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Office of Administrative Law Judges
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Issue Date: 06 September 2013

Case Number: 2012-BLA-05615

In the Matter of:

JERRY K. ADDISON,
Claimant,

v.

SEA B MINING CO.,
Employer / Carrier

Appearances: Jerry Murphree, Lay Representative
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

Timothy W. Gresham, Esq.
Penn Stuart & Eskridge
Abingdon, Virginia
For the Employer/Carrier

Before: Stephen R. Henley
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS ON LIVING MINER'S CLAIM

This proceeding arises from a subsequent claim for benefits filed by Miner Jerry K. Addison ("Claimant") on March 15, 2011 under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 (the Act) as implemented by 20 C.F.R. Parts 718 and 725. The putative responsible operator is Sea B Mining Company ("Employer"), which is self-insured. Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease. In this case, the Claimant alleges that he is a miner who is totally disabled due to pneumoconiosis.

Procedural History

The instant claim is the second filed by Claimant; he filed his initial application for federal black lung benefits on August 30, 2004, which was denied in a Proposed Decision and Order issued by the Office of Workers' Compensation Programs on June 7, 2005 when Claimant established the presence of pneumoconiosis but was unable to establish a totally disabling respiratory or pulmonary impairment. He did not appeal. (DX-1).[1]

Claimant filed this current claim on March 15, 2011. (DX-2) The Department of Labor examination was conducted by Dr. Forehand on May 20, 2011 (DX-13). On January 25, 2012, a Claims Examiner issued a Proposed Decision and Order awarding benefits, finding that the Claimant was employed as a coal miner for 11.17 years from September 1, 1963 to March 30, 1981;[2] that he contracted pneumoconiosis as a result of conditions of his coal mine employment; that such disease has caused a totally disabling respiratory or pulmonary impairment; and that Employer was the operator responsible for payment of benefits. (DX-29). Employer declined to pay (DX-30) and the case was transmitted to the Office of Administrative Law Judges on March 20, 2012 (DX-33), with interim benefits being paid by the Black Lung Disability Trust Fund.

A hearing was held before the undersigned administrative law judge on December 4, 2012 in Abingdon, Virginia. At the hearing, Directors Exhibits (DX) 1-35, Administrative Law Judge Exhibit (ALJ) 1 and Employer's Exhibits (EX) 1-6 were admitted into evidence. (Tr. at 6-12). Mr. Addison was the only witness to testify. (Tr. 14-34).[3]

Claimant provided an oral closing argument at the hearing and Employer's written closing argument was timely filed on April 2, 2013.[4] The record is now complete and the case is ready for decision. The decision that follows is based on a complete and thorough analysis of the evidence submitted for consideration in the instant living miner claim for benefits. The findings of fact and conclusions of law that follow are based on my analysis of the entire record, including all evidence admitted and any argument made by counsel. Where pertinent, I have made credibility determinations concerning the evidence. As Mr. Addison's last coal mine employment was in the Commonwealth of Virginia, Fourth Circuit law applies. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

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[1] Employer's Exhibits shall be referenced herein as EX-__, Claimant's Exhibits as CX-___, Director's Exhibits as DX-__, and Administrative Law Judge's Exhibits as ALJ-__. References to the transcript of the hearing are referenced as Tr. at __.

[2] Claimant testified he agreed with the calculation. (Tr. at 19).

[3] Mr. Addison unfortunately passed away on February 14, 2013. His widow, Shirley J. Addison, filed a separate survivor's application on April 2, 2013. Her claim was placed in pay status by the District Director under the automatic entitlement provisions of the Patient Protection and Affordable Care Act until such time as a decision in this case becomes final.

[4] By separate written order dated February 28, 2013, I granted Employer's unopposed motion to extend the filing deadline for post-hearing briefs.

DISCUSSION AND ANALYSIS

The Black Lung Benefits Act[5] provides benefits to coal miners who are totally disabled due to pneumoconiosis and to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease. In this case, Claimant is alleging he is totally disabled due to pneumoconiosis. In addition to establishing the existence of pneumoconiosis, Claimant must prove that the pneumoconiosis arose out of coal mine employment; he had a totally disabling respiratory impairment; and the total disability resulted from the pneumoconiosis. 20 C.F.R. §§ 718.202-718.205; *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-4 (1986) (en banc). The U.S. Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence if evenly balanced, the claimant must lose.[6] Thus, in order to prevail in a black lung case without the benefit of a presumption, the claimant must establish each element by a preponderance of the evidence. If a claimant proves the existence of complicated pneumoconiosis, the claimant will benefit from an irrebuttable presumption of total disability due to pneumoconiosis and will be awarded benefits. 20 C.F.R. § 718.304.

ISSUES

The issues contested by the Employer and/or the Director, OWCP, are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes that one of the applicable conditions of entitlement has changed under 20 C.F.R. § 725.309 (2008).

The Employer also reserved its right to challenge the statute and regulations. The Employer withdrew the issues of whether the Claimant was a miner, timeliness, responsible operator and number of dependents and the parties stipulated to 11.17 years of qualifying coal mine employment. (Tr. 34-36).

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[5] 30 U.S.C. § 901 *et seq.* and the implementing regulations at 20 C.F.R. Parts 410, 718, 725, and 727.

[6] In *Director, OWCP v. Greenwich Colliers*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

Factual Background and the Claimant's Testimony

Mr. Jerry K. Addison, the miner, was born July 3, 1941. He married his current wife, Shirley Jean Brown,[7] on June 20, 1966 and has no other dependents. Mr. Addison last worked as a coal miner as a section foreman with Sea "B" Mining.

Claimant testified that he "smoked for a long time." He stopped 9 years ago, when his son died, but then smoked a few packs on July 10, 2012; he has not smoked since. (Tr. at 32-33). The accounts of his smoking elsewhere in the record varied widely. Dr. Rasmussen noted in his January 11, 2005 DOL exam report that Claimant began to smoke regularly at age 15 in 1956 and stopped in August 2002. (DX-1). Dr. Forehand noted a one pack/day history from 1958 to 2003. Dr. Fino noted in his November 7, 2012 report a 44 or 46 pack year smoking history, stopping between 2001 and 2003. (EX-6 / DX-17). However, emergency room notes from Mountain View Veteran's Administration Medical Center dated July 10, 2012 indicate Claimant was still smoking a pack a day. (EX-1).

Length of Coal Mine Employment

In his August 30, 2004 application filed with DOL, Claimant alleged he worked in and around coal mines or coal preparation facilities from 1971 and stopped in 1982 because of a neck fracture and arthritis. (DX-1). Claimant alleges in his current application 13 years of coal mine employment from 1963 to 1964 and January 1970 to January 1981. (DX-3). At the hearing, Claimant testified that he worked in the coal mining industry for about 13 years. (Tr. at 15) and stipulated to a total of 11.17 years of actual coal mine employment, "taking into consideration the strike time and other things of that nature." (Tr. at 35).

Claimant's Social Security employment records reflect that he worked in the Nation's coal mines about 21 months between 1963 to 1965 and 9 years and 5 months between 1971 and 1981. (DX-6). During the administrative processing of the claim, the District Director determined that Claimant had a total of approximately 11.17 years of coal mine employment, based on the Miner's Social Security earnings records.[8] This employment history is consistent with Claimant's 2004 and 2011 applications and his hearing testimony.

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[7] Mrs. Addison was born on March 3, 1948.

[8] The District Director did not make any finding as to the nature of the Miner's coal mine employment (e.g., the length of any employment in underground mines). Under the governing regulation, if the evidence establishes that a miner worked in or around coal mines during at least 125 working days during a calendar year or partial periods totaling one year, then the miner will be considered to have worked one year in coal mine employment. If the miner worked fewer than 125 days in a year, then the miner has worked a fractional year based on ratio of the actual number of days worked to 125. § 725.101(a)(32)(i). If the evidence is insufficient to establish beginning and ending dates of a year's employment, then an administrative law judge may divide the miner's yearly income by the amount

I concur with the Director that Mr. Addison worked 11.17 years aggregate in the coal mines, and so find. In other words, based on the record before me, I find that the Claimant is unable to establish that he had at least 15 years of qualifying coal mine employment, as is necessary for application of the amended § 411(c)(4) of the Act and § 718.305 of the regulation. Since the regulatory presumption revived by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1556 (2010) (PPACA)[9] is predicated in part on a history of underground coal mine employment of at least 15 years, this claim does not meet the preliminary requirements of the Act and the provisions at 20 C.F.R. § 718.305 do not apply.

Threshold determination in a claim filed under 20 C.F.R. § 725.309

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The first determination generally must be whether the Claimant has established with new evidence that he suffers from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on a pulmonary or respiratory impairment. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits.[10]

As will be discussed in detail below, medical reports generated since the prior denial indicate that the Claimant may have a totally disabling pulmonary or respiratory impairment. Thus, I find that he has established that a change in one of the applicable conditions of entitlement has occurred.

Total Disability

To receive black lung benefits, a miner must be totally disabled due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. § 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood gas tests; (iii) a

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of the average yearly income for miners for that year reported by the Bureau of Labor Statistics. § 725.101(a)(32)(iii).

[9] On March 23, 2010, the President signed the "Patient Protection and Affordable Care Act of 2010" ("PPACA"), Pub. L. 111-148, 124 Stat. 119, into law. Among other things, § 1556 of the PPACA changed adjudication of claims under the Act by reviving the 15-year presumption at § 411(c)(4) of the Act (30 U.S.C. § 921(c)(4)), as set forth in the regulation at § 718.305, for certain claims. Under § 718.305, where the miner has 15 years or more of employment in an underground coal mine (or the equivalent), and is totally disabled due to a respiratory impairment, there is a rebuttable presumption that the miner's disability or death is due to pneumoconiosis. By its terms, § 1556 applies to claims filed after January 1, 2005, that were pending on or after the date of the PPACA's enactment. The Supreme Court of the United States recently affirmed the PPACA as a proper exercise of Congressional taxing authority. *See National Federation of Independent Business. v. Sebelius*, 567 U.S. ___, 132 S.Ct. 1958 (2012).

[10] 20 C.F.R. § 718.204(a) (2008); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3d Cir. 1995).

showing of cor pulmonale with right-sided congestive heart failure; or (iv) a reasoned medical opinion demonstrating that due to his pulmonary condition a coal miner is unable to return to work to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir. OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated that to establish total disability due to pneumoconiosis, a miner must first prove that he suffered from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Claimant has not presented evidence of complicated pneumoconiosis or cor pulmonale with right-sided congestive heart failure. As a result, Claimant must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood gas tests, or medical opinion.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction or restriction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies relied upon by the parties available in this case. Pulmonary function studies submitted by the parties in connection with the current claim were in accordance with the limitations on medical evidence contained in the regulations. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less.[11] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim.[12] As there is a variance in the recorded height of the miner from 68 to 69 inches in the three reports, I have taken the average of 68.3" in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average, or the heights listed by the persons who administered the testing.

[11] 20 C.F.R. § 718.204(b)(2)(i) (2008).
[12] *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995).

Ex. No./ Date/ Physician	Age/ Height	FEV_1 Pre-/ Post[13]	FVC Pre-/ Post	$FEV_{1/}$ FVC	Qualify?	Physician Impression
DX-13/ 5/20/11 Forehand	69/69"	2.38/2.29	3.23/3.02	74/76	no	Obstructive ventilatory pattern
DX-16 2/23/11 Craven	69/68"	2.38	1.74	73	no	Moderately severe restriction.
DX-17 10/20/11 Fino	69/68"	2.54/2.65	3.51/3.67	72.3/72.2	no	
DX-17 Renn (rebut DX-16)					no	2/23/11 spirometry study is invalid because of failure to maintain maximal effort throughout the three trials and no satisfactory FVC maneuvers were performed.

The following chart summarizes the pulmonary function test available in connection with the prior claim. It has not been considered in reaching my determination that the Claimant has established a change in conditions.

Ex. No./ Date/ Physician	Age/ Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC	MVV Pre-/ Post	Qualify?	Physician Impression
DX-1 11/24/04 Rasmussen	63/68"	2.94	3.82	77	142	no	External spirometrics normal. Diffusing capacity moderately reduced. Minimal resting hypoxia.

As the chart reflects, no FEV_1 results are equal to or less than the values in the Appendix B tables. Consequently, Claimant cannot show he suffered from a totally disabling pulmonary impairment under 20 C.F.R. § 718.204(b)(2)(i).

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli

[13] The closest height in the table at Appendix B is 68.1 inches. At that height, the FEV1standard for a miner at age 69 is 1.76. The FVC standard at age 69 is 2.27.

which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX-13	5/20/11	Forehand	38/40	67/51	Exercise meets	Exercise induced arterial hypoxemia
EX-2	7/10/12	Mountain Home VAMC	44	68	no	
DX-17	10/20/10	Fino	44/43	60/62	Resting meets	

The following chart summarizes the arterial blood gas study available in connection with the prior claim. It has not been considered in reaching my determination that the Claimant has established a change in conditions.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX-1	11/24/04	Rasmussen	41	63	no	General painful rheumatoid arthritis.

The most recent study taken on July 10, 2012 did not produce qualifying results. The May 20, 2011 study produced a qualifying result at exercise only while the October 20, 2010 study at rest equaled the applicable value set forth in the tables in Appendix C of Part 718. Two of three blood gas tests taken at rest were not qualifying and two of three blood gas tests taken at exercise were not qualifying. In other words, four of six tests did not achieve qualifying values. Claimant has not demonstrated by a preponderance of the evidence that he suffers from a totally disabling respiratory impairment under 20 C.F.R. § 718.204(b)(2)(ii).

Medical Opinions

Claimant may also establish total disability through medical opinion evidence wherein a physician has exercised reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv).

Here, the Administrative Law Judge ("ALJ") is required to compare the degree of respiratory impairment diagnosed in the medical opinion with the exertional requirements of Miner's usual coal mine work. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48 (1986) (*en*

banc), *aff'd*, 9 B.L.R. 1-104 (1986) (*en banc*). In order to do so, the ALJ must make a specific finding as to the nature of miner's usual coal mine work and the physical requirements associated with that work. *Stanley v. Eastern Assoc. Coal Corp.*, 6 B.L.R. 1-1157 (1984). It is Claimant's burden to establish the exertional requirements of miner's usual coal mine employment to provide a basis of comparison for the ALJ to evaluate a medical assessment and reach a conclusion regarding total disability. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Specifically, the exertional requirements from the miner's last coal mining job of one year's duration must be compared to the physical limitations noted by medical experts in this claim. I find that Mr. Addison's last coal mining job involved at least medium exertional requirements.

Three physicians provided medical reports, opining whether Claimant has a totally disabling respiratory or pulmonary impairment.

Dr. J. Randolph Forehand. Based on examination of Claimant and his diagnostic tests, Dr. Forehand opined that Claimant suffers from a severe impairment of alveolar gas exchange which prevents him from returning to his last coal mining job and that he is totally and permanently disabled. (DX-13).

Dr. Gregory J.. Fino. Dr. Fino examined Claimant on October 20, 2011 and found that Claimant has a significant impairment in oxygen transfer. He has idiopathic pulmonary fibrosis, which is clinically disabling and is of sufficient severity to prevent him from going back to perform his last job in the coal mines. (DX-17/EX-6).

Dr. James R. Castle. Dr. Castle did not examine Claimant but did review numerous medical records and reports, also diagnosing idiopathic pulmonary fibrosis sufficient to prevent Claimant from returning to his last coal mine job. (EX4; EX-5).

Given that all three physicians find total disability, I find that the preponderance of the medical opinion evidence shows that Claimant suffers from a totally disabling respiratory or pulmonary impairment, which Employer acknowledges as much stating that "Claimant is disabled based on the opinions of Drs. Fino and Castle." (*Employer's Closing Argument of April 2, 2013* at 8). Therefore, Claimant has demonstrated by a preponderance of the medical opinion evidence that he suffers from a totally disabling respiratory or pulmonary impairment under 20 C.F.R. § 718.204(b)(2)(iv).

Pneumoconiosis

To be entitled to black lung benefits, Claimant must establish that he suffers from either "clinical pneumoconiosis" or "legal pneumoconiosis." Clinical (medical) pneumoconiosis, consists of those diseases recognized by the medical community as pneumoconiosis, such as coal workers' pneumoconiosis or silicosis, "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." 20 C.F.R. § 718.201(a)(1). Legal pneumoconiosis is defined as "any chronic lung disease or impairment and

its sequelae arising out of coal mine employment;" "[t]his definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. 20 C.F.R. § 718.201(a)(2). To establish that a pulmonary disease or respiratory impairment was "arising out of coal mine employment" so as to qualify as legal pneumoconiosis, a claimant must show that it was "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). The legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989). Thus, to prove the existence of legal pneumoconiosis, the Claimant has the burden of establishing that a pulmonary disease or respiratory impairment was not "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b).

The existence or absence of pneumoconiosis may be established by any one or more of the following methods: (1) valid chest x-rays readings, with consideration given to the radiological qualifications of the persons interpreting the x-rays in the event of conflicting interpretations; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) by operation of irrebutable presumption for complicated pneumoconiosis set forth in 20 C.F.R. § 718.304 or the presumptions set forth in §§ 718.305 and 718.306; and (4) a determination of the existence of pneumoconiosis as defined in § 718.201 made by a physician exercising sound judgment, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories. 20 C.F.R. § 718.202(a)(1-4). Under § 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. The Fourth Circuit requires a judge to weigh all relevant evidence of pneumoconiosis together rather than independently weigh each subcategory of evidence. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-09 (4th Cir. 2000)(requiring all evidence to be weighed together).

Because the record does not contain sufficient evidence that Claimant has complicated pneumoconiosis, a regulatory presumption of pneumoconiosis on that basis is not applicable. Likewise, although Claimant has shown total disability, he has less than 15 years of qualifying coal mine employment and thus cannot invoke the presumption recently revived by the PPACA. The record does not contain biopsy or autopsy evidence. As a result, Claimant will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

Turning first to the issue of clinical pneumoconiosis, I will review the chest x-ray evidence to determine whether Claimant has demonstrated the presence of the disease. The following chest roentgenogram evidence is in the record:

X-Ray Interpretations

Date of X-ray	Date of Reading	Exhibit	Physician[14]	Interpretation[15]
5/20/11	5/20/11	DX-13	Forehand, B	Profusion category of 2/2, type p/t small opacities in all lung zones. [16]
5/20/11	7/3/11	DX-14	Gaziano, B	Quality only.[17]
5/20/11	8/21/11	DX-16	Miller, B/BCR	Profusion category of 2/1, type u/q small opacities, lower all lung zones.
5/20/11	10/3/11	DX-17	Scott, B/BCR	Negative for pneumoconiosis; peripheral and basal interstitial fibrosis.
2/23/11	11/29/11	DX-18	Scott, B/BCR	Negative for pneumo. Anterior chest surgery with sternal sutures, probably CABG. Minimal peripheral scarring. Not a pattern for silicosis/CWP.
2/23/11	3/2/11	DX-16	Alexander, B/BCR	Profusion category of 2/1, type p/t opacities. Co/id/ ih/ pi abnormalities.

[14] The following designations apply: B= NIOSH certified B reader; BCR= board certified in radiology. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds, including images of the lungs. If no qualifications are noted for any of the following physicians who read x-rays in connection with the claims, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications. Readers who are board certified radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). Finally, it is within the Administrative Law Judge's discretion to accord greatest weight to a "dually qualified" physician, i.e., a board certified radiologist who is also a NIOSH certified B reader. *Zeigler Coal Co. v. Kelley*, 112 F.3d 839, 842-43 (7th Cir. 1997); *Peranich v. Director, OWCP*, BRB No. 87-3158 BLA (Nov. 27, 1990) (unpub.).

[15] The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and did not see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102(b)(2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[16] There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories, the opacities are further defined by size. The round opacities are type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d Ed. 1981).

[17] Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of the mention of pneumoconiosis indicates pneumoconiosis was not present. *See Marra v. Consolidation Coal Co*., 7 B.L.R. 1-216, 1-219 (1985).

1/12/09	1/30/09	DX-16	Miller, B/BCR	Profusion category of 2/1, type s/s opacities.
1/12/09	11/29/11	DX-18	Scott, B/BCR	Negative for pneumoconiosis. Anterior chest surgery, probably CABG. Peripheral scarring, unknown etiology.

The following chart summarizes the chest x-ray interpretations available in connection with the prior claim. They have not been considered in reaching my determination that the Claimant has established a change in conditions.

Date of X-ray	Date of Reading	Exhibit	Physician	Interpretation
1/24/04	11/24/04	DX-1	Patel, B/BCR	Profusion category of 1/1, type t/t opacities in all six zones.

Claimant has shown by a preponderance of the x-ray evidence that he suffers from clinical pneumoconiosis under 20 C.F.R. 718.201(a)(1). There were three readings of the most recent x-ray, taken on May 20, 2011. Dr. Forehand and Dr. Miller interpreted it as positive for pneumoconiosis with a profusion category of 2/2 and 2/1, respectively, while Dr. Scott interpreted the same x-ray as negative for pneumoconiosis. Dr. Forehand is a B reader but not board certified in radiology. Drs. Scott and Miller are both dually qualified as B-readers and board-certified radiologists. Dr. Miller's opinion that the x-ray is positive for clinical pneumoconiosis is supported by Dr. Forehand's opinion. Consequently, I find that the May 20, 2011, chest x-ray is overall positive for clinical pneumoconiosis.

Drs. Alexander and Scott, both dually qualified radiologists, interpreted the next x-ray taken on February 23, 2011. Dr. Scott read the x-ray as negative for pneumoconiosis while Dr. Alexander read it as compatible with pneumoconiosis, with a profusion category of 2/1. As the equally qualified readers found pneumoconiosis to be both present and absent, I find the readings of the February 23, 2011, x-ray in equipoise as to the existence of pneumoconiosis.

Drs. Miller and Scott interpreted the January 12, 2009 x-ray. Dr. Scott read the x-ray as negative for pneumoconiosis while Dr. Miller read it as positive for pneumoconiosis, with a profusion category of 2/1. Accordingly, I find that the January 12, 2009, x-ray is in equipoise.

In conclusion, I find that one x-ray is positive for clinical pneumoconiosis and that two x-rays are in equipoise. Accordingly, I find the preponderance of the x-ray evidence supports a finding of clinical pneumoconiosis.

Medical Reports & "Other Medical Evidence" § 718.202(a)(4)[18]

Digital Chest X-rays

Digital x-ray interpretations are not considered "chest x-ray" evidence, as they do not satisfy the quality standards under Appendix A of Part 718. As a result, digital chest x-rays are "properly considered under 20 C.F.R. § 718.107 ["Other medical evidence"], where 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."[19]

On December 6, 2011, Dr. Alexander interpreted a digital x-ray taken at Buchanan General Hospital on October 20, 2011 as having a profusion category of 2/1, type q/t small opacities in all lung zones and noted cardiomegaly and previous CABG surgery with co/id/ih abnormalities. (DX-19).

On November 15, 2011, Dr. Fino interpreted the same digital x-ray as indicating no parenchymal abnormalities consistent with pneumoconiosis. Dr. Fino testified in his deposition that digital x-rays are a medically "acceptable and reasonable diagnostic tool," which NIOSH has approved since October 15, 2012 and "digital x-rays are the standard of care now" and I see them on a daily basis. (EX-6 at 9-10). He noted diffuse irregular opacities in the lower lung zones and in the peripheral portions of the middle and upper lung zones and opined this x-ray was not consistent with an occupational pneumoconiosis due to the peripheral nature of the irregular opacities. However, Dr. Fino's position is inconsistent with the Act and the implementing regulations because they do not require that the opacities be located in a specific location within the lungs to be considered clinical pneumoconiosis, or pneumoconiosis due to coal dust exposure. 20 C.F.R. §§ 718.102 and 718.202. *See also Pannier v. Wells Fargo Disability Management*, 2012 WL 3276627, BRB No. 11-0559 BLA (July 17, 2012)(unpub.) ("The administrative law judge noted that the regulations do not foreclose a diagnosis of clinical pneumoconiosis when the opacities are irregular in shape, and are in the lower, rather than the upper, zones").

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable

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[18] The presence of pneumoconiosis may be demonstrated through the use of "other evidence" as set forth at 20 C.F.R. § 718.107. Evidence submitted under this provision includes, but is not limited to, CT scans and digital x-rays. A party proffering evidence under this regulatory provision must also satisfy the requirements of 20 C.F.R. § 718.107(b) and present evidence "that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits." 20 C.F.R. § 718.107. Notably, "other evidence" is weighed under 20 C.F.R. § 718.202(a)(4) along with medical reports and treatment and hospitalization records. *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123 (2006)(en banc)(J. Boggs, concurring).

[19] *Webber v. Peabody Coal Co*, 23 B.L.R. 1-123, 1-133 (2006) (en banc) (J. Boggs, concurring) (citations omitted). *See also Harris v. Old Ben Coal Co.*, 24 B.L.R. 1-13, 1-16–17 (2007) (en banc on recon.) (J. McGranery and J. Hall, concurring and dissenting), *aff'g.*, 23 B.L.R. 1-98 (2006) (en banc).

medical evidence under 20 C.F.R. § 718.107 (2008).[20] Moreover, because the regulations do not contain quality standards for CT scans, the party proffering the CT scan "bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits."[21] The parties are entitled to introduce only one reading of "other evidence" such as CT scans.[22]

Concerning CT scans, at present, "[t]he clinical diagnosis and follow up of pneumoconiosis in most workforces at risk for pneumoconiosis are still based on the changes in the lung visible by standard X-ray techniques."[23] As a result, the Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis."[24] When CT scans are evaluated by qualified experts, however, they are "important diagnostic tools that have resulted in major improvements in the assessment of occupational lung disease."[25] Such qualified experts are generally "radiologists (some of whom may in addition be classified as B readers) who have specialized knowledge and have developed a certain expertise through years of training and experience interpreting this particular test."[26] A pulmonologist may have the knowledge, training and experience to review a CT scan and reliably discuss whether the test discloses the presence of pneumoconiosis, but a party must qualify an individual pulmonologist as such an expert. Further, the results of a CT scan must be interpreted in conjunction with the occupational history, clinical examination, pulmonary function tests, x-rays, arterial blood gas tests and the reasoned opinions of all the experts and physicians.[27] In his deposition, Dr. Castle testified that CT scans are very sensitive and used in the diagnosis and evaluation of all types of lung diseases and widely accepted in the medical community. (EX-5 at 8).

The following chart summarizes the CT scans available in connection with this claim.

Exam Date/Physician	Exhibit	Interpretation
6/27/12/Fino, B Reader	EX-3	Extensive bullous emphysema. Bilateral lower lobe lung compression which simulates irregular opacities but is actually due to severe bullous emphysema. No changes consistent with a coal mine dust associated occupation disease.

I find that the CT scan evidence does not support a finding of clinical or legal pneumoconiosis.

[20] *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991).
[21] 20 C.F.R. § 718.107(b).
[22] *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123 (2006) (en banc).
[23] *Consolidation Coal Co. v. Director, OWCP*, 294 F.3d, 885, 892 (7th Cir. 2002) (quoting Q.T. Pham, *Chest Radiography in the Diagnosis of Pneumoconiosis*, 5(5) INT. J. TUBERC. LUNG DIS. 478 (2001)).
[24] 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000).
[25] *Consolidation Coal*, 294 F.3d at 892.
[26] *Id*. at 894 (citing J.F. Wiot & O. Linton, *The Radiologist and Occupational Lung Disease*, 175(2), AM. J. ROENTGEN. 311 (2000)).
[27] *Id*. at 892.

Hospitalization and Treatment Records

Date of Treatment, Exam/Review	Ex. No.	Comments
8/9/12 Mountain Home Veteran Administration Medical Center (VAMC)	EX-1	Claimant presented with complaint of increased SOB. Has been so SOB that he could not smoke. Usually smoked a pack a day. Increased swelling in lower extremities. No chest pain. DX cardiac heart failure; chronic bronchitis. Recommend stop tobacco use because "will never get better if you continue to smoke."
6/5/08 - 6/15/08 Johnson City Medical Center/Mountain Home VAMC/Asheville VAMC	DX-16	Cardiac surgery
3/26/03 - 7/14/05 Thompson Family Health Center	DX-16	COPD with bronchitis. History of occupational exposure to coal dust. No diagnosis of coal workers' pneumoconiosis.

Claimant began working as a coal miner in 1974. The record contains hospitalization and treatment records ranging from 2003 to 2012. Over the years, none of the Claimant's treating physicians have diagnosed coal workers' pneumoconiosis. Although they did diagnose chronic obstructive pulmonary disease and bronchitis, and histories noted Claimant's coal mine employment, none of the physicians offered opinions as to the cause.[28] I find that the treatment records are non-probative on the issues of clinical or legal pneumoconiosis.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. Pneumoconiosis may be demonstrated by a documented and reasoned medical opinion under 20 C.F.R. § 718.202(a)(4). In this case, three physicians gave an opinion whether Claimant had pneumoconiosis. Dr. Forehand believes that he does, while Drs. Castle and Fino do not. In light of this conflict in medical opinions, I must first determine probative value in terms of documentation, reasoning and treating physician status.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests, physical examination, symptoms and the patient's history. *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 "documented" opinion sets forth the clinical findings,

[28] *See C.E.S. v. Consolidation Coal Co*., BRB No. 07-0329 BLA (Jan. 31, 2008) (unpub.) (the physician must attribute the respiratory or pulmonary impairment to coal dust exposure to constitute a finding of legal pneumoconiosis under § 718.201(a)(2) of the regulations).

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). In other words, a doctor who considers an array of medical documentation that is both wide (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by the objective medical tests and consistent with all the documentation in the record is entitled to greater probative weight. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the ALJ as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis.[29] A physician's report may be rejected where the basis for the physician's opinion cannot be determined.[30] An opinion may be given little weight if it is equivocal or vague.[31]

A medical opinion which is supported by more extensive documentation is entitled to greater weight than an opinion based on more limited medical data.[32] A medical opinion better supported by the objective medical evidence of record is entitled to more weight.[33] The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled.[34] More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically.[35] But a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …"[36]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in the regulations.[37] Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis.[38] The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories.[39] Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart

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[29] *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984).
[30] *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).
[31] *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).
[32] *Sabett v. Director, OWCP*, 7 B.L.R. 1-299, 1-301 n. 1 (1984).
[33] *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n.1 (1986).
[34] *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984).
[35] *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989).
[36] *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994).
[37] 20 C.F.R. § 718.202(a)(4) (2008); for the definition, *see* 20 C.F.R. § 718.201 (2008).
[38] *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986).
[39] 20 C.F.R. § 718.202(a)(4) (2008).

failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work.[40]

Third, according to 20 C.F.R. 718.104(d), in evaluating medical opinions, an administrative law judge must consider the relationship between the claimant and any treating physician. Depending on the duration, frequency, and extent of the treatment, the opinion of a physician who provided treatment for pulmonary concerns may be entitled to more probative weight than the assessment of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998)(in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician). At the same time, no presumption of greater probative weight exists merely based on a physician providing treatment. *See Consolidation Coal Co., v. Director, OWCP [Held]*, 314 F.3d 184 (4th Cir. 2002).

With these principles in mind, I turn to the three medical opinions in this case, with Dr. Forehand concluding the evidence establishes that the Claimant has clinical and legal pneumoconiosis and Drs. Castle and Fino who do not.

Dr. J. Randolph Forehand. (DX-13). Dr. Forehand is Board-certified in pediatrics, and allergy and immunology, and is Board eligible in pediatric pulmonary medicine. Dr. Forehand conducted the DOL ordered exam on May 20, 2011. He noted that Claimant said he worked 13 years as an underground miner, stopping in 1981. Claimant smoked a pack/day from 1958 to 2003; he had heart surgery in 2008. Claimant complained of daily sputum, cough, wheezing every night, and dyspnea walking uphill. Dr. Forehand diagnosed obstructive lung disease, based on Claimant's symptoms and the underlying diagnostic testing, including the ventilatory study. Dr. Forehand diagnosed coal workers' pneumoconiosis based on occupational exposure to coal mine dust, impaired gas exchange and an x-ray with a profusion category of 2/2. Dr. Forehand also found that cigarette smoking has caused a non-disabling ventilatory impairment with FEV1 of 75-78% of predicated value. On the other hand, exposure to coal mine dust has caused a severe impairment of alveolar gas exchange which would prevent Claimant from returning to his last coal mining job. In other words, Claimant is totally and permanently disabled. However, Dr. Forehand opined that not all of Claimant's impairment is due to his 45 year smoking history. Thirteen years of coal mine dust exposure has caused both clinical and legal coal workers' pneumoconiosis. Dr. Forehand further explained that coal dust exposure has had an additive effect on Claimant's respiratory condition.

Dr. Gregory J. Fino. (DX-17 and EX-6). Dr. Fino is Board-certified in internal medicine and pulmonary medicine, and a certified B-reader. Dr. Fino examined Claimant on October 20, 2011. He also reviewed medical records and objective test data from 2003 through 2011. Dr. Fino noted that Claimant's ratio of the FEV1 to FVC is normal, hence ruling out obstruction and

[40] 20 C.F.R. § 718.204(b)(2)(iv) (2008).

COPD. However, Dr. Fino found a significant impairment in oxygen transfer based on the abnormal diffusing capacity and the arterial blood gas studies. He noted that earlier x-rays and CT scans showed some interstitial fibrosis, emphysema, and pulmonary fibrosis at the bases. However, the chest x-ray Dr. Fino generated from his exam showed a marked change, with diffuse fibrosis seen in the lower lung zones extending to the upper zones in a peripheral pattern. However, he found that these changes are far too significant and occurred far too rapidly to be consistent with coal mine dust inhalation. Instead, Dr. Fino believes it is idiopathic pulmonary fibrosis, a "significant lung disease." Dr. Fino concluded Claimant is totally disabled based upon this lung disease, his blood gases, and his diffusing capacity. In his deposition, Dr. Fino stated that Claimant "clearly has some restrictive disease," but does not show any obstruction. (EX 6). Dr. Fino added that smoking can cause restrictive disease and can cause fibrosis in the lungs.

Dr. Fino opined that there is no evidence of legal or clinical pneumoconiosis. Dr. Fino cites numerous scientific studies purporting to show no correlation between occupational coal dust exposure and diffuse idiopathic pulmonary fibrosis. In his deposition, Dr. Fino explained that "idiopathic" means that he has not found a definite etiology. However, Dr. Fino stated that he can rule out coal dust exposure, because coal dust creates a nodular fibrosis, whereas this is diffuse fibrosis. Dr. Fino opined that smoking may have caused this fibrosis.

Dr. James R. Castle. (EX-4, 5). Dr. Castle is Board certified in internal medicine and pulmonary disease, and a certified B-reader. Dr. Castle did not examine Claimant but reviewed radiographic reports from July 28, 2004 to March 8, 2012; pulmonary function tests from January 29, 2007 to October 20, 2011; arterial blood gases from June 9, 2008 to August 9, 2012; and hospitalization and treatment notes from February 5, 2004 to July 10, 2012. He prepared a medical report dated November 12, 2012 in which he related that Claimant worked 13 years in coal mines, stopping in 1981. Dr. Castle identified a 44 or 46 pack year history of smoking, with Claimant stopping in 2001 or 2003. However, Dr. Castle noted that emergency room notes from Mountain Home VAMC dated July 10, 2012 indicated that Claimant was still smoking. He also noted Claimant also has a significant history of coronary artery disease necessitating interventional therapy with coronary artery bypass grafts. Cardiac catheterization released some reduction of left ventricular function. He noted that Claimant's ABG demonstrates mild and moderate degree of hypoxemia at rest.

Dr. Castle opined that all these findings can result in significant shortness of breath and physiologic changes. Dr. Castle further opined that Claimant's smoking history is significant enough to have caused COPD, chronic bronchitis and emphysema. He found that Claimant does not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He further found that Claimant also does not have consistent findings of rales, crackles or crepitations.

Dr. Castle concluded that Claimant suffers from interstitial pulmonary fibrosis affecting primarily the lower lung zones and mid lung zones with peripheral fibrotic changes in the upper lung zones. These findings are associated with significant bullous changes, honeycombing and pleural thickening. While some chest x-rays indicated presence of pneumoconiosis, Dr. Castle noted that the opacities were linear and irregular, which he stated is not typical of coal workers'

pneumoconiosis. Dr. Castle opined that these radiographic findings are due to usual interstitial pneumonitis or idiopathic pulmonary fibrosis, which is unrelated to coal mine dust exposure.

Dr. Castle also noted that the ventilatory function studies did not show evidence of airway obstruction. However, he found that Claimant does have evidence of mild to moderate restrictive disease due to idiopathic pulmonary fibrosis or usual interstitial pneumonitis and not CWP. Dr. Castle stated that a reduction in diffusion without any obstruction is typical of usual interstitial pneumonitis or idiopathic pulmonary fibrosis and is not typical of CWP. He stated that this disease occurs more frequently in heavy cigarette smokers. Dr. Castle stated in his deposition that "it is very, very, unlikely you have a significant or disabling degree of CWP without demonstrating some obstructive lung disease with it." (EX-5 at 18).

Dr. Castle concluded that Claimant does not have clinical pneumoconiosis because his chest x-rays do not show CWP. He also concluded that Claimant does not have legal pneumoconiosis because his physiologic changes are due to usual interstitial pneumonitis or idiopathic pulmonary fibrosis.

Discussion

First, I note that both Drs. Fino and Castle emphasize the fact that Claimant shows restrictive impairment without obstruction. In *Consolidation Coal Co. v. Swiger*, 98 Fed. Appx. 227, 237 2004 WL 1049097 (4th Cir. 2004) (unpub.), the Fourth Circuit Court of Appeals upheld an Administrative Law Judge's discrediting of several medical doctors who opined that the claimant did not have CWP because his impairment was obstructive in nature. The Regulations state that legal pneumoconiosis includes any chronic restrictive *or* obstructive pulmonary disease arising out of coal mine employment. *See* 20 C.F.R. § 718.201.

Moreover, even if Dr. Castle were correct that it is unlikely for an individual to have CWP without obstruction, Dr. Castle has failed to explain why Claimant could not be one of those rare cases of CWP without obstruction. A medical opinion based on generalities, rather than specifically focusing on the miner's condition, may be accorded little weight. *Knizer v. Bethlehem Mines Corp*, 8 B.L.R. 1-5 (1985).

Dr. Fino also opines that Claimant's fibrosis is "idiopathic," meaning he cannot provide a definite etiology, but added that smoking could have caused Claimant's fibrosis. The Department in its Preamble[41] recognized that the effect of coal dust exposure is additive to smoking. 65 Fed. Reg. 79,940 (Dec. 20, 2000)("coal dust is additive with smoking in causing clinically significant airways obstruction and chronic bronchitis"). Further the Department has recognized that the effects of smoke and coal dust exposure affect the lung through similar mechanisms. 65 Fed. Reg. 79,943 (Dec. 20, 2000)("dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms—namely, the excess release of destructive enzymes from dust—(or smoke—), stimulated inflammatory cells in association with a decrease in protective enzymes in the lung"). Dr. Fino has failed to offer any explanation for

[41] In *J.O. [Obush] v. Helen Mining Co.*, 24 B.L.R. 1-117, 1-125 to 1-126 (2009), the Board held that a determination of whether a medical opinion is supported by accepted scientific evidence, as determined by the Department in the preamble to the amended regulations, is a valid criterion in deciding whether to credit the opinion.

why only Claimant's smoking has caused fibrosis, without any additive effect from his coal dust exposure.

I note that Dr. Forehand's finding of legal pneumoconiosis due to Mr. Addison's smoking history and coal dust exposure is consistent with the position of the Department as outlined in the Preamble which states the following:

> Allowing decrements due to age and smoking, Attfield and Hodous demonstrated a clear relationship between dust exposure and a decline in pulmonary function of about 5 to 9 milliliters a year, even in miners with no radiographic evidence of clinical coal workers' pneumoconiosis.

65 Fed. Reg. 79,940 (Dec. 20, 2000). Further, the Department has stated:

> Coal dust exposure is additive with smoking in causing clinically significant airways obstruction and chronic bronchitis.

65 Fed. Reg. 79,940 (Dec. 20, 2000). Moreover, Dr. Forehand's conclusion that Claimant suffers from clinical and legal pneumoconiosis is supported by his diagnostic testing. Accordingly, I give more weight to the opinion of Dr. Forehand, and less weight to the opinions of Drs. Fino and Castle for the reasons I previously discussed.

Claimant Suffers from Legal and Clinical Pneumoconiosis

Based on the preponderance of the x-ray evidence, I find that Claimant has demonstrated that he suffers from clinical pneumoconiosis. Based on the medical reports I also find that Claimant has shown by a preponderance of the evidence that he suffers from legal pneumoconiosis.

Cause of Pneumoconiosis

Because Claimant demonstrated the presence of clinical pneumoconiosis, it must be determined whether the disease arose out of coal mine employment. 20 C.F.R. § 718.203.

In this case, Claimant worked ten or more years in or around coal mines and, therefore, is entitled to a rebuttable presumption that the clinical pneumoconiosis arose out of that employment. 20 C.F.R. § 718.203(b); *Andersen v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). As a result, the burden shifts to the party opposing entitlement to present evidence sufficient to establish that the disease did not stem from employment in the mines.

With regard to legal pneumoconiosis, the presumption at 20 C.F.R. § 718.203 does not apply. In *Kiser v. L&J Equipment Co.*, 23 B.L.R. 1-246, 1-259 n. 18 (2006), the Board cited to *Andersen* and *Henley v. Cowan & Co.*, 21 B.L.R. 1-147, 1-151 (1999) and agreed with the Director's position that, for a finding of legal pneumoconiosis, the fact-finder need not separately

determine the etiology of the disease under § 718.203 because the findings at 20 C.F.R. § 718.202(a)(4) will necessarily subsume that inquiry.

Dr. Forehand opined that Claimant suffers from clinical pneumoconiosis caused by coal dust exposure. Accordingly Dr. Forehand's opinion does not assist Employer in rebutting the ten-year presumption. Drs. Fino and Castle opined that Claimant does not suffer from pneumoconiosis, which is contrary to the finding of this tribunal. Additionally, I find the opinions of Drs. Fino and Castle less credible for the reasons I previously explained. Therefore, I find their opinions do not assist Employer in rebutting the ten-year presumption. Accordingly, I find that Employer has failed to rebut the ten-year presumption that coal dust exposure has caused Claimant's pneumoconiosis.

Cause of Totally Disabling Respiratory Impairment

Pneumoconiosis must be a "substantially contributing cause" to Claimant's total disability. 20 C.F.R. § 718.204(c)(1). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or 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.

20 C.F.R. § 718.204(c)(1).

Drs. Fino and Castle concluded that Claimant did not suffer from clinical or legal pneumoconiosis, which is contrary to the findings of this tribunal. As a result, the probative value of their opinions regarding disability causation is significantly compromised. *Tapley v. BethEnergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005)(proper for ALJ to discredit medical opinions with regard to disability causation where physicians concluded miner did not suffer from legal pneumoconiosis, contrary to judge's findings). Accordingly, I give their opinions less weight.

Dr. Forehand opined that Claimant's totally disabling respiratory impairment was due to pneumoconiosis and that the pneumoconiosis was caused by coal dust exposure and cigarette smoke. I find his opinion to be sufficiently documented and reasoned to support a finding that Claimant's totally disabling respiratory impairment was caused by coal workers' pneumoconiosis.

CONCLUSION REGARDING ENTITLEMENT TO BENEFITS

Claimant has demonstrated by a preponderance of the evidence that he suffers from clinical and legal pneumoconiosis, which was caused by his coal mine employment. He further

demonstrated that his totally disabling respiratory impairment was caused by his coal workers' pneumoconiosis.

Date of Entitlement

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.

The record in this case does not contain any medical evidence establishing exactly when Claimant became totally disabled due to pneumoconiosis. Therefore, entitlement to benefits is established as of March 2011, the month and year in which Claimant filed this claim for benefits.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED that the claim for living miner benefits filed by Jerry K. Addison, on March 15, 2011, is hereby GRANTED.

SO ORDERED:

Digitally signed by Stephen R. Henley
DN: CN=Stephen R. Henley,
OU=Administrative Law Judge, O=Office
of Administrative Law Judges,
L=Washington, S=DC, C=US
Location: Washington DC

STEPHEN R. HENLEY
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with 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, PO 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).