U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 February 2006

CASE NO.: 2005-BLA-5023

In the Matter of:

JOHNNY F. HURST
Claimant

v.

EIGHTY FOUR MINING COMPANY
Employer

and

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

Appearances:

Daniel L. Chunko, Esq.,
For the Claimant

George H. Thompson, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS[1]

This proceeding arises from a survivor's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on August 12, 2002. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

[1] Sections 718.2 and 725.2(c) address the applicability of the new regulations to pending claims.

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

Claimant filed the instant claim for benefits on October 31, 2003. (DX 2). He has filed no prior claims for benefits. The District Director issued a Proposed Decision and Order Denying Benefits on July 15, 2004. (DX 27) On July 20, 2004, the claimant requested a hearing before the Office of Administrative Law Judges (OALJ). (DX 29). On September 30, 2004 the case was referred to the OALJ by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing at the claimant's request. (DX 33) The case, which was initially assigned to ALJ Tierney, was reassigned to me on April 14, 2005.

On June 21, 2005, I held a hearing in Pittsburgh, Pennsylvania. Both the claimant and employer were represented by counsel.[2] No appearance was entered for the Director, Office of Workers' Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Employer's exhibits ("EX") 1-9 and Director's exhibits ("DX") 1-35 were admitted into the record. (Hearing Transcript "TR." at pp. 8-12). The claimant did not have any additional medical evidence to submit at the hearing. (TR. 11). In addition, the claimant did not testify at the hearing due to illness; however, he did testify in a deposition on October 4, 2004 and his attorney stated that his deposition testimony is essentially the same or very similar to what he would testify to at the hearing. (TR. 10). The transcript of the claimant's deposition testimony appears in the record at EX 9.

The parties submitted closing arguments post-hearing.

ISSUES

I. Whether the miner had pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner was totally disabled?

IV. Whether the miner's death was due to pneumoconiosis?

(DX 33; TR. 9).

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[2] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(*en banc*), the location of a miner's last coal mine employment, here Pennsylvania, is determinative of the circuit court's jurisdiction.

FINDINGS OF FACT

I. Background

A. Coal Miner[3]

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations,[4] for at least 22 years. (TR. 9).[5]

B. Date of Filing[6]

The claimant filed his claim for benefits under the Act on October 31, 2003. (DX 2). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

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[3] Former subsection 718.301(a) provided that regular coal mine employment may be established on the basis of any evidence presented, including the testimony of a claimant or other witnesses and shall not be contingent upon a finding of a specific number of days of employment within a given period. 20 C.F.R. § 718.301 now provides that it must be computed as provided by § 725.101(a)(32). The claimant bears the burden of establishing the length of coal mine employment. *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Any reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP,* 20 B.L.R. 1-67, 1-72 (1996)(en banc); *Dawson v. Old Ben Coal Co*., 11 B.L.R. 1-58, 1-60 (1988); *Vickery v. Director, OWCP*, 8 B.L.R. 1-430, 1-432 (1986); *Niccoli v. Director, OWCP*, 6 B.L.R. 1-910, 1-912 (1984).

[4] § 725.202 Miner defined; condition of entitlement, miner (Applicable to adjudications on or after Jan. 19, 2001).

> (a) Miner defined. A "miner" for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner.
>
> This presumption may be rebutted by proof that:
>
> (1) The person was not engaged in the extraction, preparation or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or
>
> (2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

(emphasis added).

[5] Where there is more than one operator for whom the claimant worked a cumulative total of at least one year, 20 C.F.R. § 725.493(a)(1) imposes liability on the most recent employer. *Snedecker v. Island Creek Coal Co.,* 5 B.L.R. 1-91 (1982)(§ 725.495(a) for claims filed on or after Jan. 19, 2001). One year of coal mine employment may be established by accumulating intermittent periods of coal mine employment. 20 C.F.R. § 725.493(c)) (See § 725.101(32) for adjudications on or after Jan. 19, 2001). Under 718.301 (effective Jan. 19, 2001), the length of coal mine employment "must" be computed under 725.101(a)(32) criteria.

[6] 20 C.F.R. § 725.308 (Black Lung Benefits Act as amended, 30 U.S.C.A. §§ 901-945, § 422(f)).

> (a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis that has been communicated to the miner or a person responsible for the care of the miner… There is no time limit on the filing of a claim by the survivor of a miner.
>
> (c) There shall be a rebuttable presumption that every claim for benefits is timely field…the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

C. Responsible Operator

The parties stipulated that Eighty-Four Mining Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations. (TR. 9).

D. Dependents

The parties stipulated that the claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Drema. (DX 8; TR. 9; EX 9 at 7-8).

E. Personal, Employment (and Smoking) History[7]

The claimant was born on May 31, 1938. (DX 10; EX 9 at p. 7). The Claimant's last position in the coal mines was that of a longwall belt attendant. (DX 4; EX 9 at 19). Claimant testified that he quit his mining job because he became almost completely immobile and went to the emergency room where he was told he has rheumatoid arthritis. (EX 9 at 9). He explained that he retired under the orders of Doctor Chango, his family physician, and Doctor Seaman, his rheumatologist. (EX 9 at 9-10). Claimant explained that he was admitted to Washington Hospital numerous times, most recently for high blood pressure, and also for pneumonia, rectal bleeding/polyps, and hernia surgery. (EX 9 at 29-30; 37-39).

The claimant did not testify about his job duties or his cigarette smoking history. The only evidence in the record addressing his employment and social histories are contained in the medical reports submitted by the examining physicians. Dr. Celko's examination report, which appears in the record at DX 12, contains a typed employment history report and various job descriptions. As discussed at the hearing, this employment history report is inaccurate in that it reflects that the claimant worked for Duquesne Light Company from 1970 to 1984. (DX 12). The claimant testified in his deposition that he never worked for Duquesne Light Company and the parties stipulated at the hearing that this part of the employment history report is inaccurate. (EX 9 at 21, 25; TR. 8).

II. Medical Evidence[8]

A. Chest X-rays[9]

The record contains four interpretations of three X-rays, taken on November 21, 2002, December 1, 2003, and September 22, 2004. (DX 15, 16, 17 and EX 1, 4, and 5). All of the

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[7] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

[8] *Dempsey v. Sewell Coal Co. & Director, OWCP,* 23 B.L.R. 1-47, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[9] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b).[10] All of the interpretations are negative and were rendered by physicians who are either B-readers, Board-certified in radiology, or both. The December 1, 2003 x-ray was also read solely for quality purposes by Dr. Ranavaya, who is a B-reader.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualific-ations	Film Quality	ILO Classification	Interpretation Or Impression
EX 5	11/21/02 11/01/04	Hayes	BCR/B	1	0/0	No evidence of occupational pneumoconiosis. There is no suggestion of active or indolent parenchymal disease. Specifically, there is no evidence of occupational pneumoconiosis such as silicosis, coal workers' pneumoconiosis or asbestosis. There is minimal blunting of the left costophrenic angle.
DX 15, 16	12/01/03 12/01/03	Thomeier	BCR/B	2	0/1	Interstitial nodularity in the right mid-lung and bilateral lung bases that cold be consistent with pneumoconiosis. Thin linear calcification of the left hemidia-phragm and blunting of the left CP angle.
DX 17	12/01/03 01/26/04	Ranavaya	B	1	Quality Reading	Comments illegible
EX 4	12/01/03 09/14/04	Hayes	BCR/B	1[11]	0/0	Scattered granulomas present in both lung zones, ? dislocated R (illegible). The

[10] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[11] The film is marked as quality 1 with the note "arm soft tissue (right) overlying." In his typed comments, Dr. Hayes remarked that "the film is grade 2 quality due to the fact that soft tissue from the right arm is overlying the right lateral thorax."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualific-ations	Film Quality	ILO Classification	Interpretation Or Impression
						lung parenchyma shows no anatomical markers to suggest inhalational dust disease or pneumocon-iosis of any type. There is deformity of the right shoulder girdle and clinical coalition with possible chronic subluxation of the humeral head is needed. No evidence of occupational pneumoconiosis.
EX 1	09/22/04 09/24/04	Fino	B	1	0/0	Completely negative

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. 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, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987), *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993), and *Zeigler Co. v. Kelley*, 112 F.3d 839, 842-843 (7th Cir. 1997). B-readers need not be radiologists. *Cannelton Industries, Inc. v. Director, OWCP[Frye],* Case No. 03-1232 (4th Cir. April 5, 2004)(Proper to accord more weight to radiologists' readings over non-radiologists). *Bethenergy Mines, Inc., v. Cunningham*, Case No. 03-1561 (4th Cir. July 20, 2004)(Unpub.)(Appropriate to accord greater weight to the x-ray interpretation of a dually-qualified reader over a B-reader).

**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. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

CT Scans

The record contains the interpretation of two CT scans reviewed by Dr. Thomas M. Hayes, who is a Board Certified Radiologist and B-reader. The first CT scan of the thorax was apparently dated November 29, 2002, and Dr. Hayes's interpretation appears in the record at EX 3.[12] Dr. Hayes impression was: "no evidence of occupational pneumoconiosis involving the lung parenchyma. Questionable findings raising the possibility of small pleural plaques in the posterior gutter of the thorax, bilaterally. No other significant findings identified." The second

[12] Copies of the original CT scan reports are not contained in the record; therefore, it is unclear why or where these CT scans were initially taken.

CT scan of the thorax was apparently dated March 19, 2003, and Dr. Hayes's interpretation is dated November 1, 2004 and appears in the record at EX 2. His impression is: "essentially normal CT of the thorax with the exception of questionable small focal pleural plaques. No suggestion of occupational pneumoconiosis." Pursuant to *Webber v. Peabody Coal Co.,* BRB No. 05-0325 BLA (Jan. 27, 2000), I consider only the one more recent CT.

A CT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an X-ray under § 718.304(a). A "CT" or "CAT scan" is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, brining them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)." *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). In *Consolidation Coal C. v. Director, OWCP [Stein]*, ___ F.3d ___, 22 B.L.R. 2-409, 2002 WL 1363785 (7th Cir. June 25, 2002), the Court rejected the employer's argument that a negative CT is conclusive evidence the miner does not have pneumoconiosis. The DOL has also rejected such a view. Nor need a negative CT be given controlling weight because the statutory definition of "pneumoconiosis" encompasses a broader spectrum of diseases than those pathological conditions that can be detected by clinical test such as X-rays and CT scans.

B. Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Date **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Trac-ings**	**Compre-hension** **Cooper-ation**	**Qualify *** **Con-form****	**Dr.'s** **Impression**
DX 14 12/01/03	65/ 66"	2.41/ 2.55+	_____	3.08/ 3.08	Yes	Both maximal	No Yes	Mixed mild restrictive/ obstructive pattern. No significant (illegible). Normal lung volumes. Decreased

								diffusing capacity.
EX 1 09/22/04	66/ 66”	2.39/ 2.44+	_____	2.98/ 3.12 +	Yes	Good/ Good	No Yes	MIDI x 2 puffs. PR stable.

+ indicates values after administration of a bronchodilator.

*A “**qualifying**” pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study “**conforms**” if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states “(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…”

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed “unacceptable” when the subject “[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1’S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test.” (Emphasis added).

For a miner of the claimant’s height of 66 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.67 for a male 65 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.15 or an MVV equal to or less than 67; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test.

C. Arterial Blood Gas Studies[13]

Blood gas studies are performed to detect impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

[13] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish “total disability.” It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner’s total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

Date Ex. #	Physician	PCO_2	PO_2	Qualify	Physician Impression
12/1/03 DX 13	Celko	42.0	83.0	No	
9/22/04 EX 1	Fino	40	69	No	Mild resting hypoxemia

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Exercise is contraindictated in the claimant due to arthritis of the knees and hips.

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports[14]

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 or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), 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. § 718.204(b).

Dr. Celko examined the miner on December 1, 2003 on behalf of the Department of Labor. (DX 12). His credentials are not in the record. Dr. Celko's examination report is based upon his examination of the claimant and recorded approximately 22 years of coal mine employment. Dr. Celko referenced an attached occupational history sheet that was subsequently deemed incorrect because it indicated that the claimant worked for Duquesne Light Company. As discussed in a prior section of this decision, the miner never worked for Duquesne Light Company. Dr. Celko recorded a family medical history that is positive for high blood pressure, tuberculosis, diabetes, and cancer. Dr. Celko noted that the claimant's medical history is positive for pneumonia, three times in the last ten years, daily attacks of wheezing, arthritis, high blood pressure for two to three years, and rheumatoid arthritis for three years. Dr. Celko listed hypertension as "another significant condition" and noted that the miner was hospitalized for uncontrolled hypertension and colonoscopy/rectal bleeding. He noted that the claimant began

[14] *Dempsey v. Sewell Coal Co. & Director, OWCP,* 23 B.L.R. 1-47, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

smoking cigarettes and a pipe at age thirteen, and that he still currently smokes a pack of cigarettes per day.

Dr. Celko described the claimant's symptoms as daily sputum production, wheezing both night and day, dyspnea, and daily cough upon arousal. He noted that the claimant suffers from rheumatoid arthritis and denies hemoptysis, chest pain, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea. The claimant's physical examination was essentially normal, although Dr. Celko noted trace edema, posterior wheeze on auscultation, arthritis, and an obese abdomen. Dr. Celko performed objective studies that included a chest x-ray, pulmonary function and blood gas studies, and an EKG. He noted that records from Washington Hospital revealed calcified bilateral pleural plaques.

Dr. Celko's cardiopulmonary diagnoses were chronic asthmatic bronchitis and pneumoconiosis. He wrote that the etiology of these diagnoses were occupational dust, tobacco exposures/smoking and occupational dust exposures, respectively. He indicated that the claimant had mild, non-disabling respiratory (PFT) abnormalities.

Dr. Celko submitted a clarification letter dated April 2, 2004 to the OWCP Claims Examiner. (DX 18). Dr. Celko explained that he based his diagnosis of pneumoconiosis on Dr. Thomeier's 0/1, s/p x-ray interpretation. Dr. Celko cited the legal definition of pneumoconiosis and stated that the claimant has 21+ years of coal mine employment as well as a significant smoking history. He stated that since there is no way to distinguish the percent of pulmonary impairment related to dust exposure vs. cigarette smoke, it is his opinion that both are contributing factors to the miner's pneumoconiosis.

Dr. Gregory Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, examined the claimant and reviewed the claimant's medical records on behalf of the employer. He submitted his opinions in a report, dated September 28, 2004. (EX 1). His consultation report notes 22 years of coal mine employment, with all of the coal mine employment spent underground. Dr. Fino recorded that the claimant's last job was as a long wall belt attendant, which involved occasional heavy labor. He noted that the claimant left mining because of rheumatoid arthritis.

Dr. Fino recorded that the claimant has a fifty-pack year smoking history, which began at age thirteen in 1951 and consisted of one pack per day. He noted that the claimant quit on several occasions and managed to accumulate two to three years of not smoking but recorded that the claimant is currently still smoking.

Dr. Fino recorded that the claimant's breathing problem is characterized by worsening shortness of breath of four years duration that does not interfere with his usual daily activities. Dr. Fino wrote, "he does become dyspneic when walking at his own pace on the level ground or ascending one flight of steps. Dyspnea does occur when walking up hills or grades, lifting and carrying, performing manual labor, and walking briskly on level ground." Dr. Fino noted that the claimant is limited in what he can do because of his breathing, does not complain of chest pain, daily cough, or mucous production. He recorded that the claimant reported wheezing and there is no orthopnea or paroxysmal nocturnal dyspnea.

Dr. Fino recorded the claimant's past medical history as positive for two cardiac catheterizations that revealed no abnormalities, osteoporosis, arthritis, high blood pressure, diverticulitis, hernia repair, pneumonia requiring three hospitalizations, exposure to tuberculosis from his father (Claimant tested negative), chronic bronchitis, frequent colds, fractured ribs, and chronic sinus problems. Dr. Fino noted that there is a family history of lung disease, heart disease, and malignancy. He recorded that the claimant's mother had high blood pressure, his brother has heart disease, his father had black lung, and his sister died of uterine cancer.

Dr. Fino's physical examination of the miner was essentially normal and revealed a well-developed, mildly obese white man in no acute distress, with no cyanosis, clubbing, or edema. He recorded that the lungs were clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs.

Dr. Fino performed objective tests that included a chest x-ray, classification 0/0, spirometry, which was normal with no obstruction restriction, or ventilatory impairment. He noted that the lung volumes were normal, the diffusing capacity was reduced consistent with active cigarette smoking, oxygen saturation was normal, carboxyhemoglobin level was elevated. Dr. Fino performed an arterial blood gas study that revealed mild resting hypoxemia on room air. Dr. Fino also reviewed the claimant's medical records, including his Department of Labor examination that occurred in December 2003 and hospital records from 2000.

Dr. Fino's diagnoses are: 1) Normal pulmonary examination; 2) Mild, non-disabling and non-impairing resting hypoxemia consistent with both obesity and active cigarette smoking. Dr. Fino opined that the claimant does not suffer from coal workers' pneumoconiosis based on:

1) His reading of the negative chest x-ray;

2) The acceptable spirometric evaluations are normal with no obstruction, restriction, or ventilatory impairment;

3) The reduction in diffusing capacity is consistent with active cigarette smoking. The diffusing capacity is reduced by cigarette smoking in two ways. The first is the elevation of the carboxyhemoglobin level and the second is an active inflammatory process around the alveolar walls impairing diffusion.

4) The variable hypoxemia is not consistent with a coal mine dust-related pulmonary condition. It is related to the claimant's obesity and active cigarette smoking.

5) The TLC was not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis.

Dr. Fino stated that from a functional standpoint, the claimant's pulmonary system is normal and he retains the physiologic capacity from a respiratory standpoint to perform all the requirements of his last job. He noted that this opinion assumes that the claimant's last job required sustained heavy labor. Dr. Fino explained that he based this opinion on the fact that there is no ventilatory impairment as the normal spirometry clearly shows no evidence of obstruction, restriction, or ventilatory impairment and the diffusing capacity is reduced due to active cigarette smoking.

Dr. Fino concluded that: 1) there is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis; 2) there is no respiratory impairment; 3) from a respiratory standpoint, the claimant is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort. Dr. Fino stated that even if he were to assume that the claimant has coal workers' pneumoconiosis, conclusions #2 and #3 would remain the same.

III. Hospital Records & Physician Office Notes

The record contains reports from Washington Hospital pertaining to the claimant's complaints and surgical treatment of a right inguinal hernia in February 2004. (EX 6). A preoperative chest x-ray revealed: atherosclertotic calcification present within the aorta, mild biapical pleural thickening, no evidence of acute infiltrate or pleural effusion, and the density seen on prior examination (November 21, 2002) is not visualized on current examination of the right lung. The impression is no acute pulmonary disease.

The claimant's physician treatment records from Dr. David E. Seaman's office appear in the record at EX 7. The progress reports range from two visits in March and April of 1998, and then every two months in 2001 through July 2002. The last report is a visit on January 15, 2003. The records reveal that the claimant was experiencing joint pain, swelling, and parathesias and was being followed for these complaints. Any references to his lungs during these visits indicate that they were clear on auscultation.

IV. Witness Testimony

Dr. Fino testified in a deposition on March 9, 2005. The deposition transcript appears in the record at EX 8. Dr. Fino's testimony was consistent with the information and opinion set forth in his medical report. He explained that the claimant's fifty pack year cigarette smoking history could cause a problem in a susceptible host and that the claimant's medical conditions listed in his report are significant health issues for him but do not reflect exposure to coal dust. EX 8 at pp. 8-9. Dr. Fino enumerated these conditions as rheumatoid arthritis, heart catheterization, and hypertension. *Id.* Dr. Fino testified that he interpreted the claimant's chest x-ray as negative and explained that there were a few granulomata present, which are residuals of previous infection totally unrelated to the inhalation of coal dust and consistent with the claimant's history of pneumonia. EX 8 at 10.

Dr. Fino testified that the claimant's spirometry was normal without evidence of obstruction or restrictions and his lung consistency was normal. EX 8 at 11. He explained that the claimant's reduced diffusing capacity was reduced and that this could suggest an impairment to oxygen transfer. *Id.* Dr. Fino stated that because the claimant was actively smoking, active smoking will cause a reduction in the diffusing capacity independent of any lung problem, so the fact that a person smokes will reduce the diffusion capacity. *Id.* Dr. Fino explained that the claimant's carboxyhemoglobin level, which measures the amount of carbon monoxide in the blood, was elevated consistent with his continued smoking history. *Id.*

Dr. Fino testified that the claimant's arterial blood gas showed a PO2 of 69, which represents a mild hypoxia. *Id.* He explained that he believes this is a result of the combination

of the claimant's active smoking and his obesity. *Id.* Dr. Fino explained that although the claimant's Department of Labor blood gas results were normal nine months before he examined him, a person is not going to develop a hypoxemia from a permanent lung condition and have it be reversible in that short amount of time. EX 8 at 12. He stated that obesity and smoking can cause variable hypoxemia. *Id.* Dr. Fino testified that he believes the claimant had a normal pulmonary examination and that he has mild non-disabling and non-impairing resting hypoxemia consistent with a combination of obesity and active cigarette smoking. EX 8 at pp. 13-14. Dr. Fino explained that he based these opinions on the negative chest x-ray, no abnormalities of the lung on physical examination, and pulmonary function studies that don't represent any intrinsic lung disease due to occupational exposure or actual smoking. EX 8 at 14.

Dr. Fino explained that the secondary effect in the claimant's diffusing capacity would go away in six weeks if he would stop smoking, so he does not believe that there is any real intrinsic disease. *Id.* Dr. Fino stated that he disagreed with Dr. Celko that the claimant has asthmatic bronchitis caused at least in part by coal mine dust exposure. EX 8 at 15. He explained that although Dr. Celko heard wheezing on his examination of the miner, he himself did not. *Id.* He stated that if the claimant was, in fact, wheezing and it went away by the time he examined him, it could represent asthma or an asthmatic bronchitis type condition but it wouldn't be due to coal mine dust because coal mine dust related diseases are permanent conditions that do not go away or improve over time. *Id.*

Dr. Fino testified that the interstitial nodularity noted on the DOL December 1, 2003 chest x-ray were not present on his film, and if they were present on the DOL film, they did not reach the level needed to make a diagnosis of radiographic pneumoconiosis. EX 8 at 18. He explained that the location or the opacities in this case are not consistent with coal workers' pneumoconiosis because the upper lobes are spared, the primary opacity is an irregular S type opacity which is not consistent with coal workers' pneumoconiosis, and a reading of zero/one is not consistent with any type of pneumoconiosis and is a negative reading. EX 8 at pp. 18-19. Dr. Fino testified that 21 years of underground coal mine employment is the type of coal dust exposure that could cause a lung problem in a susceptible individual.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). [*See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997)]. [*Adams v. Director, OWCP*, 886 F.2d 818, 820 (6th Cir. 1989).] The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, "[T]he

presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*,338 F.3d 501, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281; *see also Peabody Coal Co. v. Odom*, ___ F.3d ___, 2003 WL 21998333 (6th Cir. Aug. 25, 2003)(Credit treating physician on more than mere status).

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[15]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition

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[15] Regulatory amendments, effective January 19, 2001, state:

(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 pneumoconiosis, 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 silicotuberculosis, 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.
(Emphasis added).

of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (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" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[16] 20 C.F.R. § 718.202(a)(4).

The Third Circuit held that the four methods of establishing the existence of the disease, provided in 20 C.F.R. § 718.202, are not to be considered in the disjunctive; that is, relevant evidence developed under the four methods of proof are to be considered together to determine whether a claimant has pneumoconiosis. *Penn Allegheny Coal Co. v. Williams & Director, OWCP*, 114 F.3d 22 (3rd Cir. June 3, 1997) *Citing* 30 U.S.C. § 923(b) and *Kertesz v. Cresent Hills Coal Co.*, 788 F.2d 158 (3d Cir. 1986).

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of those presumptions are applicable to a living miner's claim filed after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence.[17] 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority

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[16] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

[17] "There are twelve levels of profusion classifications for the radiographic interpretation of simple pneumoconiosis…*See* N. LeRoy Lapp, '*A Lawyer's Medical Guide to Black Lung Litigation*,' 83 W.Va. Law Rev. 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th cir. 1996)(*en banc*) at 1359, n.1.

of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

Of the four physicians that interpreted the claimant's chest X-rays, three physicians are both board certified radiologists and B-readers and one physician is a B-reader. None of the physicians interpreted the claimant's chest X-rays as positive for coal workers' pneumoconiosis. Therefore, the claimant cannot establish pneumoconiosis pursuant to the chest X-ray evidence set forth in subsection 718.202(a)(1).

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[18] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Dr. Celko and Fino examined the claimant and submitted reports. Because of his various Board-certifications, B-reader status, and expertise, and because Dr. Celko's credentials are not in the record for comparison, I rank Dr. Fino's credentials over Dr. Celko's.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).[19] This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

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[18] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984).

[19] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En Banc.*). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See also Abshire v. D & L Coal Co*. 22 B.L.R. 1-203 (2002), citing *Staton v. Norfolk & Western Railroad Co.*, 65 F.3d 55, 19 B.L.R. 2-271 (6th Cir. 1995); *Woodward v. Director, OWCP,* 991 F.2d 314, 17 B.L.R. 2-77 (6th Cir. 1993); *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990); and, *Clark v. Karst-Robbin Coal Co*., 12 B.L.R. 10-149 (1989), the Board holds greater weight may be accorded to more recent X-ray evidence of record. In *Abshire*, the Board also

It is proper for an administrative law judge to accord greater weight to a physician who "integrated all of the objective evidence" more than contrary physicians of record, particularly where he considered tests results showing diffusion impairment, reversibility studies, and blood gas readings. *Midland Coal Co. v. Director, OWCP[Shores]*, 358 F.3d 486 (7th Cir. 2004).

Both physicians based their opinions on objective studies, the claimant's work and social histories, and physical examinations. In addition, Dr. Fino had the opportunity to review Dr. Celko's examination and the claimant's hospitalization records. Therefore, I find both physicians' opinions to be well documented. Dr. Celko opined that the claimant suffers from chronic asthmatic bronchitis and pneumoconiosis. He cited the legal definition of pneumoconiosis and explained that the claimant has 21+ years of coal mine employment as well as a significant smoking history. He stated that since there is no way to distinguish the percent of pulmonary impairment related to dust exposure vs. cigarette smoke, it is his opinion that both are contributing factors to the miner's pneumoconiosis.

Dr. Fino, on the other hand, opined that there is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis and there is no respiratory impairment present. He based his opinion on the negative chest X-ray evidence, his physical examination of the claimant, and the pulmonary function studies. Dr. Fino acknowledged that the claimant's occupational history would be sufficient to cause occupational pneumoconiosis, and that asthmatic bronchitis falls within the legal definition of pneumoconiosis. However, Dr. Fino disagreed with Dr. Celko's diagnosis of asthmatic bronchitis and explained in his deposition testimony that the claimant did not manifest any wheezing when he examined him nine months after Dr. Celko. Dr. Fino further explained that if the claimant did have physical evidence of asthmatic bronchitis on Dr. Celko's examination, he would have expected it to be present during his own subsequent examination, given that asthmatic bronchitis from coal dust does not improve but worsens.

Both physicians explained what medical evidence they relied on in arriving at their opinions; therefore, they are both well reasoned. However, Dr. Fino provided a more thorough discussion of the medical evidence and better explained how each element of the medical evidence assisted him in arriving at his opinion that the claimant does not suffer from coal workers' pneumoconiosis or asthmatic bronchitis. In addition, Dr. Fino's observation that the claimant did not wheeze on examination is also consistent with the treatment records from the claimant's visits with Dr. Seaman, who reported on numerous physical examinations that the "lungs were clear" and did not note any wheezing or complaints of such by the claimant. By contrast, Dr. Celko's supplemental letter stated that he based his diagnosis of pneumoconiosis in part on Dr. Thomeier's X-ray interpretation, which was 0/1 and is a negative interpretation. This negative X-ray interpretation contradicts Dr. Celko's diagnosis of pneumoconiosis. Moreover, I previously noted that Dr. Celko's credentials are not in the record and that Dr. Fino's credentials were entitled to greater consideration. Therefore, I find that Dr. Fino's opinion is entitled to greater weight than Dr. Celko's because it is better supported by all of the medical evidence of record including the claimant's treatment notes and is better reasoned. Accordingly, the claimant

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recognized *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 11 B.L.R. 2-1 (1987) (CWP is a progressive disease).

has not established pneumoconiosis pursuant to the medical opinion evidence set forth in subsection 718.202(a)(4).

Pursuant to the holding in *Penn Allegheny*, *supra*, I must weigh all of the evidence under § 718.202(a) together in order to make a determination regarding the existence of pneumoconiosis. I found that the claimant was unable to establish the existence of pneumoconiosis through chest x-ray evidence (clinical pneumoconiosis). I found that there was no biopsy evidence in the record to establish the existence of pneumoconiosis and that the presumptions at § 718.202(a)(3) were inapplicable to this case. The one CT scan I considered is negative as well. In addition, I found that the conclusion of the better reasoned medical opinion did not establish the existence of pneumoconiosis (legal pneumoconiosis) pursuant to § 718.202(a)(4). Accordingly, weighing all of the evidence together, I find that the claimant has not established the existence of pneumoconiosis pursuant to § 718.202(a) and has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven, the issue is moot.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[20] Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that the miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills;

[20] The Board has held it is the claimant's burden to establish total disability due to CWP by a preponderance of the evidence. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986)(en banc). 20 C.F.R. § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:
(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

and lay testimony.[21] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993). Neither of the claimant's pulmonary function studies produced qualifying values. Therefore, the claimant is unable to establish that he is totally disabled pursuant to § 718.204(b)(2)(i).

A claimant may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one that was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). The claimant is unable to demonstrate total disability based on the arterial blood gas study evidence because none of the arterial blood gas studies produced qualifying values.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), 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 presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

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[21] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

Dr. Celko opined that the claimant has a non-disabling respiratory impairment based on the pulmonary function studies, arterial blood gas studies, and the claimant's physical examination. Dr. Fino opined that the claimant's pulmonary system is normal and he retains the physiologic capacity from a respiratory standpoint to perform all the requirements of his last job or a job requiring similar effort. Dr. Fino also based his opinion on the claimant's physical examination and objective tests. Both of these physicians opinions are well documented and well reasoned, and both of them conclude that the miner is not totally disabled from a respiratory standpoint. Therefore, I find that the claimant has not established that he is totally disabled pursuant to § 718.204(b)(2)(iv).

Weighing all of the evidence together, I find the claimant has not met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability

The revised regulations, 20 C.F.R. § 718.204(c)(1), require a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability.[22] The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).

The Third Circuit requires pneumoconiosis be a "substantial contributor" to the miner's total disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734, 13 B.L.R. 2-23 (3d Cir. 1989). I previously found that the claimant could not prove that he suffers from coal workers' pneumoconiosis, or that he is totally disabled. Therefore, he cannot show that pneumoconiosis is a substantial contributor to his total disability.

[22] This standard is more consistent with the Third Circuit's pre-amendment "substantial contributor" standard set forth in *Bonessa v. U.S. Steel Corp*., 884 F.2d 726, 13 B.L.R. 2-23 (3d Cir. 1989) than the Fourth Circuit's "contributing cause" standard set forth in *Robinson v. Picklands Mather & Co./ Leslie Coal Co. v. Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35, 38 (4th Cir. 1990). In *Gross v. Dominion Coal Corp.,* 23 B.L.R. 1-8, BRB No. 03-0118 (2003), the Board observed that "[U]nder the existing law of the Fourth Circuit, claimant is not required to establish relative degrees of causal contribution by pneumoconiosis and smoking to demonstrate that his total disability is due to pneumoconiosis. See *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (CA4 1990)(holding that a claimant must prove that pneumoconiosis is at least a contributing cause of total disability). Pneumoconiosis must be a necessary condition of the claimant's disability in that it cannot play a merely *de minimis* role. *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1196 n.8, 19 B.L.R. 2-304, 2-320 n.8 (4th Cir. 1995)."

ATTORNEY FEE

The award of attorney's fees, under the Attorney Fee Act, is permitted only in cases in which the claimant is determined to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

The claimant did not establish that he suffers from pneumoconiosis arising out of his coal mine employment, or that he is totally disabled due to pneumoconiosis, as defined by the Act and Regulations. He is therefore not entitled to benefits.

ORDER[23]

It is ordered that the claim of Johnny F. Hurst for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[24] At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter **to Donald S. Shire, 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.

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[23] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[24] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

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.

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).