

U.S. Department of Labor

Office of Administrative Law Judges
William S. Moorhead Federal Office Building
1000 Liberty Avenue, Suite 1800
Pittsburgh, PA 15222

(412) 644-5754
(412) 644-5005 (FAX)



Issue Date: 09 July 2013

CASE NO.: 2012-BLA-5118

In the Matter of:

CHARLES E. MORRIS,
Claimant

v.

EIGHTY FOUR MINING COMPANY,
Employer

and

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

APPEARANCES:

Heath Long, Esq.,
For the Claimant

Margaret Scully, Esq.
For the Employer

Before: THOMAS M. BURKE
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. §§ 901-945 and the regulations issued thereunder, found at Title 20 of the Code of Federal Regulations. The Act provides benefits to miners who are totally disabled due to pneumoconiosis and to eligible survivors of miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung disease, is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment. In this claim, Claimant alleges that he is totally disabled by pneumoconiosis.

PROCEDURAL BACKGROUND

Charles E. Morris (“Claimant”) filed his claim for lifetime benefits on January 6, 2011. (DX 2).¹ On September 20, 2011, the district director issued a Proposed Decision and Order awarding benefits. (DX 24). On September 26, 2011, Employer disagreed with the district director’s determination and requested a hearing. (DX 25). On October 31, 2011, the claim was referred to the Office of Administrative Law Judges for a *de novo* hearing. (DX 29).

A hearing took place on September 25, 2012 in Pittsburgh, Pennsylvania. At the hearing, Eighty Four Mining Company (“Employer”) affirmed its controversion of the issues of timeliness, existence and causation of pneumoconiosis, and the existence and causation of total disability. (Tr. 6). Employer stipulated that Claimant worked as a coal miner for 34.75 years. (*Id.*). Admitted into evidence were Director’s Exhibits (DX) 1-31, Claimant’s Exhibits (CX) 1-6, and Employer’s Exhibits (EX 1-12). The record was held open to permit Employer to submit the depositions of Drs. Gregory Fino and Joseph Renn. Dr. Renn’s deposition was received on November 13, 2012, and admitted into evidence as EX 13. Dr. Fino’s deposition was received on January 16, 2013, and admitted as EX 14. Employer submitted a post-hearing brief on February 13, 2013.

FACTUAL BACKGROUND & CLAIMANT’S TESTIMONY

Claimant was 72 years old at the time of the hearing. (Tr. 8). He resides in Houston, Pennsylvania. (DX 2). He is married to Dorothy Louise. She is his only dependent for augmentation of benefits. (Tr. 8). Claimant testified that he worked as a coal miner for 34 years at the same mine. When he started work the mine was owned by Beth Energy. It was subsequently sold to Pittsburgh and Rochester Coal Company, and later to Consol Energy. (Tr. 9). He last worked as a coal miner in 2005, when he was 65 years of age. He has not worked for wages since that time. (Tr. 24). His last job was lamp man, a job he worked for about five years. (Tr. 13). He testified that the lamp man job required some heavy labor; he had to carry bags of garbage and five gallon water containers. (Tr. 14, 15). He testified that he could not return to his job as lamp man because of his breathing difficulties. (Tr. 17). Claimant testified that he worked underground for about 19 years. When he worked underground, he worked as a roof bolter for about six or seven years and as a shuttle car operator for about one year, and also as a construction utility man. (Tr. 11). He testified further that when he worked underground he worked at the face practically every day, including the days when he was roof bolting or performing the construction job because those duties required changing the coal belts. (Tr. 17).

He testified that his breathing difficulties started in the late 70s, early 80s. (Tr. 18). At that time he received a letter from NIOSH informing him that he should move his work to above ground. (Tr. 18). His family doctor, Dr. Kidsco, prescribed the medications, Advair and Spiriva for his breathing difficulties. (Tr. 26). His breathing continued to worsen, and he saw Dr. Holt at the Centerville Clinic, who put him on oxygen. (Tr. 19). He is on oxygen 24 hours a day. (Tr. 19). He also suffers from high blood pressure, sugar, gout and neuropathy from diabetes. (Tr. 21).

¹ Director’s Exhibits are marked as DX__; Claimant’s Exhibits are marked as CX__; Employer’s Exhibits are marked as EX__; pages of the hearing transcripts are marked as Tr.__.

Claimant filed a state workers' compensation claim for occupational disease with the Commonwealth of Pennsylvania on July 21, 2006. Pursuant to the claim he was examined by Dr. Robert Cohen and Dr. Gregory Fino. (Tr. 23, 24). His state claim was unsuccessful. (EX 11; Tr. 25, 26).

TIMELINESS

Employer argues that this claim is barred by the three year statute of limitations at 20 C.F.R. § 725.308, which provides that a claim for benefits shall be filed within 3 years after a medical determination of total disability due to pneumoconiosis has been communicated to the miner, or a person responsible for the care of the miner. Employer references a medical report by Dr. Robert Cohen dated May 24, 2006, which found that Claimant is totally disabled due to pneumoconiosis, as a medical determination which triggers the statute of limitations. (EX 12).

Claimant acknowledges that his attorney in 2006 reviewed Dr. Cohen's report with him. (Tr. 25). Dr. Cohen's report was apparently obtained in support of Claimant's application for benefits for occupational disease before the Commonwealth of Pennsylvania Bureau of Workers' Compensation Programs. Claimant was also evaluated in that proceeding by Dr. Gregory Fino who concluded that Claimant was not totally disabled from pneumoconiosis. (Tr. 35). Consequently, the Workers' Compensation Judge credited the report of Dr. Fino over the opinion of Dr. Cohen and determined that Claimant's breathing problems were not significantly contributed to by coal mine dust exposure. (EX 11).

The statute of limitation issue in this claim is controlled by the reasoning of the Third Circuit Court of Appeals in *Helen Mining Co. v. Director, OWCP [Obush]*, 650 F.3d 248 (3rd Cir. 2011) where the court held that a medical determination of total disability due to pneumoconiosis predating a prior, final denial of benefits is deemed a "misdiagnosis" and thus, cannot trigger the statute of limitations at 20 C.F.R. § 725.308. Employer correctly notes that the *Obush* case involved a subsequent claim under 20 C.F.R. § 725.309, whereas the present claim is a lifetime claim, and the earlier denial of benefits was a denial of a state workers' compensation claim. However, the *Obush* court's reasoning still applies. The decision in the state claim crediting Dr. Fino's conclusion and finding that Claimant's pulmonary condition was not caused by coal dust exposure presupposes that Dr. Cohen's conclusion was a misdiagnosis. In *Peabody Coal Co. v. Dir., OWCP ("Dukes")*, 48 F. App'x 140, 144 (6th Cir. 2002) the Court reasoned that "[I]f a miner's claim is ultimately rejected on the basis that he does not have the disease, this finding necessarily renders any prior medical opinion to the contrary invalid, and the miner is handed a clean slate for statute of limitation purposes." 48 F. App'x at 146.

Accordingly, it is determined that the present claim is not barred by the statute of limitations at 20 C.F.R. § 725.308 as the report by Dr. Cohen is considered to be a misdiagnosis.

MEDICAL EVIDENCE

Chest X-Rays

Exhibit/ Study Date	Doctor	B-reader/ Bd. Cert. Radiology	Film Quality	Reading	Miscellaneous
DX 16 01/26/11	Ahmed	B/BCR	1	0/0	Bullous emphysema
EX 5 01/26/11	Meyer	B/BCR	2,over- exposed		No abnormalities consistent with pneumoconiosis; asymmetric nodular opacity at right costochondral junction
DX 16 01/26/11	Gaziano	B	1	---	Read for quality
CX 1 08/04/11	Schaaf	B	1	--	No abnormalities consistent with pneumoconiosis
EX 6 08/04/11	Meyer	B/BCR	2	--	No abnormalities consistent with pneumoconiosis; calcified granulomatous
CX 2 11/04/11	Stankie- wicz	?	?	--	Few calcified granulomata
EX 7 11/04/11	Meyer	B/BCR	3	--	No abnormalities consistent with pneumoconiosis; calcified granulomatous
CX 3 10/12/11	Ahmed	B/BCR	2	1/1	Irregular densities both lungs; calcified granulomatous in both lung fields.
EX 3 10/12/11	Meyer	B/BCR	2		No abnormalities consistent with pneumoconiosis; calcified granulomatous

CX 6 02/22/12	Ahmed	B/BCR	2	1/1	Irregular densities both lungs; calcified granulomatous in both lung fields.
EX 4 02/22/12	Meyer	B/BCR	3	--	No abnormalities consistent with pneumoconiosis; calcified granulomatous

Pulmonary Function Tests

Exhibit/ Study Date	Physician	Age/ Height	FEV ₁ (L/sec) pre/post- broncho	FVC (L) pre/post- broncho	MVV (L/min) pre/post- broncho	FEV ₁ /FVC pre/post- broncho	Qualifying Values of FEV ₁ , FVC, and MVV	Qualifying Results?
DX 16 03/03/11	Holt	70 71"	2.05	3.18	--	64%	FEV ₁ = <1.96	No
			--	--	--	--	FVC= <2.53	
							55% or <	
CX 1 08/04/11	Schaaf	71 71"	1.53	3.01	--	50%	FEV ₁ =<1.93	Yes Yes
			1.65	3.14	--	52%	FVC=<2.51 55% or <	
CX 2 11/04/11	Begley	71 71.5"	1.69	2.81	73	60%	FEV ₁ = <1.93	Yes No
			1.83	3.09	77	59%	FVC= <2.51	
							MVV = <75 55% or <	
EX 1 10/12/11	Fino	71 71	1.63	2.74	--	59%	FEV ₁ =<1.93	No No
			1.84	2.95	--	62%	FVC=<2.51 55% or <	
EX 2 02/22/12	Renn	71 71	1.86	2.87	--	65	FEV ₁ =<1.93	No No
			2.04	3.18	--	64	FVC=<2.51 55% or <	

Arterial Blood Gas Study

Exhibit/ Study Date	Physician	Resting/ Exercise	pCO ₂ (mmHg)	pO ₂ (mmHg)	Qualifying Values of pO ₂	Qualifying Results?
DX 16 01/26/11	Holt	R	34	59	<66	Yes
EX 1 10/12/11	Fino	R	47	37	<53	Yes
CX 2 11/4/11	Begley	R	38	51	<62	Yes Yes
		E	38	42	<62	
EX 2 2/22/12	Renn	R	37	65	<63	No

Physicians' Reports

Dr. Daniel L. Holt

Dr. Holt is Board-certified in family practice medicine. (DX 16). He examined Claimant for the Department of Labor on March 3, 2011, and prepared a report of his findings. (*Id.*) Dr. Holt reported an x-ray interpreted as showing 0/0, COPD, and bullae; a pulmonary function test showing minimal obstructive defect; and arterial blood gas test results qualifying under the regulatory criteria. In a follow up letter dated April 14, 2011, mailed in response to questions by the claims examiner, Dr. Holt stated that his review of the pulmonary function tests, arterial blood gas tests and clinical history showed Claimant to be totally disabled from COPD, and that the disability is most likely due to both coal dust exposure and cigarette smoking, with coal dust being the primary causative factor. (DX 16).

Dr. John T. Schaaf

Dr. Schaaf evaluated the Claimant's pulmonary condition on August 4, 2011. Dr. Schaaf is Board-certified in internal medicine and pulmonary medicine. (CX 1). His evaluation included a physical examination revealing normal breath sounds except for wheezes during forced exhalation and an intermittently wet productive-sounding cough; a review of symptoms of progressive shortness of breath treated with the breathing medications, Spiriva and Advair, of equivocal benefit, and oxygen at night; notation of a smoking history of a pack a day for 35 years quitting in year 2000, and of coal mine employment from 1970 until 2005, primarily underground but last job on surface as a lamp man. Dr. Schaaf's testing included a chest x-ray interpreted as showing round opacities most likely due to old granulomatous disease; and pulmonary function tests showing severe obstructive disease with no significant change after bronchodilators. Dr. Schaaf reviewed medical records including arterial blood gas test results dated January 26, 2011, from the Centerville Clinic. Dr. Schaaf diagnosed severe chronic obstructive pulmonary disease precluding Claimant from performing his coal mine employment duties. He opined that the etiology is coal dust exposure and cigarette smoking, both of which are substantial contributing factors. (CX 1).

Dr. Schaaf testified by deposition on April 13, 2012. (CX 4). He is Board-certified in internal medicine and pulmonary medicine and has a consultation practice in pulmonary and critical care medicine. He is on staff of Hamot Medical Center in Erie Pennsylvania, where in the past he was chairman of the Department of Medicine, chief of division of pulmonary disease, chief of the critical care unit and intensive care unit, as well as president of the medical staff, and chairman of the medical staff executive committee. (CX 4 at 6). He reviewed his report evaluating Claimant. (CX 4 at 12). He testified that 34.75 years as a coal miner is a long exposure in an environment known to produce lung disease, and 35 years of cigarette smoking is significant exposure. (CX 4 at 13, 16). He read a chest x-ray as 0/0; and interpreted pulmonary function test results as showing severe impairment of lung function. (CX 4 at 17, 22). He found no evidence of asthma, and no indication that obesity was causing the pulmonary impairment. (CX 4 at 20, 24). His arterial blood gas tests show a severe lung function impairment. (CX 4 at 26). He testified that his testing found two problems, obstruction and oxygenation, and that these types of abnormalities are caused by coal dust exposure and cigarette smoking. (CX 4 at 28).

He cannot distinguish between them as causative factors and considers them both to be substantial contributing factors, and their effect to be additive. (CX 4 at 28, 29). He testified that there is nothing in Dr. Fino's report that would cause him to change his opinion on causation, and he agreed that Dr. Fino did not present any reason for finding of a lack of coal dust burden. (CX 4 at 39, 42). Dr. Schaaf testified that he diagnosed COPD and severe lung function, but that he did not diagnose emphysema because he generally doesn't diagnose emphysema without anatomic evidence. (CX 4 at 50). He opined that emphysema is an anatomic diagnosis that requires a histologic examination of the lungs to assure the diagnosis. (CX 4 at 46). He explained that a CT scan may correlate reasonably well with the pathology but a plain x-ray is a terrible way to make a diagnosis of emphysema. (*Id.*) Dr. Schaaf also stated that if emphysema is present he would not be able to distinguish its cause between cigarette smoking and coal dust exposure. (CX 4 at 47). Dr. Schaaf knows of no support for the proposition that the younger one starts smoking the higher the risk of damage to lungs. (CX 4 at 64).

Dr. Christopher J. Begley

Dr. Begley evaluated Claimant's pulmonary condition in a report dated November 30, 2011. (CX 2). Dr. Begley is Board-certified in internal medicine, pulmonary medicine and critical care medicine. (CX 1). His evaluation includes a physical examination revealing decreased breath sounds over both lungs; a review of symptoms of shortness of breath for years, treated by the breathing medications, Spiriva, Advair and supplemental oxygen since 2005; notation of a smoking history of a pack a day for 38 years quitting in year 2000. Dr. Begley's testing included a chest x-ray interpreted as showing simple coal workers' pneumoconiosis; pulmonary function tests showing mild obstructive lung disease with hyperinflation and reduction in diffusion capacity consistent with pulmonary emphysema; and resting and exercise arterial blood gas test results revealing resting and exercise arterial hypoxemia with desaturation with exercise. Dr. Begley concluded that Claimant has a severe pulmonary impairment which precludes him from returning to his coal mine employment duties. (CX 2).

Dr. Begley testified by deposition on April 12, 2012. (CX 5). He is Board-certified in internal medicine, pulmonary medicine and critical care medicine, and practices pulmonary medicine and frequently treats patients with cwp. (CX 5 at 5, 6, 7). Dr. Begley based his conclusions about Claimant's pulmonary condition on Claimant's 34.75 years of coal mine employment; his suffering from progressive shortness of breath and being on supplemental oxygen since 2005; his taking the breathing medications, Advair and Spiriva; nodular changes on x-ray suggestive of cwp; pulmonary function tests showing obstructive lung disease; severe arterial hypoxemia shown by arterial blood gas test; and no history of cardiac disease. (CX 5 at 9-14). Dr. Begley concluded that cigarette smoking and coal dust exposure are significant contributing causes of Claimant's pulmonary condition, and thus he diagnosed legal pneumoconiosis. (CX 5 at 17, 18). Dr. Begley does not believe that 35 years of coal mine employment can be discounted as contributing to Claimant's pulmonary impairment. (CX 5 at 20). Dr. Begley found no evidence of restrictive lung disease. (CX 5 at 24). Dr. Begley testified that a person's lungs are mature by age of 15. (CX 5 at, 27). Dr. Begley considers Claimant's severely abnormal arterial blood gas test result, over and above his obstructive flow rates, to be suspicious of coal dust exposure as a cause. (CX 5 at 30).

Dr. Gregory Fino

Dr. Fino evaluated Claimant's pulmonary condition in a report dated November 12, 2011. (EX 1). Dr. Fino is Board-certified in internal medicine and pulmonary disease. (*Id.*). His evaluation included: a review of occupational history of a little less than 35 years, retiring in 2005, with an estimated 19 years of underground mining, and a last job of lamp man requiring some heavy labor; symptoms of progressive shortness of breath present for last 20 years; physical examination showing markedly decreased breath sounds; chest x-ray read as 0/0, pulmonary emphysema and small granulomata seen throughout; pulmonary function tests showing moderate obstructive ventilator defect, with a bronchodilator response but overwhelmingly irreversible, normal lung volumes and reduced diffusing capacity; arterial blood gas test showing significant hypoxemia; review of medical records including report of Dr. Holt and DOL medical examination. Dr. Fino's diagnosis is severe emphysema due to smoking. He opined that the impairment is not due to coal dust exposure because Claimant's 35 years of coal mine employment is not sufficient exposure and Claimant's chest x-ray is negative.

Dr. Fino testified by deposition on December 19, 2012. (EX 14). Dr. Fino testified that he is Board-certified in internal medicine and pulmonary disease, and has an inpatient pulmonary and critical care practice. (EX 14 at 4). Dr. Fino noted a 35 year coal mine employment history and a 38 year one pack per day smoking history. (EX 14 at 6, 7). His chest x-ray was read as 0/0 and his pulmonary function tests revealed a significant obstructive abnormality. He finds the cause of the obstructive ventilatory condition to be emphysema. Prior to the deposition, Dr. Fino was supplied with medical reports by Drs. Schaaf, Begley and Renn. (EX 14 at 12). Dr. Fino rules out coal dust exposure by considering a significant smoking history, a coal mine employment history of 33 years, only 19 of which were underground, and a negative chest x-ray. (EX 14 at 15). Dr. Fino agreed that Claimant's reduction in FEV1 and diffusing capacity along with abnormalities in oxygen exchange can all be caused by coal dust exposure and by cigarette smoking. (EX 14 at 21, 22). Dr. Fino testified that he might have found coal dust exposure to be a causative factor if Claimant had worked as a coal miner for 35 years underground, or if he had a positive chest x-ray. (EX 14 at 27, 30). Dr. Fino agrees that 19 years of coal mine employment is sufficient to place a person at risk of a disabling pulmonary condition, but not Claimant. He finds that Claimant has a reduction in pulmonary capacity, but only an average reduction, not clinically significant, according to the article, *Quantitative Relation Between Emphysema and Lung Mineral Content in Coalminers* by Leigh, Driscoll, Coll, Beck, Hall and Lang. Dr. Fino agreed that if one followed the findings of the article, and assessed everyone an average reduction, no one would ever be considered disabled from a pulmonary condition. (EX 14 at 32).

Dr. Joseph J. Renn

Dr. Renn evaluated Claimant's pulmonary condition in a report dated February 17, 2012. (EX 2). His review included a review of Claimant's occupation as coal miner from 1970, with work in and around underground coal mine, until his retirement in 2005 due to shortness of breath and fatigue. He noted Claimant's last job was lamp man, and that the heaviest part of the job was a lot of walking and carrying 75 to 100 pound bags of garbage. He notes that Claimant has suffered from exertional dyspnea since 2003 when walking as little as a half block on the

level, and takes the pulmonary medications, Spiriva, Advair, and oxygen. Dr. Renn's physical examination showed lungs to be clear, he read the chest x-ray as 0/0, his pulmonary function test represented moderate-moderately severe obstruction with no significant bronchoreversibility, lung volumes revealed normal total lung capacity eliminating restrictive ventilator defect but mild air trapping consistent with obstructive ventilatory defect; diffusion capacity shows moderate obstruction; and normal resting arterial blood gas test results. He reviewed medical reports, including those from Drs. Holt, Schaaf, Begley, and Fino. Dr. Renn concluded that Claimant is totally and permanently disabled from performing his last coal mine job. He diagnosed pulmonary emphysema resulting from years of tobacco smoking. He rejected coal dust exposure as a cause of the pulmonary impairment. (EX 2).

Dr. Renn testified by deposition on October 25, 2012. (EX 13). He is Board-certified in internal medicine, pulmonary disease and forensic medicine. (EX 13 at 8). He teaches three classes at the West Virginia Medical Center, and since 2007 has practiced medicine by performing independent medical evaluations, and by record reviews. (EX 13 at 9, 10, 11). He interpreted an x-ray as showing multiple calcified granulomata, and he found Claimant's arterial blood gas tests to be normal. (EX 13 at 18, 27). He opined that the arterial blood gas test results do not indicate a total disability because his test showed an oxygen tension of 65. (EX 13 at 18). He disagreed with the findings of the other pulmonologists who found that the arterial blood gas test results reflect significant impairment due to hypoxemia. (EX 13 at 54, 55). Dr. Renn attributed Claimant's obstructive impairment on emphysema caused by cigarette smoking in light of the combination of a reduction in diffusing capacity plus the obstruction. (EX 13 at 20, 21, 30). He reasoned that Claimant has a moderate reduction of diffusing capacity whereas coal dust only mildly reduces diffusion capacity. He opined that air trapping of the lungs is consistent with cigarette smoking. (EX 13 at 21). He testified that he believed Claimant's pulmonary disease was contributed to by secondary smoke, and was contributed to by cigarette smoke because Claimant started to smoke at age 15. (EX 13 at 26). Dr. Renn diagnosed neither clinical nor legal pneumoconiosis. (EX 13 at 30). He rejected coal dust exposure as a causative factor because the testing showed "severe reduction of diffusion capacity," no cwp present by x-ray, and "severe pulmonary function test result with apparent disjuncture with arterial blood gas." He does not recall seeing this combination present in impairment due to coal dust exposure. (EX 13 at 33). (On cross-examination Dr. Renn withdrew the disjuncture of pulmonary function test and arterial blood gas test results as an explanation for finding that coal dust was not a causative factor.) (EX 13 at 53). Dr. Renn agreed that the air trapping could be the explanation for reduction in the FVC. (EX 13 at 67).

Treatment records

Treatment records from Dr. Kitsko, Washington Hospital and Canonsburg Hospital document Claimant's problems with shortness of breath, chronic obstructive pulmonary disease, hypertension, and diabetes. (EX 8, 9, 10). Treatment records of Dr. Kitsko dated November 9, 2000, and September 14, 2001, note that Claimant is a non-smoker. (EX 8). An x-ray dated April 26, 2005 is read by Dr. DeRiggi for Dr. Celko as prior granulomatous disease and no occupational disease. Pulmonary function tests on the same date were read as moderate obstructive, no bronchodilator response. (EX 8). A treatment note from Washington Hospital dated March 6, 2010, states that Claimant was a smoker until ten years earlier. He was taking

the prescription pulmonary medications Advair and Spiriva, and conditions noted were diabetes, hypertension and COPD. (EX 8). A June 3, 2012 x-ray for postop hip surgery was read as emphysematous lung and mild chronic interstitial fibrotic change. (EX 8).

LEGAL STANDARD

A Claimant is entitled to black lung benefits under Part 718 if he can prove by a preponderance of the evidence: (1) that he suffers from pneumoconiosis; (2) that the pneumoconiosis arose out of his coal mine employment; (3) that he is totally disabled; and (4) that the pneumoconiosis is a substantially contributing cause of the total disability. 20 C.F.R. §§ 718.202-718.204 (2010); *Shiko v. OWCP*, BLA 04-0476 (Feb. 17, 2005). Failure to establish any of these elements precludes a finding of entitlement. *Id.*

TOTAL PULMONARY DISABILITY

Pursuant to § 718.304(b)(1), a miner is considered to be totally disabled if (1) the § 718.304 irrebuttable presumption relating to complicated pneumoconiosis applies or (2) the miner has a pulmonary or respiratory impairment which prevents him from doing his usual coal mine employment and comparable gainful employment. 20 C.F.R. § 718.304(b)(1)(i)-(ii) (2010). In this case, there was no argument or evidence that Claimant had complicated pneumoconiosis, and so the irrebuttable presumption at § 718.304 is inapplicable.

Where, as here, the complicated pneumoconiosis presumption is not applicable, the following are probative of the existence of total disability: (1) pulmonary function tests (PFTs); (2) arterial blood gas tests (ABGs); (3) evidence of cor pulmonale with right-sided congestive heart failure²; (4) reasoned medical opinions; and (5) lay testimony. 20 C.F.R. § 718.204(b)(2)(i)-(iv). All of the medical evidence relevant to the question must be weighed, like and unlike together, with the claimant bearing the burden of establishing total disability by a preponderance of the evidence. *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987).

Pulmonary Function Tests

The four pulmonary function tests of record are equivocal on whether Claimant is totally disabled. Results of the tests by Dr. Schaaf and Dr. Begley qualify to demonstrate a total disability, and the FEV1 result of all the tests are sufficiently low to qualify. However, the results of the FVC or FEV1/FVC maneuvers of the tests by Dr. Holt, Fino, and Renn, although indicative of a disabling impairment, do not qualify to establish a total disability, even though all four physicians who administered the tests found Claimant to be totally disabled. Considering the totality of the PFTs, it is determined that the preponderance of their results do not establish a totally disabling pulmonary condition.

² There was no evidence of cor pulmonale in this case, with or without right-sided congestive heart failure.

Arterial Blood Gas Studies

The preponderance of the ABG evidence does support a finding of total pulmonary disability. The three tests administered by Drs. Holt, Fino and Begley yielded qualifying resting blood gases. Only the most recent test by Dr. Renn resulted in values that were not qualifying, and those results were only marginal. Further, all the physicians who reviewed all the ABG evidence, other than Dr. Renn, opined that the evidence revealed severe hypoxemia.

Medical Opinions and Lay Testimony

The five physicians who evaluated Claimant found him to be totally disabled from his pulmonary condition from returning to his last coal mine job. There is no contrary opinion. Thus, the uncontradicted medical opinion evidence supports a finding of total pulmonary disability.

The only lay testimony of record, Claimant's own testimony, supports a finding of total disability, as he testified to being short of breath which keeps him from doing the activities he enjoys, and to taking the breathing medications, Advair and Spiriva, and to using oxygen.

Conclusion Regarding Total Disability

The PFTs are found to not qualify to evidence a total pulmonary disability, although they show reduced pulmonary capacity. Nevertheless, the clear preponderance of the evidence, including the ABG tests and all the medical opinions, and lay testimony, supports a finding that Claimant is pulmonarily disabled from performing his last coal mine employment.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) PRESUMPTION

Because this claim was filed after January 1, 2005, 30 U.S.C. § 921(c)(4) as amended by § 1556 of the PPACA, applies. This provision expands the applicability of the rebuttable presumption found at 30 U.S.C. § 921(c)(4) to claims that are: (1) filed after January 1, 2005, and (2) pending on or after the date of enactment of the amendments. Section 921(c)(4), as amended, provides as follows:

(4) if a miner was employed for fifteen years or more in one or more underground coal mines, and if there is a chest roentgenogram submitted in connection with such miner's [...] claim under this subchapter and it is interpreted as negative with respect to [complicated pneumoconiosis], and if other evidence demonstrates the existence of a totally disabling respiratory or pulmonary impairment, then there shall be a rebuttable presumption that such miner is totally disabled due to pneumoconiosis [...] The Secretary may rebut such presumption only by establishing that

- (A) such miner does not [...] have pneumoconiosis, or that
- (B) his respiratory or pulmonary impairment did not arise out of, or in connection with, employment in a coal mine.

30 U.S.C. § 921(c)(4), as amended by Pub. L. No. 111-148, § 1556 (2010). Here, since Claimant has worked as a coal miner for 35 years, at least 19 years of which was in underground coal mining, and has met his burden of established a total pulmonary disability, the PPACA presumption applies and Claimant's pulmonary condition is presumed to be caused by coal worker's pneumoconiosis.

EXISTENCE OF PNEUMOCONIOSIS

Because the PPACA presumption applies, the burden is on Employer in this case to demonstrate that Claimant does not have pneumoconiosis. 30 U.S.C. § 921(c)(4).

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis. [See *infra*].

20 C.F.R. § 718.201 (2010).

The regulations provide several means of establishing the existence of pneumoconiosis including (1) a valid chest x-ray; (2) a biopsy or autopsy; or (3) a determination of the existence of pneumoconiosis as defined in § 718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a) (1)-(4) (2010). Here, chest x-ray readings, treatment records, and physicians' opinions are considered.

Clinical Pneumoconiosis

(a) [...] (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those 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. [...]

20 C.F.R. § 718.201 (2010). The regulations provide that the existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, and 0/1, is not evidence of pneumoconiosis. 20 C.F.R. § 718.102(b).

Ten readings were made of five chest x-rays taken during the thirteen month period January 26, 2011 through February 22, 2012. Only two of the readings were read as positive for coal workers' pneumoconiosis. Those two readings were by Dr. Ahmad of x-rays dated October 12, 2011 and February 12, 2012. Dr. Ahmad is qualified as a Board-certified radiologist and B-

reader. Those same two x-rays were read as negative by Dr. Myer, who is also dually qualified. The other six readings were negative by Dr. Meyer, Dr. Schaaf, a B-reader, Dr. Stankiewicz, a radiologist, and even by Dr. Ahmed of the January 11, 2011 x-ray. Also, an x-ray in Claimant's treating records dated April 26, 2005, was read by Dr. DeRiggi as showing no occupational or pleural disease. Accordingly, the preponderance of the x-ray readings are considered as supporting a finding that Claimant does not have clinical pneumoconiosis. In addition, none of the physicians offering reports in this case diagnosed clinical pneumoconiosis, and so the weight of the medical opinion evidence also supports a finding of no clinical pneumoconiosis. (DX 13; EX 1; EX 2; EX 4; EX 5; EX 6). I therefore find that Respondent has met its burden of showing that Claimant does not have clinical pneumoconiosis.

Legal Pneumoconiosis

- (a) [...] (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

20 C.F.R. § 718.201 (2010). Legal pneumoconiosis may also be established by opinions of physicians who have exercised sound medical judgment based upon objective medical evidence. 20 C.F.R. § 718.202(a)(4).

As previously discussed the evidence shows that Claimant has a pulmonary impairment, the first requirement for legal pneumoconiosis.

The critical question, then, is the critical question of this case: whether Claimant's respiratory impairment "arose out of" coal mine employment, which, in the language of the regulations, includes an impairment that is "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 CFR § 718.201(a)(2); § 718.201(b). Employer did present evidence to rebut the presumption that Claimant suffers from legal pneumoconiosis, as Drs. Fino and Renn opined that Claimant's respiratory problems were due to smoking alone, and not coal dust exposure. However, there are reasons to discredit both of these opinions.

Dr. Fino ruled out coal dust exposure largely based on his application of the article, *Quantitative Relation Between Emphysema and Lung Mineral Content in Coalminers* by Leigh, Driscoll, Coll, Beck, Hall and Lang. He quotes the article as stating that the extent of emphysema is strongly related to the total coal content of the lung, age and smoking. (EX 14 at 16). He applied the study here to show that Claimant's 35 years as a coal miner including 19 years underground, plus no x-ray evidence of pneumoconiosis, was insufficient to substantially affect his pulmonary capacity. Dr. Fino testified that he might have found coal dust as a causative factor had Claimant worked for 35 years in underground coal mining, or if Claimant had radiographic evidence of pneumoconiosis. Drs. Holt, Begley and Schaaf all considered Claimant's coal mine exposure to be sufficient to be a significant causative factor and they all are of the opinion that a miner may have legal pneumoconiosis without a positive x-ray. Dr. Fino's opinion is given less credit because it is not well reasoned. The Leigh article demonstrates that a

coal miner who worked a specified number of years would, on average, be subjected to a certain loss of pulmonary capacity. The study, however, refers to a typical coal miner, not Claimant. It is illogical to project the loss of pulmonary capacity of a hypothetical miner onto Claimant's exposure. Certainly, the Act and regulations recognize that a miner with 19 years of underground coal mine employment and a negative x-ray could suffer a total disability as a consequence of that employment. In fact, the Act presumes that such miner's pulmonary disability would be caused by his coal dust exposure. See 30 U.S.C. § 921(c)(4) of the Act. As acknowledged by Dr. Fino, if every miner was judged to have an average loss of pulmonary capacity pursuant to the *Leigh* article, none would ever be considered disabled from a loss of pulmonary capacity.

Particularly pertinent to Dr. Fino's reasoning is the Department's comments to the medical literature in its preamble to recently amended regulations. The comments stress:

As the majority of miners may have small or, perhaps in some cases, no decline in pulmonary function, the average decline of the population studied can appear to be relatively small. Despite this, individual miners affected can have quite severe disease, and statistical averaging hides this effect.

65 Fed. Reg. 79,941 (Dec. 20, 2000)

Further, the Board has continually rejected the argument that legal pneumoconiosis can be excluded by the absence of positive x-ray evidence. In *Martin v. Eastern Assoc. Coal Corp.*, 2011 WL 5508710, BRB No. 11-0184 BLA (Oct. 27, 2011)(unpub.), the Board held that it was proper for the Administrative Law Judge to accord less weight to the opinions of Drs. Crisalli and Zaldivar because these experts "relied on the absence of x-ray evidence of clinical pneumoconiosis to exclude coal dust exposure as a cause of claimant's COPD" and "this view is contrary to the scientific literature upon which DOL relied in amending the definition of legal pneumoconiosis."

Dr. Renn choose a smoking and second hand smoke etiology over a coal dust etiology based on such pulmonary symptoms as a severe reduction in diffusion capacity coupled with a negative chest x-ray. He found that such combination is consistent with cigarette smoking, not coal dust exposure. However, the fact that some symptoms are consistent with cigarette smoking does not preclude coal dust as also having a significant causative effect. It is Employer's burden to show that coal dust is not a significant contributor. That burden is not met by showing that cigarette smoking is a significant contributor, as such does not exclude coal dust exposure as a significant contributor to Claimant's impairment.

In short, the opinions of Drs. Fino and Renn are poorly reasoned as they do not adequately explain their rejection of coal dust exposure as a substantial cause of Claimant pulmonary impairment, do not give them much weight on this. Accordingly, it is determined that Employer has not rebutted the existence of legal pneumoconiosis by a preponderance of the evidence.

TOTAL DISABILITY DUE TO PNEUMOCONIOSIS

Claimant has established the presence of legal pneumoconiosis in the form of total pulmonary disability caused by his coal dust exposure. Therefore, a separate determination of the etiology of Claimant's disease is unnecessary as the legal pneumoconiosis inquiry necessarily subsumes that inquiry. *Kiser v. L&J Equipment Co.*, 23 B.L.R. 1-246, 1-249 n. 18 (2006).

CONCLUSION AND ONSET DATE OF BENEFITS

Claimant met his burden of establishing total disability and at least 15 years of qualifying coal mine employment, and Employer did not rebut the ensuing PPACA presumption by disproving the existence of legal pneumoconiosis or total disability due to pneumoconiosis by a preponderance of the evidence. Accordingly, Claimant is entitled to Black Lung benefits.

Benefits commence in a miner's claim on the date the medical evidence first establishes that he became totally disabled due to pneumoconiosis, or if such a date cannot be determined from the record, the first day of the month in which the mined filed his most recent claim. 20 C.F.R. § 725.503 (2004); *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1047 (1990). Claimant filed his claim on January 6, 2011. As the evidence does not clearly establish an onset date of total disability due to pneumoconiosis, benefits will be awarded as of January 1, 2011.

ATTORNEY'S FEE

Claimant's counsel shall file within 30 days of the date of issuance of this Decision and Order with this Office and with opposing counsel, a petition for a representative's fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366 (2010). Director's Counsel shall file any objections with this Office and with Claimant's counsel within 20 days of receipt of the petition for fees and costs.

It is requested that the petition for services and costs clearly provide:

- (1) counsel's hourly rate with supporting argument or documentation;
- (2) a clear itemization of the complexity and type of services rendered; and
- (3) a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals.

Ilkewicz v. Director, OWCP, 4 B.L.R. 1-400 (1982).

ORDER

IT IS HEREBY ORDERED THAT Claimant's Application for Benefits of January 1, 2011 is GRANTED.

THOMAS M. BURKE
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, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).