

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 August 2013

Case No.: 2011-BLA-05623

In the Matter of:
PHILLIP W. CAUDILL,
Claimant,

v.

LANCE COAL CORP. GOLDEN OAK,
Employer,
Self-insured through:
R&B FALCON CORP.

and

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

Appearances:

Andrew Delph, Esq.
Wolfe, Williams, Rutherford & Reynolds
Norton, Virginia
For the Claimant

Waseem Karim, Esq.
Jackson Kelly, PLLC
Lexington, Kentucky
For the Employer

Willow Fort, Esq. (on brief)
Office of the Solicitor
Nashville, Tennessee
For the Director

Before: Peter B. Silvain, Jr.
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, found at 20 C.F.R. Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners, and their dependents, who are totally disabled due to pneumoconiosis and to surviving dependents of coal miners whose death was due to pneumoconiosis. Pneumoconiosis is commonly known as black lung disease.

Pursuant to a Notice of Hearing dated August 31, 2011, the undersigned conducted a hearing on this claim on December 14, 2011, in Hazard, Kentucky. The parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges.¹ At the hearing, Philip Caudill (“the Claimant”) was the only witness.

In reaching a decision, the undersigned has reviewed and considered the entire record, including all exhibits admitted into evidence,² the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

Phillip W. Caudill (“the Claimant”) filed his first claim on June 6, 2008. Shortly after filing that claim the Claimant filed a motion to withdraw that claim. As the status of the prior claim was not entirely clear based on the records currently contained in the case file, this withdrawal was confirmed by the Office of the District Director on August 25, 2008.

The Claimant filed the present claim for benefits on February 16, 2010. (DX 2). Because a withdrawn claim is considered never to have been filed, the present claim is an initial claim. On December 18, 2010, the District Director issued a Proposed Decision and Order awarding benefits and naming Lance Coal Corp. Golden Oak as the responsible operator. On December 27, 2010, the Employer appealed and requested a hearing before the Office of Administrative Law Judges (“OALJ”). (DX 37). The claim was referred to the OALJ on March 17, 2011. (DX 40).

APPLICABLE STANDARDS

This claim was filed after the effective date of the current regulations. For this reason, the current regulations at 20 C.F.R. Parts 718 and 725 apply.³ Under these parts of the regulations, the Claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis.⁴ Failure to establish any of these elements precludes entitlement to benefits.

On March 23, 2010, the PPACA was signed into law.⁵ Section 1556 revived the potential application of the fifteen-year presumption at 30 U.S.C. §921 (c)(4), as implemented at 20 C.F.R. § 718.305, for either a miner’s claim or survivor’s claim that was: (1) filed after January 1, 2005; and (2) is pending on or after the March 23, 2010, date of enactment.⁶ Because the

¹ 29 C.F.R. Part 18A (2012).

² Director’s Exhibits (“DX”) 1-42, Claimant’s Exhibits 1-2 (“CX”) and Employer’s Exhibit (“EX”) 1 was proffered into evidence at the hearing without objection. The Employer was given ninety days post-hearing to submit EX 2-4. “Tr.” refers to the transcript of the hearing.

³ 20 C.F.R. §§ 718.2 and 725.2 (2012).

⁴ 20 C.F.R. § 725.202(d)(2)(i)-(iv).

⁵ Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 1556 (2010).

⁶ *Id.*

Claimant filed his claim on February 16, 2010, this claim falls within the category of cases which can be considered for application of the reinstated presumption.

ISSUES

The issues contested by Employer are:

1. The length of Claimant's coal mine employment;
2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations;
3. Whether the Claimant's pneumoconiosis arose out of coal mine employment;
4. Whether the Claimant is totally disabled; and
5. Whether the Claimant's total disability is due to pneumoconiosis.

(DX 40); (Tr. 9). The Employer has also noted additional issues for purposes of appeal. (DX 40).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Miner

The Employer initially contested whether the Claimant worked as a coal miner after December 31, 1969. (DX 40). However, the Employer withdrew its contest of these issues at the formal hearing. (Tr. 9). Accordingly, I find that the Claimant was a miner who worked after December 31, 1969.

Responsible Operator

The Employer initially contested whether it was the Responsible Operator in this case. (DX 40). This issue was withdrawn at the hearing. (Tr. 9, Tr. 17). Therefore, I find that the Employer is the properly named Responsible Operator.

Length of Coal Mine Employment

The nature and duration of a miner's coal mine employment is relevant to several elements of entitlement and may affect credibility findings with respect to medical opinion evidence.⁷ The Employer stipulated that the Claimant worked for nine years with the Employer, but would not stipulate to a total amount of coal mine employment. (Tr. at 9). Social Security records reflecting the Claimant's past wages are located in the Director's Exhibits. (DX 6). Although the Claimant was able to remember whether certain companies in the Social Security records were mining employers and what he did for those employers, he understandably was not able to remember the exact dates he worked for the companies. (DX 21A-4-29). Accordingly, I

⁷ See *Sellards v. Director, OWCP*, 17 B.L.R. 1-77, 1-81 (1993).

find that the Social Security records are the best evidence of the length of the Claimant's coal mine employment.

The Board has held that counting quarters in which the miner earned \$50.00 or more, while not counting the quarters in which he earned less, is a reasonable method of computation.⁸ The Claimant's Social Security records prior to 1978 include quarterly earnings as well as an annual total. (DX 6). The Claimant's records after 1977 include only an annual sum of earnings for each employer. In examining the Claimant's pre-1978 Social Security records, he earned over \$50.00 per quarter in mining employment for thirty-one quarters. Accordingly, I credit the Claimant with 7.75 years of coal mine employment prior to 1978. The Claimant's coal mine employment after 1977, and prior to the length of time stipulated to by the Employer, is set forth in the chart below. His yearly earnings are compared to the average yearly coal mine earnings set forth in Exhibit 610 of the *Office of Workers' Compensation Programs Coal Mine (BLBA) Procedure Manual*, and the Claimant is credited with the proportional amount of time.

Year	Coal Mining Employers	Total Earnings	Industry Average 125 days CME	Years of CME
1978	Lake Coal Co., Inc.; Globe Coal Co., Inc.	\$20,518.00	\$10,038.75	1.00
Total CME 1978: 1.00 years				

The Employer has offered to stipulate that the Claimant worked for the Employer for nine years. This offer to stipulate is supported by the Social Security records, which indicate that the Claimant worked for the Employer each year from 1979 until 1987. (DX 6-4-5). I therefore credit the Claimant with nine years of coal mine employment with the Employer from 1979 to 1987⁹ for a total length of coal mine employment of 17.75 years. As will be further discussed, the majority of this coal mining employment involved surface mining operations. (Tr. 11).

The Claimant operated a battery motor and then began driving coal trucks. (Tr. 12, DX 21A-8, 11). He was also a mechanic on the mine site and operated drills, graders, dozers, and augers. (Tr. 12, DX21A-16). He also "helped whatever needed to be done." (Tr. 12). The Claimant regularly was required to lift more than 100 pounds and occasionally things weighing up to 125 pounds. (Tr. 13).

Dependency

A successful claimant receives augmented benefits for certain qualified dependents.¹⁰ The Claimant listed no dependents on his claim form. (DX 2). Accordingly, I find that the Claimant has no dependents for purposes of benefits augmentation.

⁸ *Tackett v. Director, OWCP*, 6 B.L.R. 1-839 (1984).

⁹ The Claimant's Social Security record also reflects earnings from coal mine employment with Lake Coal Co., Inc. in 1979.

¹⁰ 20 C.F.R. § 725.520(c).

Controlling Law

The Claimant's testimony and record establish that Lance Coal Corporation/Golden Oak mine is located in Kentucky. (DX 21A-30, Tr. 13). As such, it is apparent that the Claimant's last significant period of coal mine employment was in the Commonwealth of Kentucky, and therefore this case is controlled by the decisional law of the United States Court of Appeals for the Sixth Circuit.¹¹

Medical Evidence

Medical evidence submitted with a claim for benefits under the Act is subject to the requirement that it must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence.¹² The regulations address the criteria for chest x-rays, pulmonary function tests, physical reports, arterial blood gas studies, autopsies, biopsies, and "other medical evidence."¹³ "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Medical evidence must comply with the limitations placed upon the submission of medical evidence.¹⁴ The regulations provide that a party is limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act.¹⁵ Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports, and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations.¹⁶ In rebuttal to evidence propounded by the opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, or arterial blood gas study.¹⁷ Likewise, the district director is subject to identical limitations on affirmative and rebuttal evidence.¹⁸

Chest X-rays

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 following table summarizes the x-ray findings.¹⁹

¹¹ See *Shupe v. Dir., OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

¹² See 20 C.F.R. §§ 718.101-718.107.

¹³ *Id.*

¹⁴ 20 C.F.R. § 725.414.

¹⁵ 20 C.F.R. §§ 725.414(a)(2)(i), 725.414(a)(3)(i).

¹⁶ *Id.*

¹⁷ 20 C.F.R. §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii).

¹⁸ 20 C.F.R. § 725.414(a)(3)(i-iii).

¹⁹ Many chest x-rays appear in the Claimant's treatment and hospitalization records after November 23, 2007. However, the majority of the x-ray interpretations do not employ the ILO Classification system, and therefore, they are not probative of the existence of pneumoconiosis. If the interpretation did employ a classification system, it is included in the chart.

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 16-1	03/24/10 Read 03/31/10	DePonte Bd. Cert. Radiologist B-reader	Negative
DX 17	03/24/10 Reviewed for quality 05/04/10	Barrett Bd. Cert. Radiologist B-reader	Acceptable
DX 20	03/24/10 Read 08/17/10	Meyer Bd. Cert. Radiologist B-reader	Negative
DX 18-2	08/19/10 Read 09/14/10	Fino B-reader	Negative
CX 2	09/13/11 Read 09/16/11	DePonte Bd. Cert. Radiologist B-reader	Negative
EX 4	09/13/11 Read 02/22/12	Wheeler Bd. Cert. Radiologist B-reader	Negative

Pulmonary Function Studies

The following chart summarizes the pulmonary function studies (“PFTs”) submitted in this claim. Here, the record contains four PFTs. The PFTs report an average height of 71.1 inches. Therefore, I have used 71.1 inches in assessing whether the pulmonary function studies are qualifying.

Exhibit No. Date Physician	Age Height	FEV ₁ Pre-/ Post RX	FVC Pre-/ Post RX	FEV ₁ / FVC Pre-/ Post RX	MVV Pre-/ Post RX	Qualify?	Comprehension and Cooperation/ Tracings?
DX 16-10 03/24/10 DeFore	61 71.25”	2.02/ 1.75	2.57/ 2.20	79%/ 80%	--/ --	Yes/ Yes	Good patient effort/ three tracings attached
DX 18-3 08/19/10 Fino	61 72”	2.15	2.55	84%	--	No	Comprehension and cooperation not noted/ three tracings attached
CX 2 09/13/11 Klayton	63 71.2”	2.56/ 2.59	3.25/ 3.27	79%/ 79%	--/ --	No/ No	Good patient effort/ three tracings attached

EX 1 11/30/11 Castle	66 70"	2.60/ 2.80	3.40/ 3.55	76%/ 79%	--/ --	No/ No	"Acceptable and reproducible"/ three tracings attached
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Arterial Blood Gas Studies

The following chart summarizes the arterial blood gas studies submitted in this claim.

Exhibit No.	Date	Physician	PCO ₂ at rest/ exercise	PO ₂ at rest/ exercise	Qualify?	Physician Impression
DX 16-22	03/24/10	DeFore	45.7/ 49.7	66/ 64.2	No/Neither ²⁰	Hypoxemia on room air.
DX 18-9	08/19/10	Fino	54/ 50	66/ 79	Yes/Neither	Mild hypoxemia and mild hypercarbia at rest.
CX 2	09/13/11	Klayton	45.4/ --	70.5/ --	No/ --	
EX 1	11/30/11	Castle	47.7/ --	74.7/ --	No/ --	Resting ABG shows normal oxygenation with mild hypercapnia.

Autopsy/Biopsy Evidence

There is no autopsy or biopsy evidence submitted in this claim.

Digital X-Ray

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
EX 1	11/30/11 Read 12/01/11	Castle B-reader	Negative

²⁰ The results of the exercise arterial blood gas studies dated March 24, 2010 and August 19, 2010, are not accounted for in the § 718 Appendix C. Accordingly, I find that they are neither qualifying nor non-qualifying for the purpose of establishing total disability pursuant to § 718.204(b)(2)(ii). However, I also find these arterial blood gas studies to be conforming according to the quality standards set forth in § 718.105 and § 718 Appendix C. Accordingly, I find that, although they are neither conforming nor non-conforming, they are probative on the issue of the Claimant's pulmonary and respiratory condition.

Narrative Medical Evidence

1. Treatment Records

The regulations allow the parties to submit treatment and/or hospital records relating to a miner's hospitalization or treatment for “*a respiratory or pulmonary or related disease*” without limitation.²¹ Accordingly, the parties have submitted treatment records, which are found at CX 1 and DX 15. Although the regulations allow for the admission of such records, only specific types of medical evidence may be used to establish pneumoconiosis,²² and total disability.²³ Therefore, although duly considered, for the sake of judicial economy the treatment records are not summarized as such. Rather, any objective studies of the type necessary to establish pneumoconiosis (including, e.g., autopsy and biopsy reports, chest-x-rays employing an ILO classification, CT scans and medical reports as defined in Section 718.104) have been previously charted or summarized. Furthermore, any objective studies of the type necessary to establish total disability (including, e.g., pulmonary function studies, arterial blood gas studies containing both a PO₂ and a PCO₂, diagnoses of cor pulmonale, and medical reports as defined in Section 718.104), have been previously charted and summarized. The remaining treatment and hospital records, though examined in their entirety, will be addressed only where relevant to the specific legal issues before me, or to the extent specifically identified and relied upon by the parties.

2. Opinions Given in Connection with the Black Lung Claim

Dr. Katie DeFore

Examination on March 24, 2010

Dr. DeFore performed the Department-sponsored complete pulmonary examination on March 24, 2010. (DX 16). Dr. DeFore is board-certified in Internal Medicine. Dr. DeFore reported that the Claimant has a total of twenty years of coal mine employment and worked for the Employer maintaining heavy strip mine equipment from 1978 until 1988. (DX 16-31). She also recorded that the Claimant is a lifelong nonsmoker. (DX 16-28, 32). The Claimant's complaints included occasional sputum production for the past one or two years; dyspnea with minimal exertion for the past one to two years; mild cough; orthopnea almost nightly for the past one to two years; ankle edema; and paroxysmal nocturnal dyspnea for one to two years. (*Id.*). Claimant reported sleeping in a recliner some nights. (*Id.*). Claimant denied any history of wheezing, hemoptysis or chest pain. (*Id.*). He also denied any limitations on his functional ability and identified his breathing as his main limitation. (*Id.*).

Dr. DeFore relied on a chest x-ray interpretation by Dr. DePonte, a dually qualified physician, as being negative for clinical pneumoconiosis. (DX 16-1, 33). Dr. DeFore conducted a pulmonary function study and noted that the results showed a moderate restrictive defect pre-bronchodilator, with no significant improvement post-bronchodilator. (DX 16-33). Dr. DeFore also provided the results of an arterial blood gas study, which she interpreted as representing hypoxemia on room air. The EKG showed sinus rhythm with right axis deviation. (*Id.*). There

²¹ 20 C.F.R. § 725.414(a)(4) (emphasis added).

²² See 20 C.F.R. § 718.202.

²³ See 20 C.F.R. § 718.204(b)(2).

were “some nonspecific ST changes and some T wave flattening in V3 in the inferior leads.” (*Id.*).

Based on Dr. DePonte’s negative interpretation of the Claimant’s chest x-ray, Dr. DeFore found no evidence of clinical pneumoconiosis. (DX 16-33). Dr. DeFore diagnosed legal pneumoconiosis based on the moderate restrictive defect with a low total lung capacity as revealed by the pulmonary function study. (*Id.*). Dr. DeFore also noted that the Claimant has an “abnormal physiological response to exercise with a decrease in his pO₂.” (*Id.*). Dr. DeFore attributed the Claimant’s impairment to his 20 years of coal mine employment as the Claimant had no smoking history and no other reported exposure. (DX 16-30).

With regard to the extent of the Claimant’s impairment, Dr. DeFore concluded that he is “totally impaired from a pulmonary standpoint based on his legal pneumoconiosis.” (DX 16-33). Dr. DeFore pointed to the Claimant’s “FEV₁ which [was] 54% of predicted and is below the Department of Labor criteria for FEV-1 for disability and impairment.” (*Id.*). Dr. DeFore also noted that, although the Claimant has an “abnormal physiological response to exercise with a decrease in pO₂,” his arterial blood gas studies were non-qualifying both at rest and after exercise. (*Id.*). Again, Dr. DeFore found that the Claimant had no other exposures that would have caused such a totally disabling impairment. (*Id.*).

Dr. Gregory J. Fino

Medical Report dated September 15, 2010

Dr. Fino examined the Claimant on August 19, 2010, and issued a report dated September 15, 2010. (DX 18-12). Dr. Fino is board-certified in Internal Medicine and Pulmonary Medicine. (DX 18-29). He is also a B-reader. (DX 18-34). Prior to his examination of the Claimant, Dr. Fino reviewed an earlier pulmonary function study from the March 24, 2010, Department of Labor examination and those findings were submitted in a July 14, 2010, report.²⁴ (*Id.*). Dr. Fino recorded that the Claimant worked in coal mine employment for twenty years, ending in 1988. (DX 18-13). He documented that ten of those years were spent underground and the other ten years were spent above ground. (*Id.*). Dr. Fino recorded that the Claimant’s last job in coal mine employment was as a mechanic at a strip mine for fifteen years, but that he also did drilling on the surface on and off for twelve years. (*Id.*). Dr. Fino documented that, during his employment underground, the Claimant “operated a motor and did inside labor.” (*Id.*). According to Dr. Fino, the Claimant’s last job as a mechanic involved heavy labor. (*Id.*). Dr. Fino noted that the Claimant never smoked. (*Id.*)

The Claimant reported to Dr. Fino that he uses a nebulizer and supplemental oxygen. (CX 18-13). The Claimant stated his symptoms as shortness of breath for the past six years and getting worse; dyspnea when walking on level ground, ascending one flight of stairs, or walking up hills or grades; and dyspnea when lifting and carrying. (*Id.*). Dr. Fino stated that the Claimant is “not limited in his usual daily activities” by his shortness of breath, but that he “is limited in what he can do because of his breathing.” (*Id.*). The Claimant also reported daily coughing with

²⁴ Although a July 14, 2010, report regarding a pulmonary function test is referenced in Dr. Fino’s September 15, 2010, report, the July 2010 report has not been included in the record. However, in the September 15, 2010, report, he does note that his review of that pulmonary function test showed that the test was valid. (DX 18-19).

mucus, which began when he was still working in coal mine employment, as well as wheezing. (*Id.*). The Claimant denied orthopnea and paroxysmal nocturnal dyspnea. (*Id.*).

Dr. Fino's physical examination of the Claimant revealed that the Claimant's lungs were clear with no wheezes, rales, rhonchi, or rubs. (DX 18-15). Dr. Fino interpreted the chest x-ray dated September 15, 2010, as negative for clinical pneumoconiosis, classification 0/0. (*Id.*). Dr. Fino opined that the pulmonary function study administered as part of his examination of the Claimant was invalid because there was a premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. (DX 18-17). Thus, according to Dr. Fino, the results of this pulmonary function study represent at least the Claimant's minimum, but not his maximum, lung function. (*Id.*). Dr. Fino also concluded that the diffusing capacity was invalid, because the inspiratory vital capacity was less than 90% of the forced vital capacity. Nonetheless, Dr. Fino opined that the diffusing capacity was normal "when taking into consideration alveolar volume." (*Id.*). Based on the results of the blood gas study, Dr. Fino diagnosed mild resting hypoxemia with mild hypercarbia at rest. Dr. Fino attributed the Claimant's mild hypoxemia and hypercarbia to his obesity. (*Id.*).

Dr. Fino also reviewed the following evidence prior to rendering his medical opinion: 1) the Claimant's claim and employment forms submitted to the Department dated January 22, 2010; 2) records of the Claimant's hospitalization from August 22, 2004 through August 29, 2004; 3) notations by Dr. Hesselson's physician's assistant dated July 29, 2008; 4) hospital records from August 2008; 5) records of a cardiac procedure performed September 18, 2008; and 6) records of the Department-sponsored examination dated March 24, 2010. (DX 18-18-19).

Dr. Fino diagnosed the Claimant with obesity-induced hypoxemia and hypercarbia. (DX 18-20). Dr. Fino opined that the Claimant does not suffer from coal workers' pneumoconiosis based on the negative chest x-rays, invalid spirometry, and "diffusing capacity values are normal after correction for alveolar volume." (*Id.*). Dr. Fino explained that "[a] normal diffusing capacity rules out the presence of clinically significant pulmonary fibrosis. Of course, pneumoconiosis is an example of pulmonary fibrosis." (*Id.*). Moreover, Dr. Fino concluded that the Claimant's pulmonary system was "normal" and that the Claimant's hypoxemia and hypercarbia were due to his body habitus.

Dr. Fino concluded that he had insufficient evidence to diagnose either clinical or legal pneumoconiosis and further, that the Claimant did not have any respiratory impairment. (DX 18-21). However, Dr. Fino opined that due to his body habitus, the Claimant did have hypoxemia and hypercarbia, but that neither of these would prevent him from returning to coal mine employment. (*Id.*). Dr. Fino reiterated that, from a respiratory standpoint, the Claimant was neither partially nor totally disabled from returning to his last coal mine employment or a job requiring similar effort. (DX 18-21). He further stated that even if the Claimant did have pneumoconiosis, he would still find that there was no respiratory impairment and that the Claimant was not totally disabled. (*Id.*).

Deposition on January 23, 2012

Dr. Fino was deposed on February 9, 2012. (EX 3). Prior to his deposition, Dr. Fino reviewed: 1) treatment records from Dr. Alam including two pulmonary function studies; 2) Dr.

Klayton's medical report; 3) Dr. Castle's medical report dated November 30, 2011; and 4) an interpretation of the chest x-ray dated March 24, 2010 by Dr. Meyer. (EX 3-9). Dr. Fino testified that, although it was unclear from his records, it appeared that the Claimant last worked either as a mechanic working underground or as a driller on the surface. (EX 3-12). Regardless, he found that the Claimant had enough coal dust exposure to cause a coal dust-related lung disease. (EX 3-11). Dr. Fino thus assumed that either job would have required "heavy and maybe very heavy manual labor." (EX 3-12).

Dr. Fino stated that the Claimant complained of shortness of breath over the last six years. Dr. Fino opined that the seventeen year interval between the termination of the Claimant's coal mine employment and the onset of his shortness of breath "kind of goes against the coal dust related etiology. It doesn't absolutely rule it out, but it would be unusual." (*Id.*)

Dr. Fino adhered to his conclusion that the pulmonary function study conducted in conjunction with his examination of the Claimant was invalid due to poor effort. (EX 3-13). Thus, Dr. Fino reiterated his opinion that the test underestimated the Claimant's true FVC and FEV1; however, after correcting for effort, his diffusion was "normal." (EX 3-13-14). Dr. Fino again diagnosed the Claimant with resting hypoxemia and hypercarbia, both of which he attributed to the Claimant's obesity. (EX 3-14). He noted that there was no impairment in the Claimant's oxygen transfer after exercise. (*Id.*). Dr. Fino then concluded that the Claimant had "no impairment." (EX 3-15).

With regard to the Claimant's treatment records, Dr. Fino disagreed with Dr. Alam's diagnosis of COPD because he found no evidence of obstruction in the Claimant's pulmonary functions studies. (EX 3-15). According to Dr. Fino, Dr. Alam "incorrectly interpreted a pulmonary function study showing restriction." (*Id.*). Thus, Dr. Fino stated that he did not "find any evidence of obstructive lung disease." (*Id.*). Dr. Fino also did not find evidence of legal pneumoconiosis because he did not "feel that there is a lung condition present caused, significantly contributed to or aggravated by coal dust." (*Id.*). He also reiterated that he found no evidence of clinical pneumoconiosis based on the x-ray evidence. (*Id.*)

With regard to the Claimant's arterial blood gas studies, Dr. Fino again attributed the Claimant's abnormal results to his obesity. (EX 3-16). Moreover, Dr. Fino noted that the Claimant's resting blood gases had improved between the time of his examination of the Claimant and his deposition. (EX 3-16). Dr. Fino found this trend to be inconsistent with pneumoconiosis because "pneumoconiosis doesn't improve." (*Id.*). Dr. Fino also noted that the results of Claimant's pulmonary function studies conducted after his examination by Dr. Fino had also improved. This, according to Dr. Fino, was inconsistent also with a diagnosis of pneumoconiosis. (*Id.*)

Dr. Fino reviewed Dr. Klayton's medical report and found no evidence of respiratory impairment. (EX 3-18). He noted that Dr. Klayton's pulmonary function tests showed improvement from the September 2010 study, which would be inconsistent with pneumoconiosis, as that is an irreversible disease. (*Id.*). Dr. Fino also disagreed with Dr. Klayton's conclusion that obesity does not cause resting hypoxemia. (EX 3-19). Dr. Fino testified that obesity is known to cause resting hypoxemia because "the increased tissue prevents adequate expansion of the lungs." (*Id.*). Regarding Dr. Castle's examination of the Claimant, Dr.

Fino found “even a better pulmonary function study with normal values, normal blood gas, normal lung volumes, normal diffusion, no evidence of hypoxemia, no evidence of obstruction, no evidence of restriction, no pulmonary impairment, no evidence of clinical or legal pneumoconiosis.” (*Id.*). Thus, these results supported his opinion that there was no impairment. (EX 3-20). In sum, Dr. Fino adhered to his conclusion that the Claimant does not have clinical or legal pneumoconiosis or any pulmonary or respiratory impairment. (EX 3-21).

Dr. Ronald J. Klayton

Examination on September 13, 2011

Dr. Klayton examined the Claimant on September 13, 2011. (CX 2). Dr. Klayton is board-certified in Internal Medicine with a subspecialty in Pulmonary Disease. Dr. Klayton recorded that the Claimant has a total of twenty-six years of coal mine employment. Dr. Klayton noted that the Claimant worked as a heavy equipment repairman at a surface mine from 1987 and 1988 and had to lift up to one hundred pounds. From 1977 until 1987, the Claimant worked for Employer as a mechanic and rock drill helper, a position that also required him to lift up to one hundred pounds. Dr. Klayton documented that the Claimant “had a heavy rock dust and light coal dust exposure” while working in these roles. (*Id.*). Dr. Klayton recorded that the Claimant has never smoked. (*Id.*).

Dr. Klayton stated that the Claimant has diabetes and had atrial fibrillation three years ago. (CX 2). The Claimant reported that he is prescribed an albuterol nebulizer and inhalers to treat COPD. He also uses a CPAP machine. The Claimant reported no history of frequent colds, pneumonia, pleurisy, attacks of wheezing, tuberculosis, chronic bronchitis, bronchial asthma, allergies, or cancer. (*Id.*). The Claimant further reported that he was hospitalized multiple times in 2010 for COPD exacerbations. (*Id.*).

The Claimant’s complaints included shortness of breath with exertion for the past five years; mild productive cough daily for the past three years; and paroxysmal dyspnea. (CX 2). The Claimant reports that he presently gets short of breath if he walks a short distance up a hill or walking up to eight steps. (*Id.*). According to the Claimant, he can walk approximately one half of a block, if it is level, before he needs to stop and rest. (*Id.*). The Claimant estimated that he is presently able to lift up to twenty-five pounds. (*Id.*).

Dr. Klayton’s physical examination revealed clear lungs with no wheezes, rales, or rhonchi. (CX 2). There was trace ankle edema bilaterally, but no clubbing or varicosities were present. (*Id.*). Dr. Klayton relied on an interpretation of a chest x-ray dated September 13, 2011, by Dr. DePonte. (*Id.*). Dr. DePonte interpreted the x-ray as negative for opacities consistent with clinical pneumoconiosis but “noted pleural plaques in the profile on the right side measuring up to ¼ of the lateral chest wall.” (*Id.*). Dr. Klayton opined that the pulmonary function studies “showed moderate restrictive lung disease and reduced diffusing capacity.” (*Id.*). The EKG was normal.

Dr. Klayton diagnosed the Claimant with coal workers’ pneumoconiosis “based on a history of 26 years of coal-mine employment, dyspnea on mild exertion, a daily productive cough of three years duration, moderate restrictive lung disease with decreased diffusing capacity on pulmonary function tests, mild hypoxemia on resting arterial blood gases, and a chest

x-ray showing pleural plaques consistent with pneumoconiosis.” (*Id.*). Dr. Klayton pointed to the Claimant’s history of rock and coal dust exposure as the etiology of his cardiopulmonary diagnosis. Dr. Klayton cited the Claimant’s obesity as a possible contributing factor to his restrictive lung disease but concluded that obesity would not cause his decreased diffusing capacity or resting hypoxemia. (*Id.*).

With regard to the degree of the Claimant’s impairment, Dr. Klayton concluded that the Claimant’s impairment is “severe” because the Claimant “cannot walk more than a short distance without having to stop to rest and cannot lift more than 25 pounds. He therefore would not be able to return to his previous coal mine employment.” (*Id.*).

Dr. James R. Castle

Examination on December 12, 2011

Dr. Castle examined the Claimant and reviewed his medical records on behalf of the Employer on December 12, 2011. (EX 1). According to his curriculum vitae, Dr. Castle is board-certified in Internal Medicine and Pulmonary disease, and he is a B-reader. Dr. Castle reported the Claimant as having worked in the mines between 20 and 25 years, both underground and as a surface miner. He noted that the Claimant worked the last ten years in surface mining as a mechanic and worked on a drill. He also reported that the Claimant was a non-smoker. The Claimant complained of shortness of breath over the past five or six years, the ability to walk 500 feet without stopping, difficulty climbing stairs or inclines, intermittent cough with sputum production over the last four to five years, and wheezing that gets worse in cold temperatures. The review of symptoms indicated that the Claimant slept in a recliner because of difficulty breathing and the use of a CPAP machine, as well as swelling of his feet in the past. (*Id.*).

The physical examination revealed equal breath sounds throughout the Claimant’s lungs with no rales, rhonchi, wheezes, rubs, crackles, or crepitations. (EX 1). A digital chest x-ray was obtained and Dr. Castle found no evidence of pneumoconiosis.²⁵ Dr. Castle also obtained valid pulmonary function studies, which he interpreted as showing evidence of mild restrictive lung disease. He also performed an arterial blood gas study and obtained an electrocardiogram. (*Id.*). Based on his examination, Dr. Castle found insufficient evidence to diagnose pneumoconiosis. (EX 1). He also assessed the Claimant as having a mild restrictive pulmonary impairment due to exogenous obesity, as well as many other non-coal mine employment related diseases.

Dr. Castle then reviewed the Claimant’s medical records. These records included: 1) the Claimant’s January 22, 2010, claim for benefits; 2) the employment history; 3) medical records from Central Baptist Hospital; 4) medical report by Dr. DeFore dated March 24, 2010; 5)

²⁵ Digital chest x-rays are considered under 20 C.F.R. § 718.107 [“Other medical evidence”], as such the Administrative Law Judge must “determine, on a case-by-case basis ... whether the proponent of the digital x-ray evidence has established that it is medically acceptable and relevant to entitlement.” *Webber v. Peabody Coal Co.*, 23 BLR 1-123, 1-133 (2006) (*en banc*) (J. Boggs, concurring) (citations omitted). *See also Harris v. Old Ben Coal Co.*, 24 BLR 1-13, 1-16–17 (2007) (*en banc* on recon.) (J. McGranery and J. Hall, concurring and dissenting), *aff’g.* 23 BLR 1-98 (2006) (*en banc*). None of the Employer’s physicians have attested to the reliability and acceptability of digital x-rays in diagnosing pneumoconiosis. Therefore, I will not consider this evidence in making my determination.

medical report by Dr. Fino dated September 15, 2010; 6) a pulmonary function study by Dr. Fino dated June 14, 2010; and 7) a radiographic report by Dr. Meyer. (EX 1). After his review, Dr. Castle confirmed his earlier assessment:

It is my opinion with a reasonable degree of medical certainty based upon a thorough review of all data including the medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gas studies, and other data that Mr. Philip Caudill does not suffer from pneumoconiosis, either medical or legal.

(*Id.*). Dr. Castle did acknowledge, however, that the Claimant had worked in the mines for a sufficient period of time for pneumoconiosis to develop in a susceptible host. However, Dr. Castle referred to the Claimant's other risk factors for pulmonary disease, obesity and cardiac disease, as being the cause of his shortness of breath, restrictive lung disease, hypoxemia, and other physiologic findings. There were no findings that he believed indicated the presence of interstitial pulmonary disease. (*Id.*).

Regarding the pulmonary function tests, he noted a significant improvement in the more recent tests. (EX 1).

At the present time he does not demonstrate a disabling abnormality of ventilatory function from any cause. While coal workers' pneumoconiosis may be associated with some restriction, it typically is associated with a mixed, irreversible obstructive and restrictive ventilatory defect when it causes impairment. It is not possible or likely that the improvement in values seen in this case could have occurred if they were due to coal workers' pneumoconiosis. The findings in coal workers' pneumoconiosis are fixed and irreversible.

It is my opinion with a reasonable degree of medical certainty that the restrictive lung disease present in this case, which has occurred in the absence of any obstruction, is entirely due to his morbid obesity. Obesity may cause a very severe degree of restriction and may be associated with other findings as well. Therefore, it is my opinion with a reasonable degree of medical certainty that the physiologic abnormalities in this case are not due in any way to coal dust exposure or coal worker's pneumoconiosis. They are due to his exogenous obesity.

(*Id.*). He also interpreted the arterial blood gas studies as showing "obesity induced hypoxemia and hypercapnia" and their results to be due to "obesity and alveolar hypoventilation due to obesity." (*Id.*).

In conclusion, Dr. Castle opined that the Claimant did not have any form of pneumoconiosis, nor was he permanently and totally disabled due to pneumoconiosis. Although he found the Claimant to have a respiratory impairment due to obesity, he did not believe this was a permanently and totally disabling respiratory condition. However, he did conclude this discussion by stating: "It is possible that he is permanently and totally disabled as a whole man because of his cardiac disease, but this is unrelated to coal mining employment and coal dust exposure." (*Id.*).

Deposition on January 5, 2012

Dr. Castle was deposed on January 5, 2012. (EX 2). When asked about the Claimant's shortness of breath, Dr. Castle stated that it was not specific to any medical condition, but could occur due to numerous causes. He opined that the Claimant's obesity had "quite a bit" of effect on the Claimant's respiratory condition, causing significant restrictive lung disease and hypoventilation syndrome. Dr. Castle described hypoventilation syndrome as "an obese individual with a BMI greater than 30, associated with a wakeful PCO₂ greater than 45 at rest without any other discernible cause. It frequently and usually is associated with some restrictive disease and may be severe enough to result in respiratory insufficiency." (EX 2 at 12:21-13:3). Ultimately, it was this disease that Dr. Castle believed was causing the Claimant's mild restriction. Dr. Castle also used the Claimant's normal diffusing capacity measurement to rule out coal mine dust inhalation as a causative factor:

That's useful in this circumstance where you have a restrictive problem, because it tells you that the restrictive problem is not due to something in the lung itself, the problem is outside the lung, because if it were due to fibrosis, let's say, in the lung, then it would have an impact and reduce both the diffusing capacity and the DL/VA, and neither of those were abnormal, and in looking at everything in this case, it makes it absolutely clear that the restriction is entirely due to his obesity.

(EX 2 at 15:17-16:4). He again stated that the pulmonary function tests, as a whole, indicated improvement in the Claimant's lung function, although he was not able to discern what caused the improvement. He was, however, able to rule out pneumoconiosis. "[Pneumoconiosis] isn't reversible, sadly, and it would not be expected to improve in that time frame or with any kind of treatment. It's a -- it can be a progressive disease, but it isn't one that gets better." (EX 2 at 18:12-16). He also noted that the Claimant was not suffering from any other lung disease, such as obstructive disease.

In sum, Dr. Castle was asked once more about his opinions as to whether the Claimant was suffering from coal workers' pneumoconiosis or whether he was totally disabled. He confirmed his opinion that the Claimant did not have pneumoconiosis based on radiographic findings and physiologic findings that were all unrelated to pneumoconiosis but more so related to his obesity hypoventilation syndrome. (*Id.*). He further opined that the Claimant did not have a totally disabling respiratory impairment from any cause, and he was specifically able to exclude, within a reasonable degree of medical certainty, that coal dust was a contributing factor to any impairment. (*Id.*).

DISCUSSION AND APPLICABLE LAW

On March 23, 2010, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1556 (2010) (PPACA) was signed into law. Section 1556 enacted significant changes regarding the adjudication of black-lung claims (1) filed after January 1, 2005, and (2) pending "on or after the date of enactment" of the amendments, which is March 23, 2010. This case falls within that category of claims. Of significance here, Section 1556 revived the fifteen-year presumption found at 30 U.S.C. § 921(c)(4), as implemented at 20 C.F.R. § 718.305. In brief, that section requires that the miner must have worked in underground coal mine employment or

substantially similar working conditions for a period of fifteen years, and that the miner have a totally disabling respiratory or pulmonary impairment. If so, a rebuttable presumption is invoked that the miner is totally disabled due to pneumoconiosis, or that his death was due to pneumoconiosis, or that at the time of death he was totally disabled due to pneumoconiosis.

I have previously found that the Claimant worked in the coal mines for a total of 17.75 years. According to the Claimant's testimony at his deposition, which is supported by his social security records, the Claimant worked a total of three to four years underground, and thirteen to fourteen years above ground as a surface miner. (DX 21A, DX 6). Therefore, the Claimant must show that when he worked as a surface miner that the dust conditions were substantially similar to underground coal mine employment conditions.²⁶ The Claimant is not required to demonstrate that environmental conditions at the surface mine were similar to the dustiest area of an underground coal mine.²⁷ Rather, the Claimant must establish that he was exposed to coal mine dust in the course of his surface mine employment.²⁸ Then, the administrative law judge, as the trier-of-fact, must make a specific finding with supporting rationale as to whether the environmental conditions of the miner's employment in surface mines were substantially similar to those in an underground mine.²⁹

At his deposition, taken on August 4, 2010, the Claimant testified that the first coal mine he worked at was Dixie Fuel Company. (DX 21A-5). According to his social security records, the Claimant worked there for one quarter in 1967. (DX 6). At Dixie Fuel Company, the Claimant testified that he worked aboveground as a mechanic, that it was "plenty" dusty with no breathing protection and the only dust protection was that the road was occasionally watered down. (DX 21A-6).

The Claimant then went to work at Newell Mining Company. The Claimant testified that he worked there for six months to a year. (DX 21A-8). Per the social security records, the Claimant worked there for three quarters from 1967-1968. (DX 6). This was underground coal mine work, where the Claimant ran a battery motor. (DX 21A-8). He did not wear a respirator and the dust was not controlled. (DX 21A-9).

The Claimant then went to work for Dan Mining Company. (*Id.*). He testified that he worked there for five to six months. (*Id.*). This is supported by the social security records, which show that he worked there for two quarters in 1968. (DX 6). The first quarter of 1968, however, overlaps with his employment at Newell Mining Company. Therefore, he is credited with only one quarter of underground coal mining for the beginning of 1968. Here, the Claimant also worked underground riding a battery motor. (DX 21A-10). Again, the Claimant did not wear a respirator and the dust conditions were "not the best." (*Id.*).

²⁶ See *Wagahoff v. Freeman United Coal Mining Co.*, 10 B.L.R. 1-100, 1-101 (1987) (citing *Luker v. Old Ben Coal Co.*, 2 B.L.R. 1-304 (1979)).

²⁷ *McGinnis v. Freeman United Coal Mining Co.*, 10 B.L.R. 1-4, 1-7 (1987) (citing *Luker*, 2 B.L.R. at 1-310).

²⁸ *Luker*, 2 B.L.R. at 1-312; accord *Dir.*, *OWCP v. Midland Coal Co.*, 855 F.2d 509, 512 (7th Cir. 1988).

²⁹ *Spese v. Peabody Coal Co.*, 19 B.L.R. 1-47, 1-54 (1995); *Luker*, 2 B.L.R. at 1-312; accord *Midland Coal*, 855 F.2d at 512.

Upon his return from the Army, the Claimant worked as a truck driver for RC Truck Company. (DX 21A-12). The Claimant clarified that this was coal mine work. (*Id.*). He stated that he worked there “a year or two.” (*Id.*). According to the social security records, the Claimant worked for RC Trucking for four quarters from 1970 to 1971. (DX 6). This work took place at an aboveground coal mine. (DX 21A-13). When asked about the dust conditions, the Claimant said it was “pretty rough” and that “when you pass somebody, you had to wait awhile to see where you was going.” (*Id.*).

The Claimant then worked at ABCD Coal Corporation, which was a strip mine. (DX 21A-14). The Claimant could not remember what years he worked there, but according to the social security records, he worked for one quarter in 1972. (DX 6). He worked there as a mechanic, right alongside the mining operation. (DX 21A-15). There was no breathing protection provided and they did not use water. (*Id.*).

Next, the Claimant went to Berry Brothers and he testified that he worked for two to three years. (DX 21A-16). Per his social security records, the Claimant worked at Berry Brothers for five quarters from 1972 to 1973. (DX 6). At Berry Brothers the Claimant ran an auger at a strip mine. (DX 21A-16). He described the dust conditions at that mine as being “pretty rough.” (DX 21A-17). He did not wear a respirator and they did not use water. (*Id.*). There were also no other kinds of dust control. (*Id.*). The Claimant further explained, “Back then, see, well, we didn’t have nothing, you know what I’m saying, ‘til lately, like these guys got it now.” (*Id.*).

After Berry Brothers the Claimant went to work at Lake Coal Company. (DX 21A-18). The Claimant testified that he worked there from 1974 to 1979. (*Id.*). However, the social security records show that the Claimant worked for Lake Coal Co. for four quarters in 1974, two quarters in 1975, and two quarters in 1977. (DX 6). As I found previously, he also worked for Lake Coal Company (and Globe Coal Company) for one year after the social security records stopped recording employment by quarters, in 1978. (*Id.*). Therefore, the Claimant worked for Lake Coal Company for a total of three years. He worked for Lake Coal Company above ground as a mechanic. (DX 21A-18). He testified that he worked around the machinery at all times. (DX 21A-19). He described the dust conditions there as “bad.” (*Id.*). He further elaborated: “See, all them years, right now, if you all understand, they got enclosed cabs. We had open cabs. No air, no nothing else.” (*Id.*).

The Claimant next worked at South East Coal Company. (*Id.*). He testified that he worked there for about two years. (*Id.*). The social security records show, however, that the Claimant worked at South East Coal Company for ten quarters, or slightly over two years. (DX 6). However, his work at South East Coal Company overlapped with Lake Coal Company in the second quarter of 1975 and the third quarter of 1977. Therefore, the Claimant can only be credited with eight quarters at South East Coal Company. The work he performed there was underground as an electrical mechanic. (DX 21A-20). He described those dust conditions as “pretty rough at times” with no dust controls. (*Id.*).

The Claimant then went to work at Globe Company in 1978. (DX 21A-22). Because of the way these earnings were recorded in the social security records, this time was included in the one year the Claimant was credited with when he worked for Lake Coal Company in 1978.

The Claimant's last coal mine employment was with Lance Coal Company, the Employer. (DX 21A-24). The Employer stipulated to nine years of employment. (Tr. at 9). While working for the Employer, the Claimant worked on repairing the rock drill. (DX 21A-24). This was aboveground work at a strip mine. (DX 21A-25). He described those conditions as "bad." (*Id.*). He testified that he had no dust protection and that "you couldn't even see, half the time, where you was at." (*Id.*). In 1987, the mine changed its name to Golden Oak, but the Claimant stated that it was the same job, just under a different name. (DX 21A-26).

Looking at his employment history as a whole, and crediting the proper amount of quarters worked, the Claimant worked for 3.0 years underground, and 14.75 years at above ground mines. The Claimant adequately discussed his exposure to dust and the conditions of each of the mines where he was employed. Amongst other descriptions, he repeatedly referred to the lack of dust protection, including the unavailability of respirators, the lack of water to spray down the dust, and having to work in open truck cabs. When asked specifically about the dust conditions he used the terms "bad," "pretty rough," "not the best," and "plenty." He also testified that the dust would be so bad that he would have problems seeing through it. I find the Claimant's testimony regarding the dusty conditions to be credible and similar to the typical testimony of underground coal miners.³⁰ As such, I find that the Claimant has met his burden of establishing that his work performed as a truck driver, mechanic, driller, and auger operator at both underground and surface mines was substantially similar in terms of dust exposure to the work performed by underground coal miners. Therefore, because the Claimant has established that he worked at least fifteen years of combined underground mining and strip mining in substantially similar conditions, he may invoke the rebuttable presumption upon a showing that he was totally disabled due to pneumoconiosis.³¹

Total Disability

In the absence of complicated pneumoconiosis, a miner may be found totally disabled from a respiratory or pulmonary standpoint if, in the absence of contrary probative evidence, the evidence meets one of the criteria set forth in 20 C.F.R. § 718.204(b).³² The regulations provide four methods by which a miner may establish total disability under the Act: (1) pulmonary function studies, (2) arterial blood gas tests, (3) a cor pulmonale diagnosis, or (4) a well-reasoned and well-documented medical opinion finding of total disability.³³ Unless outweighed by contrary probative evidence, evidence that meets the standards of subparagraphs (i), (ii), (iii), or (iv) establishes a miner's total disability.³⁴

³⁰ See e.g. *Consolidation Coal co. v. Director, OWCP*, No. 11-3637, 2013 WL 3215666, at *4 (7th Cir. June 27, 2013)(finding substantially similar condition when the miner, who drove a bulldozer, described the dust as "blowing...right back in [his] face" and the only dust control efforts as being a single water truck that was "pretty well insufficient to take care of any dust").

³¹ 20 C.F.R. § 718.305(a).

³² There is no evidence in the record to show the Miner was suffering from complicated pneumoconiosis.

³³ 20 C.F.R. § 718.204(b)(2)(i)-(iv).

³⁴ 20 C.F.R. § 718.204(b)(2).

Total disability may be established with pulmonary function studies.³⁵ The only qualifying pulmonary function study submitted in connection with this claim was taken during the Department of Labor examination on March 24, 2010. (DX 16). All three pulmonary function studies performed during the subsequent examinations resulted in non-qualifying values. Furthermore, the March 24, 2010, pulmonary function study was invalidated by Dr. Fino due to poor patient effort. (EX 3-13). Therefore, I find that the Claimant has not established total disability by the pulmonary functions studies.

Qualifying arterial blood gas studies may also be used to show total disability.³⁶ Nearly all of the arterial blood gas studies were non-qualifying. The only qualifying arterial blood gas study was performed by Dr. Fino on August 19, 2010. (DX 18). The earlier arterial blood gas study and the two later blood gas studies were all non-qualifying. Thus, I find that the weight of the arterial blood gas evidence does not establish that the Miner was totally disabled.

Total disability may also be established with medical evidence of cor pulmonale with right-sided congestive heart failure.³⁷ There is no evidence of associated right-sided congestive heart failure in the record. Therefore, I find that the Claimant has failed to establish total disability under this subsection.

Finally, a finding of total disability may be based upon a physician's reasoned medical opinion.³⁸ The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques.³⁹ In assessing total disability, the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment.⁴⁰

Dr. DeFore, who is board-certified in Internal Medicine, performed the Department of Labor examination and found that the Claimant was totally disabled from a pulmonary standpoint. (DX 16). Dr. DeFore credited the Claimant with 20 years of coal mine employment as a heavy strip mine equipment operator that required heavy labor. This length of employment is longer than what I have credited the Claimant with, but not significantly so. She based this finding of total disability on the Claimant's FEV₁, which was 54% of predicted and below the Department of Labor criteria. She noted an abnormal physiological response to exercise demonstrated by a decreased in pO₂. She also found that the Claimant had no other exposures that would have caused his totally disabling impairment.

Dr. Klayton, a pulmonologist, also determined that the Claimant was totally disabled by a respiratory impairment. (CX 2). Dr. Klayton found the Claimant to have a 26 year coal mine employment history, which is almost ten years longer than what I have found. He noted that the Claimant worked as a heavy equipment repairman where he had to lift up to 100 pounds, and as a mechanic and rock drill helper that also required him to lift up to 100 pounds. Dr. Klayton

³⁵ 20 C.F.R. § 718.204(b)(2)(i).

³⁶ 20 C.F.R. § 718.204(b)(2)(ii).

³⁷ 20 C.F.R. § 718.204(b)(2)(iii).

³⁸ 20 C.F.R. § 718.204(b)(2)(iv).

³⁹ *Id.*

⁴⁰ *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000).

determined that the Claimant was totally disabled because he could not walk more than a short distance without stopping to rest and because he could not lift more than 25 pounds. For those reasons, he noted that the Claimant would not have been able to return to his usual coal mine employment, thus making him totally disabled by a respiratory impairment.

The Employer's physicians, Drs. Fino and Castle, both found that the Claimant was not totally disabled. Dr. Fino is board-certified in Internal Medicine and Pulmonology. He determined that the Claimant had 20 years of coal mine employment, which was not significantly different than the 17.75 years of coal mine employment that I credited the Claimant. Dr. Fino found that the Claimant did not have any kind of respiratory impairment. (DX 18). He did find, however, that the Claimant's hypoxemia and hypercarbia did prevent him from returning to coal mine employment, but nothing from a respiratory standpoint. Ultimately, he concluded that because the Claimant did not have a respiratory impairment, he could not be totally disabled. Dr. Castle, on the other hand, did find that the Claimant had a mild restrictive pulmonary impairment. Dr. Castle is also board-certified in Internal Medicine and Pulmonology. He credited the Claimant as working between 20 and 25 years. Dr. Castle determined that the Claimant's mild impairment was due to his obesity and not coal-mine related factors. He also opined that the impairment was not permanently and totally disabling.

I credit Drs. DeFore and Klayton in finding that the Claimant was totally disabled due to a respiratory impairment. Unlike Drs. Fino and Castle, Drs. DeFore and Klayton effectively explained how the Claimant's condition made him unable to return to his previous coal mine employment. I give more credit to Dr. DeFore's explanation that the Claimant's low FEV₁ and abnormal physiological response to exercise would prevent him from returning to a job that required him to work on heavy machinery. Dr. Klayton's findings were even more specific in that he acknowledged that the Claimant's last coal mine employment required him to lift upwards of 100 pounds and that the Claimant is now limited to lifting less than 25 pounds and could only walk short distances.⁴¹ Although Dr. Klayton credited the Claimant with a longer coal mine employment history than I have, the logic behind his well explained opinion that the Claimant is no longer able to engage in high levels of exertion is not directly impacted by this overestimate and therefore not diminished. I give less weight to Dr. Fino and Dr. Klayton because neither doctor explained how the Claimant still retained the respiratory capacity to return to his previous coal mine employment given the heavy exertion level of that position and the Claimant's inability walk long distances without stopping, amongst other breathing-related issues.

In sum, I find that the Claimant has established the existence of a totally disabling respiratory or pulmonary impairment based on the opinions of Drs. DeFore and Klayton. As the Claimant has established more than fifteen years of coal mine employment, in underground mines or in conditions substantially similar to underground mines, and the existence of a totally

⁴¹ See *DeFelice v. Consolidation Coal Co.*, 5 B.L.R. 1-275 (1982)(finding that the presumption can be invoked when a physician adequately assesses a Claimant's ability to walk, climb, lift, and carry, and determines that those limitations would rule out the miner's ability to return to coal mine work). See also *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988)(an opinion does not have to be phrased in terms of total disability if the administrative law judge can infer from the opinion that the miner the was totally disabled).

disabling respiratory impairment, the presumption of Section 718.305 is applicable. Pneumoconiosis is established by use of presumption under Section 718.202(a)(3).

Rebuttal of the Presumption

As the Claimant has established the threshold requirements for invocation of the rebuttable presumption, the burden shifts to the Employer to rebut the presumption by establishing either (a) that the Miner did not have pneumoconiosis; or (b) that his respiratory or pulmonary impairment did not arise out of, or in connection with, coal mine employment.⁴² Importantly, the presumption cannot be rebutted on the basis of evidence demonstrating the existence of a totally disabling obstructive respiratory or pulmonary disease of unknown origin.⁴³

A. Existence of Pneumoconiosis

Rebuttal under the first prong “requires an affirmative showing that the miner does *not* suffer from pneumoconiosis. . . .”⁴⁴ Because the definition of pneumoconiosis includes both clinical and legal pneumoconiosis, to rebut the presumption, the Employer must establish that the Miner did not suffer from either form of the disease.⁴⁵

“Pneumoconiosis” is defined by the Act as “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.”⁴⁶ This definition encompasses two forms of lung disease, “clinical pneumoconiosis” and “legal pneumoconiosis.”⁴⁷ “Clinical pneumoconiosis” consists of:

[T]hose diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.⁴⁸

Clinical pneumoconiosis is “generally visible on chest x-ray films.”⁴⁹

“Legal pneumoconiosis” is more broadly defined to include “any chronic [restrictive or obstructive] pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”⁵⁰ Significantly, “[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within

⁴² 30 U.S.C. § 921(c)(4); 20 C.F.R. § 718.305(a).

⁴³ 20 C.F.R. § 718.305(d).

⁴⁴ *Morrison v. Tennessee Consol. Coal Co.*, 644 F.3d 473, 480 (6th Cir. 2011) (emphasis in original).

⁴⁵ *Shonbom v. Director, OWCP*, 8 B.L.R. 1-434, 1-435-36 (1986).

⁴⁶ 30 U.S.C. § 902(b); 20 C.F.R. §§ 718.201(a), 725.101(a)(25).

⁴⁷ 20 C.F.R. § 718.201(a); 65 Fed. Reg. at 79937 (Dec. 20, 2000).

⁴⁸ 20 C.F.R. § 718.201(a)(1); *see also Eastover Mining Co. v. Williams*, 338 F.3d 501, 509 (6th Cir. 2003) (defining “clinical pneumoconiosis” as “a lung disease caused by the fibrotic reaction of the lung tissue to inhaled dust”).

⁴⁹ *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 210 (4th Cir. 2000).

⁵⁰ 20 C.F.R. §§ 718.201(b), (a)(2).

the definition of legal pneumoconiosis.”⁵¹ Legal pneumoconiosis “encompasses a broader spectrum of diseases than those pathologic conditions which can be detected by clinical diagnostic tests such as x-rays or CT scans.”⁵² Therefore, an x-ray read as negative for pneumoconiosis should not necessarily be treated as evidence weighing against a finding of legal pneumoconiosis.⁵³

The regulations provide four means by which pneumoconiosis may be established, including chest x-ray evidence, biopsy or autopsy evidence, statutory presumption, and a physician’s reasoned medical opinion.⁵⁴ Pneumoconiosis must be established by a preponderance of the evidence in all four categories; an administrative law judge may not look exclusively to one of Section 718.202(a)’s four subsections, while ignoring contrary evidence from one of the other three subsections.⁵⁵

1. *Clinical Pneumoconiosis*

a. 20 C.F.R. § 718.202(a)(1): X-Rays

In the case of a living miner, clinical pneumoconiosis is typically established through a chest x-ray. A chest x-ray conducted and classified in accordance with the regulations may form the basis for a finding of pneumoconiosis.⁵⁶ When two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays.⁵⁷ The administrative law judge may defer to the numerical superiority of the x-ray readings, or to readings by physicians who are both B-readers and Board-certified radiologists.⁵⁸ No claim may be denied solely on the basis of chest x-ray evidence.⁵⁹

Here, the record contains five interpretations of three x-rays as affirmative evidence. All of the x-rays were interpreted as negative for pneumoconiosis. There are no conflicting interpretations. The treatment records contain x-rays, which are silent as to the existence of pneumoconiosis; it is not clear that the radiologists were even looking for the disease when reviewing the films. Therefore, I give no weight to the x-rays in the treatment records on the existence of clinical pneumoconiosis. The preponderance of the affirmative x-ray evidence is negative for clinical pneumoconiosis.

b. 20 C.F.R. § 718.202(a)(2): Autopsies or Biopsies

Autopsy or biopsy evidence may also form the basis for a finding of pneumoconiosis.⁶⁰

⁵¹ *Martin v. Ligon Preparation Co.*, 400 F.3d 302, 306 (6th Cir. 2005).

⁵² 65 Fed. Reg. at 79945 (Dec. 20, 2000).

⁵³ *Compton*, 211 F.3d at 210.

⁵⁴ 20 C.F.R. § 718.202(a).

⁵⁵ *Collins v. Pond Creek Mining Co.*, 468 F.3d 213, 218-19 (4th Cir. 2006) (citing *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 207-08 (4th Cir. 2000)); see also *Dixie Fuel Co, LLC v. Director, OWCP [Hensley]*, Case No. 11-4298, slip op. at 3 (6th Cir. Nov. 28, 2012).

⁵⁶ 20 C.F.R. § 718.202(a)(1).

⁵⁷ *Id.*

⁵⁸ See *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123, 1-138 (2006); *Staton v. Norfolk & Western Ry. Co.*, 65 F.3d 55, 60 (6th Cir. 1995).

⁵⁹ 20 C.F.R. § 718.202(b).

⁶⁰ *Id.* § 718.202(a)(2).

Autopsy and biopsy reports are generally considered to be the most reliable evidence of the existence of pneumoconiosis.⁶¹ Here, the record is devoid of autopsy or biopsy evidence. Therefore, the existence of pneumoconiosis is neither supported nor refuted by autopsy or biopsy evidence.

c. 20 C.F.R. § 718.202(a)(3): Presumptions

Three statutory presumptions are available to aid a claimant in establishing pneumoconiosis.⁶² Section 718.304 does not apply because there is no evidence of complicated pneumoconiosis in this case. Nor does Section 718.306 apply because this is not a survivor's claim. I have already found that the 15-year presumption at Section 411(c)(4) of the Act,⁶³ revived by Section 1556 of the PPACA,⁶⁴ and implemented in the regulations at 20 C.F.R. § 718.305, applies in this case.

d. 20 C.F.R. § 718.202(a)(4): Medical Opinions

A finding of pneumoconiosis may also be based upon a physician's reasoned medical opinion.⁶⁵ When weighing conflicting medical reports, the administrative law judge must address the comparative credentials of the respective physicians, the explanations for their conclusions, the documentation underlying their medical judgments, and the sophistication of, and bases for, their diagnoses.⁶⁶

Here, no physician has diagnosed clinical pneumoconiosis. Dr. DeFore found no evidence of clinical pneumoconiosis based on Dr. DePonte's negative interpretation of the Claimant's March 24, 2010, chest x-ray. (DX 16). Dr. Fino interpreted the chest x-ray that he performed on August 19, 2010, as negative for clinical pneumoconiosis. (DX 18). Dr. Klayton relied on Dr. DePonte's September 13, 2011, chest x-ray interpretation as showing no evidence of clinical pneumoconiosis. (CX 2). Dr. Castle relied on the digital x-ray that he took of the Claimant on December 12, 2011, and found no evidence of clinical pneumoconiosis. (EX 1). Therefore, I find that the medical opinion evidence is negative for clinical pneumoconiosis.

Clinical Pneumoconiosis Conclusion

In weighing all the evidence on clinical pneumoconiosis, I find that the preponderance of the evidence on clinical pneumoconiosis is negative. All of the x-rays have been interpreted as negative and the medical opinion evidence is also negative for the disease. Accordingly, I find that the Employer has sustained its burden of disproving the existence of clinical pneumoconiosis.

⁶¹ *Gray v. SLC Coal Co.*, 176 F.3d 382, 387 (6th Cir. 1999); *Terlip v. Director, OWCP*, 8 BLR 1-363 (1985).

⁶² 20 C.F.R. § 718.202(a)(3).

⁶³ 30 U.S.C. § 921(c)(4).

⁶⁴ Pub L. No. 111-148, § 1556 (2010).

⁶⁵ 20 C.F.R. § 718.202(a)(4).

⁶⁶ *See J.V.S. v. Arch of West Virginia*, 24 B.L.R. 1-78, 1-96 (2008).

2. *Legal Pneumoconiosis*

The Employer must also disprove the existence of legal pneumoconiosis.⁶⁷ Legal pneumoconiosis is broadly defined to include “any chronic [restrictive or obstructive] pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”⁶⁸ Legal pneumoconiosis “encompasses a broader spectrum of diseases than those pathologic conditions which can be detected by clinical diagnostic tests such as x-rays or CT scans.”⁶⁹ To be credited on the issue of legal pneumoconiosis, a physician’s opinion must be “reasoned,” it must demonstrate “sound medical judgment,” and it must be based upon “objective medical evidence.”⁷⁰ It is sufficient for a physician to review objective evidence, such as physical examination findings, symptoms, pulmonary function tests, arterial blood gas studies, and social and work histories, and conclude that a miner suffers from a chronic pulmonary disease or respiratory or pulmonary impairment that is causally related to dust exposure in coal mine employment.

Here, neither of the Employer’s physicians diagnosed the Claimant with legal pneumoconiosis. The Department of Labor examiner, Dr. DeFore, and Claimant’s expert, Dr. Klayton, however, both diagnosed legal pneumoconiosis. I must resolve the conflict among the physicians in determining whether the Employer has sustained its burden in disproving the existence of legal pneumoconiosis.

Dr. Fino opined that the Claimant did not suffer from coal workers’ pneumoconiosis based on the negative chest x-rays, invalid spirometry, and normal diffusing capacity values. He stated that the fact that the Claimant had normal diffusing capacity values “ruled out the presence of clinically significant pulmonary fibrosis.” Instead, Dr. Fino diagnosed the Claimant with mild resting hypoxemia and hypercarbia based on the Claimant’s obesity. Regarding the Claimant’s shortness of breath he found that the seventeen year duration between when the Claimant left the coal mines and the onset of symptoms went against coal dust related etiology. However, he did acknowledge that it would not necessarily prevent the possibility. He also ruled out the possibility of legal pneumoconiosis because he did not “feel that there is a lung condition present caused, significantly contributed to or aggravated by coal dust.” Dr. Fino also noted that the improvement in the arterial blood gas studies and pulmonary functions tests was inconsistent with pneumoconiosis because it is an irreversible disease, therefore, ruling out a diagnosis of legal pneumoconiosis. I cannot accept Dr. Fino’s opinion that the Claimant does not have legal pneumoconiosis. First, Dr. Fino’s reliance on the pulmonary function test and blood gas study results is misguided. The Board has consistently found that pulmonary function studies and arterial blood gases cannot be used to disprove the presence of pneumoconiosis.⁷¹ Just as blood gas studies and pulmonary function studies are not diagnostic of the non-existence of pneumoconiosis, they are also not diagnostic of whether or not any respiratory impairment they show does or does not arise out of coal mine employment.”⁷² Although Dr. Fino may have

⁶⁷ *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990)(where the Sixth Circuit places the burden on ruling out pneumoconiosis as a contributing factor to a miner’s total disability on the Employer).

⁶⁸ 20 C.F.R. § 718.201(b), (a)(2).

⁶⁹ 65 Fed. Reg. at 79945 (Dec. 20, 2000).

⁷⁰ 20 C.F.R. § 718.204(a)(4).

⁷¹ *Burke v. Director, OWCP*, 3 B.L.R. 1-410, 414 (1981).

⁷² *Id.*

accurately determined that the Claimant's weight did have an effect on his test results, this cannot necessarily determine that the Claimant's 17.75 years of coal mine dust exposure did not also contribute to his hypoxemia and various respiratory impairment symptoms. Furthermore, the regulations recognize that pneumoconiosis is a latent and progressive disease.⁷³ Therefore, Dr. Fino's dependence on the seventeen year delay between when the Claimant left the mines and the onset of symptoms is also misplaced as that is not determinative of a non-coal mine related impairment. Lastly, Dr. Fino's explanation that he did not "feel" like the claimant had an impairment contributed by or aggravated by coal dust is not a well-reasoned or explained opinion. Therefore, I give his opinion little weight.

Dr. Castle also found insufficient evidence to diagnose pneumoconiosis. Instead, he attributed the Claimant's hypoxemia, restrictive lung disease, and shortness of breath to his obesity and cardiac disease. He further explained that the improvement demonstrated in the pulmonary function tests was "not possible or likely" if the Claimant had pneumoconiosis. Dr. Castle also opined that the restrictive lung disease was solely due to the Claimant's obesity and "not due in any way to coal dust exposure or coal workers' pneumoconiosis." He also noted that because pneumoconiosis is irreversible and progressive, the improvement in the Claimant's lung function in the more recent tests rules out pneumoconiosis. Instead, Dr. Castle based all of the Claimant's physiological findings on his obesity hypoventilation syndrome. Dr. Castle's opinion fails for many of the same reasons as Dr. Fino's. Dr. Castel's assertions on reversibility fail to address the possibility that Claimant's condition may be attributable, in part to marginally reversible causes, and also due to the lasting and non-reversible effects of his employment related exposure to coal dust. Furthermore, like Dr. Fino, Dr. Castle also failed to explain why the Claimant's 17.75 years of coal mine employment did not contribute to his hypoxemia, restrictive lung disease, and shortness of breath, and why those diseases could not have arisen, in part, from his work as a coal miner. Therefore, I must also give Dr. Castle little weight.

The opinions of Drs. DeFore and Klayton, the only other medical opinions in the record, support the Claimant's position that he is suffering from a respiratory impairment caused, at least in part, by his coal mine employment and they make a specific finding of legal pneumoconiosis. In addition, the Claimant's treatment records also support a finding of a respiratory impairment contributed to by the Claimant's coal mine employment as he was diagnosed as early as May 6, 2009, as having mild COPD based on an x-ray interpretation. (CX 1). Because the Claimant has no history of smoking and no other plausible cause for this COPD has been stated, this finding also supports the Claimant's position. Therefore, neither the Department of Labor examination, the medical report issued by Dr. Klayton, nor the Claimant's treatment records, aid the Employer in rebutting the presumption that the Claimant has a respiratory impairment arising out of coal mine employment.

⁷³ 20 C.F.R. § 718.201(c).

Legal Pneumoconiosis Conclusion

In sum, I have not found either of the physicians who offered an opinion on legal pneumoconiosis on behalf of the Employer to be well-reasoned and the opinions of the other testifying physicians are of no assistance to the Employer in its rebuttal burden. The Employer has not sustained its burden of disproving the existence of legal pneumoconiosis. Therefore, this aspect of the presumption has not been rebutted.

B. Disability Causation

The presumption may also be rebutted with evidence that the miner's total disability did not arise in whole or in part out of coal mine employment. The issue of whether the Claimant's disability is related to pneumoconiosis is essentially the same as the issue of whether the Claimant's suffers from legal pneumoconiosis, with the expert opinions on one issue also addressing the other. The Board has noted that "there is considerable overlap between the issues of the existence of legal pneumoconiosis and total disability due to pneumoconiosis, as both concern an inquiry into whether a causal relationship exists between coal dust exposure and the miner's impairment."⁷⁴ I have already explained why I discredit Drs. Fino and Castle on the issue of whether the Claimant's respiratory impairment is related to his coal dust exposure. Accordingly, I find that the Employer has failed to establish rebuttal under the second prong.

Entitlement

The Claimant has established that he worked for more than 15 years in coal mine employment in conditions substantially similar to an underground coal mine, and that he was totally disabled by a respiratory or pulmonary impairment, thus invoking the 15-year presumption of total disability due to pneumoconiosis. The Employer has not rebutted the presumption as it has not established that the Claimant did not suffer from pneumoconiosis or that his total disability did not arise in whole or in part out of coal mine employment.

Section 725.503(b) provides that benefits are payable to a miner who is entitled beginning with the month of the onset of total disability due to pneumoconiosis. Where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed.⁷⁵ The record in this case does not contain any medical evidence establishing exactly when the Claimant became totally disabled. Entitlement of benefits is established as of June 2008, the month and year in which the Claimant filed this claim for benefits.

Attorney Fees

Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932(a), provides for the award of fees and costs to a successful claimant's attorney.⁷⁶ The Claimant's counsel shall have thirty days to submit an application for attorney's fees and costs incurred in this claim. The application

⁷⁴ *Ramage v. Island Creek Kentucky Mining*, BRB No. 11-0530 BLA, slip op. at 8 (May 22, 2012)(unpub.).

⁷⁵ 20 C.F.R. § 725.503(b).

⁷⁶ 30 U.S.C. § 932(a); *B & G Mining, Inc. v. Dir., OWCP [Bentley]*, 522 F.3d 657, 662-63 (6th Cir. 2008).

must conform to 20 C.F.R. §§ 725.365 and 725.366, and must be served upon all parties, including Employer and the Director, OWCP. Any objections to the fee application shall be filed within ten days of receipt. Counsel is prohibited by law from receiving any fee prior to approval of his or her application.⁷⁷

ORDER

1. The claim for benefits of Phillip W. Caudill is **HEREBY GRANTED**;
2. Employer shall pay Phillip W. Caudill all benefits to which he is entitled under the Act.
3. Employer shall pay Claimant's attorney fees and expenses to be established in a supplemental decision and order.

PETER B. SILVAIN, JR.
Administrative Law Judge

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

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

⁷⁷ 33 U.S.C. § 928(e); *United States Dep't of Labor v. Triplett*, 494 U.S. 715 (1990).

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).