 2 Castle B ILO Classification 0/1 DX 2 Stewart B DX 2 Hippensteel B	DX 2 Spitz BCR/B Unreadable DX 2 Wiot BCR/B Unreadable DX 2 Proto BCR/B Unreadable DX 2 Felson BCR/B Unreadable

[3] According to the NIOSH list, Dr. Patel was a B reader at the time he read the x-ray, but is now an A reader.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/01/80			DX 2Westerfield Mild cardiomegaly; otherwise unremarkable
12/19/80		DX 2 Spitz BCR/B ILO Classification 0/0 DX 2 Wiot BCR/B DX 2 Felson BCR/B ILO Classification 0/0 DX 2 Proto BCR/B DX 2 Castle B DX 2 Stewart B ILO Classification 0/1 DX 2 Hippensteel B	
04/12/81		DX 2 Spitz BCR/B ILO Classification 0/0 DX 2 Felson BCR/B ILO Classification 0/0 DX 2 Wiot BCR/B DX 2 Proto BCR/B DX 2 Castle B DX 2 Stewart B ILO Classification 0/1 DX 2 Hippensteel B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/11/81		DX 2 Felson BCR/B ILO Classification 0/0 DX 2 Proto BCR/B DX 2 Spitz BCR/B DX 2 Wiot BCR/B DX 2 Castle B DX 2 Stewart B DX 2 Hippensteel B	
09/12/81			DX 2 Straughan Normal chest.
01/17/82		DX 2 Spitz BCR/B DX 2 Felson BCR/B DX 2 Wiot BCR/B	
02/24/82		DX 2 Navani BCR/B ILO Classification 0/0	
03/11/82			DX 2 Visis Negative chest.
08/09/82			DX 2 Jones Questionable bronchitis right lung root
10/29/82			DX 2 Hashem Essentially negative chest.
11/17/82	DX 2 Westerfield BCR/A ILO Classification 1/2	DX 2 Felson BCR/B ILO Classification 0/0 DX 2 Proto BCR/B DX 2 Spitz BCR/B DX 2 Wiot BCR/B DX 2 Castle B DX 2 Stewart B DX 2 Hippensteel B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
02/24/84		DX 2 Mills ILO Classification 0/0	
		DX 2 Spitz BCR/B	
		DX 2 Wiot BCR/B	
		DX 2 Felson BCR	
		DX 2 Castle B	
		DX 2 Stewart B	
		DX 2 Hippensteel B	
10/09/89		DX 2 Spitz BCR/B	
		DX 2 Shipley B	
		DX 2 Wiot BCR/B	
12/17/90		DX 2 Spitz BCR/B	
		DX 2 Shipley BCR/B	
		DX 2 Wiot BCR/B	
11/18/91		DX 2 Spitz BCR/B	
		DX 2 Shipley BCR/B	
		DX 2 Wiot BCR/B	
05/21/93		DX 2 Spitz BCR/B	
		DX 2 Shipley BCR/B	
		DX 2 Wiot BCR/B	
03/02/94		DX 2 Dahhan B ILO Classification 0/0	
		DX 2 Spitz BCR/B	
		DX 2 Shipley BCR/B	
		DX 2 Wiot BCR/B	

Pulmonary Function Studies

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

The following chart summarizes the results of the pulmonary function studies available in the current claim. Pulmonary function studies submitted by the parties in connection with the current claim were in accordance with the limitations contained in 20 CFR § 725.414 (2006). "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height[4]**	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 18 07/18/03 Forehand	64 66"	2.52	3.08	82%	87	No	Normal
EX 3 01/20/04 Dahhan	64 169 cm (66.5")	2.78	3.38	82%	72	No	Normal
CX 2 02/18/04 Rasmussen	64 66"	2.70 2.78	3.55 3.48	76% 80%		No No	Normal without significant change following broncho-dilators.

The following chart summarizes the results of the pulmonary function studies available in connection with the prior claims.

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 66" to 66.5" in the recent studies, I have taken the mid-point (66.25") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the midpoint, or the heights listed by the persons who administered the testing. In the older studies, the recorded height varied from 66" to 69". Again, none of the studies were qualifying whether considering the midpoint, or the heights listed by the persons who administered the testing.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify ?	Physician Impression
DX 1 02/26/76 Kanwal	36 68”	3.31 3.37	3.59 3.63	92% 93%	97 89	No No	Compatible with mild to moderate degree of obstructive and restrictive lung disease.
DX 2 02/23/82 Parantha-man	41 69”	3.60	4.07	88%	135	No	Normal spirogram values
DX 2 11/17/82 Smiddy	43 68”	3.84	4.23	90%	145	No	No obstructive defect. No restrictive defect. Residual volume decreased. Total lung capacity normal. Diffusion capacity w/i normal limits.
DX 2 02/24/84 Dahhan	44 67.5”	2.95	3.40	87%		No	No airway obstruction. Borderline lung volumes. Normal diffusion capacity. Adequate ventilatory reserve.
DX 2 10/19/93 Emery	54 66”	3.14	3.63	87%		No	Normal spirometry.
DX 2 03/02/94 Dahhan	55 171 cm (67.3)”	2.85	3.38	84%	87.49	No	Normal spirometry. Normal lung volumes. Normal diffusion studies. Elevated carboxy-hemoglobin

Arterial Blood Gas Studies

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

The following chart summarizes the arterial blood gas studies available in the current claim. Arterial blood gas studies submitted by the parties in connection with the current claim

were in accordance with the limitations contained in 20 CFR § 725.414 (2006). A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 16	07/18/03	Forehand	36 29	68 51	No Yes	Exercise induced hypoxemia. Validated by Dr. Michos, DX 17
EX 3	01/20/04	Dahhan	40 38.6	73.7 87.9	No No	Minimal resting hypoxemia. Exercise showed normal values.
CX 2	02/18/04	Rasmussen	37 42	73 61	No No	Normal resting ABG. Minimal hypoxemia with exercise.

The following chart summarizes the arterial blood gas studies available in connection with the prior claims.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	02/26/76	Kanwal	32.4 26.1	94.5 107.5	No No	Mild hyperventilation after exercise
DX 2	02/23/82	Paranthaman	37.4 35.1	76.9 88.3	No No	Mild resting hypoxemia. pO_2 improved during exercise.
DX 2	11/17/82	Smiddy	34.9	84.1	No	
DX 2	02/24/84	Dahhan	31.9	83.2	No	Normal A-a gradient for O_2 Hyperventilation Respiratory alkalosis, no alkalemia
DX 2	03/02/94	Dahhan	34.7 24.8	91.6 112.9	No No	Normal A-a gradient for O_2 Hyperventilation.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to the current claim.

Dr. Forehand examined the Claimant on behalf of the Department of Labor on July 18, 2003. DX 14. Dr. Forehand is board-certified in Allergy and Immunology and Pediatrics, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 8 years. He reported a smoking history of one-half of a pack per day for 20 years. The chest examination revealed crackles at lung bases bilaterally. Dr. Forehand read the x-ray as showing pneumoconiosis (1/0). The pulmonary function test was normal. The arterial blood gas study revealed hypoxemia with exercise. Dr. Forehand diagnosed coal workers' pneumoconiosis based upon history, pulmonary function studies, arterial blood gas studies and chest x-ray. The only etiology he identified for his diagnosis was coal mine dust exposure. Dr. Forehand found that the Claimant had a "significant" impairment in function based on his lungs, and that he did not retain the respiratory capacity to perform his last job in the mines. Additionally, Dr. Forehand opined that the Claimant is totally and permanently disabled. Furthermore, he opined that coal workers' pneumoconiosis is "the predominant factor contributing to respiratory impairment. Chronic bronchitis is playing a very small role."

In response to an inquiry from the Department of Labor, Dr. Forehand wrote a letter dated September 29, 2003, in which he stated:

> I have received your letter of September 15, 2003. At the time of [the Claimant's] exam on July 18, 2003, he reported that he was employed in underground coal mining as a coal loader and highwall drill operator. His latter job is associated with exposure to very high levels of coal mine dust which is associated with a higher than normal risk of developing coal workers' pneumoconiosis. Coal

> miners who are exposed to high levels of coal mine dust for less than ten years can develop coal workers' pneumoconiosis. With [the Claimant's] coal mine employment, I am not surprised that he has developed shortness of breath and evidence of coal workers' pneumoconiosis with only 8.68 years of coal mine employment. With his work history, even this length of time is associated with developing coal workers' pneumoconiosis. [The Claimant's] pneumoconiosis arose, at least in part, out of his coal mine employment of 8.68 years for the reasons I have enumerated above.

DX 15.

Dr. Dahhan examined the Claimant on behalf of the Employer/Carrier on January 20, 2004.[5] EX 3. Dr. Dahhan is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 10 years. He reported a smoking history of one-half of a pack per day for 35 years. The chest examination was normal. Dr. Rasmussen read the x-ray as showing no pneumoconiosis. The pulmonary function test was normal and showed no restrictive or obstructive impairment. The arterial blood gas study revealed minimal hypoxemia at rest and was normal with exercise. Based upon his examination, normal pulmonary function studies, adequate blood gas exchange and negative chest x-ray, Dr. Dahhan concluded that the Claimant was not suffering from coal worker's pneumoconiosis. Dr. Dahhan found that the Claimant had no impairment in function based on his lungs, and that he retained the respiratory capacity to perform his last job in the mines.

Dr. Rasmussen examined the Claimant at the request of his counsel on February 18, 2004. CX 2. Dr. Rasmussen is board-certified in internal medicine and forensic medicine, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 10 years. He reported a smoking history of approximately one -half pack per day for 25 years. The chest examination was normal. Dr. Rasmussen reported that Dr. Patel, a board certified radiologist and B-reader, read the x-ray as showing no pneumoconiosis. The pulmonary function test was normal. The arterial blood gas study was normal at rest. The Claimant was able to exercise only for six minutes, after which there was moderate impairment in oxygen transfer and he was minimally hypoxic. Dr. Rasmussen said that the studies indicated very poor exercise tolerance and at least moderate loss of lung function. He said that the Claimant did not retain the pulmonary capacity to perform his last coal mine job. Dr. Rasmussen diagnosed no pneumoconiosis based on the negative x-ray.[6] However, he said

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[5] The Employer/Carrier suggests in its brief that because Dr. Dahhan examined the Claimant and reviewed his records in connection with the prior claims, Dr. Dahhan had more complete information available to him than did Dr. Forehand or Dr. Rasmussen. Closing Brief at 7. However, nothing in Dr. Dahhan's report suggests that he referred back to his old reports, the last of which he produced in 1994. Thus I find that there is no basis to infer that Dr. Dahhan recalled the Claimant or his medical history based on his prior reports, or, for that matter, that he remembered having seen the Claimant before at all.

[6] The Employer/Carrier interpreted the phrase in Dr. Rasmussen's report that a "diagnosis of coalworkers' pneumoconiosis cannot be established in this case" to mean that Dr. Rasmussen found no pneumoconiosis of any kind. Closing Brief at 6. Reading the report as a whole, however, it is clear that Dr. Rasmussen was excluding only clinical pneumoconiosis.

that coal mine dust and other interstitial lung diseases can cause impairment in oxygen transfer absent ventilatory impairment, citing various studies, including one he authored. He went on to state that the Claimant's abnormal lung function is a consequence of cigarette smoking and coal mine dust exposure, and that coal mine dust contributed to his loss of lung function, citing additional studies.

The following chart summarizes the medical opinions available in connection with the prior claims.

Date of Treatment, Examination, or Review of Records	Ex. No. Physician Basis for Opinion	Opinion Regarding Existence of Pneumoconiosis	Opinion Regarding Lung Impairment or Disability
02/26/76	DX 1 Dr. Kanwal DOL Examination	Diagnosed questionable chronic bronchitis	No opinion given.
11/17/82	DX 2 Dr. Smiddy Claimant's Examination	Diagnosed coal workers' pneumoconiosis.	No obstructive or restrictive defect. Normal blood gases, diffusion and lung capacity.
02/23/83	DX 2 Dr. Paranthaman DOL Examination	Diagnosed chronic bronchitis without significant airflow obstruction which may be due to coal dust exposure and/or smoking; X-ray shows no evidence of pneumoconiosis	Minimal functional impairment.
01/11/84	DX 2 Dr. O'Neill Review of Medical Data	No coal workers' pneumoconiosis based upon normal results of clinical examination and testing.	No respiratory disability; retains capacity to perform his coal mine job.
02/24/84	DX 2 Dahhan Employer requested examination	No evidence of pneumoconiosis; Diagnosed chronic bronchitis	No pulmonary impairment and should be able to continue working in coal mine.
Supplemental report 07/05/87	Supplemental report based upon review of medical data	In supplemental report, continued to find no evidence of pneumoconiosis and diagnosed chronic bronchitis	In supplemental report, no evidence of total or permanent disability and from pulmonary standpoint, could return to coal mine job.
07/08/87	DX 2 Stewart Review of medical data	No evidence of pneumoconiosis	No evidence of total respiratory disability and retains capacity to return to his coal mine job.

Date of Treatment, Examination, or Review of Records	Ex. No. Physician Basis for Opinion	Opinion Regarding Existence of Pneumoconiosis	Opinion Regarding Lung Impairment or Disability
10/16/93	DX 2 Cox Physical Examination at hospital[7]	Admitted for evaluation of congestive heart failure and possible ischemia. COPD was one of the diagnoses.	No opinion given.
03/2/94	DX 2 Dahhan Physical Examination	No evidence of pneumoconiosis	No pulmonary impairment and retains respiratory capacity to continue previous coal mine work or job of comparable physical demand.
Supplemental Report 04/05/94	Supplemental report – review of medical data		
04/18/94	DX 2 Stewart Review of medical data	No coal workers' pneumoconiosis.	No respiratory or pulmonary impairment. Not totally disabled from a respiratory impairment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f); 20 C.F.R. § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 C.F.R. § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986). As this is a subsequent claim, I first considered the evidence relating to disability introduced in the current claim to determine whether there has been a change in the applicable conditions of entitlement.

[7] Although the record contains a few other treatment records, this is the only record which mentioned a diagnosis related to the condition of the Claimant's lungs. There were no treatment records pertaining to the condition the Claimant's lungs.

Addressing the pulmonary function studies first, all of the newly submitted studies performed in connection with the current claim are non-qualifying. Therefore, I cannot find disability based upon the pulmonary function studies.

Next, looking at the arterial blood gas studies, there is one qualifying study, by Dr. Forehand; one normal study, by Dr. Dahhan; and one non-qualifying study by Dr. Rasmussen, which nonetheless shows a reduced percentage of oxygen with exercise (61%) which is close to, but does not meet the standard for disability (60%). The conflicting arterial blood gas studies support a finding of an impairment, if not a totally disabling impairment based on the blood gas studies alone.

Finally, I must consider the medical opinions in the current claim. Dr. Forehand opined that the Claimant was permanently and totally disabled. His opinion is supported by the qualifying arterial blood gas study. Therefore, I give his opinion probative weight.

Dr. Dahhan found no impairment, based on normal physical examination and normal test results. Dr. Dahhan is a well-qualified pulmonologist, and his opinion was well-documented and well-reasoned. However, there is no evidence that he was aware of the differing results achieved on examination and testing by Dr. Forehand or Dr. Rasmussen. Nothing in the record discredits, or explains the reasons for the different results. Nonetheless, as two out of three recent examinations supported the presence of an impairment, it appears that the normal results achieved by Dr. Dahhan represent an anomaly. Therefore, I give his opinion less weight.

Most recently, Dr. Rasmussen found that the Claimant did not retain the capacity to perform his last coal mine job because of the impairment in oxygen transfer revealed by the arterial blood gas study. His opinion, too, is well-documented and well-reasoned.

Weighing together the results of the arterial blood gas studies and medical opinions, I find that the opinions of Dr. Rasmussen and Dr. Forehand are entitled to greater weight than that of Dr. Dahhan on the issue of total disability. Their opinions are better supported by the objective evidence. Thus I find that the Claimant has established that he is totally disabled by a respiratory condition, and has thereby also established that there has been a change in the conditions of entitlement.

The evidence regarding total disability from the prior claims does not shed any further light on this issue. None of the pulmonary function tests or arterial blood gas studies between 1976 and 1994 were qualifying, and none of the physicians who gave opinions believed the Claimant to be disabled. Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983);

Call v. Director, OWCP, 2 B.L.R. 1-146, 1-148-1-149 (1979). As all of the medical data from the prior claims is remote in time, it is entitled to little weight.

The Claimant has shown the requisite change in conditions by establishing that he is disabled by a respiratory impairment. However, he is not entitled to benefits unless he has also established that his disability is due to his exposure to coal dust. I have considered all of the evidence from the current and previous claims in reaching my determinations on the remaining issues of entitlement.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and chronic bronchitis, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does

not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

20 CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant has less than 15 years of work in coal mines and filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

The x-ray evidence in this case is overwhelmingly negative for pneumoconiosis. Of the three x-rays read in connection with the current claim, only the July 2003 x-ray is positive; both of the more recent x-rays from 2004 are negative. Of the 21 x-rays read between 1973 and 1994 in the prior claims, only one, from 1976, was positive. I conclude that the Claimant has not established the existence of pneumoconiosis by virtue of the x-ray evidence.

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

The medical opinions found in the previous claim files were given between 1976 and 1994. The medical reports from 2003 and 2004 containing the most recent physical examinations of the miner may properly be accorded greater weight as they are likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). *See also Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). The newer reports, including test results,

indicate that the Claimant's condition has changed since his previous claim was denied in 1994. Thus, I accord little weight to the old reports.

In connection with the current claim, there are three new medical opinions, by Drs. Forehand, Rasmussen, and Dahhan. Dr. Forehand diagnosed the Claimant with clinical pneumoconiosis, while Dr. Rasmussen diagnosed legal, but not clinical, pneumoconiosis; and Dr. Dahhan found no pneumoconiosis, or indeed, no lung impairment of any kind.

Dr. Forehand based his opinion that the Claimant has clinical pneumoconiosis on a positive chest x-ray, the Claimant's medical history and examination, pulmonary function studies, and arterial blood gas studies. He provided adequate reasoning and documentation to support his opinion. Thus, I find his opinion well-documented and well-reasoned and accord it probative weight on the issue of pneumoconiosis. However, I have found that the great weight of the x-ray evidence was negative, which undermines Dr. Forehand's diagnosis of clinical pneumoconiosis. His report was silent as to the presence of legal pneumoconiosis.

Dr. Dahhan based his opinion on a negative chest x-ray, the Claimant's medical history and examination, pulmonary function studies, and arterial blood gas studies. He, too, provided adequate reasoning and documentation to support his opinion. Thus I also find his opinion well-documented and well-reasoned, and accord it probative weight on the issue of pneumoconiosis. Dr. Dahhan has the best credentials of the three, as he is a board-certified pulmonologist. However, as noted above, Dr. Dahhan found that the Claimant had no pulmonary or respiratory impairment based on normal test results on the day of his examination. However, both Dr. Forehand, and Dr. Rasmussen, who examined the Claimant before and after Dr. Dahhan, obtained test results showing such an impairment. As I have concluded that Dr. Dahhan's test results were anomalous, I give his opinion less weight than the others', despite his credentials.

Dr. Rasmussen also based his opinion on a negative chest x-ray, the Claimant's medical history and examination, pulmonary function studies, and arterial blood gas studies. He, too, provided adequate reasoning and documentation to support his opinion. Thus I also find his opinion well-documented and well-reasoned, and accord it probative weight on the issue of pneumoconiosis. Dr. Rasmussen opined that coal dust affected the Claimant's lung function, i.e., he diagnosed legal pneumoconiosis. I find that Dr. Rasmussen's opinion is entitled to the greatest weight, because it is in better accord with both the evidence underlying his opinion, and the overall weight of the medical evidence of record.

I find that the Claimant has established that he has legal pneumoconiosis based on the opinion of Dr. Rasmussen.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for less than nine years, and therefore is not entitled to the presumption. Recently the 10th Circuit Court of Appeals held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that he has

legal, but not clinical, pneumoconiosis. I also find that he has established a causal relationship between his disease and his coal mine employment through the opinion of Dr. Rasmussen, supported by the opinion of Dr. Forehand that the Claimant underwent sufficient exposure to coal dust to cause pneumoconiosis.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990)

The current regulations state that unless otherwise provided, the burden of proving a fact rests with the party making the allegation. 20 CFR § 725.103. The Benefits Review Board has held that Section 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990).

In this case, I have given greatest weight to Dr. Rasmussen's opinion that the Claimant has legal pneumoconiosis. Dr. Rasmussen stated that the Claimant's abnormal lung function has two causes: cigarette smoking, and coal dust exposure. I find that Dr. Rasmussen's opinion meets the standard for establishing that coal dust was a contributing cause to disability.

As noted above, Dr. Forehand attributed the Claimant's clinical pneumoconiosis he diagnosed entirely to coal dust exposure. Also as noted above, Dr. Forehand's opinion did not address legal pneumoconiosis; nor did it address the role cigarette smoking may have had on the Claimant's lung function. Because I have found that the Claimant established legal, but not clinical pneumoconiosis, I give Dr. Forehand's opinion less weight on the issue of what caused the Claimant's disability.

Dr. Dahhan did believe that the Claimant is disabled, so he did not give an opinion on the cause of any disability.

I find that the Claimant has established that exposure to coal dust contributed to his disability based on the opinion given by Dr. Rasmussen.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish

the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his claim for benefits in May 2003. When he was examined by Dr. Forehand in July 2003, he was already totally disabled. There is no evidence of disability prior to Dr. Forehand's examination. As I have found that Dr. Dahhan's examination results were anomalous, I find that the Claimant is entitled to benefits commencing in May 2003, the month in which he filed his claim.

Liability for the Payment of Benefits

In its closing brief filed August 8, 2005, the Employer/Carrier argued that this "subsequent" claim for benefits relates directly back to a transfer case, and that the Black Lung Disability Trust Fund is responsible for the payment of any benefits. This argument is based on a 1981 amendment to the Black Lung Act which stated,

> [N]o benefits shall be payable by any operator on account of death or total disability due to pneumoconiosis … which was the subject of a claim denied before March 1, 1978, and which is or has been approved in accordance with the provisions of § 945 of the title.

30 U.S.C. § 932(c). The Director, OWCP, responds that the claim at hand is a subsequent claim filed on May 7, 2003, and does not fall within the claims covered by Section 932(c). In this case, the Claimant's original claim was informally denied on April 14, 1976, and later reviewed without any action required on the part of the Claimant, resulting in the final denial of the claim on June 23, 1980. The Director concedes that the Fund would have been liable had benefits been awarded based on the initial claim. However, the Claimant took no further action on the initial claim, so the 1980 denial of benefits still stands. The Claimant then filed a second, "duplicate," claim on September 9, 1981, which was finally denied on December 22, 1994. Again, the Claimant took no further action on the duplicate claim, but awaited the passage of several years before filing his current, "subsequent," claim. I agree with the Director, OWCP, that the current claim does not fall within the ambit of Section 932, because it was not denied before March 1, 1978. Nor does it merge with the Claimant's prior claims, each being a separate claim. I therefore find that the Employer/Carrier is liable for the payment of benefits.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he is totally disabled due to legal pneumoconiosis. He is therefore entitled to benefits under the Act. The Employer/Carrier is liable for payment of the benefits.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney

is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on May 7, 2003, is hereby GRANTED. Benefits shall be paid by the Employer/Carrier.

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ALICE M. CRAFT
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 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 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).