U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 July 2007

Case No.: 2005-BLA-06212

In the Matter of:

T.F., [1]
Claimant,

v.

AUSTIN COAL COMPANY, INC.,
Employer,

and

KENTUCKY EMPLOYERS MUTUAL INSURANCE COMPANY,
Carrier,

and

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

APPEARANCES:

James D. Holliday, Esq.
For the claimant

Paul Jones, Esq.
For the employer/carrier

Christian Barger, Esq.
For the solicitor

BEFORE: DONALD W. MOSSER
Administrative Law Judge

[1] In any Decision and Order issued by the U.S. Department of Labor in Black Lung cases after August 1, 2006, the claimant is referred to only by initials rather than by full name in the interest of protecting their privacy.

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the "Act"). In a case involving a living coal miner, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2005).

Following proper notice to all parties, a hearing was held on October 5, 2006, in Hazard, Kentucky. The parties were given the opportunity to submit evidence at the hearing, and submit post-hearing briefs.[2] The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. The appraisal of the medical evidence has been conducted in conformity with the quality standards of the regulations. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title.

ISSUES

The following issues remain for resolution:

1. whether the named employer is the responsible operator;

2. whether the miner has pneumoconiosis as defined by the Act and regulations;

3. whether his pneumoconiosis arose from coal mine employment;

4. whether the miner is totally disabled; and,

5. whether his disability is due to pneumoconiosis.

(DX 102; Tr. 6 – 7).[3]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Claimant was born February 17, 1961, has been married for eight years and has no dependent children. (Tr. 14, 17). He completed high school but has no other education or

[2] References in this decision to DX, CX and EX pertain to exhibits of the Director, claimant and employer, respectively. I should also note that there are only three employer's exhibits (EX 1, 5 and 6) as I inadvertently identified the last exhibits submitted by employer's counsel as EX 5 and 6. The evidence identified by employer's counsel as EX 2-4 was withdrawn and not offered in evidence. (Tr. 34-35).

[3] The transcript of the October 5, 2006 hearing is cited as Tr. and by page number.

vocational training. (Tr. 21). He alleges twenty years of coal mine employment and testified at the hearing that he stopped working as a coal miner in late October of 2004. (Tr. 13). The miner stated he stopped working because his breathing became too painful to continue employment. (Tr. 14). He visits the Kentucky Lung Clinic for treatment. (Tr. 14). He currently takes several different medications for his breathing problems. (Tr. 15). Claimant admitted to smoking up to a pack and a half of cigarettes per day for twenty-nine years but at the time of the hearing he testified that he smoked one pack every two or three days. (Tr. 29).

The miner filed his claim for black lung benefits on September 25, 2003. (DX 2). On May 26, 2005, the district director issued a proposed decision and order awarding benefits. (DX 97). The employer appealed this decision and requested a formal hearing with the Office of Administrative Law Judges (OALJ) on June 6, 2006. (DX 99). The claim was transferred to the OALJ on August 16, 2005. (DX 102).

Coal Mine Employment

The duration of a claimant's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The district director found the claimant has proven at least twenty years of coal mine employment. (DX 97). At the hearing, the employer stipulated that the claimant worked for at least fifteen years in qualifying coal mine employment. (Tr. 7). Based upon my review of the record, I accept the stipulation as accurate and credit the claimant with at least fifteen years of coal mine employment. Claimant's last coal mine employment was in the Commonwealth of Kentucky, which is within the jurisdiction of the Sixth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Claimant testified that he was required to perform manual labor, including welding, repairing, and lifting. He lifted as much as one hundred pounds, but was never required to work underground. (Tr. 16, 20). According to the claimant, he can no longer perform his usual coal mine employment as a welder/repairman. (Tr. 17).

Responsible Operator

The employer, Austin Coal Company, Inc. (Austin Coal), argues that is it not the properly designated responsible operator in this claim. According to the employer, the claimant was not employed with Austin Coal for one year. Under the Act, the operator responsible for the payment of benefits is the operator that most recently employed the miner for one cumulative year. 20 C.F.R. § 725.494(c). One cumulative year means "a period of one calendar year (365 days) … during which the miner worked in or around a coal mine or mines for at least 125 'working days.'" 20 C.F.R. § 725.101(a)(32).

I find the evidence of record establishes that the miner was employed with the employer for at least one cumulative year. The documentary evidence indicates that the miner began working for the employer in September of 2003. (DX 3; DX 5; DX 9; DX 10). According to the payroll records submitted by the employer, Austin Coal began paying the miner in September of 2003 and continued to pay him for at least ten months until July of 2004. (DX 9). Other evidence of record indicates that the miner was paid by Austin Coal until October of 2004. Claimant submitted a pay

stub showing he was paid for fifty hours of work for the period of October 10 – 16, 2004. (DX 8). In addition, claimant testified at the hearing that he last worked for the employer on October 28 or 29 of 2004. (Tr. 14). The named employer has not provided any evidence to contradict this statement and consequently it has not met its burden in proving that it is not the potentially liable operator. Therefore, I find that Austin Coal Company, Inc. is the properly designated responsible operator in this claim.

Pneumoconiosis and Related Issues

Medical Evidence

X-Ray Reports

Exhibit	**Date of X-ray**	**Physician/Qualifications**	**Interpretation**
DX 18	02/09/04	G.R. Baker/B-reader	1/0
DX 27	02/09/04	W.W. Scott/B-reader, Board-certified radiologist	No evidence of pneumoconiosis
DX 33	02/09/04	M.S. Alexander/B-reader, Board-certified radiologist	1/0
DX 21	02/24/04	B.C. Broudy/B-reader	0/0
DX 93	02/24/04	M.S. Alexander/B-reader, Board-certified radiologist	1/0
EX 1	08/12/04	D.M. Rosenberg[4]	No parenchymal abnormalities consistent with pneumoconiosis
DX 93	08/12/04	M.S. Alexander/B-reader, Board-certified radiologist	1/0

[4] I note that Dr. Rosenberg's qualifications show that he was not a B-reader at the time he read the August 12, 2004 x-ray.

Pulmonary Function Studies

Exhibit/ Date	Age/ Height	Broncho-dilator?	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 18 [5] 04/09/04	43 74”	No	2.05	4.81	N/A	43%	Yes	Fair cooperation, good effort
DX 18 02/09/04	42 74”	No	2.15	5.31	N/A	40%	Yes	Fair cooperation, good effort
DX 21 02/24/04	42 74”	No Yes	1.60 2.68	3.97 5.13	61 96	40% 52%	Yes	Good effort
EX 01; CX 02 08/12/04	43 75”	No Yes	2.00 2.38	3.76 4.51	51 56	53% 53%	Yes	Good cooperation and effort

Blood Gas Studies

Exhibit	Date of Exam	Resting/ Exercise	pCO_2	pO_2
DX 18	02/09/04	Resting	35	78
DX 21	02/24/04	Resting	35.8	74.2
EX 01	08/12/04	Resting	35.5	74.2

Medical Reports

Glenn Ray Baker, Jr., M.D., who is board-certified in internal medicine and pulmonary diseases, examined claimant on February 9, 2004, at which time he took a patient history of symptoms and recorded an employment history as a supervisor and drill operator. Claimant advised the physician that he worked in coal mine employment for twenty years. (DX 18). Dr. Baker noted claimant had a history of pneumonia, wheezing, chronic bronchitis and arthritis. Claimant stated he began smoking cigarettes in 1977 and currently smokes about one pack per day. The physician performed a chest x-ray, pulmonary function tests and arterial blood gas studies. The chest x-ray was read as positive for pneumoconiosis. The physician reported the pulmonary function tests showed moderate obstructive ventilatory defect, and the arterial blood gas studies showed moderate resting arterial hypoxemia.

[5] Dr. N.K. Burki found the pulmonary function studies performed on February 24, 2004 and April 9, 2004 to be unacceptable due to the miner’s less than optimal effort, cooperation and comprehension. (DX 18).

Upon reviewing the results of the examination and tests, Dr. Baker diagnosed claimant with coal workers' pneumoconiosis, chronic obstructive pulmonary disease (COPD), hypoxemia and chronic bronchitis. Dr. Baker attributed the coal workers' pneumoconiosis to coal dust exposure and the other diseases to coal dust exposure and cigarette smoking. He based his diagnosis of coal workers' pneumoconiosis on the miner's abnormal chest x-ray and coal dust exposure. (DX 18). He further stated that the miner was moderately impaired with a decreased FEV_1 level, chronic bronchitis, and decreased PO_2 level. (DX 18).

Dr. Baker examined the claimant's medical records and provided a supplement to his initial medical report dated October 7, 2004. (DX 34). Based on his review of the miner's records, Dr. Baker opined that the miner had clinical and legal pneumoconiosis. He based this diagnosis on the miner's x-ray results and long history of coal dust exposure of twenty years. In Dr. Baker's opinion, both the coal dust exposure and cigarette smoking caused the chronic bronchitis and obstructive airway disease, which resulted in resting arterial hypoxemia. The physician stated that the miner's coal dust exposure was a substantially aggravating factor in the etiology of his chronic bronchitis and obstructive airway disease. He further stated that the miner has a class three pulmonary impairment and does not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment. In Dr. Baker's opinion, coal worker's pneumoconiosis, COPD, mild resting hypoxemia and chronic bronchitis all have a material adverse affect on the miner's respiratory system. (DX 34).

At the request of the claimant, Dr. Baker provided an additional medical report dated August 30, 2006. (CX 1). In addition to his own medical findings, Dr. Baker reviewed the miner's pulmonary function tests performed by Drs. Broudy and Rosenberg on February 24, 2004 and August 12, 2004, respectively. Dr. Baker opined that both of these tests produced valid results. After comparing these results with his own results, Dr. Baker continued to opine that the miner is totally disabled from a respiratory or pulmonary standpoint. (CX 1).

Dr. Baker also testified by deposition on September 14, 2006. (CX 6). During the deposition, he further reiterated the findings provided in his medical report. He also stated he was aware that Dr. Burki found his pulmonary function studies to be invalid. However, Dr. Baker testified that he reviewed the studies performed by the physicians of record and he felt that they all accurately reflected the miner's pulmonary condition. After reviewing Dr. Koura's notes, Dr. Baker noted that it appeared the miner's condition had worsened from August of 2005 to June of 2006. According to Dr. Baker, the miner is "totally and permanently disabled" based on the pulmonary function test results which show mild to moderate obstructive defect without bronchodilation and moderate to mild obstructive defect even with the bronchodilators. He stated that the miner would have trouble doing physical labor due to the "obvious liability of his airways." (CX 6).

The miner was seen in consultation on February 24, 2004 by Bruce Broudy, M.D., who is board-certified in internal medicine and pulmonary diseases. (DX 21). The examination consisted of obtaining the miner's pertinent history and performing a physical examination, spirometry, arterial blood gas study and chest x-rays. The physician noted that the miner was a forty-three year old male who began smoking at age seventeen and has consumed one to one and one-half packs of cigarettes per day since then. He reported a fifteen-year coal mine employment history. At the time of the examination, the miner was still working for Austin Coal Company where he had been

employed for five months. According to Dr. Broudy, the miner stated he was able to perform his job duties but he had trouble coughing and sometimes blacked out due to severe coughing. He occasionally coughed up blood and has had cough with daily sputum and wheezing for at least four years. (DX 21).

Upon physical examination, Dr. Broudy noted that the miner was well developed and well nourished and in no apparent distress. (DX 21). The lungs showed inspiratory and expiratory wheezing throughout. The spirometry testing showed moderately severe obstruction with marked improvement after bronchodilation. The arterial blood gas study indicated continued exposure to smoke. The chest x-rays showed clear lungs and Dr. Broudy saw no evidence of coal workers' pneumoconiosis. The physician diagnosed the claimant with chronic asthmatic bronchitis with significant responsiveness to bronchodilation. He attributed the chronic asthmatic bronchitis to cigarette smoking and some predisposition to asthma or bronchospasm. After dilation, Dr. Broudy noted that the miner exceeded the minimum federal criteria for disability and he opined that the miner's lung function would improve even more with regular treatment for his asthmatic bronchitis. (DX 21).

Dr. Broudy testified by deposition on April 30, 2004. (DX 23). During the deposition, Dr. Broudy reiterated the opinions provided in his medical report. He further stated that he was able to determine the miner's disability was a result of cigarette smoking and not coal mine employment based on several reasons. First, he stated that smoking and bronchial asthma usually cause an obstructive defect, which was present in the miner's case. Second, he noted that the miner responded to bronchodilation, which is not a feature of impairment associated with coal dust exposure. In addition, Dr. Broudy testified that the impairment associated with coal dust exposure is usually a restrictive impairment. Dr. Broudy did admit upon cross-examination that coal dust exposure can also cause an obstructive impairment. Lastly, he noted that when there is a large degree of impairment as indicated in the miner's case, there is usually evidence of advanced coal workers' pneumoconiosis, and this was not the case with the miner. (DX 23).

Dr. David Rosenberg, who is board-certified in internal medicine and pulmonary disease, examined the miner on August 12, 2004 and performed a records review of the miner's file. He then completed a medical report dated September 1, 2006. (EX 1). The physician stated he reviewed the following medical records: B-readings of the miner's chest x-ray dated February 9, 2004 by Drs. Wheeler and Scott[6], the evaluations of Drs. Broudy, Baker and Williams, and current pulmonary function tests, chest x-rays, EKGs and arterial blood gas studies.

At the time of Dr. Rosenberg's physical evaluation, the miner reported that he was short of breath and had been so for the last fourteen or fifteen years. (EX 1). According to the claimant, the

[6] As claimant has noted, the B-reading of Dr. Wheeler was not admitted into evidence in the current claim and therefore should not have been reviewed by Dr. Rosenberg in his medical report. However, considering Dr. Rosenberg's limited reliance on the x-ray results, and the Board's holding that "exclusion is not a favored option," it is appropriate in this case to factor in Dr. Rosenberg's reliance upon his own medical evidence when deciding the weight to which his opinion is entitled. *See Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006) (en banc); *Brasher v. Pleasant View Mining Co.*, 23 B.L.R. 1-141 (2006). Accordingly, because Dr. Rosenberg based his diagnoses on other objective evidence, including his own physical examination of the miner, I find Dr. Rosenberg's limited reliance on Dr. Wheeler's x-ray reading to be insufficient to justify discrediting or discounting his report.

symptoms had worsened over the last four to five years. He reported cough and sputum production on a regular basis. Claimant reported he began smoking at age sixteen or seventeen and averaged about a pack and a half of cigarettes per day until he "cut down recently." Dr. Rosenberg listed a work history of twenty-three years in the coal mining industry, all of which were on the surface of the mines. The miner reported to the physician that he was employed as a welder on a strip job and repaired equipment in the field. He also reported that he had to regularly lift sixty to seventy pounds. Dr. Rosenberg performed a chest x-ray, pulmonary function test and arterial blood gas study. He found no abnormalities consistent with pneumoconiosis on the x-ray. The pulmonary function test revealed severe airflow obstruction with a bronchodilator response, while the arterial blood gas study showed preserved oxygenation with an elevated carboxyhemoglobin level.

Based on his review of the miner's examination and medical records, Dr. Rosenberg opined that the miner does not have coal workers' pneumoconiosis. (EX 1). He noted the TLC level was normal, indicating the miner does not have restriction. In addition, Dr. Rosenberg found that the alveolar capillary bed of the miner's lungs was intact and no chronic rales were noted. From a functional perspective, Dr. Rosenberg opined that the miner has severe airflow obstruction and cannot perform his previous coal mining job or similarly arduous type labor. He stated that this impairment relates to severe COPD. According to Dr. Rosenberg, the miner's COPD is a result of his "long and continued smoking history" and is not related to coal dust exposure. He based this opinion on the results of studies that indicated that coal mine dust exposure does not cause significant reduction in FEV_1%. He also noted that miners suffering from coal workers' pneumoconiosis typically show no improvement after bronchodilators. Dr. Rosenberg stated that the claimant showed severe reduction in his FEV_1% and he had a bronchodilator response, which led him to believe that the miner does not suffer from pneumoconiosis. In this physician's opinion, the miner's test results are not within the pattern of coal dust related obstructive lung disease. Therefore, Dr. Rosenberg conceded that while the miner is disabled from a pulmonary perspective, this disability is due to cigarette smoking and the miner does not have either medical or legal coal workers' pneumoconiosis. (EX 1).

Dr. Rosenberg provided two supplemental letters dated October 30, 2006. (EX 5; EX 6). In these letters, he reviewed medical records and reports from Dr. Koura and Dr. Baker. According to Dr. Rosenberg, his previous conclusions remained intact after a review of these records. The claimant's pattern of impairment is consisted with airflow obstruction caused by smoking, not coal dust exposure, according to this physician. (EX 5; EX 6).

Claimant's treating physician, Dr. Firas Koura, provided a medical report dated September 13, 2006. (CX 5). Dr. Koura, who is board-certified in internal medicine and board-eligible in pulmonary medicine, has treated the miner since August 15, 2005. (CX 4; CX 5). Based on his examinations of the miner, review of Dr. Baker's medical reports, patient history, pulmonary function tests and chest x-rays, Dr. Koura opined that the miner suffers from an occupational disease caused by coal mine employment. Dr. Koura classified the miner as having both clinical and legal pneumoconiosis. He also diagnosed COPD and asthma, both significantly contributed to by coal dust exposure. In Dr. Koura's opinion, the miner is totally disabled based on his severe impairment. He added that this impairment is related to pneumoconiosis and is worsened by tobacco smoke. The physician stated that the miner does not have the respiratory capacity to perform the work of a coal miner or to perform related work in a dust-free environment. (CX 5).

Treatment Records

The miner was treated at the Kentucky Lung Clinic on several dates in 2005 and 2006. Records from these visits were submitted by the claimant to be considered as part of the record. (CX 3). On August 15, 2005, claimant's treating physician, Dr. Firas Koura, performed a spirometry test which revealed moderate obstructive lung disease with improvement after bronchodilator use. Claimant visited the clinic on numerous occasions subsequent to this spirometry study, chiefly complaining of cough with yellow sputum, black out spells after coughing, smothering, fatigue, chest congestion, wheezing, and sinus drainage. On June 6, 2006, Dr. Koura performed another spirometry test which revealed severe obstructive lung disease with evidence of restrictive effect. (CX 3).

Other Medical Evidence

The employer submitted as part of the record the miner's physical examination for employment taken on September 2, 1980.[7] (DX 27). The examining physician indicated that the miner had not worked in the mines before and his past medical history was negative for serious illnesses or injuries. The miner's lung fields were found to be clear and resonant without rales or rhonchi. The chest x-ray performed showed normal thoracic cage and cardiac silhouette. Lumbar spine x-ray and vision tests were also performed. The overall impression was that the miner was a "normal male suitable for employment." (DX 27).

Discussion

Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 C.F.R. Parts 718 and 725 apply. 20 C.F.R. §§ 718.2 and 725.2 (2005). Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.,* 12 BLR 1-111, 1-112 (1989).

[7] Claimant argues that this pre-employment physical is actually a medical report and therefore violates evidentiary limitations. However, I am not persuaded by claimant's argument. Section 725.414(a)(1) defines a medical report as a physician's written assessment of the miner's respiratory or pulmonary condition. Section 718.107 allows for the introduction of "[t]he results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis…" Here, the claimant's pre-employment physical was performed by a physician and demonstrates the absence of pneumoconiosis. The physical exam results are not a written assessment of the miner's respiratory condition, but rather the physician's assessment of the results of the routine physical exam that focused on the claimant's ability to perform manual labor. Therefore, the employer properly listed the physical exam as "other medical evidence" under Section 718.107.

Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence.[8] The record in the current claim contains seven readings of three x-rays. Of these interpretations, four were read as positive for pneumoconiosis, while three were read as negative. Dr. Baker read the February 9, 2004 chest x-ray as category 1/0, while Dr. Scott read the same x-ray as negative for the disease. However, Dr. Alexander re-read this x-ray and agreed with the interpretation of Dr. Baker. All of the physicians who read the February 9, 2004 x-ray are qualified B-readers, but only Drs. Scott and Alexander are dually qualified as B-readers and board certified radiologists. However, in light of the fact that Dr. Alexander's interpretation is supported by Dr. Baker, I am inclined to lend greater weight to the interpretation of Dr. Alexander. Therefore, I find the February 9, 2004 x-ray to be positive for pneumoconiosis.

The February 24, 2004 x-ray was interpreted as negative for the existence of the disease by a B-reader, but then re-read as positive for the disease by Dr. Alexander, who, as noted, is dually qualified. I am entitled to lend greater weight to the readings of the higher qualified physician. The August 12, 2004 x-ray was found to be positive for pneumoconiosis by a dually-qualified radiologist and found negative by Dr. Rosenberg. The qualifications submitted for Dr. Rosenberg indicate his B-reader status was through June 30, 2004. (EX 1). Therefore, I also find both the February 24, 2004 x-ray and the August 12, 2004 x-ray to be positive for pneumoconiosis. Because the weight of the x-ray readings is positive for pneumoconiosis, I find that the x-ray evidence establishes the existence of pneumoconiosis under Section 718.202(a)(1).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable herein because the record contains no such evidence. Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982 and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under this section, a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. I am mindful that an administrative law judge must consider a

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[8] When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board and the Sixth Circuit Court of Appeals have approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Warmus v. Pittsburgh & Midway Coal Mining Co.* 839 F.2d 257, 261, n.4 (6th Cir. 1988); *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984). A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

medical report as a whole, *see Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988), and *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984), and may not discredit an opinion merely because it is based on an x-ray interpretation which is outweighed by the other x-ray interpretations of record. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986); *cf. Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111 (1989).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2005). In the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." *Eastover Mining Co. v. Williams*, 338 F.3d 501, 513 (6th Cir. 2003).

A medical opinion may also be given less weight if the physician does not consider whether the claimant's pulmonary disease was contributed to or aggravated by exposure to coal dust. The Sixth Circuit Court of Appeals has held that a determination that coal dust exposure did not contribute to or aggravate the claimant's respiratory problems requires an explanation by the physician as to why coal mine employment was eliminated as a possible cause. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

In the case at hand, the miner was examined by four physicians. Two of the four physicians, Drs. Broudy and Rosenberg, opined that the miner does not suffer from pneumoconiosis. I am not persuaded by either of their opinions. First of all, their opinions are not in accord with the objective medical evidence submitted in the claim. As mentioned previously, I have determined that the chest x-ray evidence is positive for the existence of pneumoconiosis. However, I do not discredit their opinions merely because they are based on x-ray interpretations which were outweighed by the other x-ray interpretations of record. The opinions of Drs. Broudy and Rosenberg are also discredited due to their failure to explain how coal dust exposure did not contribute to the miner's respiratory condition.

Both Drs. Broudy and Rosenberg conclude that the miner suffers from some respiratory impairment. Dr. Broudy states that the miner suffers from chronic asthmatic bronchitis, while Dr. Rosenberg states that the miner has severe COPD. As Dr. Koura mentions, both COPD and chronic asthmatic bronchitis can be aggravated by cigarette smoke and coal dust exposure. However, Drs. Broudy and Rosenberg adamantly opine that the miner's illnesses are due solely to cigarette smoke inhalation and coal mine dust exposure played no part in the miner's impairment. To distinguish between the two causes, Dr. Broudy states that smoking usually causes an obstructive defect, while

coal dust exposure usually cases a restrictive defect. However, he also admitted that coal dust exposure can also cause an obstructive defect. Both physicians also state that the miner's responsiveness to bronchodilation proves that he does not suffer from pneumoconiosis, but the Sixth Circuit Court of Appeals had held that the reversibility of pulmonary function values after use of a bronchodilator does not necessarily eliminate a finding of disabling coal workers' pneumoconiosis. *Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350, 358 (6th Cir. 2007) (J. Rogers, concurring) Drs. Broudy and Rosenberg have not adequately explained how the miner's fifteen or more years of coal mine employment played no part in his lung impairment. Therefore, I grant their opinions little weight.

By contrast, Drs. Baker and Koura opined that the miner suffered from pneumoconiosis. As mentioned previously, Dr. Koura is the miner's treating physician and he is board-certified in internal medicine. He had the opportunity to examine the claimant on several occasions over the course of one year, while the other physicians of record examined the miner on only one occasion. Dr. Koura performed pulmonary function tests and physical examinations upon the miner. In addition, Dr. Koura reviewed the miner's medical records and his opinion is in accord with the objective evidence submitted with this case. Therefore, I find his opinion very persuasive and lend it controlling weight.

Dr. Koura's opinion is further supported by the opinion of Dr. Baker, who also had the opportunity to examine the miner. I find Dr. Baker's opinion to be well-reasoned and well-supported by the objective evidence. Of note, Dr. Baker addressed in detail the miner's significant coal mine employment history and the effects of coal dust on the miner's respiratory condition. Dr. Baker's conclusion that both cigarette smoking and coal dust exposure contributed to the miner's lung impairments is logical and well-supported by the evidence in the record. Thus, I find that the claimant has established the existence of pneumoconiosis by a preponderance of the evidence pursuant to Section 718.202(a)(4) based on the well-reasoned and supported opinions of Drs. Koura and Baker.

Once it is determined that a claimant suffers from pneumoconiosis, it must be determined whether the claimant's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). Because the miner worked over ten years in coal mine employment, the claimant is entitled to a rebuttable presumption that the miner's pneumoconiosis arose from coal mine employment. *See* 20 C.F.R. § 718.203(b). The evidence fails to rebut this presumption.

The miner also alleges that he is totally disabled due to the disease. A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304, or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c). The regulations provide the pertinent methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d). There is not sufficient evidence in the record to show that the claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies and medical opinions.

The record contains six pulmonary function studies. Of these studies, the only one that did not produce qualifying values was the study performed after bronchodilation on February 24, 2004.[9] Since the majority of the studies produced qualifying values, I find that claimant has established total disability per Section 718.204(b)(2)(i).

Three blood gas studies of the claimant were submitted and none of these produced qualifying values. Therefore, I find that the miner has failed to establish total disability per Section 718.204(b)(2)(ii).

The final pertinent way to establish a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion. The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. *Id*. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment. 20 C.F.R. § 718.204(b)(2)(iv). A finding that the miner should limit further exposure to coal mine dust does not constitute a finding of disability pursuant to the regulations or case law. *See Zimmerman v. Director, OWCP*, 871 F2d 564, 567 (6th Cir. 1989). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. In assessing total disability, the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-51.

The physicians' reports are summarized above. Of the four physicians who examined the miner, only Dr. Broudy opined that he could continue to perform his regular work as a coal miner or perform comparable work in a dust-free environment. However, Dr. Broudy admits that the miner suffers from some form of lung impairment, namely, asthmatic bronchitis. According to Dr. Broudy, the miner initially showed moderately severe obstruction on the pulmonary function study, but there was marked improvement after the administration of bronchodilation. Dr. Broudy opined that this indicated that the miner's condition would improve with treatment, but it appears from the evidence submitted that the miner's condition has actually worsened. As Dr. Baker testified at his deposition, the miner was treated by Dr. Koura on a frequent basis for one year with no improvement of his pulmonary function studies. This would indicate that the miner's condition is deteriorating. Therefore, I lend little credibility to Dr. Broudy's opinion as to total disability. I find the opinions of Drs. Baker, Koura, and Rosenberg to be controlling on the issue of total disability. When all of the medical reports are considered conjunctively, I find that the miner has established total disability per Section 718.204(b)(2).

Finally, claimant must also establish that his total disability is due to pneumoconiosis. 20 C.F.R. § 718.204(b). To satisfy this requirement, the United States Court of Appeals for the Sixth Circuit requires a claimant to prove that his totally disabling respiratory is due "at least in part" to his pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d, 818, 825 (6th Cir. 1989). This means the miner "must affirmatively establish that pneumoconiosis is a contributing cause of some discernable

[9] A qualifying pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A non-qualifying test produces results that exceed the table values.

consequence to his totally disabling respiratory impairment. The miner's pneumoconiosis must be more than merely a speculative cause of his disability." *Peabody Coal Co. v. Smith*, 127 F.3d 504, 507 (6th Cir. 1997). In reviewing the medical opinion evidence regarding etiology, opinions wherein the physicians did not diagnose the miner as suffering from pneumoconiosis may be accorded little probative value. *See Toler v. Easter Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989).

In this case, the claimant identified Dr. Koura as his current treating physician. Dr. Koura is highly qualified in the area of internal medicine and he saw the miner on a consistent basis for one year. Dr. Koura, along with Dr. Baker, opined that the miner suffers from pneumoconiosis and he is totally disabled due to the disease. Drs. Broudy and Rosenberg did not opine that the miner is totally disabled due to pneumoconiosis. However, the opinions of Drs. Broudy and Rosenberg are entitled to little weight because they did not diagnose the miner as suffering from pneumoconiosis, and I have found that the evidence supports the existence of the disease.

In weighing these conflicting medical opinions, I give greater deference to the opinions of Drs. Koura and Baker. Dr. Koura is the miner's treating physician and has had the opportunity to examine him on numerous occasions. His opinion is well-supported in light of the miner's extensive coal mine employment and the results of the objective testing and physical examinations. Furthermore, Dr. Koura's opinion is also well-supported by the similar opinion of Dr. Baker. Therefore, I find that the miner has established that his total disability is due to pneumoconiosis.

In conclusion, the evidence submitted in this claim establishes that claimant is totally disabled due to coal workers' pneumoconiosis. Accordingly, the claimant is entitled to benefits.

Entitlement

I reiterate that the claim involved in this proceeding was filed on September 25, 2003. (DX 2). Section 725.503(b) provides for the payment of benefits for a living miner either from the month of onset of total disability due to pneumoconiosis or from the beginning of the month in which the claim was filed. 20 C.F.R. § 725.503(b). However, Section 725.504 precludes the payment of benefits for any period during which the miner engaged in coal mine employment or comparable and gainful work. 20 C.F.R. § 725.504. *See Donadi v. Director, Office of Workers' Comp. Programs*, 12 BLR 1-166, No. 87-2354, 1989 WL 245204 at 1-2 (holding that the administrative law judge made an error of law in awarding benefits beginning on the date of filing when the evidence was uncontradicted that the miner was engaged in coal mine employment at the time of the filing).

The claimant testified that he was still employed in the coal mining industry at the time he filed his claim. Since the evidence is unclear as to the exact date the claimant ended his coal mine employment other than that it was around the end of October 2004, I find that his benefits should commence on November 1, 2004. (Tr. 14).

Attorney's Fee

Claimant's counsel has thirty days to submit an application for an attorney's fee. The application shall be prepared in strict accordance with 20 C.F.R. §§ 725.365 and 725.366. The application must be served on all parties, including the claimant, and proof of service must be filed with the application. The parties are allowed thirty days following service of the application to file objections to the fee application. In the event this decision is appealed, claimant's counsel can elect to withhold the filing of his fee petition pending the appeal.

ORDER

The employer is hereby ORDERED to pay the following:

1. to claimant, all benefits to which he is entitled under the Act, augmented by his reason of his one dependent, commencing on November 1, 2004;

2. to claimant, all medical and hospitalization benefits to which he is entitled, commencing November 1, 2004;

3. to the Secretary of Labor, reimbursement for any payment the Secretary has made to claimant under the Act, with the employer being allowed to reduce such amounts, as appropriate, from the amounts the employer is ordered to pay under paragraph 1 above; and,

4. to the Secretary of Labor or to claimant, as appropriate, interest computed in accordance with the provisions of the Act or regulations.

A

DONALD W. MOSSER
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

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

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

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