U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 06 March 2006

CASE NO.: 2005-BLA-5337

In the Matter of:

DEWEY SPARKS,
Claimant,

v.

CONSOLIDATION COAL COMPANY,
Employer,

and

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

Appearances: Joseph Wolfe, Esquire
For the Claimant

Christopher M. Hunter, Esquire
For the Employer/Carrier

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a request for benefits under the Black Lung Benefits Act ("the Act"), 30 U.S.C. § 901 *et seq.* In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing. Claimant, Dewey Sparks, filed this claim after January 19, 2001, so it is governed by 20 C.F.R. Part 718 (2004).[1]

A formal hearing was held by me in this case on May 10, 2005 in Big Stone Gap, Virginia. Claimant's attorney waived his client's appearance at the hearing and elected to

[1] All cited regulations refer to Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. The following abbreviations will be used as citations to the record: "DX" for Director's Exhibits, "EX" for Employer's Exhibits, "CX" for Claimant's Exhibits, and "Tr." For Hearing Transcript.

proceed on the existing evidentiary record. Tr. at 5, 24-25. Employer did not object, and the parties were thereafter afforded time post-hearing to submit written closing arguments. Tr. 25. DX 1 through 80 were admitted into evidence based on the parties' representation that admitting all those exhibits into the record was consistent with the evidentiary limitations imposed by 20 C.F.R. § 725.414.[2] Tr. 9-14. EX 1, part of EX 7, and all of EX 8, 10, and 18-20 were also admitted. Tr. 17-24.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made.

ISSUES

1. Whether one of the applicable conditions of entitlement has changed since the last final denial of benefits?

2. Whether a mistake in a determination of fact was made during the last denial of benefits?

3. Whether the Claimant has coal workers' pneumoconiosis ("pneumoconiosis" or "CWP") as defined by the Act and regulations?

4. Whether the pneumoconiosis, if proven, arose out of coal mine employment?

5. Whether Claimant is totally disabled?

6. Whether the Claimant's total disability, if proven, is due to pneumoconiosis?

PROCEDURAL HISTORY

Claimant originally filed a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, on December 19, 1989, and that claim was finally denied by Administrative Law Judge Joel R. Williams on October 31, 1991. DX 1. Judge Williams found that Claimant had failed to establish that he suffers from pneumoconiosis or that he is totally disabled due to pneumoconiosis.

Claimant's second claim for benefits, filed November 16, 1994, was denied by the District Director on February 24, 1995 and was not appealed. DX 1.

Claimant's third claim for benefits, filed July 9, 1996, was denied on August 27, 1999 by Administrative Law Judge Daniel J. Roketenetz, based on Claimant's failure to establish

[2] Employer's counsel noted that DX 68 included an x-ray interpretation by Dr. Hippensteel included as part of his complete pulmonary examination. Counsel further stated that he was offering Dr. Hippensteel's report exclusive of the x-ray interpretation inasmuch as including that interpretation would run afoul of the evidentiary limitations. DX 68, excluding Dr. Hippensteel's x-ray interpretation, was thus admitted into evidence without objection. Tr. 16.

pneumoconiosis or total disability due to pneumoconiosis. DX 1.

Claimant filed his current claim for benefits on February 15, 2001. DX 2. Administrative Law Judge Linda S. Chapman found in her May 7, 2003 decision and order denying benefits that Claimant failed to establish the presence of pneumoconiosis or that his total respiratory disability was due to pneumoconiosis.[3] DX 46. She therefore found that Claimant had failed to establish a material change in the applicable conditions of entitlement since Judge Roketenetz's August 27, 1999 denial of benefits. *Id.*

Claimant subsequently appealed Judge Chapman's decision to the Benefits Review Board, but he then, on December 18, 2003, requested modification and remand by the Board to the District Director. DX 48, 59, 64. The Board thereafter remanded the claim, the District Director issued a Proposed Decision and Order on Remand awarding benefits on October 1, 2004, and Employer's attorney thereafter requested a formal hearing. DX 70, 72.

As noted above, a formal hearing was held by me in Big Stone Gap, Virginia on May 10, 2005. Subsequently, based upon my review of the parties' closing briefs and the evidentiary record, I determined that Judge Chapman had committed a mistake of fact when she relied on evidence submitted by the parties which exceeded the evidentiary limitations imposed by 20 C.F.R. § 725.414. I therefore granted Claimant's request for modification and ordered the parties to designate, from the evidence already of record, affirmative, rebuttal, and rehabilitation evidence consistent with the evidentiary limitations.

On August 26 and 30, 2005, Claimant and Employer, respectively, designated affirmative evidence in compliance with my August 12, 2005 Decision and order Granting Modification and Directing the Filing of Supplemental Briefs. Employer's counsel thereafter designated certain evidence as rebuttal evidence in a supplemental designation received September 16, 2005. A supplemental closing brief was also filed by Employer's counsel on October 14, 2005. No further brief was submitted by Claimant's counsel.

---

[3] As noted above, because the subsequent claim decided by Judge Chapman was filed by Claimant on February 15, 2001 (DX 2), the Department of Labor regulations which became effective January 19, 2001 govern that claim. As a result, under § 725.414(a), parties are entitled to submit, in support of their affirmative case, no more than two chest X-ray interpretations, two pulmonary function tests, two arterial blood gas studies, one autopsy or biopsy report, and two medical opinions. Additionally, under § 725.310(b), in a modification proceeding, claimant and the employer shall each be entitled to submit no more than one additional chest x-ray interpretation, one additional pulmonary function test, one additional arterial blood gas study, and one additional medical report in support of its affirmative case along with the evidence authorized by § 725.414. Despite these limitations, Judge Chapman admitted, without objection from Claimant, a total of eighteen medical exhibits offered by Employer. DX 44 at 9. Those exhibits included multiple chest x-ray interpretations and medical opinions which far exceed the limits imposed by § 725.414(a) and § 725.310(b). Therefore, on August 12, 2005, I issued a Decision and Order Granting Modification and Directing the Filing of Supplemental Briefs, in which I directed the parties to identify from the existing record those exhibits upon which each intended to rely as affirmative, rebuttal, and rehabilitative evidence within the evidentiary limitations of 725.414(a) and § 725.310(b). The parties thereafter submitted designations of chest x-ray, pulmonary function, study, arterial blood gas study, and medical opinion evidence which comply with the evidentiary limitations. Only that evidence designated by the parties in their supplemental filings in August and September 2005 is admitted with respect to the instant claim seeking modification of the Miner's subsequent claim.

FINDINGS OF FACT AND APPLICABLE LAW

Length of Coal Mine Employment

Claimant stated that he has 22 years of coal mine employment. DX 2. Employer conceded that Claimant has at least 18 years of coal mine employment. Employer Pre-Hearing Report at 2; Tr. 5. The Director found that the Miner was a coal miner for more than 20 years. DX 70. Also, the Miner's Social Security Earnings Record supports a finding of approximately 20 years of coal mine employment. DX 6. Based upon the documented evidence of record, I find that Claimant was a coal miner within the meaning of § 402(d) of the Act and 20 C.F.R. § 725.202 of the regulations for approximately 20 years. He last worked as a coal miner in 1989. DX 2.

Applicable Law

As noted above, I have already found that modification of Judge Chapman's decision is appropriate based on her admission into the record evidence which exceeded the limitations imposed by 20 C.F.R. § 725.414. Thus, this claim shall be treated as a subsequent claim. A subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. §§ 725.309(d)(2), (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement. In making that determination, I must also consider whether the newly submitted evidence differs "qualitatively" from the evidence submitted during the previously adjudicated claim. *Sharondale Corp. v. Ross*, 42 F.3d 993, 999, 19 BLR 2-10 (6th Cir. 1994).

MEDICAL EVIDENCE

Chest X-Ray Evidence[4]

Ex. No.	Physician	B-Reader /BCR[5]	Date of X-Ray	Film Quality	Reading

[4] Employer submitted Dr. Hippensteel's June 11, 2001 x-ray interpretation (DX 12) and Dr. Castle's November 25, 2002 interpretation (DX 41) as affirmative evidence under § 725.414(a)(3)(i). Employer submitted Dr. Hippensteel's May 13, 2004 interpretation (DX 68) as an addition x-ray interpretation as allowed in modification proceedings under § 725.310(b). Claimant submitted Dr. Forehand's July 2, 2002 interpretation (DX 42) and Dr. Patel's September 24, 2003 interpretation (DX 59) as affirmative evidence under § 725.414(a)(2)(i). Employer submitted Dr. Wheeler's July 3, 2002 interpretation (DX 41) and Dr. Wiot's September 24, 2003 interpretation (EX 8) as rebuttal evidence under § 725.414(a)(3)(ii). Dr. Forehand's March 27, 2001 interpretation (DX 10) was provided by the Office of Workers' Compensation Programs as required under § 725.406(a). Employer submitted Dr. Wiot's March 27, 2001 interpretation (DX 11) as rebuttal evidence of the interpretation provided for by the Office of Workers' Compensation Programs.

[5] "BCR" refers to a board-certified radiologist. B-reader qualifications are recorded on the B-reader List published on DOL's website. *List of Approved B-Readers* (June 21, 1999), *at* http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm. Board Certification is reflected in the listings by the

DX 10	Forehand	B-Reader	3/27/01	1	No CWP
DX 11	Wiot	B-Reader/ BCR	3/27/01	1	No CWP
DX 12	Hippensteel	B-Reader	6/11/01	1	0/1; s/t
DX 42	Forehand	B-Reader	7/3/02	1	1/0; s/t
DX 41	Wheeler	B-Reader/ BCR	7/3/02	2	No CWP
DX 41	Castle	B-Reader	11/25/02	1	0/1; t/s
EX 8	Wiot	B-Reader/ BCR	9/24/03	1	No CWP
DX 59	Patel	B-Reader/BCR	9/24/03	2	1/0; s/s
DX 68	Hippensteel	B-Reader	5/13/04	1	No CWP

Pulmonary Function Studies[6]

Ex. No.	Physician	Date of Study	Conforming?	Qualifying?	Age/ Height	FEV_1[7]	FVC	MVV	Comments
DX 10	Forehand	3/27/01	Yes	Yes Yes	62 yrs./ 69 in.	1.56 1.92	2.58 2.95	47 51	Not noted
DX 11	Hippensteel	6/11/01	Yes	Yes Yes	62 yrs./ 70 in.	1.45 1.52	2.10 2.38	34	Variable effort
DX 42	Forehand	7/3/02	Yes	Yes Yes	63 yrs./ 69 in.	1.30 1.41	2.07 2.38	30 40	Not noted
DX 41	Castle	11/25/02	Yes	Yes Yes	64 yrs./ 70 in.	1.54 1.54	2.35 2.37	34	Part of test invalid
DX 59	Rasmussen	9/24/03	Yes	Yes Yes	64 yrs./ 69 in.	1.63 1.74	2.86 2.93	33 45	Not noted
DX 68	Hippensteel	5/13/04	Yes	Yes Yes	65 yrs./ 70 in.	1.24 1.29	2.28 2.31	30	Not noted

American Board of Medical Specialties ("ABMS"). *American Board of Medical Specialties*, *at* abms.org (last visited September 1, 2004). Judicial notice has been taken of these resources if the qualifications of the physicians are not otherwise of record. *See Maddaleni v. Pittsburg and Midway Coal Co.*, 14 BLR 1-135 (1990).

[6] Employer submitted Dr. Hippensteel's June 11, 2001 pulmonary function test ("PFT") (DX 11) and Dr. Castle's November 25, 2002 PFT (DX 41) as affirmative evidence under § 725.414(a)(3)(i). Employer submitted Dr. Hippensteel's May 13, 2004 PFT (DX 68) as allowed in modification proceedings under § 725.310(b). Claimant submitted Dr. Forehand's July 3, 2002 PFT (DX 42) and Dr. Rasmussen's September 24, 2003 PFT (DX 59) as affirmative evidence under § 725.414(a)(2)(i). Dr. Forehand's March 27, 2001 PFT (DX 10) was provided for the Office of Workers' Compensation Programs as required under § 725.406(a).

[7] Where two values are indicated, the first represents the value before a bronchodilator was used and the second is the result after dilation.

Blood Gas Studies[8]

Ex. No.	Physician	Date of Study	Qualifying?	Altitude	Resting(R) Exercise(E)	PCO_2	PO_2	Comments
DX 11	Hippensteel	6/11/01	No	0-2999	R	45.8	65.9	Not noted
DX 42	Forehand	7/3/02	Yes No	0-2999	R E	41.0 45.0	60.0 65.0	Pt. was cooperative with good effort
DX 41	Castle	11/25/02	No	0-2999	R	41.3	66.2	ABGs normal
DX 68	Hippensteel	5/13/04	No	0-2999	R	41.6	64.0	Not noted

Physicians' Opinions[9]

1) Physician Opinion of Dr. Hippensteel

Dr. Hippensteel conducted a medical examination of Claimant on June 11, 2001, which included taking appropriate medical and social histories, performing a physical examination, and administering clinical tests. DX 12. His medical opinion is dated November 19, 2001. *Id.* at 1. Claimant reported 22 years of coal mine experience, taking off one year of work beginning in March 1989 because of breathing problems. *Id.* According to Claimant his last employment was as a beltman, a job he had for one year, which required him to lift 55-gallon oil barrels and rock dust bags, and engage in other heavy manual labor. *Id.* He had previous jobs as a roof bolter, a miner operator, and general inside laborer. *Id.* He has not worked since his last job with Employer. *Id.*

Claimant stated that he has had continuous problems breathing since 1984. *Id.* He reported being hospitalized two or three times since 1989, his last admission being in March 2000, and said he had multiple other emergency room visits because of breathing difficulties. *Id.* Claimant stated that he takes regular breathing medications with a nebulizer and inhalers. *Id.* He has been taking Prednisone since 1989, which has aggravated his cataracts for which he has had operations. *Id.* He takes Dilantin and Aciphex also. *Id.* Claimant had a heart attack in approximately 1992 and a stroke in October 1994, which has given him subsequent seizures. *Id.*

---

[8] Employer submitted Dr. Hippensteel's June 11, 2001 arterial blood gas study ("ABG") (DX 11) and Dr. Castle's November 25, 2002 ABG (DX 41) as affirmative evidence under § 725.414(a)(3)(i). Employer submitted Dr. Hippensteel's May 13, 2004 ABG (DX 68) as allowed in modification proceedings under § 725.310(b). Claimant submitted Dr. Forehand's July 3, 2002 PFT (DX 42) as affirmative evidence under § 725.414(a)(2)(i).

[9] Employer submitted Dr. Hippensteel's June 11, 2001 medical opinion (DX 12) and Dr. Castle's December 16, 2002 medical opinion (DX 41) as affirmative evidence under § 725.414(a)(3)(i). Employer submitted Dr. Hippensteel's May 13, 2004 medical opinion (DX 68) as allowed in modification proceedings under § 725.310(b). Claimant submitted Dr. Forehand's July 2, 2002 medical opinion (DX 42) and Dr. Smith's April 25, 2002 medical opinion (DX 42) as affirmative evidence under § 725.414(a)(2)(i). Claimant submitted Dr. Rasmussen's September 24, 2003 medical opinion (DX 59) as allowed in modification proceedings under § 725.310(b).

He has used oxygen at night and for most of the day for five years. *Id.* He stated that he gets occasional colds and rhinitis symptoms. *Id.* Claimant indicated that he can walk about one-half block on flat ground or maybe up one flight of stairs before having to stop and catch his breath. He noted that he coughs up a good deal of sputum each day. *Id.* at 2. He asserted that he has no history of asthma or tuberculosis. *Id.* Claimant reported smoking for about one year at age 20, but not since then. *Id.* His family medical history includes hypertension, heart disease, cancer, and strokes. *Id.*

On physical examination, Dr. Hippensteel measured Claimant at 70 inches and weighed him at 204 lbs. *Id.* at 2. He found no significant inflammation or polyps in Claimant's nose or throat. *Id.* Dr. Hippensteel found mild wheezes in Claimant's lungs bilaterally with no rales heard. *Id.* He found Claimant's heart rhythm to be regular with no distinct murmur. *Id.* Claimant walked with a distinct right hemiparetic gait, such that he was unable medically to perform a treadmill exercise. *Id.*

Dr. Hippensteel summarized the diagnostic testing that was done on Claimant. *Id.* Claimant's chest x-ray was suggestive of chronic bronchial inflammation with the classification of s/t, 0/1 in lung bases. *Id.* Dr. Hippensteel opined that the x-ray was not suggestive of pneumoconiosis. *Id.* Claimant's pulmonary function studies showed difficulty getting consistent efforts, but were suggestive of severe obstruction with only mild improvement after using a bronchodilator. *Id.* Dr. Hippensteel found his lung volumes to show air trapping with no restriction present. *Id.* Claimant's MVV result was invalid with grossly variable effort on this part of the pulmonary function test. *Id.* Dr. Hippensteel found Claimant's diffusion to reduce to 61% of the predicted value, but to be normal when corrected for volume inhaled for this part of the test. *Id.* Claimant's resting arterial blood gas studies showed a mildly reduced pO_2 with an elevated pCO_2 value, but a normal alveolar-arterial oxygen gradient. *Id.* Dr. Hippensteel found Claimant's resting electrocardiogram to show a sinus rhythm, but no significant abnormalities. *Id.* at 3.

Dr. Hippensteel gave a conclusion based on the examination and the clinical studies. *Id.* He stated that Claimant has chronic airways disease without evidence of emphysema or restrictive disease that has been treated with bronchodilators and prednisone, suggestive of asthma. *Id.* He found no evidence of pneumoconiosis. *Id.* Dr. Hippensteel noted that bronchodilators and prednisone are not useful for pneumoconiosis. *Id.* He indicated that Claimant does not have criteria compatible with industrial bronchitis, since at the time of examination, it had been more than 10 years since his last mine employment. *Id.* Dr. Hippensteel also ruled out emphysema because his diffusion was normal for the volume inhaled. *Id.* He opined that given Claimant's repeated hospitalizations, emergency room visits, and multiple medications, he suffers from asthma as the cause of his obstructive lung disease. *Id.* This obstructive impairment is enough to keep Claimant from returning to his previous job in the mines. *Id.* Dr. Hippensteel also opined that Claimant's lung problems are complicated by diabetes, hypertension, heart disease, stroke, nerve problems, seizure disorder and stomach pain which also keep him from returning to his prior mine employment. *Id.*

Dr. Hippensteel subsequently reviewed additional records. *Id.* Specifically, he reviewed Claimant's claim for benefits, dated February 2001, stating that he worked in the coal mines for 22 years until he stopped in 1989 because of his health. *Id.* Dr. Hippensteel also reviewed an interrogatory answered by Claimant dated April 20, 2001 detailing his coal mine employment and Dr. Forehand's March 27, 2001, medical opinion. *Id.* at 3-4.

Dr. Hippensteel stated that this additional documentation did not significantly change his conclusions. *Id.* at 4. He again opined that Claimant does not have radiographic evidence of pneumoconiosis. According to Dr. Hippensteel, Claimant's impairment is consistent with chronic obstructive airways disease but not compatible with coal dust exposure. *Id.* His reason for this conclusion was that coal dust exposure does not cause airways disease responsive to prednisone and bronchodilators beyond a problem with industrial bronchitis which should end after leaving coal mine employment for such a long period of time. *Id.* Dr. Hippensteel further reasoned that his findings regarding Claimant's condition are suggestive of impairment from asthma because of Claimant's recurrent episodes requiring hospital visits. *Id.* This lung disease, in addition to other multiple diseases Claimant possesses, is enough to prevent his return to working in the mines. *Id.* at 4-5. Dr. Hippensteel opined that even if pneumoconiosis were present in Claimant, which he does not believe it is, the pattern of impairment present is not typical for impairment caused by pneumoconiosis. *Id.* at 5. As a result, he concluded within a reasonable degree of medical certainty that Claimant does not have findings suggestive of legal pneumoconiosis. *Id.*

2) Physician Opinion of Dr. Smith

Dr. Smith gave a medical opinion dated April 25, 2002. DX 42. She noted that Claimant was under her care at the time for steroid dependent chronic obstructive pulmonary disease ("COPD"). *Id.* He had been recently hospitalized because of this disease. *Id.* He had significant incapacity from it and was oxygen dependent. *Id.* His peak flow was only 110, markedly reduced for his age and size, according to Dr. Smith. At the time, he was taking Advair Inhaler 550, 10 mg of Prednisone per day, Albuterol and Atrovent Inhalers, and Jet Aerosol treatments. *Id.* The purpose of Dr. Smith's letter was to "verify that his black lung is getting somewhat worse." *Id.* She opined that Claimant had a marked limitation and continued to be totally disabled.

3) Physician Opinion of Dr. Forehand

Dr. Forehand conducted a medical examination of Claimant on July 2, 2002. DX 42. His medical opinion is dated August 15, 2002. Dr. Forehand concluded that Claimant's symptoms arose from pneumoconiosis and chronic bronchitis from smoking cigarettes. *Id.* at 1.

Dr. Forehand based his diagnosis on four factors. First, he noted that Claimant had an employment history of working in underground coal mining for 22 years. *Id.* According to Dr. Forehand, 86% (19 years) of Claimant's work experience was as a roof bolter, the dustiest job in coal mining and the one most closely associated with pneumoconiosis because of the amount of hard rock (silica) inhaled during the bolting process. *Id.* Second, he found crackles during Claimant's chest examination. *Id.* Third, Dr. Forehand interpreted Claimant's chest x-ray as s/t,

1/0. *Id.* Last, he explained that Claimant had a pattern of respiratory impairment, specifically an obstructive ventilatory pattern. *Id.*

Dr. Forehand indicated that Claimant's chest x-ray revealed opacities at the bases. *Id.* at 2. He noted that while the majority of coal miners with pneumoconiosis show rounded opacities in the upper lung zones, 20%, like Claimant, show irregular opacities at the bases. *Id.* He stated that although pneumoconiosis can impair the lungs by restricting ventilation, smoking coal miners with pneumoconiosis, like Claimant, have an obstructive rather than restrictive ventilatory pattern. *Id.*

Dr. Forehand indicated that although Claimant smoked cigarettes for 16 years, enough time to impair lung function, this smoking history does not explain his severe respiratory impairment. *Id.* Claimant lost 58% (1,770 cc's) of his measurable lung function. *Id.* Dr. Forehand explained that smokers lose 60-80 cc's of lung function for each year of smoking, while Claimant lost 110 cc's of lung function for each year he smoked. *Id.* He noted that the reason for the difference between the expected loss and Claimant's measured loss of lung function is the existence of pneumoconiosis. *Id.* at 3. He opined that Claimant would not be as disabled from smoking cigarettes if he did not have pneumoconiosis. *Id.*

Dr. Forehand concluded that Claimant has a totally and permanently disabling respiratory impairment, which arose from a combination of inhaling cigarette smoke for 16 years and coal and rock dust for 22 years. *Id.* He also stated that Claimant does not have the respiratory capacity to return to his last coal mining employment without aggravating his condition. *Id.*

4) Physician Opinion of Dr. Castle

Dr. Castle conducted a medical examination of Claimant, dated November 25, 2002, which included taking appropriate medical and social histories, performing a physical examination, and administering clinical tests. DX 41. He noted at the time that Claimant was a 64-year-old Caucasian male who complained of shortness of breath since about 1984. *Id.*

Claimant indicated that he can walk about 50 feet on level ground or maybe up one flight of stairs before having to stop and catch his breath. *Id.* Claimant walks with a cane due to a past stroke and numbness in his right upper and lower extremities. *Id.* The stroke also caused him leg numbness. *Id.* at 2. He stated that he also had swelling of the feet and slept in a recliner at night. He reported wheezing since the 1980s, which is worsening, and that his cough produces white sputum most days. *Id.* at 1. Claimant has used oxygen at night for five years. *Id.* He had a heart attack in 1992 and is bothered by chest pain that comes on when he is wheezing or exercising. Claimant denied any history of asthma, pneumonia or tuberculosis. *Id.* He also has a past medical history of medical infarction, diabetes, atherosclerosis, and arthritis. *Id.* at 2. He stated that he only smoked a small amount between the age of 20 and 21, but has not smoked any significant amount since. *Id.* at 1-2. He was taking the following medications at the time of examination: Accupril, Theophylline, Vioxx, Cartia XT, Neurontin, Avandia, Alprazolam, Dilantin, Hydrocodone, Prednisone, Atrovent, a nebulizer, and Albuterol. *Id.*

Dr. Castle took Claimant's occupational history. *Id.* Claimant reported working in the mines for 22 years, having last worked in 1989. *Id.* He stopped working in the mines because of breathing problems. *Id.* He stated that during his last year of employment, he worked on the belt head, requiring him to shovel spills, carry oil and rock dust, and perform some other heavy labor. *Id.* Prior to that, he was a roof bolter. *Id.* He also operated a continuous miner, which was quite dusty, with some heavy labor involved as well. *Id.*

On physical examination, Dr. Castle measured Claimant at 70 inches and weighed him at 200 lbs. *Id.* A chest examination revealed normal AP diameter. *Id.* He had no intercostal retractions and did not use the accessory muscles with quiet breathing. *Id.* Claimant had bilateral exploratory wheezes heard throughout both lungs posteriorly and laterally. *Id.* Dr. Castle heard no rales, rhonchi, crackles or crepitations. *Id.* A cardiac exam revealed the PMI to be diffuse, with no murmurs or gallops present. *Id.* The abdominal exam revealed Claimant to be obese without organomegaly, masses, tenderness, or bruits. *Id.* His extremities revealed no cyanosis, clubbing, or edema. *Id.*

Dr. Castle performed a chest x-ray on Claimant; the x-ray film is dated November 25, 2002. *Id.* at 3. He found a few t/s type opacities in both lower zones with a profusion of 0/1. There were also old right rib fractures and calcified granulomas. *Id.* Dr. Castle opined that there were no changes consistent with pneumoconiosis. *Id.*

Dr. Castle also conducted pulmonary function tests. *Id.* He opined that the spirometry was not technically valid because of variable effort and obstruction of the mouthpiece. *Id.* Dr. Castle felt that this did not represent Claimant's maximal physiologic effort. *Id.* The studies showed some degree of airway obstruction. *Id.* Dr. Castle performed a resting arterial blood gas study. *Id.* The pH was 41.3, the pCO2 was 41.3 mm Hg, and the pO_2 was 66.2 mm Hg. *Id.* The carboxyhemoglobin level was minimally elevated at 1.8%. *Id.* Dr. Castle performed an electrocardiogram as well. *Id.*

At the time of evaluation, Claimant gave Dr. Castle a letter from Dr. Krishnan, dated August 14, 2002, indicating that Claimant suffered from diabetic peripheral neuropathy of the legs and feet, hypertension, and coronary artery disease. *Id.* The letter also noted that Claimant had a seizure disorder and a history of cerebrovascular accident as well as anxiety. *Id.* Dr. Krishnan noted that these conditions were in addition to Claimant's history of pneumoconiosis and COPD. *Id.* Claimant also gave Dr. Castle a letter from Dr. Smith, dated August 6, 2002, indicating that Claimant was too disabled from his lung disease to undergo further tests. *Id.* Dr. Castle stated that Claimant indicated he could not undergo an exercise test. *Id.*

Dr. Castle then gave a conclusion based on the data available to him at the time of his examination. *Id.* He opined that there was no evidence of pneumoconiosis by physical examination, radiographic evaluation, or arterial blood gases. *Id.* He found that Claimant had chronic airway obstruction and cerebrovascular disease, status post-cerebrovascular accident. *Id.* Dr. Castle noted that the spirometry was invalid. *Id.* He also opined that Claimant suffered from post CVA seizure disorder, coronary artery disease, non-insulin dependent diabetes mellitus, arthritis and probable angina pectoris and diabetic neuropathy. *Id.* at 4. He noted that the data used in making this diagnosis was based on the history and physical examination as stated by

Claimant and dictated in Claimant's presence. *Id.*

Dr. Castle subsequently reviewed additional medical data, including medical histories, physical examinations, radiographic evaluations, physiologic testing, and arterial blood gases, as well as the data obtained at the time of his evaluation. *Id.* After this review, he again concluded within a reasonable degree of medical certainty that Claimant does not suffer from pneumoconiosis. *Id.* at 19. Dr. Castle acknowledged that Claimant worked in or around the underground mining industry for sufficient time to have developed pneumoconiosis if he were a susceptible host, having worked for 22 years as a coal miner. *Id.*

Dr. Castle listed other risk factors for Claimant developing his existing pulmonary symptoms. *Id.* First, he listed tobacco use as a risk factor, noting that while Claimant indicated to him that he did not have a lengthy smoking history, Dr. Forehand noted a smoking history of 16 years. *Id.* If true, Dr. Castle stated that this could have contributed to Claimant's airway obstruction. *Id.*

Next, Dr. Castle noted that another risk factor for Claimant's pulmonary disease is his bronchial asthma. *Id.* Dr. Castle asserted that Claimant's hospital records from 1988 and 1989 indicate that he had a history of bronchial asthma for at least 25 years. *Id.* Two hospitalizations appeared to note that Claimant had status asthmaticus and responded appropriately to therapy for that process. *Id.* Dr. Castle also determined that Claimant demonstrated a significantly reversible degree of airway obstruction, without restriction or diffusion abnormality. *Id.* According to Dr. Castle, Claimant told him that he was diagnosed with bronchial asthma. *Id.* Claimant stated that his symptoms and wheezing were made worse by exposure to bleach, cooking odors and cold air, all consistent with bronchial asthma. *Id.* This condition, untreated, results in fixed airway obstruction. *Id.*

The last risk factor for the development of Claimant's pulmonary symptoms, according to Dr. Castle, is cardiovascular disease. *Id.* He explained that Claimant has documented coronary artery disease and apparently has been treated for congestive heart failure. *Id.* These conditions also can result in significant shortness of breath as well as pulmonary function abnormalities. *Id.*

Dr. Castle stated that in his opinion and the opinion of a number of radiologists and B-readers, there is no evidence of pneumoconiosis radiographically. *Id.* at 20. Some radiologists and B-readers felt that minimal changes of pneumoconiosis were present, but the changes were irregular opacities in the lower lung zones, not typical or indicative of pneumoconiosis. *Id.* Dr. Castle explained that changes due to pneumoconiosis are primarily small, round, regular opacities occurring in the upper lung zones, which were not found in this case. *Id.*

Dr. Castle determined that Claimant's pulmonary function tests, when valid, showed some degree, mild or moderate, of airway obstruction with a significant degree of reversibility. *Id.* He explained that this is typical of intermittent airway obstruction associated with bronchial asthma, not pneumoconiosis. *Id.* According to him, patients with pneumoconiosis have airway obstruction that is irreversible because of the nature of the disease process. *Id.* Those were not his findings here. *Id.*

Dr. Castle stated that most of the arterial blood gas studies that were done were normal and Claimant had a normal response to exercise. *Id.* He did note that on some occasions, when Claimant had exacerbations of his asthma, especially those times with status asthmaticus, he had significant abnormality of his blood gases. *Id.* With treatment, however, they returned to normal, a finding not associated with pneumoconiosis. *Id.*

Dr. Castle noted that Claimant is permanently and totally disabled as a result of his bronchial asthma, not any coal mine dust induced lung disease. *Id.* He determined that Claimant is also disabled as a whole because of a previous cerebrovascular accident, cerebrovascular disease, coronary artery disease, peripheral neuropathy, diabetes, and seizure disorder, all unrelated to coal mining employment and coal dust exposure. *Id.* Dr. Castle opined that even if the radiographic evidence indicates simple pneumoconiosis, he is not impaired or disabled because of pneumoconiosis because he has not had had physiologic changes to indicate disability due to pneumoconiosis. *Id.*

5) Physician Opinion of Dr. Rasmussen

Dr. Rasmussen conducted a medical examination of Claimant on September 24, 2003, which included taking appropriate medical and social histories, performing a physical examination, and administering clinical tests. DX 59. Dr. Rasmussen noted that Claimant was 64 years old at the time of the examination. *Id.* Claimant reported having shortness of breath with exertion for 18 to 20 years. *Id.* He stated that climbing one flight of stairs causes him breathing problems. Claimant described a chronic, minimally productive cough and wheezing that increased with exertion. *Id.* He denied having ankle swelling, hemoptysis, chest pain, other known cardiovascular illnesses, or prior respiratory illness. *Id.* Claimant noted that he had systemic hypertension for which he took medication. *Id.*

Dr. Rasmussen took a patient's medical history. Claimant reported no previous significant illnesses, injuries, or allergies, but did have bilateral cataract surgery. *Id.* His weight was stable. Claimant explained that he had diabetes mellitus two years prior to the examination. *Id.* He stated that he began smoking two cigarettes regularly at age 52 in 1990. *Id.* He asserted that he did not drink alcohol. *Id.* At the time, Claimant was taking Brethene, Proventil, Atrovent, Vanceril, Singulair, Prednisone, and was using Oxygen. *Id.* at 2. His father had heart disease. *Id.*

Dr. Rasmussen reported Claimant's occupational history. *Id.* He stated that Claimant had many jobs, including working in saw mills and cutting timber. *Id.* In addition, Claimant worked in the coal mining industry for a total of 22 years. *Id.* He worked as a hand loader, cutting machine operator, general inside laborer, roof bolter and other face work, as well as working on the belt. *Id.* His last job was that of belt head operator, in which he had to shovel to clean up spills, carry rock dust bags between 100 and 200 feet, and remove timber and rock from the belt. *Id.* This job involved considerable heavy manual labor. *Id.*

On physical examination, Dr. Rasmussen measured Claimant at 69 inches and weighed him at 205 lbs. *Id.* He reported hearing no bruits and found no adenopathy or thyroid enlargement. *Id.* Dr. Rasmussen found Claimant's chest expansion diminished and his breath

sounds markedly reduced. *Id.* He noted that inspiratory and expiratory wheezes and expiratory rhonchi were present. *Id.* Also, there was a prolonged expiratory phase with forced respirations. *Id.* Dr. Rasmussen indicted that Claimant's heart tones were normal, with no murmurs, gallops, or clicks. *Id.*

Dr. Rasmussen summarized the diagnostic testing that was done on Claimant. *Id.* He did not perform his own chest x-ray interpretation, but noted that Dr. Patel, a board-certified radiologist and B-reader, rendered an interpretation of pneumoconiosis s/s with a profusion of 1/1 throughout all lung zones. *Id.* Dr. Rasmussen explained that an electrocardiogram of Claimant was within normal limits. *Id.* He indicated that Claimant's ventilatory function studies revealed moderately severe, irreversible obstructive ventilatory impairment. *Id.* Claimant's breathing capacity was markedly reduced, but improved significantly after bronchodilator therapy. *Id.* Claimant's total lung capacity was normal, his residual volume was moderately increased, and his single breath carbon monoxide diffusing capacity was moderately reduced. *Id.*

Claimant also underwent an incremental treadmill exercise study, beginning at 1.8 miles per hour at 0% grade, and increased 2% per minute. *Id.* at 3. Claimant exercised for only 6 minutes and reached a maximum of 1.8 miles per hour at a 6% grade. *Id.* His oxygen uptake was 11.5 cc/kg/min., 44% of his predicated maximum oxygen uptake. *Id.* Claimant denied having chest pain. His EKG and blood pressure responses were normal. *Id.* He exceeded his anaerobic threshold slightly at 39% of his predicted maximum oxygen uptake. *Id.* Claimant's volume of ventilation was markedly increased and he retained a breathing reserve of only 27 liters. *Id.* He suffered minimal impairment in oxygen transfer. *Id.*

Dr. Rasmussen concluded that Claimant had moderately severe loss of his lung function, such that he did not retain sufficient pulmonary capacity to perform his last regular coal mine job. *Id.* He also explained that Claimant had a significant history of exposure to coal mine dust. Dr. Rasmussen further noted that the changes in the x-ray of Claimant's lungs were consistent with pneumoconiosis and that it was medically reasonable to conclude that the pneumoconiosis arose from coal mine employment. *Id.* He continued that the two risk factors for Claimant's impaired function were cigarette smoking and coal dust exposure, both contributing to his condition. *Id.* Dr. Rasmussen opined that both factors cause lung tissue and airway damage, sometimes sharing the same cellular and biochemical mechanisms. *Id.* He noted that epidemiological studies and mortality studies show that coal miners suffer from and die excessively from chronic obstructive lung disease. *Id.* Finally, Dr. Rasmussen opined that to a reasonable degree of medical certainty, Claimant's coal mine dust exposure is a major contributing factor to his disabling lung disease. *Id.* at 4.

6) Physician Opinion of Dr. Hippensteel

Dr. Hippensteel conducted a second medical examination of Claimant on May 13, 2004, which included taking appropriate medical and social histories, performing a physical examination, and administering clinical tests. DX 68. His medical opinion is dated May 27, 2004. *Id.* He noted at the time that Claimant was a 65-year-old Caucasian male who reported 22 years of coal mine experience, last working in March 1989 after hospitalization for breathing problems. *Id.* at 1. According to him, Claimant was last employed as a beltman, a job he had for

1 ½ years, which required him to lift 55-gallon oil barrels and rock dust bags, and perform other heavy manual labor. *Id.* He had previous jobs as a pinner and a miner operator. *Id.* Claimant thought he was a roof bolter for about 10 years. *Id.*

Claimant claimed that he has had continued problems breathing since the 1980s. Claimant indicated that he can walk very little and has to stop and catch his breath after walking 50 to 75 feet on a flat surface. *Id.* He asserted that he has no history of asthma, allergies, sinus trouble, tuberculosis, pneumonia or bird exposure. *Id.* at 1-2. Claimant said he gets about one upper respiratory infection per year. *Id.* at 1. He reported being hospitalized multiple times because of breathing symptoms, the last time in July 2003 for about 17 days. *Id.* at 2.

Claimant stated that his breathing is bothered most by hot, humid weather and cold weather. *Id.* He indicated that he sleeps in a recliner so that he can get his breath. *Id.* Claimant stated that he has used a nebulizer four times per day for the last five to six years as of the time of the examination, takes periodic antibiotics, and has been on prednisone since 1989. *Id.* He takes medication for heartburn while on prednisone. *Id.* He has used oxygen at night since 1995 because of gradually worsening breathing problems. *Id.*

Claimant has taken medication for high blood pressure and diabetes for two years prior to the examination and a "nerve pill" fours time per day. *Id.* He also reported taking a narcotic pain pill once a day as needed for his arthritis. *Id.* He stated that he had a heart attack in 1992, but now has no chest pain. *Id.* Claimant had a seizure in 1994 and was put on Dilantin for that reason with no seizure since then. *Id.*

Claimant indicated that he had a smoking history of two to three cigarettes per week while working in the mines, but none since being put on oxygen in 1995. *Id.* He used to drink alcohol, but quit in 1980. *Id.* Claimant's family history is positive for diabetes and hypertension. *Id.* At the time of examination, he was seeing Dr. Krishnan and Dr. Smith. *Id.*

On physical examination, Dr. Hippensteel measured Claimant at 70 inches and weighed him at 208 lbs. *Id.* He found no significant inflammation in Claimant's nose or throat. *Id.* Dr. Hippensteel found mild wheezes in Claimant's lungs bilaterally with no audible rales. *Id.* He found that Claimant's breathing was mildly labored at rest. *Id.* He found Claimant's heart rhythm to be regular with an S4 gallop and an audible murmur. Claimant's abdomen had no organomegaly or tenderness. *Id.* Because Claimant was on oxygen, Dr. Hippensteel could not do an exercise test. *Id.*

Dr. Hippensteel summarized the diagnostic testing that was done on Claimant. *Id.* Dr. Hippensteel opined that Claimant's chest x-ray was negative for pneumoconiosis with a classification of 0/0. *Id.* He found evidence of hyperinflation in both upper lobes which compresses lung markings in Claimant's base. *Id.* Dr. Hippensteel found arteriosclerosis of the aorta and a calcified right hilar lymph node. *Id.*

Claimant's pulmonary function studies showed severe airflow obstruction with no significant improvement post-bronchodilator. *Id.* at 3. Dr. Hippensteel found Claimant's MVV value severely reduced with small tidal volumes. *Id.* Claimant's lung volumes showed no

restriction, but had significant air trapping. *Id.*

Claimant's resting arterial blood gas studies suggested mild hypoxemia but a normal alveolar/arterial oxygen gradient given Claimant's age. *Id.* Dr. Hippensteel measured Claimant's barometric pressure equal to 716 and his carboxyhemoglobin level in normal range at 0.8%. *Id.* Claimant's resting electrocardiogram was normal. *Id.*

Dr. Hippensteel reviewed additional medical records, including previous medical reports and examinations, as well as chest x-ray interpretations. *Id.* According to him, the data obtained in his examination and a review of the additional records show that Claimant has severe enough lung impairment to be unable to return to his previous job in the mines. *Id.* Dr. Hippensteel determined that the etiology of this impairment is severe obstructive lung disease, which developed over the years due to asthma and more cigarette smoking than Claimant admitted to. *Id.*

He also stated that Claimant's use of allergy medications is in keeping with a diagnosis of asthma, even though Claimant denied such a history. *Id.* Dr. Hippensteel explained that Claimant was diagnosed with asthma in the past by physicians, as well as in Claimant's response to bronchodilators in pulmonary function tests. *Id.* He asserted that Claimant's fixed obstruction is a natural progression of asthma which becomes less reversible because of the remodeling of airways referable to this disease. *Id.* Dr. Hippensteel noted that asthma is not associated with or aggravated by coal mine dust exposure, nor does coal mine dust cause occupational asthma. *Id.* He continued that although Claimant has had some chest x-ray abnormalities, they have not been suggestive of pneumoconiosis as a cause for these abnormalities. *Id.*

In addition, Claimant does not have significant gas exchange impairment from any cause. *Id.* at 6. Dr. Hippensteel concluded within a reasonable degree of medical certainty that Claimant's progressive obstructive impairment is related to his history of asthma with chronic bronchitis, not pneumoconiosis. *Id.* As such, according to him, there is insufficient evidence to make a diagnosis of pneumoconiosis. *Id.* Claimant has additional medical problems, also unrelated to coal dust exposure, that impair him and keep Claimant from going back to the mines. *Id.* Dr. Hippensteel opined that the evidence shows that, with a reasonable degree of medical certainty, Claimant would have been just as ill from the same problems from a pulmonary standpoint "had he never stepped foot in the coal mines." *Id.*

<u>Deposition Testimony</u>

1) Deposition of Dr. Hippensteel

Dr. Hippensteel gave a deposition on January 20, 2003. DX 41. He reviewed his medical qualifications. *Id.* at 4. He stated that he was board certified in pulmonary diseases and internal medicine in 1978 and that a vast majority of his work is as a pulmonologist. *Id.* In order to become board certified in pulmonary medicine, Dr. Hippensteel took two years of fellowship training in the specific subspecialty of pulmonary diseases, which involved training in reading x-rays, in specific diseases that affect the lungs, such as pneumoconiosis, and in pathology. *Id.* at 5. He also noted that he is a certified B-reader. *Id.* at 7.

Dr. Hippensteel stated that he examined Claimant on June 11, 2001. *Id.* at 8. He explained that although Claimant denied any history of allergies or asthma, he was taking prednisone, a medication used commonly in people that have reactive airways disease or asthma. *Id.* at 10. Dr. Hippensteel noted that Claimant told him that he worked in the mines for 19 years, then later stated that he had 22 years of coal mine employment. *Id.* at 12. He explained that this is a sufficient period of time for a susceptible individual to get pneumoconiosis, but that a minority of workers with that length of exposure would get the disease. *Id.* at 12, 13.

Dr. Hippensteel discussed his chest x-ray interpretation of Claimant, noting that the film was classified as s/t, 0/1 in the lung bases. *Id.* at 13. He opined that this reading was suggestive of chronic basilar bronchial inflammation, but not pneumoconiosis. *Id.* Dr. Hippensteel further explained that pneumoconiosis does not cause s and t type opacities. *Id.* at 14. Instead, chronic bronchitis generally causes that type of abnormality. *Id.*

Dr. Hippensteel gave an opinion as to Claimant's degree of disability. *Id.* at 20. He stated that Claimant could not return to his last coal mining job due to the heavy manual labor without medications. *Id.* However, if he was rigorously treated for his asthma, he might be more of borderline case. *Id.* Dr. Hippensteel continued that Claimant has other medical problems unrelated to coal mine dust exposure or pulmonary status that would keep him from working or exercising, including a past stroke, diabetes, hypertension, heart disease, nerve problems, seizure disorder, and stomach pain. *Id.* at 21.

He also noted that Claimant's asthma is not related to coal dust exposure. *Id.* He also stated that Claimant does not have any respiratory impairment that has been caused by, contributed to, or aggravated by coal mine dust exposure. *Id.* at 22. Dr. Hippensteel opined that Claimant has neither medical nor legal pneumoconiosis. *Id.* at 23.

On cross-examination, Dr. Hippensteel discussed Claimant's smoking history. *Id.* at 27. He stated that the effects of smoking normally manifest themselves at the time the individual is smoking, but that they can worsen even after quitting. *Id.* Dr. Hippensteel agreed that from information provided by Claimant, as well as other medical reports, it appeared that Claimant had a 16 year smoking history, quitting in 1970. *Id.* at 28. He also agreed that there is no record of Claimant smoking in the 1980s or 1990s. *Id.* at 29. Dr. Hippensteel conducted a carboxyhemoglobin test that showed that Claimant did not smoke at the time of the examination. *Id.* at 30. He stated that the Claimant's lung obstruction is a result of his asthma, not his smoking. *Id.* at 32.

On redirect examination, Dr. Hippensteel discussed asthmatic conditions and industrial bronchitis. *Id.* at 35, 36. He explained that bronchodilators give no greater than 15 percent improvement of pulmonary function when an individual has industrial bronchitis. *Id.* at 36. He continued that Claimant's pulmonary improvement was at times over 15 percent, up to 24 percent in fact, indicative of asthmatic responses rather than industrial bronchitis or chronic bronchitis attributable to smoking. *Id.* Dr. Hippensteel noted that, to his knowledge, no physician diagnosed Claimant with industrial bronchitis at any time. *Id.*

2) Deposition of Dr. Castle

Dr. Castle gave a deposition on January 28, 2003. DX 41. He reviewed his medical qualifications. *Id.* at 4. He stated that he was board certified in internal medicine and in the subspecialty of pulmonary diseases. Dr. Castle also noted that he has been a certified B-reader since 1985. *Id.* at 4, 5. He is not a radiologist. *Id.* at 5.

Dr. Castle stated that he examined Claimant on November 25, 2002. *Id.* at 9. At the time, Claimant was 64 years old. *Id.* at 10. He performed a physical examination. *Id.* at 13. In conducting a chest x-ray, Dr. Castle found a few t and s type opacities in both lower lung zones with a profusion of 0/1, insufficient for a finding of pneumoconiosis. *Id.* at 14. Dr. Castle continued that the opacities also were not the type normally associated with pneumoconiosis because of their location. *Id.*

He performed a pulmonary function test, which he claimed was invalid because of less than maximal effort and partial obstruction of the mouthpiece. *Id.* at 15. Because of the diffusing capacity, Dr. Castle concluded that, based on the valid part of the testing, there was no restriction and there was some degree of airway obstruction. *Id.* He continued that because of the diffusion capacity, he concluded Claimant did not suffer from emphysema. *Id.* Dr. Castle noted that some of the Claimant's past pulmonary function tests were invalid because of less than maximal effort. *Id.* at 16.

Dr. Castle also did a resting arterial blood gas study, but not an exercise test. *Id.* at 19. He found that Claimant's resting study was normal. *Id.* In reviewing Claimant's past arterial blood gas studies, Dr. Castle found them to be normal. *Id.* at 20, 21.

Dr. Castle then concluded that Claimant was disabled from returning to his usual coal mine employment. *Id.* at 21. The cause of his disability, according to Dr. Castle, was bronchial asthma. *Id.* He opined that there was no relationship between pneumoconiosis and coal dust exposure with asthma. *Id.* at 22. He stated that there are occupational causes of asthma, but that coal mine dust exposure was not one of them. *Id.* Dr. Castle also concluded that Claimant does not have pneumoconiosis. *Id.* at 23. He based his conclusion on Claimant's coal mining employment history, his conditions over the years, the physical examination, radiographic evaluation, physiologic testing, and arterial blood gas studies. *Id.* Dr. Castle stated that the only indication that Claimant is a candidate for pneumoconiosis is his employment history. *Id.*

On cross-examination, Dr. Castle explained that coal dust can trigger an asthmatic attack. *Id.* at 27. According to him, coal dust does not cause asthma, nor does it aggravate or worsen asthma. *Id.* He opined that there is no evidence that Claimant's work in the coal industry precipitated his asthma. *Id.* at 28. Dr. Castle stated that the lack of treatment of asthma causes it to become worse because of increased inflammation. *Id.* at 28, 29.

3) Deposition of Dr. Hippensteel

Dr. Hippensteel gave a second deposition on April 26, 2005. EX 19.[10] He stated that he

[10] I have not summarized pages 1 through 8 of Dr. Hippensteel's April 26, 2005 deposition because the testimony is

last examined Claimant on May 13, 2004. *Id.* at 9. He again discussed Claimant's smoking history. *Id.* at 11. According to Dr. Hippensteel, Claimant stated that he only smoked two to three cigarettes per week while he was working in the mines and not at all since being put on oxygen in 1995. *Id.* He stated that this smoking history was inconsistent with what Claimant told other physicians. *Id.* at 12. Dr. Hippensteel mentioned that Claimant told Dr. Forehand that he smoked for 16 years and told Dr. Rasmussen that he smoked from age 20 until September 2003. *Id.*

Dr. Hippensteel interpreted a chest x-ray during his physical examination, which he found negative for pneumoconiosis with a classification of 0/0. *Id.* at 13. He found hyperinflation in the upper lobes that compressed the lung markings in Claimant's bases, which he stated can often be mistaken for pneumoconiosis. *Id.* Dr. Hippensteel explained that radiographically, pneumoconiosis begins in the upper lobes, so that increased markings in the lower lobes are not typically pneumoconiosis. *Id.* at 14.

Dr. Hippensteel was able to obtain valid spirometry from Claimant. *Id.* He found that Claimant had severe air flow obstruction with no significant improvement post-bronchodilator. *Id.* Dr. Hippensteel noted that although there was no reversibility, asthma is still a possibility. *Id.* at 16. He explained that there is variability regarding acute reversibility with treatment of bronchodilators and that asthma becomes less reversible over time due to airway remodeling due to chronic inflammation. *Id.* Airway remodeling makes airways less responsive to bronchodilators. *Id.* He further stated that diffusion capacity problems are not necessarily associated with asthma. *Id.*

Dr. Hippensteel also conducted a resting blood gas study on Claimant. *Id.* He found Claimant's pO_2 to be mildly reduced, but his alveolar arterial oxygen gradient to be normal. *Id.* No exercise study was conducted. *Id.*

Dr. Hippensteel discussed Claimant's smoking history and stated that Claimant had asthma. *Id.* at 19. He noted that Claimant had inspiratory and expiratory wheezes, common in asthma. *Id.* Dr. Hippensteel stated that his impairment could be due to asthma making Claimant less resistant to the adverse effects of cigarette smoking and coal mine dust exposure. *Id.* He found that because Claimant stopped working in 1989, but smoked until 2003, any aggravation is due to smoking, not coal mine dust exposure. *Id.* Dr. Hippensteel opined that asthma plays the largest role in Claimant's impairment, but smoking also contributes. *Id.* at 20. He stated that there is no connection between coal mining and asthma. *Id.*

Dr. Hippensteel testified as to Claimant's level of impairment. *Id.* at 21. He determined that Claimant has enough lung impairment such that he is unable to return to his previous mine employment. *Id.* He noted that Claimant also has chronic bronchitis, not due to coal mine dust exposure, but as a result of his asthma. *Id.* The chronic bronchitis has disabled Claimant. *Id.*

Dr. Hippensteel concluded that Claimant has neither legal nor clinical pneumoconiosis. *Id.* at 22. He explained that legal pneumoconiosis is any lung disease caused by, contributed to,

---

identical, *verbatim*, to his testimony in his January 20, 2003, deposition, submitted as DX 41, which is summarized above.

or significantly aggravated by coal mine dust exposure. *Id.* He stated that he holds these opinions within a reasonable degree of medical certainty. *Id.*

On cross-examination, Dr. Hippensteel stated that dust can trigger asthmatic attacks in some people. *Id.* at 26. He continued that there is no evidence that coal mine dust exposure was a contributing factor to Claimant's asthma. *Id.* at 28. Dr. Hippensteel stated that there is no evidence that Claimant missed work due to exposure to coal dust. *Id.* at 29. He admitted that asthmatic attacks can start out being mild. *Id.* He stated that chronic bronchitis is related to continued exposure. *Id.* at 32. Because Claimant's coal mine employment ended in 1989, Dr. Hippensteel opined that it is not likely to have subsequently affected his bronchitis. *Id.* at 31.

DISCUSSION AND CONCLUSIONS OF LAW

Under § 725.202(d), to be eligible for benefits, Claimant must show, by a preponderance of the evidence, that he is a coal miner, has pneumoconiosis that arose out of coal mine employment, is totally disabled, and that the pneumoconiosis contributed to the total disability. § 725.202(d). I find, for the reasons set forth below, that Claimant has now established that he is totally disabled, and he has thus shown that at least one of the conditions of entitlement upon which the prior claim was denied has now changed.[11]

Total Disability

Under § 725.202(d)(2)(iii), Claimant must establish that he is "totally disabled" to be eligible for benefits. Section 718.204(b) defines "total disability" as follows:

> A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:
>
> (i) From performing his or her usual coal mine work; and
>
> (ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time.

All of the valid pulmonary function tests support a finding of total disability. The values measured by the physicians establish total disability as set forth in § 718.204(b)(2)(i) and Appendix B to Part 718. Dr. Hippensteel noted that the MVV value of the pulmonary test he administered on June 11, 2001 was invalid because of grossly variable effort. DX 11. Dr. Castle noted that the pulmonary test he gave was not technically valid because of variable effort and obstruction of the mouthpiece. DX 41. Nonetheless, the other values for the pulmonary tests administered by the physicians establish total disability as set forth in § 718.204(b)(2)(i) and Appendix B to Part 718. DX 10; DX 42; DX 59; DX 68.

[11] Since my finding regarding total disability requires that all previously submitted evidence be considered in determining whether Claimant is now entitled to benefits, my discussion and findings regarding pneumoconiosis arising out of coal mine employment are discussed below and are based on a review of the entire evidentiary record.

The blood gas tests do not establish total disability as a whole. The values measured by the physicians in three of the four blood gas studies do not establish total disability as set forth in § 718.204(b)(2)(ii) and Appendix C to Part 718. DX 11; DX 41; DX 68. Only one of the values, for a test administered by Dr. Forehand on July 3, 2002, supports total disability. DX 42.

The medical opinions in the record support a finding of total disability as set forth in § 718.204(b)(2)(iv). Dr. Hippensteel, one of Employer's experts, opined that Claimant's lung disease is sufficiently severe to prevent his return to working in the mines. DX 12 at 4-5; DX 68 at 3. Dr. Smith, a treating physician, similarly noted, albeit in a conclusory fashion, that he is totally disabled. DX 11. Dr. Forehand also found that Claimant has a totally and permanently disabling respiratory impairment. DX 42 at 3. Dr. Castle, like Dr. Hippensteel, concluded that Claimant is permanently and totally disabled as a result of respiratory impairment. DX 41 at 20. Dr. Rasmussen also concluded that Claimant did not retain sufficient pulmonary capacity to perform his last regular coal mine employment. DX 59 at 3.

The newly submitted medical evidence viewed in its entirety supports a finding that Claimant is totally disabled. I thus find that Claimant has established total disability under § 725.202(d)(2)(iii).

Evidence from Prior Claims

As noted above, a subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied has changed and is now present. §§ 725.309(d)(2), (3). Because one of the applicable conditions of entitlement, total disability, has changed since Judge Roketenetz's decision and order denying benefits, dated August 27, 1999, under § 725.309(d)(4), I must consider all relevant admissible evidence submitted in Claimant's prior claims. This evidence is catalogued below.

1. Chest X-Ray Evidence

Ex. No.	**Physician**	**B-Reader /BCR**	**Date of X-Ray**	**Film Quality**	**Reading**
DX 1	Mathur	B-Reader/BCR	12/28/89	1	1/1; p/s
DX 1	Ahmed	B-Reader/BCR	12/28/89	1	1/0; p/p
DX 1	Cappiello	B-Reader/BCR	12/28/89	1	1/1; p/q
DX 1	Pathak	B-Reader	12/28/89	1	1/0; p/p
DX 1	Fisher	B-Reader/BCR	12/28/89	1	2/2; p/t
DX 1	Ranavaya	B-Reader/BCR	12/28/89	1	1/0; s/t
DX 1	Robinette	B-Reader/BCR	12/28/89	1	1/0; q /t
DX 1	Speiden	B-Reader/BCR	12/28/89	1	1/0; t/p
DX 1	Fino	B-Reader/BCR	12/28/89	1	No CWP
DX 1	Templeton	B-Reader/BCR	12/28/89	1	No CWP
DX 1	Spitz	B-Reader/BCR	12/28/89	1	No CWP
DX 1	Shipley	B-Reader/BCR	12/28/89	1	No CWP
DX 1	Wiot	B-Reader/BCR	12/28/89	1	No CWP
DX 1	Wheeler	B-Reader/BCR	12/28/89	1	No CWP

DX 1	Scott	B-Reader/BCR	12/28/89	2	No CWP
DX 1	Abramowitz	B-Reader/BCR	1/18/90	1	No CWP
DX 1	Gogineni	B-Reader/BCR	1/18/90	1	No CWP
DX 1	Wershba	BCR	1/18/90	1	No CWP
DX 1	Binns	B-Reader/BCR	1/18/90	1	No CWP
DX 1	Abernathy		1/18/90	1	0/1; s/t
DX 1	Greene	B-Reader/BCR	1/18/90	1	No CWP
DX 1	Duncan	B-Reader/BCR	1/18/90	1	No CWP
DX 1	Fino	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Castle	B-Reader	7/12/90	1	0/1; s/s
DX 1	Scott	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Spitz	B-Reader/BCR	7/12/90	2	No CWP
DX 1	Shipley	B-Reader/BCR	7/12/90	2	No CWP
DX 1	Wiot	B-Reader/BCR	7/12/90	2	No CWP
DX 1	Wheeler	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Abramowitz	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Gogineni	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Wershba	BCR	7/12/90	1	No CWP
DX 1	Binns	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Duncan	B-Reader/BCR	7/12/90	1	No CWP
DX 1	Shahan	BCR	12/5/94	1	No CWP
DX 1	Gaziano	B-Reader	12/5/94	1	0/1; t/t
DX 1	Wiot	B-Reader/BCR	12/5/94	1	No CWP
DX 1	Forehand	B-Reader	8/1/96	2	No CWP
DX 1	Wiot	B-Reader/BCR	8/1/96	1	No CWP
DX 1	Spitz	B-Reader/BCR	8/1/96	1	No CWP
DX 1	Abramowitz	B-Reader/BCR	1/8/97	1	No CWP
DX 1	Binns	B-Reader/BCR	1/8/97	3	No CWP
DX 1	Gogineni	B-Reader/BCR	1/8/97	2	No CWP
DX 1	Castle	B-Reader	1/8/97	2	No CWP

2. Pulmonary Function Studies

Ex. No.	Physician	Date of Study	Conforming?	Qualifying?	Age/ Height	FEV1	FVC	MVV	Comments
DX 1	Fino	7/6/88	Yes	No	49 yrs./ 72 in.	3.58	4.44	106.6	Not noted
DX 1	Lowery	10/11/89	Yes	No	50 yrs./ 72 in.	2.71	3.46	121	Not noted
DX 1	Ranavaya	12/28/89	Yes	Yes	51 yrs./ 70 in.	1.87	2.88	70.1	Not noted
DX 1	Abernathy	1/18/90	Yes	No	51 yrs./ 70 in.	2.70 3.08	3.49 3.82	96 112	Not noted
DX 1	Endres-Bercher	7/12/90	Yes	No	51 yrs./ 70 in.	2.95	3.94	121	Good effort
DX 1	Forehand	8/1/96	Yes	Yes No	57 yrs./ 69 in.	1.86 2.18	3.01 3.04	68 50	Not noted
DX	Castle	1/8/97	Yes	Yes	58 yrs./	1.65	2.60	54	No change

1				Yes	68 in.	1.82	2.82	68	post-bronchodilator

3. Blood Gas Studies

Ex. No.	Physician	Date of Study	Qualifying?	Altitude	Resting(R) Exercise(E)	PCO_2	PO_2	Comments
DX 1	Mull	3/27/89	Yes	0-2999	R	41.2	51.7	Not noted
DX 1	Ranavaya	12/28/89	Yes	0-2999	R	35	61	Not noted
DX 1	Abernathy	1/18/90	No No	0-2999	R E	39 42	66 77	Not noted
DX 1	Pritchard	7/12/90	No No	0-2999	R E	38.9 38.4	76.7 81.5	Not noted
DX 1	Forehand	12/5/94	No No	0-2999	R E	38 36	66 88	Not noted
DX 1	Forehand	8/1/96	No No	0-2999	R E	40 41	61 67	Not noted

4. Physicians' Opinions

Claimant and Employer both offered numerous medical opinions in the earlier claims.

Dr. Ranavaya submitted a medical opinion, dated January 13, 1990, in which he opined that Claimant had pneumoconiosis caused by coal mine employment and was permanently or totally disabled. DX 1. He based his conclusion on the Claimant's work history, pulmonary function tests and radiological evidence. *Id.* at 3.

Dr. Abernathy conducted a medical examination of Claimant on January 18, 1990, in which he found no pneumoconiosis, but did find asthma such that Claimant could only mildly exert himself. *Id.*

Dr. Endres-Bercher submitted a medical opinion, dated July 12, 1990, in which he found that Claimant did not demonstrate pneumoconiosis. *Id.*

Dr. Fino submitted a medical opinion, dated February 4, 1991, in which he found that there was insufficient medical evidence to justify a diagnosis of simple pneumoconiosis. *Id.*

Dr. Castle submitted a medical opinion, dated February 8, 1991, in which he found with a reasonable degree of medical certainty that Claimant did not suffer from pneumoconiosis and was not permanently or totally disabled. *Id.*

Dr. Forehand conducted a medical examination on December 5, 1994 in which he found that Claimant had chronic bronchitis, but that it was a minor impairment that would not interfere with his last coal mine job. *Id.* Dr. Forehand conducted another examination on August 1, 1996

in which he stated that Claimant had chronic bronchitis and asthma, but that with use of a bronchodilator, he may be able to return to his last coal mine job. *Id.* He did note that coal dust exposure could aggravate his level of impairment. *Id.*

Dr. Castle authored another medical opinion, dated February 27, 1997, in which he found that Claimant did not suffer from pneumoconiosis, but that he was permanently or totally disabled. *Id.*

Dr. Fino submitted a medical opinion, dated February 22, 1998, in which he found that there was insufficient medical evidence to justify a diagnosis of simple pneumoconiosis. *Id.*

Dr. Dahhan submitted a medical opinion, dated October 6, 1998, in which he found that there was insufficient medical evidence to justify a diagnosis of pneumoconiosis. *Id.*

Presence of Pneumoconiosis

Claimant must show that he has either clinical or legal pneumoconiosis as defined in § 718.201. The regulations provide four methods for establishing the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305 and 718.306, and medical opinions. § 718.202(a)(1)-(4).

In determining the probative value of chest x-ray evidence, the date of the study and the qualifications of the interpreting physicians are factors to be considered. *Wheatley v. Peabody Coal Co.*, 6 B.L.R. 1-1214 (1984); *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984). Because pneumoconiosis is a progressive, irreversible and incurable disease, more recent x-ray evidence finding the presence of pneumoconiosis is given more weight than past negative x-ray readings. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993); *Chaffin v. Peter Cave Coal Company*, No. 02-0643 BLA, 2003 WL 24030241 (BRB June 17, 2003). This principle is especially applicable where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). However, due to the progressive nature of pneumoconiosis, subsequent negative x-ray evidence is not given more weight than past positive x-ray readings *solely on the basis of its later date*. *Woodward*, 991 F.2d at 320. (Emphasis added).

Greater weight may be accorded the x-ray interpretation of a dually-qualified (B-reader and board-certified radiologist) physician over that of a board-certified radiologist. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished). The Benefits Review Board has held that it is also proper to credit the interpretation of a dually-qualified physician over the interpretation of a B-reader. *Zeigler Coal Co. v. Director, OWCP [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.).

Courts have addressed the issue of "numerical superiority" with regards to the number of chest x-ray interpretations submitted into evidence. The Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). With regards to numerical superiority in

weighing x-ray evidence, the United States Court of Appeals for the Fourth Circuit exhibited disfavor in "counting heads." *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992); *Copley v. Arch of West Virginia, Inc.*, Case No. 93-1940 (4th Cir. June 21, 1994)(unpublished).

The qualifications of the interpreting physicians, as noted above, must be considered. Here, with respect to the newly submitted chest x-ray evidence,[12] Drs. Forehand, Hippensteel, and Castle are all B-readers, but not board-certified radiologists. DX 10; DX 12; DX 41. Drs. Wiot, Wheeler, and Patel are all dually-qualified physicians, as they are B-readers and board-certified radiologists. DX 11; DX 41; DX 59. As a result of their qualifications, their x-ray interpretations can be given greater weight.

Neither Dr. Forehand, nor Dr. Wiot, read the March 27, 2001 chest x-ray as positive for pneumoconiosis. DX 10, 11. This x-ray thus cannot support a finding of pneumoconiosis.

Dr. Hippensteel found Claimant's June 11, 2001 and March 13, 2004 x-rays negative for pneumoconiosis. DX 12, 68. Dr. Castle similarly read a November 25, 2002 x-ray as negative for pneumoconiosis. DX 41. There are no contrary readings of these x-rays, and thus they also do not support a finding of pneumoconiosis.

With respect to the July 3, 2002 chest x-ray, Dr. Forehand, a B-Reader, read it as revealing a profusion of 1/0 opacities, while Dr. Wheeler, a dually-qualified physician, read this same x-ray as showing no pneumoconiosis. DX 41, 42. Given Dr. Wheeler's superior qualifications, I find this x-ray does not support a finding of pneumoconiosis.

Finally, with respect to the September 24, 2003 chest x-ray, Dr. Patel interpreted it as 1/0 while Dr. Wiot read it as negative for pneumoconiosis. DX 59, EX 8. I find this x-ray evidence to be in equipoise and, since it is Claimant's burden to prove his claim by a preponderance of the evidence, I further find this chest x-ray interpretation does not support a finding of pneumoconiosis.

Based on a review of all the chest x-ray evidence, both individually and collectively, I find that Claimant has failed to establish the presence of pneumoconiosis pursuant to § 718.202(a)(1).

There is no biopsy or autopsy evidence of record and Claimant has thus failed to establish pneumoconiosis pursuant to § 718.202(a)(2).

Because there is no evidence of complicated pneumoconiosis, Claimant is not entitled to the presumption in § 718.304. The claim was filed after 1982, and so he is thus not entitled to the presumption in § 718.305. Because this is not a claim for survivor's benefits, the presumption in § 718.306 also does not apply. Therefore, Claimant cannot establish the presence of pneumoconiosis pursuant to § 718.202(a)(3).

---

[12] The previously submitted chest x-ray evidence is fully described in the prior decisions denying benefits, and after a review of that evidence I find, as did Judges Roketenetz and Chapman, that it does not support a finding of pneumoconiosis.

Finally, with respect to § 718.202(a)(4), I find, for the reasons set forth below, that the medical opinion evidence as a whole does not support a finding that Claimant has pneumoconiosis.

Dr. Hippensteel's medical opinions dated June 11, 2001 and May 27, 2004 are thorough, well-reasoned, and well documented. He concluded that there was no evidence of pneumoconiosis based on Claimant's medical and work history, his chest x-rays, his history of treatment with bronchodilators and prednisone, and his recurrent hospitalizations, all of which are consistent with a diagnosis of asthma and not pneumoconiosis. He noted that Claimant's fixed obstruction is a natural progression of his asthma, which becomes less reversible over time because of a remodeling of airways referable to the disease, and stated that asthma is not associated with or aggravated by coal mine dust exposure, nor does coal mine dust cause occupational asthma. Because his opinions are well reasoned and supported by objective test results and other medical evidence of record, I give those opinions substantial weight.

Dr. Smith's conclusory medical opinion, dated April 25, 2002, is neither documented nor well-reasoned. She simply noted that Claimant was under her care because of steroid dependent COPD and significant incapacity requiring oxygen dependence and stated, without elaboration, that Claimant's "black lung" was worsening. I thus give her opinion little weight.

Dr. Forehand's opinion of July 2, 2002, although more thorough than the conclusory opinion of Dr. Smith, is not particularly well-reasoned and is inconsistent with other better reasoned opinions of record. He concluded that the Miner's respiratory symptoms arose from a combination of pneumoconiosis, chronic bronchitis, and cigarette smoke. Inasmuch as I have found the weight of the x-ray evidence does not support a finding a pneumoconiosis, Dr. Forehand's reliance on his chest x-ray interpretation undermines the value of his opinion. I also note that Dr. Forehand concluded that the 1/0 profusion of irregular opacities he saw on x-ray in the bases of Claimant's lungs were consistent with pneumoconiosis, rather than some other disease process, yet the only explanation he gave for this conclusion was that 20% of coal miners who have pneumoconiosis develop such opacities. His recognition of the fact that *most* miners who have pneumoconiosis develop rounded opacities in the upper lobes, rather than the irregular opacities he observed in Claimant's lower lobes, further diminishes the weight of his opinion. Finally, I note that Dr. Forehand failed to diagnose asthma, a condition found by other physicians and well-documented throughout Claimant's medical history. Given the above-noted deficiencies, I find that Dr. Forehand's opinion is entitled to diminished weight.

Dr. Castle's medical opinion, dated November 25, 2002, in which he concluded that there was no evidence of pneumoconiosis, is thorough, well reasoned and well documented. He diagnosed, *inter alia*, bronchial asthma, cerebrovascular disease, seizure disorder, coronary artery disease, and diabetic neuropathy but found no evidence of pneumoconiosis. Dr. Castle noted that Claimant's medical records revealed a history of bronchial asthma for 25 years and that Claimant demonstrated a significantly reversible degree of airway obstruction, without restriction or diffusion abnormality. He further noted that Claimant's symptoms were made worse by exposure to bleach, cooking odors and cold air, all consistent with bronchial asthma. Dr. Castle, like Dr. Hippensteel, concluded that Claimant's bronchial asthma was unrelated to coal dust exposure. I find that Dr. Castle's medical opinion is entitled to substantial evidentiary

weight.

Dr. Rasmussen concluded in his medical opinion of September 24, 2003 that Claimant suffered from pneumoconiosis due to both smoking and coal dust exposure. He based his opinion, in part, on the x-ray interpretation of Dr. Patel which found pneumoconiosis with a profusion of 1/1 throughout all lung zones. However, as noted above, the weight of the chest x-ray evidence does not support such a finding. Dr. Rasmussen also stated that it was "medically reasonable to conclude the [Miner] has coal workers' pneumoconiosis which arose from his coal mine employment [based on his smoking history and on his significant history of exposure to coal mine dust]." DX 59 at 3. However, exposure to coal dust, either by itself or in combination with smoking, is insufficient to support a diagnosis of pneumoconiosis. In support of his conclusion, Dr. Rasmussen cites medical studies which show that cigarette smoking and exposure to coal dust cause chronic obstructive lung disease. However, he fails to note any objective findings in this case, other than the above-noted positive x-ray evidence, which explain how such studies support his conclusion with respect to this Miner. Furthermore, he concluded that Claimant had a "moderate to severe irreversible obstructive ventilatory impairment" but did not diagnose Claimant as suffering from asthma. Claimant's COPD is, according to Employer's experts, attributable to asthma and not emphysema or bronchitis.[13] In addition, asthma, according to Employer's experts, is not caused by exposure to coal dust. This conclusion appears to be consistent with the regulatory history of the revised regulations applicable to Black Lung benefits, *i.e.*, when the regulations were revised to expand the definition of pneumoconiosis in December 2001, the Department expressly took note of multiple medical studies which showed that exposure to coal dust is linked to the development of chronic obstructive pulmonary disease. *See*, *e.g.*, Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 79920, 79939-42 (Dec. 20, 2000) ("Final Rule"). The Department further noted that "[t]he term 'chronic obstructive pulmonary disease' (COPD) includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema and asthma." *Id.* at 79939. Its discussion of the studies linking coal dust exposure to COPD, however, appear to link such exposure and COPD only in the context of bronchitis and emphysema. For example, quoting one study, the Department wrote:

> Most evidence to date indicates that exposure to coal mine dust can cause chronic airflow limitation in life and emphysema at autopsy, and this may occur independently of CWP * * * The relationships between hypersecretion of mucus (chronic bronchitis) and chronic airflow limitation (emphysema) on the one hand and environmental factor of coal mining exposure on the other appear to be similar to those found for cigarette smoking.

Id. at 79939. As noted above, the medical evidence in this case, including the opinions of Employer's experts, establishes that Claimant's principal respiratory impairment results from asthma, not from emphysema or bronchitis caused by coal dust exposure. I find, based on the

[13] While Dr. Hippensteel acknowledged in his second deposition that Claimant has chronic bronchitis, he further testified that the Miner's chronic bronchitis was not due to coal mine dust exposure but was rather a result of his asthma. EX 19 at 21. He explained that asthma becomes less reversible over time due to airway remodeling due to chronic inflammation and thus leads to an irreversible impairment which is not significantly improved through the use of bronchodilators. *Id.* at 14, 21.

foregoing, that Dr. Rasmussen's opinion is not well reasoned or documented and is thus entitled to diminished weight.

With one exception, the medical opinions admitted in Claimant's earlier claims do not support a finding of pneumoconiosis. DX 1. However, the one opinion supporting the conclusion that Claimant has pneumoconiosis, Dr. Ranavaya's January 13, 1990, medical report, is not well-reasoned. He bases his opinion on chest x-ray evidence, pulmonary function tests, and Claimant's coal mining experience. As noted above, the chest x-ray evidence, as a whole, does not support a finding of pneumoconiosis. Furthermore, exposure to coal dust alone does not support a diagnosis of pneumoconiosis, and the pulmonary function evidence, according to the better reasoned opinions of Drs. Hippensteel and Castle, support a diagnosis of asthma which is unrelated to coal dust exposure. I thus find Dr. Ranavaya's opinion less persuasive than the more recent detailed and through opinions of Drs. Hippensteel and Castle and accord it less probative value.

Based on the foregoing, I find that Claimant has failed to show by a preponderance of the medical opinion evidence that he suffers from pneumoconiosis as defined under § 718.202(a)(4). I thus further find that Claimant has failed to demonstrate the presence of pneumoconiosis under any of the criteria set forth in § 718.202(a)(1)-(4).

Causation of Pneumoconiosis and Total Disability

Claimant must show that his pneumoconiosis arose out of coal mine employment and that his total respiratory or pulmonary impairment is caused or contributed to by that disease. § 725.202(d)(2)(ii), (iii). Since Claimant has not shown the existence of pneumoconiosis in this case, he also cannot demonstrate that pneumoconiosis resulted from his coal mine employment.

With respect to the causation of Claimant's total disability, § 718.305 provides, in relevant part, that a miner who was employed for fifteen years or more in one or more underground coal mines, is entitled to a rebuttable presumption that he is totally disabled due to pneumoconiosis. Since I have found that Claimant was an underground coal miner for approximately 20 years, the presumption applies in this case. However, I find, for the reasons set forth above, that the medical evidence offered by Employer establishes that Claimant does not have pneumoconiosis or any respiratory or pulmonary impairment which arose out of his coal mine employment. Such evidence is therefore sufficient to overcome the presumption, and I thus further find that Claimant has failed to establish that he is totally disabled as a result of pneumoconiosis.

CONCLUSION

As Claimant failed to establish all of the requisite elements of entitlement, I find that he is not entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of Dewey Sparks for benefits under the Black Lung Benefits Act is hereby **DENIED**.

A

STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefit Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601***. A copy of this Notice of Appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.