U.S. Department of Labor

Office of Administrative Law Judges
11870 Merchants Walk - Suite 204
Newport News, VA 23606

(757) 591-5140
(757) 591-5150 (FAX)

Issue Date: 09 February 2010

CASE NO.: 2007-BLA-06085

In the matter of:

ARLIS HENSLEY,

Claimant,

v.

DIXIE FUEL COMPANY, LLC/
BITUMINOUS CASUALTY CORPORATION,

Employer/Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES: Jerry Murphree
Lay Representative

Gayle G. Huff
Attorney for Employer

BEFORE: KENNETH A. KRANTZ
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations at 20 C.F.R. Parts 718 and 725. A hearing was held in Harlan, Kentucky on April 29, 2009. The documentary evidence admitted at the hearing includes Director's Exhibits (DX) 1 to 50, Employer's Exhibits (EX) 1 to 8, and Claimant's Exhibits (CX) 1 to 11. The transcript of the hearing is cited by (TR) and page number.

Overview of the Black Lung Benefits Program

Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as "black lung," is defined in the Act as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) (2006).

ISSUES

The following issues listed as contested on the CM-1025 that continue to be contested are:

1. Whether the Claimant suffers from pneumoconiosis as defined by the Act and regulations;

2. If the Claimant suffers from pneumoconiosis, whether it arose out of coal mine employment;

3. Whether the Claimant is totally disabled;

4. Whether the Claimant's disability is due to pneumoconiosis;

5. Whether Dixie Fuel Company, LLC, is the responsible operator; and

6. Whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. 725.309(c), (d).

(DX 48; TR at 5–6.)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

The Claimant filed an initial claim for benefits under the Act on August 24, 1990. (DX 1 at 59.) The Department of Labor denied benefits on January 25, 1991, finding that the Claimant had not established that he had pneumoconiosis, that pneumoconiosis arose out of coal mine employment, or that he was totally disabled by the disease. (DX 1 at 6.) Claimant took no further action on the claim.

The Claimant filed a second claim on October 1, 2003. (DX 2 at 146.) The District Director issued a proposed decision and order denying benefits on September 9, 2004, on the ground that the evidence did not establish total disability, even though the Claimant had pneumoconiosis arising out of his coal mine employment. (DX 2 at 5.) No further action was taken on this claim.

On December 4, 2006, the Claimant filed the instant claim for benefits under the Act. (DX 4.) The District Director issued a Proposed Decision and Order awarding benefits on June 25, 2007. (DX 40.) The Employer requested that the Proposed Decision and Order be reconsidered based upon reported errors. (DX 42.) The District Director issued a Revised Proposed Decision and Order affirming the earlier findings of fact and conclusions of law. (DX 43.) The Employer requested a formal hearing on August 3, 2007, and the case was forwarded to the Office of Administrative Law Judges on September 14, 2007. (DX 46; DX 47.)

Because this claim was filed after January 19, 2001, the current regulations at 20 C.F.R. Parts 718 and 725 apply. The claim arises out of the Claimant's coal-mine employment in Kentucky and is therefore within the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Factual Background

Claimant was born on August 26, 1949. He graduated from high school. (DX 4.) He is married and claims only his wife as a dependent. (TR at 17–18.)

Claimant has been credited by the Department of Labor with thirteen years of coal mine employment between July 1972 and January 1988. (DX 40.) He testified that the company with which he was employed for most of his mining career was Grays Knob Coal Company. (TR at 13.) He explained that Gray's Knob was one of the companies owned by Clyde Bennett and he had worked for one of Mr. Bennett's companies his entire mining career. The other companies included Dixie Fuel, Totz, Dione, and Mary Helen. (TR at 22–23.)

He testified that he worked for approximately ten years as a continuous miner operator and that while working at the face of the mine he was exposed to a lot of dust. He sometimes wore a company-provided mask. (TR at 15.) He testified that he subsequently worked as a pinner helper at the face, which required him to make bolts and hand them to the pinner man. He estimated that the bundles of bolts he lifted weighed 60 to 80 pounds. (TR at 14.) While working as a pinner helper, he injured his hand and arm when they got caught in a belt head. After the injury, his employer moved him outside the mine where he worked light duty for three to six months until quitting in 1988 upon the advice of his doctor. (TR at 13, 16, 19.) Claimant also listed belt man, timber man, and feeder man among the jobs he has performed at coal mines. (DX 5.)

Claimant testified that he has had no employment since ceasing to work for the mines in 1988. (TR at 16.) He stated that he filed for and received social security disability benefits after his hand was injured. (TR at 20.)

Claimant testified that he smoked approximately half a pack of cigarettes a day for 10 to 12 years but that he quit 21 or 22 years before the hearing. (TR at 15, 18.)[1]

[1] According to records kept by Dr. Baker and Dr. Dahhan, Claimant reported smoking half a pack a day for approximately 20 years (DX 16 at 14, DX 34 at 20).

Claimant testified that he first noticed breathing problems toward the end of 1987 when he was still working in the mines. (TR at 16.) He reported that he has had surgery on his knee and back and that he also has thyroid gland trouble. He said he was told he had a little arthritis in his knees but had undergone no treatment for that. (TR at 20.) Claimant stated that he drives, visits his children and grandchildren, goes to church, and otherwise stays around his home. (TR at 21.) The Claimant stated that he was being treated by his family physician, Dr. Stoltzfus, whom he had seeing for five to six years, and by Dr. Powers, a lung specialist. (TR at 17.)

Responsible Operator

The operator responsible for payment of benefits under the Act is considered the "responsible operator." This operator is the "potentially liable operator" that last employed the miner. A coal mine operator is considered a "potentially liable operator" if (1) the miner's disability arose at least in part out of employment in and around coal mines during a period when the mine or facility was operated by such operator (there is a rebuttable presumption that such was the case); (2) the operator was a mine operator for any period after June 30, 1973; (3) the miner was employed by the operator for a cumulative period of not less than one year; (4) the miner's employment with the operator included at least one working day after December 31, 1969; and (5) the operator is capable of assuming liability for payment of continuing benefits under the Act. 20 C.F.R. § 725.494 and 20 C.F.R. § 725.495. For the purposes of determining a "potentially liable operator," a cumulative period of not less than one year means a cumulative period of regular employment of not less than 125 "working days." 20 C.F.R. § 725.494 and 20 C.F.R. § 725.101(a)(32.)

Dixie Fuel Company payroll records show that Claimant was employed with the company from 1974 to 1988. (DX 2 at 134–36.) His Form CM-911 lists employment with Dixie Fuel Company from October 1974 to January 1988. (DX 1 at 57.) Claimant was awarded workers' compensation payments payable by Dixie Fuel Company. (DX 1 at 44.) He testified that he worked regularly at one of the mines owned by Clyde Bennett, including Dixie Fuel, until he was injured on the job. (TR at 18, 23.) He quit working in 1988. (TR 22.) Moreover, at the hearing, the Employer stated that there was no evidence at that time that it was not the Responsible Operator, and it has not submitted any additional evidence or argument on this issue. (TR at 6.) Therefore, I find Dixie Fuel Company is the last employer for whom the miner worked a cumulative period of at least one year and is properly designated responsible coal mine operator in this case under §§ 725.494 and 725.495.

MEDICAL EVIDENCE

A claim filed after January 19, 2001, is subject to the revised regulations of Parts 718 and 725. These regulations impose two requirements on the submission of medical evidence. Initially, they require that the evidence be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. See 20 C.F.R. §§ 718.101–718.107 (2008). Secondly, the medical evidence must comply with the limitations of Sections 725.414, 725.456, 725.457, and 725.458.

Regarding the initial evidence offered in support of entitlement to benefits, the regulations provide that claimants and responsible operators are limited to the submission of no more than two chest x-ray interpretations, two pulmonary function tests, two arterial blood-gas studies, two medical reports, one report of each biopsy and one autopsy report. 20 C.F.R. § 725.414(a)(2)(i), (3)(i) (2008). In addition, the regulations caution that x-ray interpretations, pulmonary function studies, arterial blood-gas studies, autopsy or biopsy reports, and physician opinions contained in a medical report "must each be admissible" under Section 725.414(a)(2)(i), (3)(i), (a)(4).

The regulations also provide limitations on medical evidence submitted in rebuttal of the opposing party's evidence. 20 C.F.R. § 725.414(a)(2)(ii), (3)(ii) (2008). Each party may submit no more than one physician interpretation of each chest x-ray, pulmonary function study, arterial blood-gas study, and autopsy or biopsy report submitted by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii), (3)(ii) (2008). A party may submit evidence rehabilitative of the evidence rebutted by the opposing party. The party is permitted to submit one "additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," or "from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." 20 C.F.R. § 725.414(a)(2)(ii), (3)(ii) (2008).

The Claimant designated Dr. Rosenberg's initial report and accompanying objective test results (including an x-ray reading by Dr. Halbert) as treatment records. However, Dr. Rosenberg only offered an opinion regarding the Claimant's condition and did not recommend any course of treatment. Moreover, his report was addressed to Employer's counsel rather than the Claimant. Accordingly, I find that the evidence contained in CX 8 does not constitute treatment records and is therefore subject to the evidentiary limitations at Section 725.414. The Claimant designated CX 6, which contain the opinions of Dr. Powers and Dr. Stoltzfus, as his initial medical reports, designated two x-ray interpretations by Dr. Miller and Dr. Alexander as his initial x-ray evidence, and designated Dr. Alexander's reading of the July 28, 2008, x-ray as rebuttal evidence of Dr. Rosenberg's reading. Because the Claimant has already designated two medical reports and two x-ray reports as initial evidence, as well as another x-ray to rebut Dr. Rosenberg's reading, I find that the evidence contained in CX 8, including the medical report and x-ray interpretations, exceeds the evidentiary limitations and is not admissible as Claimant's evidence. However, the Claimant specifically designated the pulmonary function study conducted by Dr. Rosenberg as one of his two pulmonary function studies and so this study is admissible. Additionally, I note that Dr. Rosenberg's report, as well as the underlying testing, was designated as evidence by the Employer and will therefore be considered. However, Dr. Halbert's x-ray interpretation was not designated by either party, and therefore is not admissible.

The Employer designated a reading of the July 28, 2008, x-ray by Dr. Wheeler as rebuttal evidence. The Claimant did not designate any readings of the July 28, 2008, x-ray as initial evidence and, as discussed above, neither Dr. Rosenberg's nor Dr. Halbert's interpretation is admissible as Claimant's evidence. The Claimant did designate a reading of that x-ray by Dr. Alexander as rebuttal evidence of Dr. Rosenberg's reading. The Employer may not rebut its own initial evidence, and Dr. Wheeler's reading may not be admitted as rehabilitative evidence in response to the Claimant's rebuttal because Dr. Wheeler is not the physician who originally

interpreted the x-ray. 20 C.F.R. § 725.414(a)(3)(ii). Therefore, Dr. Wheeler's reading of the July 28, 2008, x-ray is excluded from the evidence.

Pursuant to Section 725.309, "Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim." 20 C.F.R. § 725.309(d)(1) (2008). The medical evidence submitted in the current claim is bolded in the charts below.

X-ray Evidence

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment.

The existence of pneumoconiosis may be established by x-rays classified as category 1, 2, 3, A, B, or C, according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3 in ascending order of profusion) may be classified as round (p, q, or r) or irregular (s, t, or u), and may be evidence of "simple pneumoconiosis". Large opacities (greater than 1 centimeter) may be classified as A, B, or C (in ascending order of size) and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0", including subcategories 0/-, 0/0 and 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b).

For cases of conflicting chest x-ray reports, the regulations provide that "when two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays" 20 C.F.R. § 718.202(a)(1). Greater weight may be accorded to X-ray interpretations by dually qualified physicians. *Sheckler v Clinchfield Coal Co.*, 7 B.L.R. 1-218, 1-131 (1984). The following table summarizes the x-ray findings admitted in this case.

Exhibit	**Date of X-ray/ Reading**	**Physician/ Qualifications**	**Film Quality**	**Interpretation**
DX 1-25	9/10/90	Dahhan B	1	<u>Small Opacities</u> Profusion: 0/1 s/q, mid and lower zones - No pleural abnormalities consistent with pneumoconiosis
DX 1-24	9/10/90	Gordonson B/BCR	1	<u>Small Opacities</u> Profusion: 0/1 s/t, all zones - No pleural abnormalities consistent with pneumoconiosis
DX 1-23	9/10/90	Sargent B/BCR	2	<u>Small Opacities</u> Profusion: 1/0 t/s, all zones

				- No pleural abnormalities consistent with pneumoconiosis
DX 2-91	2/23/04	Baker B	2	<u>Small Opacities</u> Profusion: 2/1 t/s, mid and lower zones - No pleural abnormalities consistent with pneumoconiosis - Pleural thickening of an interiobar fissure
DX 2-105	2/23/04	Barrett B/BCR	1	- Quality Reading Only - Definite emphysema - Scarring in right lower lung
DX 2-24	2/23/04	Halbert B/BCR	3	- No parenchymal abnormalities consistent with pneumoconiosis - No pleural abnormalities consistent with pneumoconiosis
CX 1	**11/1/06**	**Alexander, B/BCR**	**2**	**<u>Small Opacities</u> Profusion: 2/2 p/s, all zones** - **Right diaphragm elevated and ill-defined** - **Scarring or atelectasis in right lower zone**
EX 7	**11/1/06**	**Wheeler, B/BCR**	**3**	- **No parenchymal abnormalities consistent with pneumoconiosis** - **No pleural abnormalities consistent with pneumoconiosis** - **Obesity contributes to minimal hypoinflation and crowded lower lung markings** - **Accentuated underexposure on both views and a broad band of discoid atelectasis in RML more likely than scar** - **Increased lung markings in bases and lateral periphery mid and upper lungs are probably pulmonary vascular prominence but early linear and irregular interstitial lung disease could be present possibly mixed with few tiny nodules** - **Possible 8-9mm nodule in lateral right upper lung overlying anterolateral right rib2 compatible with granuloma or tiny tumor**
DX 16	**1/5/07**	**Baker, B**	**1**	**<u>Small Opacities</u> Profusion: 2/1 q/p, all zones** - **No pleural abnormalities consistent with pneumoconiosis**

DX 17	**1/5/07**	**Barrett, B/BCR**	**2**	**- Quality Reading - Right basal scar**
DX 38/39	**1/5/07**	**Wheeler, B/BCR**	**3**	**- No pleural abnormalities consistent with pneumoconiosis - Hypoinflation with broad discoid atelectasis more likely than scar right lower lateral lung involving pleura - Probable tiny calcified granuloma lateral left mid lung - Pulmonary vascular prominence more likely than interstitial lung disease lower lung accentuated hypoinflation and underexposure**
CX 4	**1/5/07**	**Ahmed, B/BCR**	**1**	**<u>Small Opacities</u> Profusion: 1/2 q/t, all zones - Minute soft irregular and rounded parenchymal densities scattered throughout both lungs - Pleural abnormalities consistent with pneumoconiosis - Very poor inspiratory effort, infiltrate in the right lower lunch that could be atelectasis - No evidence of localized pneumonia**
DX 33/34	**4/12/07**	**Dahhan, B**	**1**	**<u>Small Opacities</u> Profusion: 1/1 q/q, upper and middle zones - No pleural abnormalities consistent with pneumoconiosis. - Opacities in mid and upper zones consistent with Category 1 simple coal workers' pneumoconiosis - Coalescence in right lower lobe with thickening of the major fissure**
EX 4 CX 8	**7/28/08**	**Rosenberg, B**	**1**	**- No pleural abnormalities consistent with pneumoconiosis - Linear scarring in the mid and lower lung zones with some atelectasis or infiltrate in right lower lung zone**
CX 3	**7/28/08**	**Alexander, B/BCR**	**1**	**<u>Small Opacities</u> Profusion: 2/2 t/p, all zones <u>Large Opacities</u> Category A - No pleural abnormalities consistent with**

				pneumoconiosis - **20 mm large opacity in the right lower zone consistent with complicated CWP (follow-up recommended)**
CX 2	**1/16/09**	**Miller, B/BCR**	**1**	**<u>Small Opacities</u>** **Profusion: 2/3** **t/q, all zones** - **Diffuse small, predominantly irregular opacities compatible with pneumoconiosis** - **Pleural abnormalities consistent with pneumoconiosis** - **Scarring or atelectasis at the right lung base**
EX 10	**1/16/09**	**Wheeler, B/BCR**	**3**	- **No pleural abnormalities consistent with pneumoconiosis** - **Moderate linear and irregular interstitial infiltrate or interstitial fibrosis lower half lungs involving pleura and possibly mixed with few nodules in lateral periphery and possible subtle interstitial infiltrate or fibrosis in lower lateral upper lobes involving pleura compatible with interstitial lung disease: usual interstitial pneumonitis, autoimmune disease or possible lymphatic spread of cancer with possible few small granulomata from histoplasmosis.** - **Transverse band of discoid atelectasis or scar between lower right hilum and lateral pleura**

Biopsy Evidence

Biopsies may be the basis of a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 C.F.R. § 718.202(a)(2). The biopsy report must contain a detailed gross macroscopic and microscopic description of the lungs or visualized portion of the lung. If a surgical procedure was performed to obtain a portion of the lung, the evidence should include a copy of the surgical note and pathology report of the gross and microscopic examination of the surgical specimen. 20 C.F.R. § 718.106(a). The Benefits Review Board has held that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113, 1-114 (1988). 20 C.F.R. § 718.106(c) specifically provides that "a negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive results are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis."

Claimant underwent a needle core biopsy on March 24, 2008, for evaluation of a right lung mass. A surgical pathology report completed by Dr. Thomas Eberts reported no normal lung tissue present in the sample and that "the specimen consists of a granulomatous inflammatory process characterized by areas of geographic caseous necrosis, surrounded by layers of

histiocytes." No malignancy was identified. The pathologic diagnosis was caseating granulomatous pneumonitis. A non-diagnostic fine needle aspiration biopsy of the mass showed blood histiocytes and bronchial epithelial cells. (CX 6.)

Dr. Everett F. Oesterling Jr. examined slides and a cytologic preparation of the materials removed during the biopsy. Dr. Oesterling is Board-certified in Anatomic Pathology, Clinical Pathology, and Nuclear Medicine. He found there was evidence of coal mine dust inhalation. He stated that the specimens were adequate to diagnose the presence or absence of a tumor but did not adequately include interstitial tissue to allow a sufficient diagnosis of interstitial lung disease, and therefore the changes could not be attributed to coal dust exposure. (EX 11.)

Pulmonary Function Tests

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity ("FVC"), forced expiratory volume in one-second ("FEV1") and maximum voluntary ventilation ("MVV").

Exhibit No.	Physician	Date of Study	Age/ Height[2]	Broncho-Dilator?	FEV1	FVC	MVV	FEV/ FVC	Comments	Qualify-ing
DX 1-26	Dahhan	9/10/90	41/66.75	No	3.65	4.45	137	N/A	Good cooperation and comprehension	No
DX 2-93	Baker	2/23/04	54/66.5	No	2.11	3.20	66	N/A	Fair Cooperation; Tracings inconsistent; Loops suggestive of suboptimal effort	No
DX 16 at 4	**Baker**	**1/5/07**	**57/ 67.25**	**No**	**1.57**	**2.33**	**N/A**	**68**	**Question maximum effort**	**Yes**
DX 33 at 8, 34 at 23	**Dahhan**	**4/12/07**	**57/ 66.5**	**No Yes**	**1.01 1.18**	**1.40 1.48**	**23**	**72 80**	**Good cooperation and**	**Yes Yes**

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983). I will use the height found by the Claimant's treating physician, Dr. Powers, which is 67 inches.

									comprehension	
CX 6	**Powers**	**3/12/08**	**58/ 67**	**No**	**1.51**	**2.32**	**N/A**	**65**	**N/A**	**Yes**
EX 5 **CX 8**	**Rosenberg**	**7/28/08**	**59/ 67**	**No** **Yes**	**1.34** **1.89**	**2.03** **2.71**	**24.81** **36.43**	**66.16** **69.68**	**Patient understood and cooperated well with good effort**	**Yes** **No**

The following chart summarizes the results of the pulmonary function studies available in this case. In a "qualifying" pulmonary study, the FEV1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV1/FVC ratio must be 55 percent or less. 20 C.F.R. § 718.204(b)(2)(i) (2008).
On January 3, 2007, Dr. Mettu filled out a report indicating that the January 5, 2007, pulmonary function study results were acceptable. (DX 16 at 3.) Dr. Vuskovich submitted a report dated April 21, 2007, stating that the January 5, 2007, pulmonary function study was invalid because the Claimant did not display maximum effort, the essential requirement for valid results. Dr. Vuskovich is Board-certified in Occupational Medicine. (DX 34.)

Arterial Blood-Gas Studies

Blood-gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect in that ability will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen ("PO2") and the percentage of carbon dioxide ("PCO2") in the blood. The lower the level of oxygen ("O2") compared to carbon dioxide ("CO2") in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood-gas studies available in this case. A "qualifying" arterial blood-gas study yields values which are equal to or less than the applicable values set forth in Appendix C of Part 718. 20 C.F.R. § 718.204(b)(2)(ii). If the results of a blood-gas test at rest do not satisfy Appendix C, then an exercise blood-gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2008).

Exhibit No.	Physician	Date of Study	Resting/ Exercising	PCO2	PO2	Altitude	Qualifying
DX 1-30	Dahhan	9/10/90	Resting Exercise	36.9 32.0	79.3 104.9	0–2999	No No
DX 2-97	Baker	2/23/04	Resting	37	77	0–2999	No
DX 16 at 8	**Baker**	**1/5/07**	**Resting**	**39**	**72**	**0–2999**	**No**
DX 34 at 31 **33 at 8**	**Dahhan**	**4/12/07**	**Resting**	**38.4**	**72.1**	**0–2999**	**No**
EX 6 **CX 8**	**Rosenberg**	**7/28/08**	**Resting** **Exercise**	**37** **32.1**	**81.3** **66.9**	**0–2999**	**No** **Yes**

Treatment Records

On November 27, 2006, the Claimant had an annual checkup at the Chronic Respiratory Clinic of Stone Mountain Health Services ("Stone Mountain"). He underwent a history and physical, reporting shortness of breath. Kellie Brooks, who performed the examination, is a Registered Nurse and a Board-certified Family Nurse Practitioner. The Claimant reported that he had been a coal miner for 13.5 years and worked as continuous miner operator for 10 of those years. During that period, he worked 8 hour per day, 5 to 6 days per week. He further reported that he wore respiratory protection while working. Claimant's symptoms included daily productive cough, wheezing, shortness of breath on exertion, orthopnea, nightly paroxysmal nocturnal dyspnea ("PND"), arthritis and back pain, and chronic left arm pain. Ms. Brooks noted that Claimant had a past medical history of severe COPD, coal workers' pneumoconiosis, pneumonia, hypothyroidism, osteoarthritis, 1987 left hand injury with continued pain, right carpal tunnel syndrome, and chronic left hand pain.[3] Claimant reported smoking one-half of a pack per day for 10 years before quitting in 1986. Ms. Brooks noted the following immunizations: tetanus in 2002; pneumovax in 2005; flu vaccine in 2006; and negative PPD in November, 2006. (CX 7.)

Upon physical examination, Ms. Brooks noted that the Claimant had a barrel chest, good, symmetric expansion, hyperresonance to percussion, and his breath sounds were diminished but clear. Ms. Brooks observed no clubbing, cyanosis or edema but did note varicosities in the Claimant's ankles. She further noted decreased range of motion in the Claimant's left hand with what appeared to be contractures of the fourth and fifth digits. Ms. Brooks diagnosed the Claimant with coal workers' pneumoconiosis, COPD, and shortness of breath. (CX 7.)

On March 24, 2008, the Claimant had a fluid specimen tested for tuberculosis and right lung mass tested for fungal infection. There was no growth in either culture after five weeks. The Claimant had tuberculosis (PPD) tests administered on July 25, 2008, November 24, 2008, and January 27, 2009. The results were negative. On November 25, 2008, the Claimant underwent a battery of tests to determine the presence of a fungal infection, including histoplasmosis. No evidence of infection was detected. (CX 6.)

The Claimant saw Dr. Powers on November 24, 2008, for a follow-up appointment regarding coal workers' pneumoconiosis, abnormal CT-scan/chest x-ray, occasional wheezing, and increased shortness of breath. The Claimant's oximetry was 92 percent at rest on room air. Dr. Powers noted that the March 2008 biopsy revealed caseous granuloma changes. Dr. Powers's assessment reads as follows

CWP vs. histoplasma [changes] – more dyspnea?

[3] The Claimant's arthritis, back pain, and chronic left arm pain, were noted under the section titled "RHEUM."

? Caplan's syndrome[4]/[rheumatoid arthritis] + fibrosis; CWP

(CX 6.)

The Claimant visited Dr. Powers again on December 15, 2008. The Claimant's symptoms included increased cough, wheezing, sinus problems, and dyspnea. The Claimant's oximetry was 100 percent at rest on room air. Dr. Powers noted that the Claimant had a mild restriction and that his DLCO/VA was within normal limits. Dr. Powers diagnosed the Claimant with "likely CWP +/- granulomas," rhinitis, arthritis in his shoulder, and caseous granulomas. He further noted that the Claimant had a restrictive impairment secondary to those diagnoses. Dr. Powers ordered a PPD test and a CT-scan. (CX 6.)

On January 29, 2009, the Claimant had several blood tests conducted. The Rheumatoid Factor test was positive. Several other tests were positive, and the comments indicate that the results obtained were associated with Sjögren syndrome[5] and SLE. The Claimant was also tested for histoplasma infection, but these tests were negative. (CX 6.)

On February 5, 2009, the Claimant had another annual checkup at Stone Mountain. The examination was conducted by Paul Augustine, M.D., who is Board-certified in Internal Medicine. (CX 7.) The Claimant reported working in the mines until 1987. His symptoms included chronic dyspnea, wheezing, and cough with expectoration of thick whitish sputum. Dr. Augustine noted that the Claimant had a history of frequent respiratory infections, but no history of orthopnea, PND, pedal edema, or hemoptysis. The Claimant reported smoking half a pack a day for 10 years before quitting in 1986. (CX 7.)

On examination, Dr. Augustine noted that the Claimant's sinus rhythms were regular and observed no murmurs, rubs, gallops, or clicks. Examining the lungs, Dr. Augustine observed decreased air entry bilaterally. Dr. Augustine also summarized the results of a pulmonary function test that was conducted on January 6, 2009, which showed an FEV1 that was 56 percent of the predicted value, an FVC that was 51 percent of the predicted value, and an FEV1/FVC ratio of 69 percent. Dr. Augustine noted that a B-reading of a chest x-ray had been performed but the report was still pending. Dr. Augustine diagnosed the Claimant with coal workers' pneumoconiosis and COPD, as well as chronic dyspnea as a result of these two conditions. (CX 7.)

CT-Scans

CT-scans fall under the category of "Other medical evidence" and must satisfy the requirements of Section 718.107 to be admissible. Specifically, the proffering party bears the burden of demonstrating that the CT-scans are "medically acceptable and relevant to establishing

---

[4]I take judicial notice that Caplan syndrome is "swelling (inflammation) and scarring of the lungs in people with rheumatoid arthritis who have been exposed to mining dust, such as coal, silica, or asbestos." http://www.nlm.nih.gov/medlineplus/ency/article/000137.htm.

[5]I take judicial notice that Sjögren syndrome "is an autoimmune disorder in which the glands that produce tears and saliva are destroyed. The condition may affect many different parts of the body, including the kidneys and lungs." http://www.nlm.nih.gov/medlineplus/ency/article/000456.htm.

or refuting a claimant's entitlement to benefits." 20 C.F.R. § 718.107 (2008); *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA, slip op. at 4–5 (May 26, 2005) (unpub.). Additionally, only one reading or interpretation of each CT-scan may be submitted as affirmative evidence. *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123 (2006) (en banc), *aff'd on recon.*, 24 B.L.R. 1-1 (2007) (en banc).

In this case, results from several CT-scans were included in the treatment records submitted by Claimant. (CX 6.) Additionally, the results of these CT-scans were part of the medical records reviewed by Dr. Rosenberg in his April 27, 2009, supplemental report. (EX 9.) The CT-scans in question were ordered by Dr. Powers, one of the Claimant's treating physicians, for the purpose of determining the nature of the abnormalities seen in the Claimant's lungs. Given that these tests were ordered by the Claimant's treating physician for the purpose of diagnosing his lung condition and were relied upon by Dr. Rosenberg in his opinion regarding the nature of that condition, I find that the CT-scans are medically acceptable and relevant to establishing or refuting the Claimant's entitlement to benefits.

A CT-scan of the Claimant's chest taken on February 19, 2008, revealed:

> 1) Findings compatible with segmental consolidation and/or atelectasis of the lateral segment of the right middle lobe is associated with soft tissue fullness in the adjacent right pulmonary hilum, which may represent right hilar adenopathy
> 2) Incidental finding is made of a 3.7 cm ovoid-shaped mass with spiculated margins are seen at the right lung base and differential diagnoses will have to include the possibility of neoplastic or inflammatory mass.
> 3) A moderate amount of infiltrates at the left lung base was also identified.

(CX 6.)

A CT-scan of the Claimant's chest taken on July 22, 2008, revealed:

> 1. Pulmonary fibrosis, primarily basilar
> 2. Multiple nodules within the lungs including a [3.7 cm] dominant right lower lobe mass which has undergone a previous biopsy. This mass is stable in appearance. The numerous smaller nodules are most suggestive of noncalcified or partially calcified granulomata.

An addendum to the report was added later that day, after the CT-scan was compared with the February 19, 2008, CT-scan. The addendum states:

> 1. Limited correlation with prior exam with inability to window or level the prior examination.
> 2. Interval development of multiple pulmonary nodules, most noncalcified. Diffuse granulomatous disease or early neoplasm is certainly a consideration.
> 3. Stable atelectasis in the region of the major fissure on the right side and stable soft tissue nodularity, right lower lobe.

(CX 6.)

A CT-scan of the Claimant's chest taken on January 27, 2009, revealed "[m]ultiple pulmonary nodules and masses and adenopathy, as well as scattered scarring, atelectasis, and inflammatory changes, without significant change from 11-4-08. The largest mass remains at the right lung base." (CX 6.)

Medical Reports

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative chest x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 C.F.R. § 718.201. 20 C.F.R. §§ 718.303(a)(4) (2008). Thus, even if the chest x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director*, OWCP, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2008).

Where total disability cannot be established by pulmonary function tests, arterial blood-gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood-gas studies are medically contraindicated, total disability may nevertheless be found if a physician, exercising reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv) (2008).

<u>Dr. Glen Baker</u>

Dr. Baker conducted the Department-sponsored examination of the Claimant on January 5, 2007. He filled out a CM-988 Evaluation Form summarizing the results of the examination and his opinions regarding Claimant's condition. (DX 16.) Dr. Baker is Board-certified in Internal Medicine with a subspecialty in Pulmonary Diseases. (DX 40.) He is also a B-Reader. His evaluation of the Claimant consisted of a physical examination, chest x-ray, pulmonary function test, arterial blood-gas study, and EKG. (DX 16 at 15.) Dr. Baker also reviewed Claimant's work, medical, and smoking history. A copy of the Claimant's CM-911a Employment History form was attached. (DX 16 at 17.) Dr. Baker noted that Claimant reported 14 years of mine employment through 1988, including time as a belt man, timber man, feeder man, and continuous miner helper.

Claimant reported that he began experiencing daily coughing, wheezing, sputum production, and dyspnea 15 years earlier and orthopnea between 10 and 15 years earlier. He reported using two pillows at night and stated that he used an inhaler to help with his shortness of breath. Claimant reported that he had a history of peptic ulcer disease, a back injury in 1981 or 1982, and pneumonia in 2005 and December 2006. He also reported past surgeries for his back in 1982, thyroid in 1974, gallbladder, and hernia in 1976. Dr. Baker noted that Claimant had smoked a half a pack of cigarettes per day for 20 years and stopped smoking more than 20 years earlier. (DX 16 at 14.)

Dr. Baker also discussed the objective test results. The pulmonary function testing showed a moderate obstructive defect with a mild degree of restriction. The chest x-ray was consistent with pneumoconiosis, category 2/1. (DX 16 at 11.) The arterial blood-gas study showed mild resting arterial hypoxemia, and the EKG showed a normal sinus rhythm. (DX 16 at 15.)

Based on these tests and his examination, Dr. Baker diagnosed Claimant with clinical and legal pneumoconiosis. (DX 16 at 14.)

Dr. Baker diagnosed the Claimant with clinical pneumoconiosis, opining that that Claimant's alleged 14 years of coal dust exposure with no other condition to account for the x-ray changes created a presumptive diagnosis that the changes were due to coal dust and represent coal workers' pneumoconiosis. He noted a lung biopsy would be necessary for proof but was not clinically indicated at the time. (DX 16 at 11.)

Dr. Baker also diagnosed the Claimant with legal pneumoconiosis. He stated that the Claimant had chronic obstructive pulmonary disease ("COPD") with a moderate degree of obstruction and a mild degree of restriction, mild resting arterial hypoxemia, and chronic bronchitis, all of which he determined to have been significantly contributed to or substantially aggravated by coal dust exposure. Dr. Baker noted that the Claimant had a 10 pack year smoking history and that he had stopped smoking over 20 years earlier. Dr. Baker opined that this was not a significant enough history to produce the Claimant's impairment. (DX 16 at 11.)

Upon review of Claimant's pulmonary function studies, Dr. Baker reported a class 3 impairment or 25 to 50 percent impairment of the whole person based on the Claimant's FEV1 value between 40 and 59 percent of predicted. On that basis, Dr. Baker opined that Claimant "would not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust free environment." He concluded by stating that the Claimant's coal workers' pneumoconiosis, COPD, mild resting arterial hypoxemia, and chronic bronchitis all contributed to his pulmonary impairment, and reiterated that all of these conditions were primarily caused by his coal mine dust exposure. (DX 16 at 11.)

Dr. Abdul K. Dahhan

Dr. Dahhan examined the Claimant on April 12, 2007, reviewed prior medical records, and prepared a report summarizing the results of the examination and his opinions concerning

Claimant's condition. (DX 34.) Dr. Dahhan is Board-certified in Internal Medicine and Pulmonary Medicine. (DX 34 at 36.) He is also a B-Reader. His evaluation of the Claimant consisted of an arterial blood-gas study at rest, pulmonary function test, chest x-ray, and EKG. He also reviewed Dr. Baker's report, chest x-ray, pulmonary function test, and arterial blood-gas study of January 5, 2007, as well as the Claimant's claim for benefits, the Department of Labor employment history for Claimant, and a description of his coal mining work. (DX 34 at 21–22.)

Considering Claimant's smoking and medical history, Dr. Dahhan noted Claimant had smoked half a pack of cigarettes a day for approximately 20 years but quit 20 years ago at the age of 37. He also noted Claimant had a history of rheumatoid arthritis for which he was on medication. (DX 34 at 20.)

Dr. Dahhan discussed the objective test results. The arterial blood-gas test showed minimum hypoxemia. The chest x-ray showed opacities in the mid and upper zones consistent with Category 1 simple coal workers' pneumoconiosis. The EKG showed regular sinus rhythm with occasional PVCs. Dr. Dahhan concluded that Claimant's pulmonary function studies during his exam under-estimated his true ventilatory reserve based on the test done by Dr. Baker in which Dr. Baker noted fair cooperation. (DX 34 at 21–22.)

Dr. Dahhan stated the following conclusions based on his review of the medical records and examination of the Claimant:

1. Mr. Hensley has Category 1 simple coal workers' pneumoconiosis
2. Mr. Hensley's pulmonary function studies during my exam under-estimate his true ventilatory reserve as confirmed by the data from Dr. Baker despite his indication that the cooperation was only fair during his exam with an FVC of 60% and FEV1 of 50%.
3. From a respiratory standpoint, Mr. Hensley does not retain the physiological capacity to return to his previous coal mining work or job of comparable physical demand.
4. Mr. Hensley's rheumatoid arthritis could very well be responsible for the changes noted on the chest x-rays including the opacities in the thickening of the major fissure. Rheumatoid arthritis is known to affect the lungs in various modalities including the presence of pulmonary fibrosis and nodules.
5. Mr. Hensley's pulmonary disability has resulted from his rheumatoid lung disease and possibly contributed to by his smoking habit. Rheumatoid arthritis can cause bronchiolitis obliteran, pleural thickening, interstitial pulmonary fibrosis, sterile pleural effusion and rheumatoid nodules. This patient has three of [these] findings, i.e. interstitial pulmonary fibrosis, bronchiolitis obliteran and thickening of the major fissures. Rheumatoid arthritis is a condition of the general public at large and is not caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis, hence, this patient has no evidence of legal pneumoconiosis.

(EX 34 at 22.)

On February 25, 2009, the employer deposed Dr. Dahhan regarding his medical findings and additional medical evidence he had reviewed since writing his original report. That evidence included the lung biopsy results. Dr. Dahhan opined that "the biopsy did not show the changes that you expect to see due to pneumoconiosis. Rather, it showed non [sic] caseating granuloma which is seen in patient[s] with rheumatoid involvement of the lung rather than coal dust impact on the lung." (EX 1 at 10.)

Dr. Dahhan offered additional explanation for his previous opinion that the Claimant's impairment was due to his rheumatoid arthritis. He stated that a more proper characterization of the condition was rheumatoid disease because it affects more than just the joints and is an inflammatic process of collagen. He stated:

> In this case, it's affected by developing of granulomas and it can affect the joints, it affects the lungs, it affects the bronchial pipes, it affects the pleura which is the lining of the lung, as well as the kidneys and subcutaneous tissue so it manifests itself by arthritis, vasculitis, inflammation of the blood vessels, kidney failure, pleural effusion, interstitial lung disease and conglomerate masses in the lungs as well as masses in the subcutaneous tissue. Nobody knows the exact cause of the disease.

(EX 1 at 7.) Dr. Dahhan also discussed the affects of the disease on the pulmonary system, stating:

> It affects the pulmonary system in two (2) ways. It can cause an obstruction as well as restriction. The entity called bronchiolitis obliterans which is a condition well described in the literature and means inflammation of the bronchial walls and that will cause a mixed obstructive or restrictive defect. In addition, when there is interstitial disease, there will be a restriction in the pulmonary function studies.

(EX 1 at 9.)

He noted that x-ray images of rheumatoid disease affecting the respiratory system could appear on an x-ray to be similar to markings caused by coal workers' pneumoconiosis. Such markings would include pleural effusion manifesting itself as fluid or thickening, scars in the lungs from pulmonary fibrosis, or pulmonary nodules appearing as lumps on the lungs. (EX 1 at 8.)

Dr. Dahhan also commented on the changes since his first examination of the Claimant in 1990. (EX 1 at 11.) At that time, Dr. Dahhan read a September 10, 1990, x-ray as showing s/q small opacities in the lower zones and the mid right zone with a profusion of 0/1. (DX 1 at 25.) Rheumatoid arthritis is a progressive disease, and therefore could account for the additional spots seen on the Claimant's lungs in the 2007 x-ray. (EX 1 at 11–12.) Dr. Dahhan also commented on the pulmonary function test taken as part of his 1990 examination of the Claimant. (DX 1 at 26.) That test showed better values than the 2007 test, which could be accounted for by the progression of the Claimant's rheumatoid arthritis. (EX 1 at 13.) He opined that rheumatoid disease is a progressive disease and that he had patients with rheumatoid arthritis who displayed

similar x-ray manifestations and respiratory impairment. He further opined that since the Claimant had not been exposed to coal dust since 1987 or 1988, coal dust exposure should not account for the changes in the Claimant's condition, although he acknowledged that the literature did not rule out the latent impact of coal dust on the respiratory system. Dr. Dahhan concluded that the Claimant's condition was made worse by his rheumatoid disease as well as aging. (EX 1 at 12–13.)

Dr. David M. Rosenberg

Dr. Rosenberg examined the Claimant on July 28, 2008, reviewed prior medical records, and prepared a report summarizing the results of the examination and his opinions concerning Claimant's condition. (EX 3.) After reviewing additional prior medical evidence on April 27, 2009, he prepared a supplemental report. (EX 9.) Dr. Rosenberg is Board-certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine. He is also a certified B-reader. (EX 3.)

His evaluation of the Claimant included a resting and exercise arterial blood-gas test, an EKG, a chest x-ray, and a pulmonary function test. He reviewed the Claimant's answers to interrogatories, his claim application, the reports by Dr. Baker and Dr. Dahhan, various chest x-ray readings, and the pathology report from Claimant's biopsy. (EX 3.)

Dr. Rosenberg noted Claimant's 14 years of coal mine employment and a 22-year, half-a-pack-per-day cigarette habit. He also noted Claimant had a history of rheumatoid arthritis. Dr. Rosenberg discussed the test results. He stated the chest x-ray revealed no micronodularity related to past coal mine dust exposure but did show linear scarring in the mid and lower lung zones with some atelectasis or infiltrate in the right lower lung zone. Claimant showed improvement on a pulmonary function test when bronchodilators were used. The arterial blood-gas test revealed worsening oxygenation in association with exercise. The EKG revealed a normal sinus rhythm. (EX 3 at 3–4.)

Regarding the x-ray, Dr. Rosenberg stated that when coal mine dust exposure causes interstitial lung disease, it is as a micronodularity in the upper lung zones, not linear changes in the lower lung zones. He found that the result of the biopsy, finding the presence of a caseating granulomatous pneumonitis, was suggestive of a condition such as tuberculosis or a fungal infection. He also noted that rheumatoid arthritis commonly manifests as interstitial involvement in the lungs. (EX 3 at 4.) Examining studies that found a relationship between linear interstitial lung disease and coal mine dust exposure, Dr. Rosenberg concluded that such studies could not be used to establish a causal relationship between coal mine dust exposure and the development of linear interstitial lung disease because the studies did not control for factors known to cause interstitial linear scarring, such as smoking. He cited other studies showing interstitial involvement in patients with rheumatoid arthritis. (EX 3 at 5.)

Examining the Claimant's impairment, Dr. Rosenberg opined that the Claimant was disabled based on the significant fall in PO2 in association with exercise shown by the arterial blood-gas study. However, he attributed this impairment to the presence of linear interstitial basilar predominate scarring related to rheumatoid arthritis and other disorders but not to past

coal mine dust exposure. Additionally, he stated that Claimant's marked bronchodilator response in the pulmonary function test indicated that his airflow obstruction did not represent the presence of legal coal workers' pneumoconiosis. (EX 3 at 5.)

Dr. Rosenberg ultimately determined "while Mr. Hensley does have interstitial lung disease, it is of a linear character which is unrelated to past coal mine dust exposure." He concluded that although Claimant was disabled, he did not have clinical or legal coal workers' pneumoconiosis. (EX 3 at 6.)

On April 27, 2009, Dr. Rosenberg reviewed the Claimant's medical records and prepared a supplemental report. Specifically, he reviewed the following: Dr. Powers's treatment notes; Dr. Powers's March 9, 2009, report; the CT-scans taken February 19, 2008, July 22, 2008, and January 27, 2009; Dr. Stoltzfus's January 6, 2009, report; the results of several tuberculosis and histoplasmosis tests; and Dr. Wheeler's reading of the November 1, 2006, x-ray. (EX 9 at 1–3.)

He stated that the CT-scans did not show micronodularity related to coal mine dust exposure. Rather, they showed linear interstitial scarring, granulomas changes over the past year, and a large mass formation in the right lower lung zone. A biopsy of this mass revealed the presence of caseating granulomata, which Dr. Rosenberg opined was not indicative of a coal-mine-dust-related disorder; rather, such a finding represented the presence of either an inflammatory process, such as vasculitis or necrotizing sarcoidosis, or an infection, even though Claimant's test results were negative. Dr. Rosenberg cited to various articles discussing granulomata formation and stated that they supported his conclusion that coal mine dust does not cause this type of pathologic finding. (EX 9 at 3.)

Dr. Rosenberg criticized the opinions of Dr. Powers and Dr. Stoltzfus, which found that Claimant's coal mine dust exposure contributed to his respiratory impairment, arguing that such conclusions were not objectively supported. Specifically, he reiterated that the caseating granulomatous inflammation was unrelated to past coal dust exposure and that rheumatoid arthritis commonly causes linear interstitial scarring, which is not coal-mine-dust-related. He opined that the Claimant's restriction was related to his linear interstitial changes related to his arthritic condition and the granulomatous changes noted above. Additionally, Dr. Rosenberg noted that the Claimant's response to bronchodilators, even though his values did not return to normal, supported the existence of an obstruction unrelated to coal mine dust. He noted that coal mine dust causes chronic airway scarring, which is not associated with bronchodilator response, and that the Claimant's partial but clinically significant improvement in airflow means that chronic irreversible scarring is not present. He reiterated that a total reversal to normal is not required to support this conclusion. Dr. Rosenberg concluded that the Claimant did not have a coal-mine-dust-related condition and that his earlier conclusions were still supported. (EX 9 at 3–4.)

<u>Dr. Richard G. Stoltzfus</u>

Dr. Stoltzfus wrote a letter regarding the Claimant on January 6, 2009, stating:

> The patient is a regular patient of mine. He has a history of working in the mines underground for 14 years and does have x-ray changes which, in my opinion, are consistent with coal workers' pneumoconiosis. Further he does have Sjögren syndrome as well as a history of cigarette smoking, none for 20 years. In my opinion, both of these conditions may be contributing factors to his chronic lung condition. There is no evidence of histoplasmosis.

(CX 6.)

Dr. William P. Powers

Although his credentials are not in the record, I take judicial notice that Dr. Powers is Board-certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine. *See D.S. v. Double S Mining, Inc.*, 2005-BLA-05218, slip op. at 12 (ALJ Oct. 29, 2008).

Dr. Powers wrote a letter regarding the Claimant on March 9, 2009, stating:

> Mr. Hensley has moderate respiratory airflow obstruction with reduction in lung volumes and diffusion capacity. He has a tobacco history, a mining history and a history likely of histoplasmosis. He also has a history of arthritis which I suspect may well be rheumatoid. . . . [A]ll of these entities can cause abnormalities of respiratory physiology and abnormal radiographic findings. Although the predominant radiographic findings are lower lung field and more linear than reticulonodular, I cannot say with certainty that all of the changes came from the other entities. It is my opinion that all of the above entities are playing some role in his respiratory impairment but it is impossible for me to tell how much can be evenly attributed to each disease process.

(CX 6.)

STANDARD FOR ENTITLEMENT

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718. Under Part 718, the Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-3 (1986) (en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986) (en banc). Evidence which is in equipoise is insufficient to sustain Claimant's burden in this regard. *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), *aff'g sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F. 2d. 730 (3rd Cir. 1993). Failure to establish any one of these elements precludes entitlement to benefits.

Subsequent Claim

Claimant's second, 2003 claim for benefits was denied on September 9, 2004, by the District Director. As a result, the December 4, 2006, claim involved in this proceeding constitutes a "subsequent claim" under the regulations. The provisions of Section 725.309(d) apply to subsequent claims and are intended to provide relief from the traditional notions of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248, 1253–54 (10th Cir. 1990); 20 C.F.R. § 718.201(c). Under Section 725.309(d), subsequent claims must be denied on the grounds of the prior denial unless new evidence submitted in connection with the subsequent claim demonstrates that one of the applicable conditions of entitlement that was previously found against the Claimant has changed. 20 C.F.R. § 725.309(d)(2), (3) (2008). Thus, the initial analysis is limited to a review of the condition or conditions of entitlement upon which the prior denial was based. In the denial of the Claimant's 2003 claim, the District Director determined that the evidence failed to establish that the Claimant was totally disabled. (DX 2.) Therefore, if the newly-submitted evidence establishes that the Claimant is totally disabled, then I must review the entire record to determine entitlement to benefits.

Total Disability

In order to establish that he is entitled to benefits, the Claimant must establish that he is totally disabled by a pulmonary or respiratory impairment. A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304 (2008), or if he has a pulmonary or respiratory impairment that prevents him from doing his usual coal mine employment or comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204 (b) (2008).

<u>Complicated pneumoconiosis</u>

The Claimant is entitled to the irrebuttable presumption that he is totally disabled under 20 C.F.R. § 718.304 if he has complicated pneumoconiosis. *See Usery v. Turner Elkhord Mining Co.*, 428 U.S. 1, 2, 11 (1976); *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 255 (4th Cir. 2000).

Section 718.304 sets out three methods by which a claimant may establish the existence of complicated pneumoconiosis: a) when diagnosed by x-ray, yields one or more large opacities classified as Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization; b) when diagnosed by biopsy or autopsy, yields massive lesions in the lungs, or c) when diagnosed by other acceptable medical procedures, would be a condition which could reasonably be expected to yield the results above. § 718.304(a)–(c). The Benefits Review Board has held that Sections 718.304(a)–(c) do not provide alternative means of establishing complicated pneumoconiosis. Rather, the Board requires the administrative law judge to first evaluate the evidence in each category, and then to weigh together the categories at Sections 718.304(a)–(c). *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (en banc).

The only evidence of complicated pneumoconiosis in this case is Dr. Alexander's reading of the July 28, 2008, x-ray: specifically his finding of a Category A large opacity in the right lower lung zone. (CX 3.) The other x-ray interpretations in the record, including several written by dually-qualified physicians, noted the abnormality in the Claimant's right lower lung zone, but did not indicate that it was consistent with pneumoconiosis. Moreover, the mass in question was biopsied on March 24, 2008, and was determined to consist of "a granulomatous inflammatory process characterized by areas of geographic caseous necrosis, surrounded by histiocytes." Both Dr. Rosenberg and Dr. Dahhan opined that the biopsy findings were not consistent with changes associated with pneumoconiosis, and there are no contrary medical opinions. (EX 3 at 4; EX 9 at 3; EX 1 at 10.) Thus, I find that the medical evidence does not establish the presence of complicated pneumoconiosis, and the Claimant has therefore failed to establish that he is entitled to the presumption at Section 718.304.

The regulations also provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood-gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinion; and (5) lay testimony. Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, all the evidence must be weighed in determining whether disability has been established. 20 C.F.R. § 718.204(b)(2); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

Pulmonary Function Tests

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV1 values equal to or less than those listed in the tables and either: (1) FVC values are equal to or below listed table values, (2) MVV values are equal to or below listed table values, or (3) a percentage of 55 or less results when the FEV1 test results are divided by the FVC test results.

The record contains four pulmonary function tests. The FEV1 and FVC values for each of the four tests obtained without the use of bronchodilators are qualifying. Two of the tests also contained results from testing after the use of a bronchodilator. The April 12, 2007, post-bronchodilator pulmonary function test resulted in qualifying values, while the August 28, 2008, test did not.

In regard to the January 5, 2007, test, which showed qualifying results, the technician conducting the test noted fair cooperation and good comprehension, but questioned whether the Claimant gave maximum effort. (DX 16 at 4.) Although Dr. Mettu later asserted that the results were valid, Dr. Vuskovich opined that the lack of maximum effort rendered the results invalid. (DX 16 at 3, DX 34.) In the April 12, 2007, test, which was also qualifying, the technician noted good cooperation and good comprehension. (DX 33 at 8.) Dr. Dahhan, however, concluded that the test underestimated the Claimant's true ventilatory reserve. (DX 34 at 21–22.) The March

12, 2008, test, which also showed qualifying values, included no comment on the Claimant's effort, making the study non-conforming. (CX 6.) The only conforming study, dated July 28, 2008, displayed qualifying pre-bronchodilator results but non-qualifying post-bronchodilator results. (EX 5.)

I am persuaded by Dr. Vuskovich's opinion that valid results require maximum effort and therefore accord little weight to the January 5, 2007, study, and the March 12, 2008, study, the latter of which contained no comment regarding the Claimant's effort. I also accord little weight to the April 12, 2007, study because of Dr. Dahhan's opinion that the test underestimated the Claimant's true ventilatory reserve. The only conforming study, taken July 28, 2008, had conflicting pre- and post-bronchodilator results. Accordingly, I find that the pulmonary function studies fail to establish that the Claimant is totally disabled.

Arterial Blood-gas Studies

Total disability may also be found under 20 C.F.R. § 718.204(b)(2)(ii) if there are arterial blood-gas studies with results equal to or less than those contained in the tables found at Appendix C to Part 718.

The record contains three arterial blood-gas studies. The resting values for each of the three studies are non-qualifying. The July 28, 2008, study also included an exercise test that did result in qualifying values. Weighing the blood-gas study evidence, I find that it fails to establish that the Claimant is totally disabled.

Cor Pulmonale

Subsection 718.204(b)(2)(iii) provides that a miner may establish his total disability if he has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure. There is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure.

Medical Opinions

Under 20 C.F.R. § 718.204(b)(2)(iv), total disability may be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable gainful work. The record contains medical opinions from three doctors regarding the Claimant's level of impairment.

Upon review of Claimant's pulmonary function studies, Dr. Baker reported a class 3 impairment based on the Claimant's FEV1 value equaling between 40 and 59 percent of the predicted value. On that basis, Dr. Baker opined that Claimant "would not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust free environment." (DX 16 at 11.)

In addition to performing his own evaluation of the Claimant, Dr. Dahhan reviewed Dr. Baker's report. Although he concluded that the January and April 2007 pulmonary function studies underestimated the Claimant's true ventilatory reserve, he concluded "from a respiratory standpoint, Mr. Hensley does not retain the physiological capacity to return to his previous coal mining work or a job of comparable physical demand." (DX 34 at 22.)

Dr. Rosenberg reviewed the opinions of Dr. Baker and Dr. Dahhan and conducted his own evaluation of the Claimant. He opined that the Claimant was disabled based on the significant fall in PO2 seen on his exercise arterial blood-gas study. (EX 3 at 5–6.)

Examining the medical opinions regarding disability, I note that all three physicians found the Claimant to be totally disabled. Dr. Baker relied on the pulmonary function test conducted during his evaluation of the Claimant, which I have accorded little probative weight. Accordingly, I give Dr. Baker's opinion regarding disability less weight. However, Dr. Dahhan, who acknowledged the nonconforming nature of both Dr. Baker's study and his own study, still opined that the Claimant was totally disabled. Likewise, Dr. Rosenberg opined that the Claimant was disabled based on his significant decrease in PO2 associated with exercise. I note that Dr. Rosenberg was the only physician to conduct an exercise blood-gas study. Therefore, I find that the medical opinion evidence establishes that the Claimant is totally disabled. 20 C.F.R. § 718.204(b)(2)(i).

The finding that the Claimant is totally disabled satisfies the requirement that the Claimant demonstrate a material change in condition for a subsequent claim under 20 C.F.R. § 725.309(d). The remainder of the record now must be analyzed to determine if the Claimant has pneumoconiosis, if the pneumoconiosis arose out of his coal mine employment, and if he is totally disabled due to pneumoconiosis and is therefore entitled to benefits.

Existence of Pneumoconiosis

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2008).

Moreover, Section 718.203(b) provides that, if it is determined that the Claimant suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the Claimant suffered from pneumoconiosis but worked less than ten years in the coal mines, then the Claimant must establish causation by competent medical evidence. 20 C.F.R. § 718.203(c) (2008); *see Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986).

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2008).

<u>Chest x-ray evidence</u>

When weighing chest x-ray evidence, the provisions at Section 718.202 require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." 20 C.F.R. § 718.202(a)(1). In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-Reader or Board-certified radiologist over that of a physician without these specialized qualifications. *See Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Alley v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-Reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. See *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

Six readings (including one quality reading) of two x-rays were submitted in the prior claims.

Dr. Sargent, a dually qualified Board-certified radiologist and B-reader, interpreted an x-ray taken on September 10, 1990, as positive for pneumoconiosis. However, Dr. Gordonson, a dually qualified Board-certified radiologist and B-reader, and Dr. Dahhan, a B-reader, interpreted the same x-ray as negative for pneumoconiosis. As the film was read by two dually-qualified physicians and one B-reader with contrary findings, I find this x-ray to be in equipoise.

Dr. Baker, a B-reader, interpreted an x-ray taken on February 23, 2004, as positive for pneumoconiosis. However, Dr. Halbert, a dually qualified Board-certified radiologist and B-reader, interpreted the same x-ray as negative for pneumoconiosis. Because Dr. Halbert is a dually-qualified physician, I accord his interpretation greater weight than that of Dr. Baker and find this x-ray to be negative for pneumoconiosis.

Eleven x-ray readings (including one quality reading) of five x-rays were submitted in the current claim.[6]

Dr. Alexander and Dr. Wheeler, both Board-certified radiologists and B-readers, interpreted an x-ray taken on November 1, 2006. Dr. Alexander observed small opacities with a profusion of 2/2. Dr. Wheeler interpreted the x-ray as negative for pneumoconiosis. As the film was read by two equally-qualified readers with contrary findings, I find this x-ray to be in equipoise.

An x-ray taken on January 5, 2007, was read by Dr. Baker, Dr. Wheeler, and Dr. Ahmed. Dr. Barrett, a Board-certified radiologist and B-reader, did the quality reading on the film and noted a right basal scar. Dr. Baker, a B-reader, observed small opacities with a profusion of 2/1. Dr. Wheeler, a Board-certified radiologist and B-reader, interpreted the x-ray as negative for pneumoconiosis. Dr. Ahmed, a Board-certified radiologist and B-reader, observed small opacities with a profusion of 1/2. As the film was read by two dually-qualified physicians and one B-reader with contrary findings, I find this x-ray to be in equipoise.

Only one interpretation was submitted for an x-ray taken on April 12, 2007. Dr. Dahhan, a B-reader, observed small opacities with a profusion of 1/1 which he determined to be consistent with simple coal workers' pneumoconiosis. Accordingly, I find this x-ray to be positive for pneumoconiosis.

Dr. Rosenberg and Dr. Alexander interpreted an x-ray taken on July 28, 2008. Dr. Rosenberg, a B-reader, interpreted the x-ray as negative for pneumoconiosis. Dr. Alexander, a Board-certified radiologist and B-reader, observed small opacities with a profusion of 2/2.[7] Because Dr. Alexander is a Board-certified radiologist and B-reader and Dr. Rosenberg is only a B-reader, I give greater weight to Dr. Alexander's interpretation and find this x-ray to be positive for pneumoconiosis.

---

[6] A twelfth x-ray reading submitted by the Employer, a reading of the July 28, 2008, x-ray by Dr. Wheeler, was improperly classified as a rebuttal reading and will not be considered.

[7] Dr. Alexander's finding of a Category A large opacity has already been weighed in the previous section discussing total disability.

An x-ray taken on January 16, 2009, was interpreted by Dr. Miller and Dr. Wheeler, both Board-certified radiologists and B-readers. Dr. Miller observed small opacities with a profusion of 2/3. Dr. Wheeler interpreted the x-ray as negative for pneumoconiosis. Because Dr. Miller and Dr. Wheeler are equally-qualified readers with contrary findings, I find this x-ray to be in equipoise.

The April 12, 2007, and July 28, 2008, x-rays are found to be positive for pneumoconiosis. The February 23, 2004, x-ray is found to be negative for pneumoconiosis, The September 10, 1990, November 1, 2006, January 5, 2007, and January 16, 2009, x-rays are found to be in equipoise. Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In this case, the most recent x-rays have been found to be either positive for pneumoconiosis or in equipoise. The only negative x-ray is from 2004. I give greater weight to the more recent x-rays and, accordingly, find that the x-ray evidence establishes the presence of pneumoconiosis.

Biopsy evidence

The next method to determine pneumoconiosis is through biopsy or autopsy evidence. 20 C.F.R. § 718.202(a)(2). There is no autopsy evidence available in the record, but there is biopsy evidence. The March 24, 2008, needle core biopsy did not find pneumoconiosis. (CX 6.) Additionally, Dr. Oesterling stated in his report that the specimens did not adequately include interstitial tissue to allow a sufficient diagnosis of interstitial lung disease, and therefore the changes could not be attributed to coal dust exposure. (EX 11.) Accordingly, the biopsy evidence fails to establish the presence of pneumoconiosis.

Presumption

Pneumoconiosis may be established by presumption as described in 20 C.F.R. §§ 718.304, 718.305, and 718.306. 20 C.F.R. § 718.202(a)(3) (2008). The presumptions in Sections 718.305 and 718.306 are not applicable, and I have previously found the Claimant is not entitled to the presumption under Section 718.304 because the evidence does not establish that he has complicated pneumoconiosis.

Medical Opinions

The fourth method of establishing pneumoconiosis is through the documented and reasoned opinion of a physician. Case law has established what a well-reasoned, well-documented medical report entails. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields*, 10 B.L.R. 1-19. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc).

"In weighing the medical evidence of record . . . the adjudicating office must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record." 20 C.F.R. § 718.107(d). Specifically, the adjudication officer should take into consideration the nature and duration of the treating physician's relationship with the miner as well as the frequency and extent of the treatment. *Id.* Additionally, "the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole." *Id.*

Six physicians provided medical opinions regarding the Claimant's condition. I note that all six are Board-certified in Internal Medicine and that Dr. Powers, Dr. Baker, Dr. Dahhan, and Dr. Rosenberg are also Board-certified in Pulmonary Diseases. Dr. Powers has been the Claimant's treating physician for his lung condition in 2008 and 2009. His treatment of the Claimant has included physical examinations, CT-scans, a lung biopsy, blood tests, and tuberculosis tests. Dr. Powers's treatment notes reveal diagnoses of Caplan Syndrome/rheumatoid arthritis + fibrosis, coal workers' pneumoconiosis, rhinitis, and caseous granulomatosis. In his March 9, 2009, letter, he noted that the Claimant had a history of tobacco use, a history of mining, a history likely of histoplasmosis, and a history of arthritis, which he believed to be rheumatoid. He noted that the predominant radiographic findings were in the lower lung field and were more linear than reticulonodular, but that he could not say with certainty that these changes were due solely to non-dust-related causes. He opined that all of these conditions can cause abnormalities of respiratory physiology and abnormal radiographic findings. He concluded that all of these causes were playing some role in the Claimant's respiratory impairment but that it was impossible for him to estimate how much of that impairment was attributable to each disease process. (CX 6.)

An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186–87 (6th Cir. 1995). In this case, Dr. Powers opined that he "could not say with certainty that [the Claimant's x-ray changes] were due solely to a non-dust related disease," and that all of the Claimant's conditions, including his coal mine dust exposure were playing "some role" in his respiratory impairment. I find that this opinion is too equivocal and vague to support a finding that the Claimant's respiratory impairment is significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

Dr. Stoltzfus is the Claimant's family physician and has been treating the Claimant for the past five to six years. However, it is unclear what his treatment consisted of in regard to the Claimant's respiratory condition, as most of the treatment records submitted by the Claimant are from Dr. Powers or list him as the treating physician. (CX 6.) Dr. Stoltzfus opined that the

Claimant had worked for 14 years underground in the mines and that his x-ray changes were consistent with coal workers' pneumoconiosis. He also noted that there was no evidence that the Claimant had histoplasmosis, but that the Claimant had Sjögren syndrome and a history of cigarette smoking, both of which might be contributing factors to his chronic lung condition.

A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984). In this case, it is unclear upon what evidence Dr. Stoltzfus based his opinion, as none of his treatment records were submitted into evidence. Additionally, although he stated that the Claimant's x-ray changes were consistent with coal workers' pneumoconiosis, he did not indicate which x-rays he was referring to and how they supported his conclusion. Accordingly, because it is unclear as to what evidence Dr. Stoltzfus based his opinion on, I give his opinion little probative weight.

Dr. Baker conducted a pulmonary evaluation of the Claimant, which consisted of a physical examination, a pulmonary function test, an arterial blood-gas study, an EKG, and a chest x-ray. He also noted the Claimant's personal medical history and his occupational history. Dr. Baker diagnosed the Claimant with coal workers' pneumoconiosis based on his chest x-ray and coal mine dust exposure, noting that there was no other condition to account for the x-ray changes. Dr. Baker also diagnosed the Claimant with COPD, chronic bronchitis and mild resting arterial hypoxemia and opined that coal dust exposure significantly contributed to or substantially aggravated these conditions. Dr. Baker opined that the Claimant's smoking history was not a significant enough to produce his impairment. (DX 16 at 11.)

After conducting his evaluation of the Claimant, Dr. Baker determined that the only potential causes of the Claimant's impairment were coal mine dust exposure and his smoking history. An opinion may be given less weight where the physician did not have a complete picture of the miner's condition. *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). Dr. Baker, who wrote his report on January 5, 2007, did not have the benefit of reviewing a number of pieces of evidence admitted in this case, including the results of three CT-scans, a lung biopsy, blood tests, and the Claimant's treatment records. As noted by Dr. Powers, Dr. Dahhan, and Dr. Rosenberg, these records support a diagnosis of rheumatoid disease, which they opined was responsible, at least in part, for the Claimant's lung condition and respiratory impairment. Accordingly, because the evidence available to Dr. Baker only indicated coal mine dust exposure and smoking as potential causes of the Claimant's impairment, and because subsequent medical evidence indicated the possibility of rheumatoid disease, which was not considered by Dr. Baker, I accord little weight to his opinion regarding the etiology of the abnormalities seen on the Claimant's x-rays, as well as his opinion regarding the cause of the Claimant's COPD, chronic bronchitis, and mild resting hypoxemia. For the same reasons, I accord little probative weight to Dr. Augustine's diagnosis of coal workers' pneumoconiosis. Although he examined the Claimant and was aware of his employment and smoking history, there is no indication in his February 5, 2009, treatment note that he was aware of the Claimant's rheumatoid arthritis. (CX 7.)

Dr. Dahhan conducted a pulmonary evaluation of the Claimant, which consisted of a physical examination, a pulmonary function test, an arterial blood-gas study, an EKG, and a chest x-ray. He also noted the Claimant's personal medical history and his occupational history. Additionally, he reviewed several other pieces of evidence, including the Claimant's claim form

and employment history, as well as Dr. Baker's report and the results of the objective tests taken during his evaluation of the Claimant. Dr. Dahhan subsequently reviewed additional medical evidence, including the results of the Claimant's lung biopsy, and was deposed. In his initial report, Dr. Dahhan diagnosed the Claimant with simple coal workers' pneumoconiosis but opined that the Claimant's pulmonary disability was caused by his rheumatoid lung disease and possibly his smoking habit. He noted that rheumatoid arthritis can cause bronchiolitis obliterans, pleural thickening, interstitial pulmonary fibrosis, sterile pleural effusion and rheumatoid nodules and the Claimant possessed three of these findings, i.e., interstitial pulmonary fibrosis, bronchiolitis obliteran and thickening of the major fissures. (DX 34 at 22.)

A medical opinion submitted for consideration under 20 C.F.R. § 718.204(a)(4) (2008) is entitled to little weight if the diagnosis regarding the presence or absence of pneumoconiosis is based on a chest x-ray alone. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). In this case, Dr. Dahhan stated that the "[c]hest x-ray showed opacities in the mid and upper zones consistent with Category 1 simple coal workers' pneumoconiosis," and his diagnosis was "Category 1 simple coal workers' pneumoconiosis." Although he conducted various other tests to measure the Claimant's impairment, he opined that such impairment was attributable to the Claimant's rheumatoid arthritis. Accordingly, because Dr. Dahhan's diagnosis of pneumoconiosis appears to be based solely on the chest x-ray he examined, and because that x-ray was already considered in the section of this decision discussing the x-ray evidence, I give little weight to this diagnosis under Section 718.202(a)(4).

Dr. Rosenberg conducted a pulmonary evaluation of the Claimant, which consisted of a physical examination, a pulmonary function test, an arterial blood-gas study, an EKG, and a chest x-ray. He also noted the Claimant's personal medical history and his occupational history. Additionally, he reviewed several other pieces of evidence, including the Claimant's answers to interrogatories and claim application, Dr. Baker and Dr. Dahhan's reports, various chest x-ray readings, and the pathology report from Claimant's biopsy. (EX 3.) He prepared a supplemental report after reviewing the treatment records and opinions of Dr. Powers and Dr. Stoltzfus as well as Dr. Wheeler's reading of the November 1, 2006, chest x-ray. (EX 9.) Dr. Rosenberg opined that the Claimant did not have any condition caused by or related to coal mine dust exposure.

Based on the forgoing analysis, I find that the medical opinion evidence does not establish the presence of pneumoconiosis.

In cases arising within the jurisdiction of the Sixth Circuit, the Board has held that the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc); *Jones v. Badger Coal Co.*, 21 B.L.R. 1-103 (1998) (en banc). As discussed above, the Claimant has established the existence of pneumoconiosis pursuant to Section 718.202(a)(1).

Etiology of the Pneumoconiosis

"In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment." 20 C.F.R. § 718.203(a). If it is determined that the claimant suffered from pneumoconiosis and

has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). Claimant has been credited by the Department of Labor with 13 years of coal mine employment between July 1972 and January 1988. (DX 40.) Therefore, the Claimant is entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mine employment.

Dr. Dahhan initially diagnosed the Claimant with simple coal workers' pneumoconiosis based on the chest x-ray. He also diagnosed the Claimant with rheumatoid arthritis, based on his history and the fact that the Claimant had interstitial pulmonary fibrosis, bronchiolitis obliteran, and thickening of the major fissures. (DX 34 at 22.)

In his deposition, Dr. Dahhan confirmed his diagnosis of rheumatoid arthritis. He reiterated that x-ray images of rheumatoid disease affecting the respiratory system could appear on an x-ray to be similar to markings caused by coal workers' pneumoconiosis, including pleural effusion manifesting itself as fluid or thickening, scars in the lungs from pulmonary fibrosis, or pulmonary nodules appearing as lumps on the lungs. (EX 1 at 8)

In regard to the Claimant's condition, he noted that the Claimant developed more abnormalities on his x-ray and his pulmonary function deteriorated between 1990 and 2007. He further noted that "the biopsy did not show the changes that you expect to see due to pneumoconiosis. Rather, it showed non [sic] caseating granuloma which is seen in patient[s] with rheumatoid involvement of the lung rather than coal dust impact on the lung." He opined that rheumatoid disease is a progressive disease and that he had patients with rheumatoid arthritis who displayed similar x-ray manifestations and respiratory impairment. He further opined that since the Claimant had not been exposed to coal dust since 1987 or 1988, coal dust exposure should not account for the changes in the Claimant's condition, although he acknowledged that the literature did not rule out the latent impact of coal dust on the respiratory system. Dr. Dahhan concluded that the Claimant's condition was made worse by his rheumatoid disease as well as aging. (EX 1 at 10–13.)

As noted above, to establish the etiology element, the Claimant's pneumoconiosis need only be shown to have arisen, in part, due to his coal mine employment. Dr. Dahhan opined that although both coal mine dust and rheumatoid arthritis could cause the abnormalities seen on the Claimant's x-ray, only rheumatoid arthritis was responsible.

Initially, I will address the biopsy evidence, which is referenced by Dr. Dahhan, and, as discussed below, by Dr. Rosenberg. The biopsy results of the right lung mass were negative for pneumoconiosis, and, based on the opinions of Dr. Dahhan and Dr. Rosenberg, support the existence of some non-coal-mine-dust-related condition. I have already determined that this mass was not caused by coal mine dust exposure. Only one physician who interpreted a chest x-ray opined that the mass was consistent with pneumoconiosis; however, he also noted small opacities consistent with pneumoconiosis. Moreover, biopsy results found to be negative for pneumoconiosis do not constitute conclusive evidence that the miner does not have pneumoconiosis. *See* 20 C.F.R. § 718.106(c) (2008). Accordingly, I find that the biopsy evidence is insufficient to rebut the presumption that the *other* abnormalities noted on the x-rays,

which were found to be consistent with pneumoconiosis, were caused by the Claimant's coal mine dust exposure.

Dr. Dahhan fails to adequately explain his rationale for completely excluding coal mine dust as a cause of the changes seen on the Claimant's chest x-ray. Rather, his only rationale for doing so appears to be that because the Claimant had not been exposed to coal mine dust since 1988, coal mine dust exposure should not have caused the change in his condition between 1990 and 2007. As noted by Dr. Dahhan, the literature on the subject has found that coal mine dust can have a latent and progressive impact on a miner's respiratory system; in fact, this scientific fact has been codified in the regulations. *See* Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 79,920, 79,923 (Dec. 20, 2000); 20 C.F.R. § 718.201(c) (2008). Although Dr. Dahhan acknowledged this literature, he did not cite any medical evidence or offer any explanation for his contrary opinion that, in the Claimant's case, coal mine dust "should not" have had a latent impact on his respiratory system. Accordingly, I find his opinion regarding the etiology of the Claimant's lung abnormalities to be unreasoned and insufficient to rebut the presumption that the Claimant's pneumoconiosis arose, at least in part, from his coal mine employment.

Dr. Rosenberg also offered an opinion on the changes in the Claimant's lungs. He stated that the CT-scans did not show micronodularity related to past coal dust exposure; rather, they showed linear interstitial scarring, granulomous changes over the past year, and a large mass in the right lower lung, which the lung biopsy revealed to be caseating granulomata. He opined that the presence of caseating granulomata was not indicative of a coal-mine-dust-related disorder; rather, such a finding represented the presence of either an inflammatory process, such as vasculitis or necrotizing sarcoidosis, or an infection, even though Claimant's test results were negative. He further stated that the linear interstitial scarring was related to the Claimant's rheumatoid arthritis and was not related to coal mine dust. He stated that when coal mine dust causes interstitial lung disease it is the form of micronodularity in the upper lung zones, as opposed to linear interstitial changes in the lower lung zones, and he cited a number of studies to support his opinion.[8]

The biopsy evidence has already been addressed. Moving on to Dr. Rosenberg's opinion regarding linear interstitial fibrosis, I find that the studies he cited support his opinion that rheumatoid arthritis is related to such interstitial scarring.[9] However, I find that his criticisms of the studies indicating a relationship between coal dust exposure and linear interstitial fibrosis are not well-reasoned. Dr. Rosenberg stated that linear interstitial lung disease can be due to a number of causes, including smoking and age. (EX 3 at 5.) In support of his opinion regarding age, he cited a study that did indicate a strong relationship between lung abnormalities and age. However, the authors of that study stated that "[t]he strong age-dependence of both small lung opacities and pleural abnormalities is in accordance with the irreversible character of fibrotic

[8] No copies of these studies were submitted by the Employer. I take judicial notice of the studies that could be located online.

[9] Of the three studies cited by Dr. Rosenberg, only one could be located online, Dawson J. K., *et al.*, *Fibrosing Alveolitis in Patients with Rheumatoid Arthritis as Assessed by High Resolution Computed Tomography, Chest Radiography, and Pulmonary Function Tests*, 56 THORAX 622 (2001). I take judicial notice of this study, which can be found at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1746113/pdf/v056p00622.pdf.

processes." Zitting, Anders J., *Prevalence of Radiographic Small Lung Opacities and Pleural Abnormalities in a Representative Adult Population Sample*, 107 CHEST 126, 130 (1995).[10] Thus, this study does not indicate that age itself is a cause of interstitial fibrosis, but merely that such fibrosis increases with age. Moreover, the study noted that small lung opacities and pleural abnormalities were associated with industrial occupations, particularly in men, and concluded that occupational differences between men and women, specifically dust exposure, probably constituted the strongest factor to explain the strong association between lung abnormalities and gender. *Id.*

Dr. Rosenberg criticized several studies that indicated a relationship between coal mine dust exposure and linear interstitial scarring, stating that they failed to control for known factors causing interstitial lung disease and therefore could not be relied upon. Specifically, he noted one study that evaluated 124 coal miners and ex-coal miners. He stated that the majority of miners in the study were smokers or ex-smokers, and because smoking was not controlled for, the study could not be used to support the theory that primary linear interstitial disease is related to coal mine dust exposure. However, after reviewing the study, it is clear that the authors did take smoking into account when interpreting their data, breaking down the group into smokers, non-smokers, and ex-smokers. The authors noted that irregular opacities[11] were significantly higher for smokers than for non-smokers. However, they noted that both non-smokers and smokers separately showed an increase in irregularity of opacities related to years of underground exposure, with a greater effect in non-smokers. They opined that smoking might be enhancing dust-related disease processes. Cockroft, A, et al., *Prevalence and Relation to Underground Exposure of Radiological Irregular Opacities in South Wales Coal Workers with Pneumoconiosis*, 40 BRIT J. IND. MED. 169, 170–72 (1983).[12]

Dr. Rosenberg did not specifically state what control data was lacking in the other three studies he cited. I note that the authors of the Collins study accounted for age, smoking history, and level of dust exposure in the analysis of their data. They determined that the profusion of both rounded and irregular opacities was related to dust exposure, and that the "[r]esults from those who had predominantly irregular small opacities . . . showed no significant effect of variations in smoking habit. . . . The regression analysis, however, indicated that the chance of having small irregular opacities increased with dust exposure and with age . . . ." Collins, H.P.R., *Irregularly Shaped Small Shadows on Chest Radiographs, Dust Exposure, and Lung Function in Coalworkers' Pneumoconiosis*, 45 BRIT J. IND. MED. 43, 44, 47 (1988).[13] Full versions of the other two studies cited by Dr. Rosenberg could not be located. Based on the studies reviewed, I find Dr. Rosenberg's criticisms to be unfounded. Therefore, I find his opinion that linear interstitial fibrosis is not related to coal mine dust exposure to be unreasoned. As this opinion was the basis for his conclusion that the linear interstitial fibrosis on the Claimant's x-ray was unrelated to his coal mine dust exposure, I likewise find that conclusion to be unreasoned.

---

[10] I take judicial notice of this study, which can be found at http://chestjournal.chestpubs.org/content/107/1/126.full.pdf.

[11] According to one of the studies cited by Dr. Rosenberg, the term "irregular" includes linear. Collins, 45 BRIT J. IND. MED. at 50.

[12] I take judicial notice of this study, which can be found at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1009166/pdf/brjindmed00054-0049.pdf.

[13] I take judicial notice of this study, which can be found at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1007944/pdf/brjindmed00141-0051.pdf.

Based on the forgoing, I find that the opinions of Dr. Dahhan and Dr. Rosenberg are insufficient to rebut the presumption that Claimant's pneumoconiosis arose, at least in part, out of his coal mine employment. Neither physician offered a reasoned opinion explaining why the pneumoconiosis identified on the Claimant's x-rays was unrelated to coal mine dust exposure. *See D.L.T. v. Cannelton Industries, Inc.*, BRB No. 07-0830 BLA, slip op. at 5 (July 24, 2008) (unpub.) (finding that the physicians relied upon by the employer failed to explain why the abnormalities seen on the claimant's x-ray could not be reflective of both coal workers' pneumoconiosis and rheumatoid arthritis). Accordingly, I find that the Claimant's pneumoconiosis arose out of his coal mine employment pursuant to Section 718.203(a).

Total Disability Due to Pneumoconiosis

Under the regulations, a miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. 20 C.F.R. § 718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the disability if it: (i) has a material adverse effect on the miner's respiratory and pulmonary condition; or (ii) materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.* In the preamble to the regulations, the Department noted that the addition of the word "material" and "materially" to the foregoing provisions reflects the view that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause to that disability." 65 Fed. Reg. at 79,946. Total disability due to pneumoconiosis can be established by means of a documented and reasoned medical report. 20 C.F.R. § 718.204(c)(2).

Dr. Baker opined that the Claimant's impairment was caused by his coal workers' pneumoconiosis, COPD, mild resting hypoxemia, and chronic bronchitis. A physician's opinion may be reasoned and documented as to some issues and not as to others. *Drummond Coal Co. v. Freeman*, 17 F.3d 361, 366–67 (11th Cir. 1994). I gave little weight to Dr. Baker's opinion regarding the etiology of the abnormalities present on the Claimant's x-ray and the etiology of the Claimant's other conditions because Dr. Baker was unaware of the Claimant's rheumatoid arthritis. For the purposes of this section, however, given my finding that the x-ray evidence establishes the presence of pneumoconiosis and that the Claimant's pneumoconiosis arose out of his coal mine employment, I give probative weight to Dr. Baker's finding of coal workers' pneumoconiosis and his opinion that this disease contributed to the Claimant's impairment.[14]

Dr. Rosenberg noted that the Claimant's response to bronchodilators supported the existence of an obstruction unrelated to coal mine dust. He noted that coal mine dust causes chronic airway scarring, which is not associated with bronchodilator response, and that the Claimant's partial but clinically significant improvement in airflow means that chronic

[14] As discussed above, Dr. Baker also found that the Claimant's COPD, mild resting hypoxemia, and chronic bronchitis were attributable to coal mine dust exposure and opined that the Claimant had legal pneumoconiosis. Because my finding of pneumoconiosis was based solely on the chest x-rays pursuant to Section 718.202(a)(1), I continue to give little weight to Dr. Baker's opinion regarding the etiology of the Claimant's other conditions.

irreversible scarring due to coal mine dust exposure is not present. (EX 3 at 5; EX 9 at 3–4.) However, pneumoconiosis need not be the sole cause of a claimant's disability. As discussed above, it is enough if the pneumoconiosis has a material adverse affect on the Claimant's respiratory and pulmonary condition. Because Dr. Rosenberg described the Claimant's impairment as obstruction, restriction, and fall in PO2, I find that his opinion that the Claimant's obstruction is not due to coal mine dust exposure does not, by itself, support a finding that the Claimant's disability is not "due to" pneumoconiosis.

Dr. Rosenberg further opined that the Claimant's restriction was related to his linear interstitial changes and the granulomatous changes in his lungs. He also stated that the Claimant was disabled based on the marked fall in PO2 associated with exercise, which was related to the Claimant's linear interstitial basilar predominate scarring. (EX 3 at 5; EX 9 at 3.) Dr. Dahhan attributed the Claimant's impairment to bronchiolitis obliterans and interstitial lung disease. (EX 1 at 9.)

As discussed above, the x-ray evidence establishes that the Claimant's lung abnormalities, including his linear interstitial fibrosis, constitute pneumoconiosis, and the presumption that the Claimant's pneumoconiosis arose, in part, from his coal mine employment, has not been rebutted. Given this finding, the opinions of Dr. Rosenberg and Dr. Dahhan that the Claimant's linear interstitial fibrosis was responsible for the Claimant's restriction, as well as Dr. Rosenberg's opinion that the Claimant's loss in PO2 was attributable to his linear interstitial fibrosis, support a finding that pneumoconiosis is a substantially contributing cause of the Claimant's impairment. Accordingly, based on their opinions, as well as Dr. Baker's, I find that the Claimant's impairment is due to his pneumoconiosis. Therefore, I find that the medical evidence establishes that the Claimant is totally disabled due to pneumoconiosis.

CONCLUSION

In view of the foregoing, I find that the Claimant has established a material change in condition since the September 9, 2004 determination denying benefits. I have reviewed his claim de novo, and I find that the Claimant has pneumoconiosis, that it arose at least in part out of his coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. He is therefore entitled to benefits under the Act.

COMMENCEMENT OF BENEFITS

Section 725.503(b) of the regulations provides that payment of benefits is to commence with the beginning of the month of onset of total disability due to pneumoconiosis. If the date of onset is not ascertainable, benefits are payable from the beginning of the month in which the claim was filed. 20 C.F.R. § 725.503(b). The evidence in the record establishes that the Claimant became totally disabled sometime between September 9, 2004, the date his last claim was denied, and January 5, 2007, the date of his Department of Labor evaluation. Therefore, I find that the date of onset of total disability is not ascertainable from the evidence. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984) (holding that the date of the first medical evidence of record indicating total disability merely indicates that the miner became totally

disabled at some point prior to the date that such tests were performed). Accordingly, benefits shall be payable from December 1, 2006, the month in which the Claimant filed this application for benefits. (DX 3.)

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. 30 U.S.C. § 932 (2006) (incorporating Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928). No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty (30) days is hereby allowed to Claimant's counsel for submission of such an application and his attention is directed to Sections 724.365 and 725.366 of the Regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten (10) days following receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The subsequent claim by Arlis Hensley for benefits under the Act, filed on December 4, 2006, is hereby **GRANTED**. It is hereby **ORDERED** that the Claimant shall be paid all benefits to which he is entitled under the Act, commencing December 1, 2006, the month in which the claim was filed.

A

KENNETH A. KRANTZ
Administrative Law Judge

KAK/WHS/mrc
Newport News, Virginia

NOTICE OF APPEAL RIGHTS

If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is:

Benefits Review Board
U.S. Department of Labor
P.O. Box 37601
Washington, DC 20013-7601

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

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

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to 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).