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Issue Date: 31 May 2011

In the Matter of
MICHAEL S. DAY, SR.
Claimant

Case No.: 2006 BLA 5411

v.

EASTERN ASSOCIATED COAL CORP./
OLD REPUBLIC INSURANCE CO.,
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Derrick W. Lefler, Attorney
For the Claimant

Mr. Paul E. Frampton, Attorney
Ms. Laura Metcoff Klaus, Attorney (on remand)
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER ON REMAND –
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. Michael S. Day, Sr., for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

Procedural Background¹

On August 7, 2009, due to failure to establish the presence of pneumoconiosis, I denied Mr. Day's claim for black lung disability benefits. In response, on September 8, 2009, Mr. Day appealed the adverse determination. On March 23, 2010, while Mr. Day's appeal was pending before the Benefits Review Board ("BRB" and "Board"), Section 1556 of the Patient Protection and Affordable Care Act ("PPACA"), Public Law No. 111-148, was enacted into law. The provisions of Section 1556 amended two portions of the Black Lung Disability Act. First, the 15 year rebuttable presumption in 30 U.S.C. § 921(c)(4) was revived for all claims filed after January 1, 2005 and pending as of March 23, 2010. Second, the automatic entitlement to survivor benefits under certain conditions in 30 U.S.C. § 932(l) was extended to survivor claims filed after January 1, 2005 and pending as of March 23, 2010. On October 14, 2010, after providing the parties an opportunity to respond to the new legislation and affirming several factual findings and evidentiary determinations in my decision, the BRB concluded that the amended provision regarding the rebuttable presumption may be applicable in Mr. Day's claim. As a result, the Board vacated my denial of his claim and remanded the case for re-adjudication in light of the revived rebuttable presumption. The BRB also directed that I provide the parties an opportunity to submit additional evidence to address the change in the law.

Consistent with the Board's instruction, I re-opened the record on March 4, 2011 through April 4, 2011. To date, neither party has submitted additional evidence. According, in light of the Board's affirmed evidentiary determinations,² my decision in this case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 29, CX 1 to CX 9, CX 11, EX 1 to EX 3, and EX 5 to EX 8.³

Remand Issues

1. Whether Mr. Day has pneumoconiosis.
2. If Mr. Day has pneumoconiosis, whether his disease arose out of coal mine employment.
3. Whether Mr. Day is totally disabled due to coal workers' pneumoconiosis.

¹In my August 7, 2009 decision, I previously summarized the procedural history of Mr. Day's claim through the February 11, 2009 hearing.

²Specifically, the interpretations of Dr. Scatarige and Dr. Wheeler of the May 23, 2005 CT scan are both admissible, and the opinions of Dr. Crisalli and Dr. Wheeler do not lose probative due to their consideration of radiographic interpretations not in the record.

³The following notations appear in this decision to identify exhibits: DX – Director exhibit; EX – Employer exhibit; CX – Claimant Exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated: a) Mr. Day had post-1969 coal mine employment, b) Mr. Day had at least 33 years of coal mine employment, and c) Eastern Associated Coal Corporation is the responsible operator (TR. p. 8, 47, and 48).

Affirmed Findings

In its October 14, 2010 decision, the BRB affirmed the following determinations that I rendered in the initial decision and order: a) Mr. Day had at least 33 years of coal mine employment; b) Mr. Day has a totally disabling respiratory impairment under 20 C.F.R. § 718.204(b); c) the weight of the chest x-ray evidence is insufficient to establish the presence of simple pneumoconiosis under 20 C.F.R. § 718.202(a);⁴ and, d) the weight of medical evidence is insufficient to establish the presence of complicated pneumoconiosis under 20 C.F.R. § 718.304.

Preliminary Findings

Born on August 29, 1946, Mr. Day married Mrs. Nyoka G. Day on July 25, 1969. Mr. Day started working as a coal miner on September 2, 1969 and continued until January 16, 2004. He last worked in coal miner as a shuttle car operator in a coal mine located in West Virginia. In his last job, on occasions when his equipment broke down or he was called in to work Saturdays, Mr. Day also helped with a pinner, set timbers, and rock dusted, which required heavy labor associated with lifting 50 pound bags of rock dust. Mr. Day smoked one to one and a half packs of cigarettes per day from 1968 to 1998, with a ten year break. Additionally, as I determined in my first decision, and absent evidence to the contrary, Ms. Stepheny M. Day's condition meets the disability definition under the Social Security Act and she is unable to engage in substantial gainful activity. Accordingly, Ms. Stepheny M. Day, Mr. Day's adult daughter, is a qualified dependant for the purpose of augmenting any benefits that may be payable under the Act. (DX 2, DX 4, DX 8 and TR. p 30 – 45)

Miner's Claim

To receive black lung disability benefits under the Act, a claimant must prove by preponderance of the evidence four conditions of entitlement. First, the miner must establish the presence of pneumoconiosis.⁵ Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.⁶ Third, the miner has to demonstrate he is totally disabled.⁷ And fourth, the miner must prove the total disability is due to pneumoconiosis.⁸

⁴This finding relates only to Mr. Day's case-in-chief. I will again address the chest x-ray evidence in considering whether the Employer has established rebuttal under 20 C.F.R. § 718.305(a).

⁵20 C.F.R. § 718.202.

⁶20 C.F.R. § 718.203(a).

Issue # 1 – Presence of Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.⁹ The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as “any chronic lung disease . . . arising out of coal mine employment.”¹⁰ The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”¹¹ As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989). Further, 20 C.F.R. § 718.203(b) establishes that if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (20 C.F.R. § 718.202(a)(1)), autopsy or biopsy report (20 C.F.R. § 718.202(a)(2)), regulatory presumption (20 C.F.R. § 718.202(a)(3)),¹² and medical opinion (20 C.F.R. § 718.202(a)(4)). In light of these provisions, and since the weight of medical evidence is insufficient to establish complicated pneumoconiosis under 20 C.F.R. § 718.304 and no biopsy evidence has been submitted, Mr. Day must establish the presence of pneumoconiosis through the rebuttal presumption associated with total disability and 15 years of coal mine employment, chest x-rays, or medical opinion. Additionally, because Mr. Day last worked as a coal miner in West Virginia, under the guidance of *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must consider all the evidence together to determine whether he can establish the presence of pneumoconiosis in his lungs.

⁷20 C.F.R. § 718.204(b).

⁸20 C.F.R. § 718.204(a).

⁹20 C.F.R. § 718.201(a).

¹⁰20 C.F.R. §§ 718.201(a)(1) and (2) (emphasis added).

¹¹20 C.F.R. § 718.201(b).

¹²If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982 or after January 1, 2005, if the coal miner has fifteen years or more coal mine employment and is totally disabled, there is a rebuttable presumption he is totally disabled due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

**Regulatory Rebuttal Presumption, 20 C.F.R. § 718.305 –
Total Disability and 15 Years Coal Mine Employment**

As recently revived by Congress in the PPACA, for pending claims filed after January 1, 2005, under 20 C.F.R. § 718.305, if the irrebuttable presumption under 20 C.F.R. § 718.304 has not been invoked, a miner was employed for fifteen years or more in underground coal mines (or conditions of the miner's employment at a coal mine were "substantially similar" to conditions in an underground mine), and other evidence establishes the existence of a totally disabling respiratory or pulmonary impairment, then a rebuttable presumption of total disability due to pneumoconiosis, death due to pneumoconiosis, or total disability due to pneumoconiosis at time of death is established. According to 20 C.F.R. § 718.305(c), the determination of the existence of a totally disabling respiratory or pulmonary impairment is made under the provisions of 20 C.F.R. § 718.204.

In a claim for black lung disability benefits, an invoked presumption may be rebutted under 20 C.F.R. § 718.305(a) if the opposing party is able to establish by a preponderance of the evidence that either: a) the miner did not have pneumoconiosis (clinical and legal), or b) his respiratory impairment did not arise out of coal mine employment.

With these principles in mind, I first note that since Mr. Day has not established the presence of complicated pneumoconiosis, he is unable to invoke the irrebuttable presumption under 20 C.F.R. § 718.304. Next, based on my previous affirmed determination, Mr. Day has proven total disability under 20 C.F.R. § 718.204. Further, through the parties' stipulation of fact, and as also affirmed by the BRB, Mr. Day has established at least 33 years of coal mine employment. Consequently, the invocation of the rebuttable presumption rests on a determination of whether at least 15 years of that coal mine employment occurred in underground coal mines or dust conditions substantially similar to underground coal mine conditions.

When Mr. Day presented his claim, he indicated on his history of coal mine employment that he worked in "underground" coal mines from 1969 to 2004 as a continuous miner operator, "roof bolter," scoop operator, "brattice man," and shuttle car operator, DX 4. In describing his job as a continuous miner operator, which covered a period from 1969 to 1987, Mr. Day indicated that he worked at the face of the coal mine and had to hang curtains, DX 5. At the February 11, 2009 hearing (TR, p. 30-44), Mr. Day testified that in last job as a shuttle car operator, which according to DX 4 covered a period from 1998 to 2004, he occasionally helped with the pinner "to get the top caught up," and timbers. And, he affirmatively responded to the question of whether he was underground operating a piece of equipment that hauled coal.

In light of Mr. Day's uncontested statements, and his credible testimony, I find Mr. Day worked in underground coal mines for 33 years, which satisfies that final requisite for invocation of the rebuttable presumption. Accordingly, I find Mr. Day has invoked the rebuttable presumption that he is totally disabled due to pneumoconiosis under 20 C.F.R. § 718.305. In light of that invocation, I next consider whether the Employer is able to rebut the presumptions under 20 C.F.R. § 718.305(a) and (d) by proving that either: (1) Mr. Day did not have pneumoconiosis (clinical and legal), or (2) he was not totally disabled due to pneumoconiosis,

that is, his respiratory impairment did not arise in whole or part out of dust exposure in his coal mine employment.

Pneumoconiosis

The applicable medical evidence regarding the presence of pneumoconiosis consists of film chest x-rays, digital chest x-rays, a CT scan, and medical opinion.

Film Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
September 7, 2004	CX 3	Dr. Leef	Nodular fibrosis consistent with occupational pneumoconiosis present throughout both lungs. Coalescent nodular masses in the upper lobes. Findings consistent with complicated coal workers' pneumoconiosis.
March 30, 2005	DX 12	Dr. Zaldivar, B ¹³	Positive for pneumoconiosis, profusion 2/2, ¹⁴ type q/r opacities. ¹⁵ Category C large opacity consistent with pneumoconiosis present.
(same)	DX 13	Dr. Wheeler, BCR, B	Negative for pneumoconiosis, profusion 0/1, type q opacities. No large opacity consistent with pneumoconiosis. 7 cm mass in right upper long & lower right apex, few 3 cm masses in right mid lung, 7 cm mass in left mid and upper lung compatible with conglomerate granulomatous disease, tuberculosis, or histoplasmosis. Few small nodules in mid lungs compatible with granulomata. Small nodules could be coal workers' pneumoconiosis.

¹³The following designations apply: B – B reader, and BCR – Board Certified Radiologist. 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. *See also* 20 C.F.R. § 718.202(a)(1)(ii).

¹⁴The 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 didn't see any marks that would cause him or her to seriously consider category 1. **According to 20 C.F.R. § 718.102(b), a profusion of 0/1 does not constitute evidence of pneumoconiosis.**

¹⁵There 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).

June 1, 2005	DX 13	Dr. Scott, BCR, B	Negative for pneumoconiosis and large opacity consistent with pneumoconiosis. 7 cm mass in right upper lung. 10 by 3 cm mass in left upper lung. Scarring extending to pleura. Changes probably due to tuberculosis, unknown activity.
(same)	CX 5	Dr. Willis, BCR, B ¹⁶	Positive for pneumoconiosis, profusion 2/2, type q/r opacities. Positive for large pulmonary opacity, Category B, consistent with pneumoconiosis. Diffuse scattered pulmonary parenchymal opacities consistent with occupational pneumoconiosis. Two large opacities in both upper lobes consistent with conglomerate masses.
(same)	EX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis and a large opacity consistent with pneumoconiosis. 7 cm mass in right upper lung and other large masses compatible with conglomerate granulomatous disease, tuberculosis, or histoplasmosis with minimal bilateral pleural involvement. Few ill defined infiltrates or scars in the lower lateral periphery of the lungs. Linear discoid atelectasis or scar at level of lower right hilum noted. No background small nodules to suggest coal workers pneumoconiosis.

The uncontested interpretation by Dr. Leef of the September 7, 2004 chest x-ray establishes that the film is positive for simple pneumoconiosis.

In the March 30, 2005 film, Dr. Zaldivar, a B reader, observed small opacities consistent with pneumoconiosis. Dr. Wheeler, a dual qualified radiologist, also noted small opacities consistent with pneumoconiosis but considered the profusion insufficient to classify the chest x-ray positive for pneumoconiosis. Since as a dual qualified radiologist Dr. Wheeler is better qualified to interpret a film for the presence of pneumoconiosis than Dr. Zaldivar, his interpretation has greater probative weight.¹⁷ As a result, Dr. Wheeler's more probative interpretation outweighs Dr. Zaldivar's contrary finding and establishes that the March 30, 2005 chest x-ray is negative for the presence of pneumoconiosis.

Dr. Willis, a dual qualified radiologist, concluded the June 1, 2005 chest x-ray was positive for pneumoconiosis. Dr. Wheeler and Dr. Scott, also a dual qualified radiologist, opined the film was negative for pneumoconiosis. Since the three radiologists are equally well qualified, the consensus of Dr. Wheeler and Dr. Scott establishes that the June 1, 2005 film is negative for pneumoconiosis.

¹⁶I take judicial notice of Dr. Willis' board certification.

¹⁷See *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003) and *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader.)

In summary, of the three film radiographic studies, the September 7, 2004 chest x-ray is positive for pneumoconiosis, and the March 30, 2005 and June 1, 2005 films are negative for pneumoconiosis. Consequently, the preponderance of the film chest x-rays is negative for pneumoconiosis.

*Digital Chest X-Rays*¹⁸

March 3, 2003

Dr. Kisor Pathak, a dual qualified radiologist,¹⁹ interpreted the March 3, 2003 digital chest x-ray as positive for pneumoconiosis, profusion 2/2, type q/r opacities (CX 7). He also observed a Category B large opacity consistent with pneumoconiosis. There were large areas of progressive massive fibrosis in both upper lobes. Mr. Day had underlying COPD (chronic obstructive pulmonary disease) changes bilaterally with small emphysematous bullae in both upper lobes.

When Dr. Wheeler interpreted the March 3, 2003 chest x-ray, he observed a mass visible in the right upper lung and an ill defined mass in the lateral left upper lung (EX 3 and EX 6). There was also a small mass in the right upper lung compatible with conglomerate granulomatous disease, tuberculosis, or histoplasmosis. He further observed small infiltrate in the left mid lung and a pneumatocele which is air collection within the lung due to necrosis of the lung. For several reasons, Dr. Wheeler concluded that the noted masses were not large opacities of coal workers' pneumoconiosis. First, Mr. Day's masses involved the apex of the lungs; whereas, "large opacities of coal workers' pneumoconiosis are surrounded by many nodules in the central portion, mid and upper lungs, so most of the large opacities of coal workers' pneumoconiosis are not very far from the hila." The position of the masses in Mr. Day's chest are "out of the strike zone for where you expect large opacities of coal workers' pneumoconiosis" and the large opacities are not surrounded by nodules of fairly high profusion to form the masses." Second, because Mr. Day's masses involved the pleura, they are not related to pneumoconiosis since the pleura does not have alveoli, which are associated with pneumoconiosis. Third, masses in the pleura are due to an infection or granulomatous disease. Fourth, Mr. Day's nodules were not central and symmetrical and coal workers' pneumoconiosis nodules "tend to be filtered out in the central alveoli" and the dust particles have a difficult time moving to the periphery. Fifth, the profusion of any background interstitial lung disease is very low.

¹⁸Although no physician specifically determined in this case that a digital chest x-ray is medically acceptable to diagnosis pneumoconiosis, I note that neither Dr. Wheeler nor Dr. Scott challenged the acceptability of the digital radiographic studies and instead both radiologists evaluated the studies for the presence of pneumoconiosis.

¹⁹Dr. Pathak obtained his board certification in Britain.

September 2, 2003
(CX 3)

Dr. Frank Muto noted multiple areas of consolidation projecting over both lungs. The distribution was predominately in the perihilar regions. Areas of streaky opacities with a more confluent area in the right upper lobe. Bilateral lung opacities were present. "The differential is extensive for this appearance. . . included in the differential would be atypical infection, including fungal disease, septic emboli, or neoplasm."

January 6, 2004
(CX 3)

Dr. J. Leef observed nodular fibrosis present consistent with an occupational pneumoconiosis with coalescence of some nodules in the mid lung zones. Conglomerate masses were in the upper lobes, right more than left. The findings were consistent with complicated coal workers' pneumoconiosis "unaltered" since September 2003.

May 23, 2005
(EX 1)

Dr. William Scott opined that the May 23, 2005 chest x-ray was negative for pneumoconiosis and large pulmonary opacity consistent with pneumoconiosis. Dr. Scott observed bilateral mid and upper lung masses and infiltrates extending to the pleura. The changes seen in the chest x-ray were more likely tuberculosis, unknown activity, rather than silicosis/coal workers' pneumoconiosis based on the pleural involvement and the lack of a background of small rounded opacities.

January 8, 2007
(CX 3)

Dr. Russell King made the following findings: Bilateral pulmonary opacities in upper lobes without significant change since June 2005. Most consistent with progressive massive fibrosis secondary to pneumoconiosis.

Discussion

Dr. Pathak, a dual qualified radiologist, determined the March 3, 2003 digital x-ray was positive for pneumoconiosis and a large Category B pulmonary opacity consistent with pneumoconiosis. Dr. Wheeler, a dual qualified radiologist, disagreed and found the chest x-ray negative for a large pulmonary opacity consistent with pneumoconiosis and he did not find sufficient evidence of pneumoconiosis; instead, he noted that the profusion of any background interstitial lung disease was very low. Since Dr. Pathak and Dr. Wheeler are similarly well qualified, I find their professional dispute renders the March 3, 2003 chest x-ray inconclusive for the presence of pneumoconiosis.

Although Dr. Muto noted significant abnormalities in the September 2, 2003 film, he neither specified the size of the consolidation and opacities nor attributed the opacities to pneumoconiosis. Yet, at the same time, his differential diagnosis did not actually exclude pneumoconiosis. Consequently, considering the imprecise nature of his findings, I consider the September 2, 2003 to be inconclusive for pneumoconiosis.

Dr. Leef's uncontested interpretation of the January 6, 2004 chest x-ray establishes the presence of simple pneumoconiosis.

Likewise, based on Dr. Scott's uncontested interpretation, the May 23, 2005 digital chest x-ray is negative for pneumoconiosis.

Finally, while insufficient to establish the presence of complicated pneumoconiosis, Dr. King's uncontested interpretation nevertheless supports a finding of simple pneumoconiosis.. As a result, the January 8, 2007 chest x-ray is positive for pneumoconiosis.

In summary, setting aside the inconclusive digital chest x-rays of March 3, 2003 and September 2, 2003, the studies of January 6, 2004 and January 8, 2007 are positive for pneumoconiosis; whereas the remaining digital chest x-ray from May 23, 2005 is negative for pneumoconiosis. Accordingly, the preponderance of the probative digital chest x-rays establishes the presence of simple pneumoconiosis.

*CT Scan*²⁰

When Dr. Frank Muto²¹ read the May 23, 2005 CT scan (CX 5), he noted bilateral upper lobe masses with small satellite nodules in a relatively symmetric pattern. The mass in the right lung measured 4.6 by 4.2 centimeters. The mass in the left lung measured 2.3 centimeters. There were smaller nodules scattered in the perihilar region, again in the bilateral and symmetrical pattern. Many of the nodules had irregular borders. Dr. Muto opined the findings were compatible with Mr. Day's given history of coal workers' pneumoconiosis. However, without an older CT scan for comparison, an underlying neoplasm was difficult to exclude, although less likely.

Dr. John Scatarige, a board certified radiologist and B reader, observed in the May 23, 2005 CT scan a 4.2 by 4.6 centimeter mass in the central right upper lung with extensive calcification (DX 13). He also noted a 2.3 centimeter mass in the left upper lung. Mr. Day had linear and nodular opacities. Dr. Scatarige diagnosed tuberculosis, non-tuberculosis mycobacterial infection, fungal disease, sarcoidosis, and less likely, lymphoma or Kaposi

²⁰Dr. Wheeler stated that since a CT scan consists of multiple, sectional views, that type of radiographic study provides greater detail and is a better diagnostic tool than a chest x-ray, EX 6, p. 19. Likewise, Dr. Crisalli indicated that a CT scan is "far more sensitive" than a chest x-ray in diagnosing pneumoconiosis and valid diagnostic tool, EX 8, p. 14-15 and 18. Accordingly, I find the CT scan is admissible evidence under 20 C.F.R. § 718.107. *See Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123 (2006)(en banc) (J. Boggs, concurring) and *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98, (2007) (en banc on recon.) (J. McGranery and J. Hall, concurring and dissenting), *aff'g.*, 23 B.L.R. 1-98 (2006) (en banc).

²¹I take judicial notice that Dr. Frank Muto has never qualified as a B reader.

sarcoma. He opined the changes were unlikely to be due to silicosis or coal workers pneumoconiosis based on the involvement in the pleural and lower lobe and the lack of background small opacities.

Upon evaluation of the May 23, 2005 CT scan, Dr. Wheeler observed a mass in the right upper lung and right apex with areas of low density compatible with conglomerate granulomatous disease and focal necrosis (EX 7). Dr. Wheeler saw a smaller mass in the right mid lung with irregular calcification involving the lower hilum, which contained tiny calcified granuloma. Mr. Day had a mass in his lateral left upper lobe and lower left apex and a mass in his right lower lobe compatible with conglomerate granulomatous disease, tuberculosis, or histoplasmosis. Both lungs had nodules and linear scars compatible with granulomatous disease, tuberculosis, or histoplasmosis. For three reasons, Dr. Wheeler concluded the masses were not associated with pneumoconiosis. First, the noted necrosis is usually found with “fast growing tumors or infections that have outgrown their blood supplies.” The condition is not expected to be seen with emerging silicotic nodules “which are avascular.” Second, the small mass in the right lung has calcification, which is “strongly indicative of granulomatous disease,” which is a “group of inflammatory cells.” Third, coal workers’ pneumoconiosis was unlikely without symmetrical small nodular infiltrates in the central mid and upper lungs. Mr. Day’s large masses were in the periphery, not the center and lacked sufficient profusion. Coal workers’ pneumoconiosis does not contain calcified granulomata or low density areas of necrosis and does not involve the pleura.

Dr. Muto’s interpretation establishes the presence of pneumoconiosis. However, Dr. Muto’s finding is outweighed by the probative consensus of Dr. Scatarige and Dr. Wheeler, who are also both qualified radiologists and B readers, that the May 23, 2005 CT scan is negative for pneumoconiosis. As a result, the preponderance of the CT scan evidence, the May 23, 2005 radiographic study, is negative for pneumoconiosis.

Medical Opinion

To help evaluate the diverse medical opinion, a review of the remaining objective medical evidence in the record is helpful.

Pulmonary Function Tests

Exhibit	Date Doctor	Age Height	FEV₁ pre²² post²³	FVC pre post	MVV pre post	FEV₁/ FVC pre post	Qualified²⁴ pre post	Comments
CX 4	January 6, 2004 Dr. Al-Asadi	57 71"	2.44	2.89	93	84%	No ²⁵	
CX 4	January 6, 2005 Dr. Al-Asadi	58 71"	2.18 2.26	2.76 2.74	89	79% 83%	No ²⁶ No	
DX 12	March 30, 2005 Dr. Zaldivar	58 70"	2.46	4.67	---	79%	No ²⁷	Fair effort. Mild restriction.
DX 13	May 23, 2005 Dr. Crisalli	58 71"	2.28 2.51	2.88 2.97	109	79% 84%	No No	No obstruction. Mild restrictive defect. No post-bronchodilator improvement.
CX 4	January 5, 2006 Dr. Al-Asadi	59 71"	2.13 2.15	2.64 2.62	89 99	81% 82%	Yes ²⁸ No	
CX 4	January 8, 2007 Dr. Al-Asadi	60 71"	2.18 2.30	2.62 2.90	84	83% 79%	No ²⁹ No	
CX 4	January 8, 2008 Dr. Al-Asadi	61 71"	2.06 2.03	2.73 2.75	66	75% 74%	Yes ³⁰ No	

²²Test result before administration of a bronchodilator.

²³Test result after administration of a bronchodilator.

²⁴Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV₁ must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), and either the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, or the ratio FEV₁/FVC has to be equal to or less than 55%.

²⁵For 71" and age 57, the qualifying FEV₁ value is 2.17 or less.

²⁶For 71" and age 58, the qualifying FEV₁ value is 2.15 or less.

²⁷For 70" and age 58, the qualifying FEV₁ value is 2.06 or less.

²⁸For 71" and age 59, the qualifying FEV₁ value is 2.14 or less and the qualifying FVC and MVV values are 2.72 or less and 86 or less respectively.

²⁹For 71" and age 60, the qualifying FEV₁ value is 2.12 or less.

³⁰For 71" and age 61, the qualifying FEV₁ value is 2.11 or less and the qualifying FVC and MVV values are 2.68 or less and 84 or less respectively.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ² (rest) pCO ² (exercise)	pO ² (rest) pO ² (exercise)	Qualified	Comments
DX 12	March 30, 2005 Dr. Zaldivar	32 28	88 71	No ³¹ Yes ³²	Hypoxemia with exercise.
DX 13	May 23, 2005 Dr. Crisalli	38	81	No ³³	

Dr. Stafford Warren
(CX 2)

In the spring of 2003, Mr. Day presented for evaluation with a one year history of continuous chest squeezing/tightness and chronic dyspnea. Although a stress test did not reveal any ischemic electrocardiographic abnormalities and Mr. Day did not experience any chest pain, a radiologist believed there was “a probable small anterior wall myocardial infarction.” Consequently, he was referred to Dr. Warren on September 2, 2003 for a diagnostic cardiac catheterization. Mr. Day had been a deep coal miner for 34 years. He smoked one and a half packs of cigarettes per day for 25 to 30 years but quit 5 years prior to the examination. Mr. Day had a history of black lung, indicating that he had 30% black lung. Upon examination, Dr. Warren noted Mr. Day’s lungs were clear. After conducting another stress test at the request of Mr. Day, Dr. Warren concluded Mr. Day did not need a cardiac catheterization. The physician diagnosed continuous chest tightness of uncertain etiology, false positive stress test, and abnormal chest x-ray.

Dr. Lo’ Ay Al-Asadi
(CX 1)

On January 6, 2004, Dr. Al-Asadi examined Mr. Day due to an abnormal chest x-ray. Mr. Day reported progressive shortness of breath for the previous two years and occasional wheezing. Mr. Day smoked one pack of cigarettes per day for 20 years, quitting in 1999. An active coal miner, Mr. Day had mined coal for 34 years. Upon examination, Dr. Al-Asadi found good air entry bilaterally with no active wheezing, rales or rhonchi. His pulmonary function test showed a moderate restrictive pattern with no sign of obstructive lung disease. Mr. Day’s digital September 2003 chest x-ray revealed bilateral upper lobe lesions consistent with coal workers’ pneumoconiosis. Dr. Al-Asadi opined the “abnormalities on the chest x-ray [were] most probably secondary to coal workers’ pneumoconiosis.” The physician additionally concluded that Mr. Day’s moderate restrictive lung disease was secondary to coal mine dust inhalation. Dr. Al-Asadi advised Mr. Day “to pull out of the mines as soon as possible.”

³¹ For the pCO² of 32, the qualifying pO² is 68 or less.

³² For the pCO² of 28, the qualifying pO² is 72 or less.

³³ For the pCO² of 38, the qualifying pO² is 62 or less.

Mr. Day was seen again on May 6, 2004. Dr. Al-Asadi noted he had a history of coal workers' pneumoconiosis. Mr. Day's digital January 6, 2004 chest x-ray demonstrated coal workers' pneumoconiosis with no change from his prior x-ray. Mr. Day had quit his coal mining job since his last appointment. Mr. Day did not report a history of increased shortness of breath or cough. Upon examination, Dr. Al-Asadi determined Mr. Day's lungs had fair air entry bilaterally with no active wheezing, rhonchi, or rales.

Dr. Al-Asadi reexamined Mr. Day on September 7, 2004. Mr. Day had a history of coal workers' pneumoconiosis. Dr. Al-Asadi commented that Mr. Day was doing "remarkably well since [his] last visit." Mr. Day reported no history of increased shortness of breath or cough. Mr. Day had fair air entry bilaterally with no active wheezing, rhonchi, or rales.

On January 6, 2005, Dr. Al-Asadi noted a mild increase in Mr. Day's dyspnea on exertion. Mr. Day had diminished air entry bilaterally with no active wheezing, rhonchi, or rales. Mr. Day's spirometry showed mild reduction in the FEV₁ and FVC from the prior year, but not a significant drop. The physician also observed that the film September 7, 2004 chest x-ray showed no change in his pneumoconiosis. Dr. Al-Asadi determined there was a mild deterioration both subjectively and objectively of Mr. Day's coal workers' pneumoconiosis.

During multiple office visits between May 3, 2005 and May 8, 2008, Dr. As-Asadi noted that Mr. Day had no increased shortness of breath or cough and continued to do "fairly well." He continued to have fair to diminished air entry bilaterally with no active wheezing, rales, or rhonchi. The spirometries and a digital January 8, 2007 chest x-ray showed no change.

Dr. George Zaldivar
(DX 13, CX 8, and CX 9)

Dr. Zaldivar, board certified in internal medicine, pulmonary medicine, and sleep medicine, conducted a medical examination of Mr. Day on March 30, 2005. Mr. Day worked in the mines from 1969 to 2004. His last job was as a shuttle car operator. Mr. Day smoked one pack of cigarettes per day from 1968 to 1999.

Mr. Day had a history of wheezing attacks. He presented with wheezing, dyspnea, and cough. Mr. Day's breath sounds were normal. His film chest x-ray showed complicated coal workers' pneumoconiosis. Mr. Day's pulmonary function test revealed a mild restriction and his arterial blood gas study resulted in an abnormal drop in pO₂. Dr. Zaldivar diagnosed restrictive lung impairment due to complicated coal workers' pneumoconiosis. Dr. Zaldivar opined Mr. Day was 100% disabled from returning to coal mine work.

In a July 16, 2008 deposition, Dr. Zaldivar reviewed his March 30, 2005 pulmonary assessment of Mr. Day, who was a shuttle car operator from 1969 to 2004. Mr. Day complained of attacks of wheezing, cough, and shortness of breath. He smoked one pack of cigarettes per day from 1968 to 1999. Mr. Day's chest x-ray showed coal workers' pneumoconiosis and a large Category C pulmonary opacity that qualified as complicated pneumoconiosis. Dr. Zaldivar based his complicated pneumoconiosis diagnosis solely on the chest film. The pulmonary function test showed a restrictive impairment of vital capacity.

Dr. Zaldivar opined that with complicated pneumoconiosis, one would usually see a restrictive and obstructive impairment, although obstruction may not be picked up in the pulmonary tests in some cases. Mr. Day's arterial blood gas studies showed a drop with exercise, which is abnormal. According to Dr. Zaldivar, a person could reasonably conclude that the pneumoconiosis seen in Mr. Day's x-ray was caused by his work in the coal mines based on his history.

Dr. Zaldivar acknowledged that complicated pneumoconiosis does not always cause a physiological pulmonary impairment. However, based on the exercise arterial blood gas study, which showed an abnormal drop in oxygenation, Mr. Day is totally disabled under the regulations.

Regarding differential diagnoses for the large pulmonary masses, Dr. Zaldivar noted that cancer and infectious disease such as tuberculosis or histoplasmosis were possible. However, those pulmonary diseases are associated with severe illness and Mr. Day's medical record does not indicate treatment for severe illness. The remaining two possibilities are sarcoidosis, which is generally benign, and pneumoconiosis. He further commented that other differential diagnoses that could cause the opacities seen in the chest x-ray were granulomas and cancer but they were unlikely based on the presentation.

Dr. Zaldivar acknowledged that Mr. Day's oxygen transfer at rest was normal. Likewise, the pulmonary function tests did not establish total disability.

As shuttle car operator, Mr. Day was required to perform manual labor when the equipment was down. Based on his drop in blood gas oxygenation with exercise, Dr. Zaldivar opined that Mr. Day would be totally disabled from performing his previous coal mine work.

Dr. Robert Crisalli
(DX 13, EX 5 and EX 8)

On May 23, 2005, Dr. Crisalli, board certified in internal medicine and pulmonary disease, examined Mr. Day and diagnosed coal workers' pneumoconiosis and emphysema. Mr. Day worked in the coal mines for 34 years, retiring in January 2004. His last job was as a shuttle car operator which at times required him to lift up to 50 pounds. Mr. Day smoked one pack of cigarettes per day for 20 years stopping in 1999. He complained of 15 to 20 years of shortness of breath, cough productive of sputum, orthopnea, chest pain on exertion, and occasional paroxysmal nocturnal dyspnea.

Upon examination, Dr. Crisalli noted diminished chest wall motion bilaterally and diminished breath sounds bilaterally. His pulmonary function tests showed no evidence of obstruction but did reveal a mild restrictive defect, mild air trapping, and moderate diffusion impairment. There was no improvement with bronchodilators. Mr. Day's chest x-ray demonstrated coal workers' pneumoconiosis, and a type B large opacity. The interpretation of the CT scan done at the exam showed bilateral perihilar and upper lobe densities compatible with

coal workers' pneumoconiosis, although a physician would need older CT scans to rule out neoplasm.

Dr. Crisalli opined Mr. Day had coal workers' pneumoconiosis based on the chest x-ray and CT scan. He had a mild restrictive defect and moderate diffusion impairment. Mr. Day had normal resting arterial blood gas studies. Dr. Crisalli could not obtain an exercise arterial blood gas sample because Mr. Day had inadequate collateral circulation about both his wrists. Dr. Crisalli opined Mr. Day had coal workers' pneumoconiosis but retained the pulmonary functional capacity to perform his previous job in the coal mines or a job requiring similar effort outside the mines. At the same time, Dr. Crisalli agreed to reassess his conclusions upon review of Dr. Zaldivar's exercise arterial blood gas study and radiographic reviews by Dr. Wheeler.

In a subsequent February 2, 2009 deposition, Dr. Crisalli indicated that he had reviewed additional respiratory test and radiographic evidence, including Dr. Zaldivar's exercise arterial blood gas study and Dr. Wheeler's CT scan interpretation. Based on this new medical evidence, and for several reasons, Dr. Crisalli significantly revised his pulmonary diagnosis, concluding: a) Mr. Day did not have coal workers' pneumoconiosis, and b) Mr. Day was totally disabled.

Although numerous chest x-rays showed evidence of coal workers' pneumoconiosis, Dr. Wheeler's interpretation of the CT scan indicated the absence of simple pneumoconiosis in the background and the location of the large masses in apex and periphery, involving the pleura. Additionally, some of the lesions were calcified. These CT findings were consistent with granulomatous disease, rather than pneumoconiosis.

Dr. Crisalli further explained that coal workers' pneumoconiosis develops at the junction where small airways divide, "the air makes the turn, the coal dust doesn't and it impacts on the tissue." If the coal dust causes a fibrotic reaction, then a coal macule, or lesion, develops from cells surrounding the coal mine dust. If a chest x-ray indicates such lesions but the more sensitive CT scan does not, then a physician has to conclude "there is no lesion."

The location of opacities in the pleura is significant because "pleural involvement does not occur with coal workers' pneumoconiosis, but it does commonly occur with granulomatous lung disease of an infectious origin in particular."

In addition, the calcification present likely indicates that Mr. Day has tuberculosis or histoplasmosis not coal workers' pneumoconiosis. The focal necrosis signifies granulomatous or infectious disease, which has destroyed a portion of the lung.

Further, Mr. Day's disease was seen predominantly in the peripheries, which usually indicates infectious disease that caused granulomatous lung disease such as tuberculosis or histoplasmosis because the periphery is where oxygen tension is highest, so that is where the organism grows best. On the other hand, coal workers' pneumoconiosis tends to develop in the middle portions of the lungs. If it occurs in the upper lungs, pneumoconiosis will be in the center portion and not the periphery or pleura.

Based on Dr. Zaldivar's exercise arterial blood gas study, which showed a significant drop in oxygenation during exercise, Dr. Crisalli concluded Mr. Day is totally disabled. However, his reduction in respiratory function is not related to coal dust exposure. The impairment is due to the granulomatous lung disease.

With the information in front of him, Dr. Crisalli was unable to come to a definitive diagnosis "except to say that there's a granulomatous lung disease with any of the possible causes."

Dr. Crisalli believed Mr. Day had a granulomatous disease even though nothing in Mr. Day's history would have suggested a history of granulomatosis.

In light of the x-ray and CT scan reading associated with his May 2005 pulmonary evaluation, Dr. Crisalli diagnosed pneumoconiosis and emphysema. However, later, Dr. Crisalli abandoned the coal workers' pneumoconiosis diagnosis but retained the emphysema finding. Dr. Crisalli does not believe that Mr. Day's emphysema contributed to Mr. Day's impairment. Dr. Crisalli changed his opinion based on the additional x-ray reports and Dr. Wheeler's more definitive and detailed CT scan report, which discussed location, calcification, pleura involvement and the absence of small nodular densities.

Dr. Paul Wheeler³⁴
(EX 6)

Dr. Wheeler, a B reader and board certified radiologist, was deposed on February 10, 2009. Having reviewed the radiographic record, he provided his multiple reasons for concluding the radiographic evidence indicated Mr. Day's large pulmonary masses were not associated with pneumoconiosis. In particular, the masses were not complicated pneumoconiosis given the distribution and profusion of the nodules, the pleura involvement, and the calcification in the smaller right lung mass. In light of several years of radiographic studies, Dr. Wheeler believes cancer is excluded.

Dr. Wheeler also noted that even if Mr. Day has never received a diagnosis of tuberculosis or histoplasmosis, another common form of tuberculosis remains a viable explanation.

Dr. Wheeler noted that in the mid-1970's, physicians saw some coal workers' pneumoconiosis nodules extending to the periphery but only in miners who worked unprotected during and before World War II. However, typically, the coal workers' pneumoconiosis nodules that produce the large pulmonary opacities of complicated pneumoconiosis are in the central portions of the mid and upper lungs.

Dr. Wheeler acknowledged that on very rare occasions, all the smaller nodules may come together to form a large opacity such that an underlying profusion is not present.

³⁴Since the Employer has one evidentiary slot open for a medical opinion under regulatory evidentiary restrictions, 20 C.F.R. § 725.414, I consider Dr. Wheeler's deposition admissible as the second medical opinion.

Dr. Wheeler acknowledged that a person could have both changes related to coal dust exposure and histoplasmosis at the same time but a physician could not diagnose that situation based solely on an x-ray. Instead, a physician uses “the x-ray to find out where to biopsy and then [goes] after the lesion.” Usually histoplasmosis will self-cure but if the disease gets out of bounds and goes systemic then it requires treatment.

Discussion

Dr. Al-Asadi, Dr. Warren, and Dr. Zaldivar opined that Mr. Day had pneumoconiosis. Dr. Crisalli and Dr. Wheeler reached a contrary conclusion. Due to this conflict in medical opinion I must evaluate the probative value of the respective opinions 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 and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (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 objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician’s conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Third, according to 20 C.F.R. § 718.104(d), in evaluating medical opinion, 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 first find that although a treating physician, Dr. Warren’s terse annotation of a history of black lung has little probative value due insufficient reasoning. Specifically, Dr. Warren did not render an independent diagnosis and failed to discuss the underlying medical evidence that support a historical diagnosis of pneumoconiosis.

Next, an assessment of the probative value of the remaining medical opinions is facilitated by considering the issues of clinical and legal pneumoconiosis separately with a preliminary resolution regarding the conflict in the radiographic evidence.

Clinical Pneumoconiosis

Since the remaining three medical opinions relied on multiple and different types of radiographic studies to diagnose clinical pneumoconiosis, I must first address the conflicting results from the film chest x-rays, digital chest x-rays, and CT scan. As previously discussed, the preponderance of the film chest x-ray evidence is negative for pneumoconiosis, the preponderance of the digital chest x-rays is positive for the pneumoconiosis, and the May 23, 2005 CT scan is negative for pneumoconiosis.

In considering this conflict, I first note that the two types of chest x-rays essentially stand in equipoise, rendering the cumulative chest x-ray evidence actually inconclusive for pneumoconiosis; whereas, the remaining radiographic study, the May 23, CT scan remains negative for pneumoconiosis. Additionally, and more significantly, based on the representations by Dr. Wheeler and Dr. Crisalli that a CT scan provides better detail and is “far more sensitive” than a chest x-ray in diagnosing pneumoconiosis, I considered the May 23, 2005 scan to be a more accurate radiographic representation of Mr. Day’s lungs and thus more probative than either the film or digital chest x-ray evidence in the record. Consequently, I find that the chest x-ray evidence is inconclusive for pneumoconiosis and the May CT scan is definitively negative for pneumoconiosis. With these radiographic determinations in mind, I return to the conflicting medical opinion.

As a treating physician with multiple contacts with Mr. Day, Dr. Al-Asadi was well positioned to provide an exceptionally probative opinion. However, based on reliance on inaccurate documentation, his diagnosis of clinical pneumoconiosis suffers a loss of probative value. Specifically, Dr. Al-Asadi rendered his diagnosis on digital and film chest x-rays that were positive for pneumoconiosis. However, I have determined that when considered together the digital and film chest x-ray evidence is actually inconclusive for pneumoconiosis.

While he conducted a thorough pulmonary examination, Dr. Zaldivar’s diagnosis of pneumoconiosis his diminished probative value due to his reliance on a positive film chest x-ray which is inconsistent with digital and film chest x-ray evidence that is actually inconclusive for the presence of pneumoconiosis.

Having conducted a pulmonary evaluation, Dr. Crisalli presented a documented medical opinion. While initially diagnosing clinical pneumoconiosis based on a chest x-ray and a positive interpretation of the May 23, 2005 CT scan, Dr. Crisalli subsequently and reasonably concluded that Mr. Day did not have clinical pneumoconiosis based on Dr. Wheeler’s subsequent negative and more detailed interpretation of the May 23, 2005 CT scan, which is consistent with my determination that the consensus of Dr. Wheeler and Dr. Scatarige outweighs Dr. Muto’s contrary interpretation of the CT scan study.

While Dr. Wheeler's referenced prior radiographic studies of older coal miners, his conclusion that the CT scan evidence in Mr. Day's case demonstrates that he does not have clinical pneumoconiosis remains viable given his specific identification of, and emphasis on, the necrosis and calcification of the masses in Mr. Day's chest in his CT scan interpretation.

Legal Pneumoconiosis

Dr. Wheeler did not address the presence of legal pneumoconiosis.

In his initial evaluation, after diagnosing clinical pneumoconiosis, Dr. Al-Asadi opined that Mr. Day's moderate restrictive impairment was attributable to coal dust inhalation. However, his diagnosis of legal pneumoconiosis has diminished probative value due to a reasoning insufficiency. Besides his diagnosis of clinical pneumoconiosis based on positive chest x-rays, which has diminished probative value since the preponderance of the chest x-ray evidence is actually inconclusive, Dr. Al-Asadi provided no explanation for his additional finding that Mr. Day's respiratory problem was related to coal mine dust inhalation. Other than his repeated reference to positive chest x-rays, Dr. Al-Asadi's treatment notes contain no discussion of how any other objective medical evidence besides positive chest x-rays led to his diagnosis of legal pneumoconiosis.

Dr. Zaldivar's finding that Mr. Day's disabling respiratory impairment was due to pneumoconiosis also suffers a loss of probative since he relied solely on the presence of complicated pneumoconiosis to render that finding, while the evidentiary record fails to establish the presence of complicated pneumoconiosis.

In light of Dr. Wheeler's detailed findings in the CT scan, which showed the location of the pulmonary abnormalities in the peripheral areas of lungs, involvement of the pleura, calcification, which are consistent with granulomata, and the absence of small nodularities in area typically associated with coal mine dust lesions, Dr. Crisalli reasonably concluded that the abnormal masses in Mr. Day's lungs impacting his respiratory capacity were due to granulomatous lung disease and not his coal mine dust exposure. Additionally, given the restrictive nature of Mr. Day's impairment, Dr. Crisalli also reasonably concluded that the noted emphysema, regardless of etiology, was not impacting his respiratory function or contributing to his impairment.

Conclusion

For documentation and reasoning issues, the opinions of Dr. Al-Asadi and Dr. Zaldivar have diminished probative value. The probative consensus of Dr. Wheeler and Dr. Crisalli establishes that Mr. Day did not have clinical pneumoconiosis and the probative opinion of Dr. Crisalli establishes that Mr. Day did not have legal pneumoconiosis. Consequently, having established by a preponderance of the probative objective medical evidence that Mr. Day does not have either clinical or legal pneumoconiosis, the Employer has rebutted the presumption invoked by Mr. Day under 20 C.F.R. § 718.305.

Chest X-Rays

As previously affirmed by the BRB, the weight of the film chest x-ray evidence is insufficient to establish the presence of simple pneumoconiosis under 20 C.F.R. § 718.202(a)(1).³⁵

Medical Opinion

Finally, after considering the entire radiographic record, including the digital chest x-rays and CT scan, I find the preponderance of the probative medical opinion, consisting the consensus of Dr. Crisalli and Dr. Wheeler regarding clinical pneumoconiosis and Dr. Crisalli's opinion on the issue of legal pneumoconiosis, establishes that Mr. Day did not have pneumoconiosis. Accordingly, Mr. Day is unable to establish the presence of pneumoconiosis through probative medical opinion under 20 C.F.R. § 718.202(a)(4).

Summary

Although Mr. Day invoked the rebuttal presumption under 20 C.F.R. § 718.305, the Employer has rebutted that presumption under 20 C.F.R. § 718.305(a) by proving through the preponderance of the probative CT scan and medical opinion that Mr. Day does not have clinical or legal pneumoconiosis. Correspondingly, Mr. Day is unable to prove the presence of pneumoconiosis through film chest x-ray evidence, regulatory presumption, or medical opinion under 20 C.F.R. §§ 718.202(a)(1)(3) and (4).

Compton Analysis

Since Mr. Day is unable to establish the presence of pneumoconiosis through the preponderance of the probative film chest x-ray evidence or medical opinion, consideration of all that evidence together understandably does not establish the presence of pneumoconiosis.

Conclusion

Although Mr. Day invoked the presumption under 20 C.F.R. § 718.305, the Employer has rebutted that presumption. Further, the preponderance of the probative film chest x-ray evidence and medical opinion fails to establish that Mr. Day has pneumoconiosis. Consequently, since Mr. Day has failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, his claim for black lung disability benefits must be denied.

³⁵Although the preponderance of the digital chest x-rays is positive for pneumoconiosis, such radiographic evidence is only admissible as other medical evidence under 20 C.F.R. § 718.107(b). Specifically, in *Webber v. Peabody Coal Co*, 23 B.L.R. 1-123 (2006)(en banc) (J. Boggs, concurring), the BRB adopted the Director's position and held that digital x-ray interpretations are not considered "chest x-ray" evidence under 20 C.F.R. §§ 718.101(b), 718.102, 718.202(a)(1), and Appendix A to Part 718 as they do not satisfy the quality standards at Appendix A.

ORDER

Accordingly, the claim of Mr. MICHAEL S. DAY, SR., for black lung disability benefits under the Act is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: May 31, 2011
Washington, DC

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).