

**U.S. Department of Labor**

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**Issue Date: 28 October 2013**

BRB No.: 10-0363 BLA

CASE NO.: 2007-BLA-06085

In the Matter of:

ARLIS HENSLEY,

Claimant,

v.

DIXIE FUEL COMPANY, LLC,  
BITUMINOUS CASULATY  
CORPORATION

Employer/Carrier,

DIRECTOR, OFFICE OF WORKERS'  
COMEPNSATION PROGRAMS, UNITED  
STATES DEPARTMENT OF LABOR

Party-in-Interest

**DECISION AND ORDER ON REMAND**

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 et seq. 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 pulmonary and respiratory impairments, arising out of coal mine employment. 30 U.S.C. § 902(b). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis. Because Claimant's last coal mine employment occurred in Kentucky, the law of the United States Court of Appeals for the Sixth Circuit applies.

**PROCEDURAL HISTORY**

The Claimant filed an initial claim for benefits 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 with 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 with the 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 on 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).

On February 9, 2010, I issued a Decision and Order Awarding Benefits. *Hensley v. Dixie Fuel Company*, 2007-BLA-06085, slip op. at 1 (Feb. 9, 2010). I found that the medical evidence established that Claimant is totally disabled. *Id.* at 25. In addition, I found that the x-ray evidence established the existence of pneumoconiosis. *Id.* at 28. However, I found that the medical evidence did not establish the presence of pneumoconiosis. I cited *Furgeson v. Jericol Mining, Inc.* for the proposition that the Claimant may establish the existence of pneumoconiosis under any of the alternate methods set forth at Section 202(a), and determined that Claimant successfully demonstrated the existence of pneumoconiosis under Section 718.202(a)(1). 22 B.L.R. 1-216 (en banc). I found that Claimant's pneumoconiosis arose out of his coal mine employment. *Hensley v. Dixie Fuel Company*, 2007-BLA-06085, slip op. at 35 (Feb. 9, 2010). I also found that Claimant is totally disabled due to the pneumoconiosis. *Id.*

On March 3, 2010, Employer appealed my decision to the Benefits Review Board ("Board"). In a March 30, 2011 opinion, the Board affirmed the decision. *Hensley v. Dixie Fuel Company*, Ben. Rev. Bd. No. 10-0363, slip op. at 15 (Mar. 30, 2011). On April 29, 2011, Employer filed a Motion for Reconsideration En Banc which was denied by the Board. Employer appealed to the U.S. Court of Appeals for the Sixth Circuit. The Sixth Circuit issued an opinion on November 28, 2012. *Dixie Fuel Co. v. Director, OWCP*, No. 11-4298, slip op. at 1 (6th Cir. 2012). In this opinion, the Sixth Circuit joined with the Fourth Circuit, which has held that all of the evidence must be weighed together when making a determination of whether Claimant suffers from pneumoconiosis. *Id.* at 3, citing *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208 (4th Cir. 2000). The court quoted the Fourth Circuit case of *Island Creek Coal Co v. Compton*, and stated that "whether or not a particular piece or type of evidence actually is a sufficient basis for a finding of pneumoconiosis will depend on the evidence [as a whole] in each case." *Id.* citing *Island Creek Coal Co.*, 211 F.3d at 209. In addition, the court noted that the Director has stated that "although section 718.202(a) enumerates four distinct methods of establishing pneumoconiosis, all types of relevant evidence *must be weighed together* to determine whether the claimant suffers from the disease." *Id.* at 4. The Sixth Circuit noted that I

need not reconsider my prior judgment as to the chest x-rays and other types of evidence individually or come to a different conclusion in my opinion on remand. *Id.* at 5.

### **ISSUES ON REMAND**

1. Reconsider the evidence for and against a finding of pneumoconiosis, weighing all relevant evidence together, “before granting benefits.”

*Id.* at 5.

### **Positions of the Parties**

#### **Claimant’s Position**

Claimant submitted a brief on remand on September 10, 2013. (Claimant’s Brief at 1). Claimant argued that the positive chest x-ray evidence outweighs the medical opinion evidence and establishes that Claimant suffers from pneumoconiosis. (Claimant’s Brief at 4). Claimant argued that, focusing on the most recent x-rays, the x-ray evidence is persuasively positive for pneumoconiosis. (Claimant’s Brief at 16). Regarding the biopsy, Claimant noted that Dr. Eberts found “no normal lung tissue present in the sample.” (Claimant’s Brief at 16). In addition, Claimant emphasized that Dr. Oesterling did not find the biopsy sample to be adequate for diagnostic purposes. (Claimant’s Brief at 17). Furthermore, Claimant argued that the medical opinion evidence does not undermine the radiographic findings. Regarding the medical opinions, Claimant emphasized that Dr. Dahhan’s opinion is equivocal and Dr. Rosenberg’s opinion is based on a faulty x-ray reading. (Claimant’s Brief at 21). Claimant also argued that the x-ray evidence undermines Dr. Rosenberg’s opinion that Claimant’s changes are due to rheumatoid arthritis. Claimant opined that, when the evidence is weighed together, he has properly demonstrated that he suffers from pneumoconiosis.

#### **Employer’s Position**

Employer submitted a brief on remand on September 10, 2013. Employer noted that the prior decision conclusively determined that Claimant does not suffer from complicated pneumoconiosis. (Employer’s Brief at 9). Employer also noted that the medical opinions did not establish that Claimant had clinical or legal pneumoconiosis. (Employer’s Brief at 9). In addition, the Employer noted that the CT scans were not interpreted as positive for pneumoconiosis.

Employer argued that the x-ray evidence is probative evidence for a finding of no pneumoconiosis. Specifically, Employer argued that I should not have interpreted the July 2008 x-ray as positive for pneumoconiosis. (Employer’s Brief at 10). Employer noted that I reached this opinion by refusing to consider Dr. Wheeler’s reading. Employer argued, as it had previously argued before the Board, that excluding Dr. Wheeler’s reading violated its due process rights. (Employer’s Brief at 10).

Regarding the x-ray analysis, Employer further argued that I erred in placing greater weight on the more recent x-rays. Employer argued that, in the absence of extraordinary circumstances, judges should not place more weight on the recent x-ray readings. (Employer's Brief at 11). Employer argued that the readings did not disclose a progression of pneumoconiosis but instead disclosed a conflict among the readers. (Employer's Brief at 11). Employer also argued that the April 12, 2007 film reading was too equivocal to constitute a positive finding of pneumoconiosis. Employer also argued that the x-ray readings are not convincing evidence for a finding of pneumoconiosis when considered in the light of the record as a whole. (Employer's Brief at 12). Employer stated that the biopsy and the CT evidence was not positive for pneumoconiosis. In addition, Employer stated that the "doctors who explained the meaning. . . of the x-rays agreed that the films disclosed the effects of [Claimant's] rheumatoid arthritis or some other condition, but not the effects of remote coal dust exposure." (Employer's Brief at 12). Employer determined that the evidence, weighed together, demonstrated that Claimant is not suffering from pneumoconiosis.

### **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).

The existence of pneumoconiosis may be established by 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). In remanding the case, the court cited *Island Creek Coal Co.*, and stated that the “plain meaning of [the ‘all the relevant evidence’] language is that all relevant evidence is to be considered together rather than merely within the discrete subsections of § 718.202(a).” *Dixie Fuel Co. v. Director, OWCP*, No. 11-4298, slip op. at 4 (6th Cir. 2012).

#### Chest x-ray evidence

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.

At the outset, I note that Employer advanced multiple arguments for why I erred in determining that the x-rays constituted persuasive evidence for a finding of pneumoconiosis. (Employer’s Brief at 11). Employer did not address the fact that the Sixth Circuit remanded the case merely so I could weigh all of the types of evidence together. *Dixie Fuel Co. v. Director, OWCP*, No. 11-4298, slip op. at 5 (6th Cir. 2012); *Hensley v. Dixie Fuel Company*, Ben. Rev. Bd. No. 10-0363, slip op. at 15 (Mar. 30, 2011).

In remanding the case, the court stated:

The ALJ must weigh all of the evidence- for and against a finding of pneumoconiosis- before granting benefits. This is not to say that the ALJ must reconsider his prior judgment with respect to any one piece of contrary evidence or end up with a different conclusion. All of that is up to the ALJ in the first instance.

*Dixie Fuel Co. v. Director, OWCP*, No. 11-4298, slip op. at 5 (6th Cir. 2012).

As the court emphasized that it was only necessary to evaluate all of the evidence together and not to reevaluate each subsection of evidence, I decline to address Employer's arguments regarding the x-ray analysis.

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.<sup>1</sup>

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. Because Dr. Alexander is a Board-certified radiologist and B-reader and Dr. Rosenberg is only a

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<sup>1</sup> 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.

B-reader, I give greater weight to Dr. Alexander's interpretation and find this x-ray to be positive for pneumoconiosis.

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.

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."

Dr. Powers performed a needle core biopsy on Claimant's right lung mass on March 24, 2008. (CX 6 at 7). Dr. Powers noted that "no normal lung tissue is present." (CX 6 at 7). He also noted that the specimen demonstrated "a granulomatous inflammatory process characterized by areas of geographic caseous necrosis." In addition, he noted that no malignancy was identified. Dr. Powers also performed a fine needle aspiration biopsy. (CX 6 at 8). The Diff-Quick smear demonstrated "some benign bronchial epithelial cells and histiocytes. . ." (CX 6 at 8).

Employer asked Dr. Oesterling to review the slides. (EX 11 at 1). Dr. Oesterling noted that Dr. Powers performed a core biopsy. Dr. Oesterling noted that, unfortunately, this method of biopsy is primarily aimed at identifying tumors. From the biopsy cross sections, Dr. Oesterling determined that there was evidence of coalmine dust inhalation. (EX 11 at 2). He also noted that the specimens were adequate to diagnose the presence or absence of a tumor. However, Dr. Oesterling noted that the biopsies did not include sufficient interstitial tissue for a diagnosis of interstitial lung disease. He stated that, due to the insufficiencies of the biopsy, it was impossible to classify the changes in relationship to coal dust exposure. (EX 11 at 2).

Dr. Oesterling explained:

Without more significant tissue I am unable to give you any further information than what I have just provided concerning this gentleman's exposure to coal dust. Unfortunately, the limited tissue precludes an adequate way of assessing the extent of change, and therefore in any way assessing any respiratory distress which he may have suffered due to his coalworkers' disease.

(EX 11 at 3).

As the tissue obtained through the biopsy was insufficient to aid the doctors in determining whether Claimant suffers from pneumoconiosis, this evidence is not probative.

### 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 was 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. 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 obliterans 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.

#### 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 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.)

Dr. Rosenberg stated that the CT-scans did not show micronodularity related to coal mine dust exposure. Rather, they showed linear interstitial scarring, granulomatous changes over the past year, and a large mass formation in the right lower lung zone. 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.)

### Treatment Reports

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 hours 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.<sup>2</sup> 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 breath sounds that 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:

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<sup>2</sup> The Claimant's arthritis, back pain, and chronic left arm pain, were noted under the section titled "RHEUM."

CWP vs. histoplasma [changes] – more dyspnea?  
? Caplan's syndrome<sup>3</sup>/[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<sup>4</sup> 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 January 6, 2009 pulmonary function test, 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.)

### **Evidence Weighed as a Whole**

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<sup>3</sup>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>.

<sup>4</sup>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>.

In determining whether Claimant suffers from pneumoconiosis, all types of relevant evidence must be weighed together to determine whether the claimant suffers from pneumoconiosis. *Dixie Fuel Co. v. Director, OWCP*, No. 11-4298, slip op. at 4 (6th Cir. 2012).

### X-Ray Evidence

I find the x-ray evidence persuasively suggests that Claimant suffers from pneumoconiosis. 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). All of the post-2004 x-rays are either positive for pneumoconiosis or in equipoise. The April 12, 2007 x-ray was read as positive by a B-reader. The July 28, 2008 x-ray was read as positive by Dr. Alexander, who is both a Board-Certified physician and a B-reader. Of the three most recent x-rays, two are positive for pneumoconiosis. Therefore, as previously analyzed, I find the x-ray evidence to be positive for pneumoconiosis. X-rays provide an objective test for the disease. Therefore, I find this evidence to be highly persuasive.

### Medical Opinion Evidence

The evidence contained the opinions of six physicians; Drs. Powers, Baker, Dahhan, Rosenberg, Stoltzfus, and Augustine. Of those opinions, I accorded little weight to the opinions of Drs. Powers, Baker, Stoltzfus, Augustine, and Dahhan. I determined that Dr. Powers' opinion was too equivocal and vague. I accorded little weight to the opinions of Drs. Baker and Augustine because they based their opinions on an incomplete medical picture of Claimant. In addition, I accorded little weight to Dr. Stoltzfus' opinion because it was unclear what evidence he relied upon in his determination. Finally, I accorded little weight to Dr. Dahhan's opinion because it appeared to be based solely on his examination of the x-ray. I only accorded weight to the opinion of Dr. Rosenberg. As I found it necessary to discount the opinions of five of the six physicians, and as I find that the medical opinion evidence is more subjective than the x-ray interpretations, I find that the medical opinion evidence is not as persuasive as the x-ray interpretations.

### Biopsy Evidence

Although the biopsy evidence is not positive for pneumoconiosis, it is also not affirmative evidence that Claimant does not have pneumoconiosis. Due to the insufficiencies of the slides, the biopsy does not serve as helpful evidence for Claimant or Employer. Dr. Oesterling noted that the tissue confirmed that Claimant inhaled some component of coal mine dust. He also emphasized that without more significant tissue, he would not be able to assess or classify Claimant's disease process. Although Dr. Dahhan noted that Claimant's biopsy involved a "generous piece that was removed from the lung," Dr. Oesterling emphasized that the tissue was insufficient to perform a meaningful analysis. (EX 1 at 10). As Dr. Oesterling, the physician who devoted a three page report to an analysis of the biopsy, opined that the biopsy tissue was insufficient to perform a meaningful inquiry, I find that the biopsy evidence is neutral as to whether Claimant suffers from pneumoconiosis.

## CT Scan Evidence

In addition, the CT scans submitted in this case are of minimal probative value. Claimant had a CT scan performed on February 20, 2008. (CX 6 at 17). This scan revealed “segmental consolidation involving the lateral segment of the right middle lobe.” (CX 6 at 17). Furthermore, the physician noted an ovoid-shaped 3.7 cm rounded soft tissue mass. The physician noted that the findings were compatible with segmental consolidation or atelectasis of the right middle lobe.

A CT scan was performed on July 22, 2008. The CT scan revealed a dominant mass in the right lower lobe which measured 3.7 cm. (CX 6 at 14). In addition, Dr. Goodwin noted numerous noncalcified nodules or masses scattered throughout the lungs, although he stated that some of the nodules may have contained a small amount of calcium. (CX 6 at 14). He stated that the numerous smaller nodules were most suggestive of “noncalcified or partially calcified granulomata.” (CX 6 at 14). In an appended report for the July 22, 2008 scan, Dr. Cox stated that some of the nodules in the right upper lobe showed partial calcification, although he noted that most of the nodules were not calcified. (CX 6 at 15).

The January 12, 2009 CT scan revealed “small lymph nodes” and “partially calcified nodes.” (CX 6 at 13). The CT scan demonstrated a soft tissue mass at the right lung base as well as scarring in the lung bases. (CX 6 at 13). As an impression, Dr. Tiu listed “multiple pulmonary nodules and masses and adenopathy, as well as scattered scarring, atelectasis, and inflammatory changes. (CX 6 at 13).

Only one of the opining physicians specifically analyzed the CT-scans. Dr. Dahhan’s deposition and medical report did not mention the CT scans. (EX 1; DX 34 at 21). Similarly, Drs. Baker, Stolfus, Powers, and Augustine did not discuss the CT scans in their reports. (DX 16 at 11; DX 16 at 15; CX 6 at 1; CX 7 at 1-4).

The CT scan reports assess Claimant’s lungs for segmental consolidation, masses, nodules, and lymph nodes. However, the physicians reviewing the CT scans did not explicitly analyze whether Claimant suffered from clinical pneumoconiosis. In addition, the physicians also did not analyze whether the CT scans provided findings consistent with legal pneumoconiosis. The only physician to analyze the relationship between the CT scans and coal dust exposure was Dr. Rosenberg. (EX 9 at 3). Dr. Rosenberg opined that the CT scan demonstrated linear interstitial scarring with the evolution of granulomas changes. Dr. Rosenberg believed that the CT scans did not support a diagnosis of pneumoconiosis. The CT scan reports themselves do not address pneumoconiosis, and as only one of the opining physicians addressed the CT scans. As there is very little evidence presented in which a physician explicitly utilizes these scans to determine whether Claimant suffers from pneumoconiosis, I place limited weight on the scans.

## Treatment Records

Claimant submitted treatment records to support his argument that he suffers from pneumoconiosis. In these treatment records, Ms. Brooks, a registered nurse at Stone Mountain Health Services, diagnosed Claimant with coal workers’ pneumoconiosis. (CX 7). Dr. Powers, a

physician who treated Claimant in 2008, diagnosed Claimant with “likely CWP.” (CX 6). Unfortunately, the medical professionals created their reports for treatment purposes and did not focus on etiology and other aspects relevant to a black lung claim. However, these reports do demonstrate that Claimant’s treating physicians were concerned that Claimant was suffering from pneumoconiosis. I find these treatment reports to have some limited probative value.

#### Weight Accorded to the Types of Evidence

I have weighed the x-ray, medical opinion, biopsy, CT scan, and treatment record evidence. I find that the x-ray evidence is persuasively positive for pneumoconiosis. Of the three most recent x-rays, two are positive for pneumoconiosis and one is in equipoise. The physicians who read the x-rays as positive have commendable qualifications. I find the objective x-ray tests to be persuasive evidence.

I find the medical opinion, biopsy, and CT scan evidence to be less persuasive. Six physicians provided medical opinions. Dr. Baker and Dr. Augustine based their opinions on an incomplete medical record. I determined that Dr. Powers’ opinion was too equivocal and vague. I accorded little weight to Dr. Stoltzfus’ opinion because it was unclear what evidence he relied upon in his determination. Finally, I accorded little weight to Dr. Dahhan’s opinion because it appeared to be based solely on his examination of the x-ray. I only placed weight on Dr. Rosenberg’s opinion. As the evidence is less objective, and as the medical opinions contained significant failings, I place more emphasis on the x-ray evidence than on the medical opinion.

I also place more emphasis on the x-ray than on the biopsy evidence. Dr. Oesterling, the physician who devoted a three page report to an analysis of the biopsy, opined that the biopsy tissue was insufficient to perform a meaningful inquiry. Therefore, I find that the biopsy evidence is not probative. Furthermore, I place little weight on the CT scans. The CT scan reports do not address whether the findings are consistent with clinical or legal pneumoconiosis. In addition, only one of the opining physicians addressed the CT scans. As the evidence regarding the CT scans is sparse and unelaborated, I place little weight on the scans. I find the diagnoses of pneumoconiosis in the treatment records to be somewhat probative, but I bear in mind that the records are short and do not thoroughly substantiate the underlying bases for the diagnoses.

Weighing all of the evidence together, I find the x-ray evidence, which I have analyzed as positive for pneumoconiosis, to be the most probative. Therefore, I find that Claimant established that he suffers from pneumoconiosis.

#### 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 obliterans, 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.<sup>5</sup>

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.<sup>6</sup> 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 processes." Zitting, Anders J., *Prevalence of Radiographic Small Lung Opacities and Pleural Abnormalities in a Representative Adult Population Sample*, 107 CHEST 126, 130 (1995).<sup>7</sup> Thus,

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<sup>5</sup> No copies of these studies were submitted by the Employer. I take judicial notice of the studies that could be located online.

<sup>6</sup> 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>.

<sup>7</sup> I take judicial notice of this study, which can be found at <http://chestjournal.chestpubs.org/content/107/1/126.full.pdf>.

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<sup>8</sup> 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).<sup>9</sup>

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).<sup>10</sup> 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.

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<sup>8</sup> According to one of the studies cited by Dr. Rosenberg, the term “irregular” includes linear. Collins, 45 BRIT J. IND. MED. at 50.

<sup>9</sup> 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>.

<sup>10</sup> 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.<sup>11</sup>

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 irreversible scarring due to coal mine dust exposure is not present. (EX 3 at 5; EX 9 at 3-4.)

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<sup>11</sup> 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.

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 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 twenty (20) 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.

KENNETH A. KRANTZ  
Administrative Law Judge

KAK/ECD/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).