



Issue Date: 24 January 2008

In the Matter of

Mr. G.E.S.,¹
Claimant

Case No.: 2007 BLA 5305

v.

DICKINSON RUSSELL COAL COMPANY/
BIRMINGHAM FIRE INSURANCE COMPANY
Employer/Insurer

and

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

Appearances: Mr. Frederick K. Muth, Attorney
For the Claimant

Mr. H. Ashby Dickerson, Attorney
Mr. Timothy W. Gresham, Attorney (on brief)
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER –
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. G.E.S. 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.

¹Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

Procedural Background

On November 4, 2005, Mr. S. filed his claim for black lung disability benefits (DX 2).² The District Director denied the claim on October 23, 2006 (DX 30). On October 27, 2006, through counsel, Mr. S. appealed the adverse decision (DX 32). In response, the District Director forwarded the claim to the Office of Administrative Law Judges on December 1, 2006 (DX 35). Pursuant to a Notice of Hearing, dated February 5, 2007, I conducted a hearing in Bristol, Tennessee³ on May 15, 2007 with Mr. S., Mr. Muth, and Mr. Dickerson. My decision in this case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 37, CX 1, CX 2, and EX 1 to EX 8.

ISSUE

Whether Mr. G.E.S. has complicated pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. S. has at least 16 years of coal mine employment, and b) Dickenson Russell Coal Company is the responsible operator. (TR, p. 7-8)

Preliminary Findings

Born on September 21, 1966, Mr. S. married Mrs. L.S. on September 30, 1989. They have two children, Danielle, born October 3, 1992, and Tyler, born April 26, 1994. Mr. S. started mining coal around 1985. He continues to work as a coal miner for the Employer in Virginia, operating an underground, continuous miner. Mr. S. has never smoked cigarettes. (DX 2, DX 7, DX 10, DX 14, and TR p.15-18)

Issue – Complicated Pneumoconiosis

In order to receive black lung disability benefits under the Act, a claimant must prove by preponderance of the evidence four elements of entitlement. First, the miner must establish the presence of pneumoconiosis.⁴ 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.⁵ Third, the miner has to demonstrate he is totally disabled.⁶ And fourth, the miner must prove the total disability is due to pneumoconiosis.⁷

²The 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.

³Although I conducted the hearing in Bristol, Tennessee, Mr. S. is employed as a coal miner in Virginia (TR, p. 17).

⁴20 C.F.R. § 718.202.

⁵20 C.F.R. § 718.203(a).

The third element of entitlement – total disability – is the focus in this case. Since Mr. S. is presently working as a coal miner, the only viable means for him to prove total disability while still employed is by invoking the irrebuttable presumption of total disability due to coal workers’ pneumoconiosis under 20 C.F.R. § 718.304 by establishing that he has complicated coal workers’ pneumoconiosis. In the Black Lung Benefits Act, 30 U.S.C. § 921(c)(3)(A) and (C), as implemented by 20 C.F.R. § 718.304(a), Congress determined that if a miner is suffering from a chronic dust disease of the lung “which when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C...there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis. . . .”⁸ This type of large opacity is called “complicated pneumoconiosis.” 20 C.F.R. §§ 718.304(b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit⁹ in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by “congressionally defined criteria.” As a result, the statute’s definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. § 921(c)(3)(A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. §§ 921(c)(3)(B) and (C). *Id.* at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. §§ 921(c)(3)(B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. § 921(c)(3)(A).¹⁰ Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community’s definition of the disease. *Id.* at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated,

⁶20 C.F.R. § 718.204(b).

⁷20 C.F.R. § 718.204(a).

⁸The definition section of the standard ILO chest x-ray classification worksheet, Form CM 9331, states concerning large opacities that “the categories are defined in terms of dimensions of the opacities.” The form then lists three categories, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities “larger or more numerous than Category A” whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

⁹Mr. S.’s case arises within the jurisdiction of this court.

¹⁰*See also* 20 C.F.R. §§ 718.304(b) and (c).

if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id.*

Subsequently, in *Clinchfield Coal Co. v. Lambert*, No. 06-1154, 206 Fed. Appx. 252, 255 (4th Cir. Nov. 17, 2006), the court emphasized that *Scarbro* does not shift the burden of persuasion to the Employer to establish that the opacities do not exist or are due to a disease other than pneumoconiosis. Instead, *Scarbro* means “that once the claimant presents legally sufficient evidence (here, x-ray evidence of large opacities classified as category A, B, or C in the ILO system, *see* 30 U.S.C. § 921(c)(3)), he is likely to win unless there is contrary evidence (typically offered by the employer) in the record.” However, during this process the burden of proof remains at all times with claimant.

Additionally, after *Scarbro*, referencing a 1993 Fourth Circuit case, *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993), the Benefits Review Board (“BRB” and “Board”) in *Mullins v. Plowboy Coal Co.*, BRB No. 04-0716 BLA (July 8, 2005) (unpub.) emphasized that in determining whether complicated pneumoconiosis is present, an ALJ “must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis.” That mandate is consistent with other case law indicating that all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

Further, in *Mullins v. Plowboy Coal Co.*, BRB No. 06-0900 BLA (Aug. 30, 2007) (unpub.), the Board directed that during the adjudication of each subsection under 20 C.F.R. § 304, chest x-ray, biopsy/autopsy, and other medical evidence including CT scans, an administrative law judge must determine whether the preponderance of the evidence under the subsection establishes both a) the presence of pneumoconiosis (chronic lung disease) and b) the presence of a large pulmonary opacity greater than one centimeter.

In light of these statutory, regulatory, and judicial principles, and considering the BRB’s specific directions, my adjudication of whether Mr. S. is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a two step process.

First, I must determine whether the Claimant is suffering a chronic lung disease because: A) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C, consistent with pneumoconiosis, under recognized standards,¹¹ 20 C.F.R. § 718.304(a); or B) biopsy evidence shows massive lesions in the lungs, which are

¹¹According to the Board, an ILO interpretation that notes a mass that is larger than one centimeter in the comments section but does not diagnose pneumoconiosis with an opacity size of A, B, or C is not sufficient to assist a claimant in establishing complicated pneumoconiosis under 20 C.F.R. § 718.304(a). *Mullins v. Plowboy Coal Co.*, BRB No. 06-0900 BLA (Aug. 30, 2007) (unpub.), slip op. fn 8.

equivalent to chest x-ray evidence of large opacities and pneumoconiosis, 20 C.F.R. § 718.304(b); or C) other diagnostic results exist which are equivalent to the requisite chest x-ray evidence of large opacities and pneumoconiosis, 20 C.F.R. § 718.304(c).

Second, if the presence of large pulmonary opacities, consistent with pneumoconiosis, is established, I must also evaluate all the relevant medical evidence together to determine whether the claimant has complicated pneumoconiosis.

1. Presence of Large Pulmonary Opacities Consistent with Pneumoconiosis

A. Chest X-Rays, 20 C.F.R. § 718.304(a)

Date of x-ray	Exhibit	Physician	Interpretation
July 12, 2005	CX 2	Dr. D. Patel, BCR, B, ¹²	Positive for pneumoconiosis, profusion 2/1, ¹³ type p/s opacities. ¹⁴ Large densities present in upper lobes, possible PMF (progressive massive fibrosis) formation or malignancy.
(same)	EX 3	Dr. Wheeler, BCR, B	Negative for pneumoconiosis and large pulmonary opacity consistent with pneumoconiosis. Ill-defined 4.5 cm mass right apex and ill-defined mass infiltrate left apex, compatible with granulomatous disease and interstitial fibrosis due to histoplasmosis or TB (tuberculosis).

¹² The 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).

¹³ The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1.

¹⁴ There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

February 6, 2006	DX 16	Dr. D. Patel, BCR, B	Positive for pneumoconiosis, profusion 2/2, type p/q opacities, and large Category A opacity consistent with pneumoconiosis.
(same)	DX 15	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion 1/2, type t/q opacities. Negative for large pulmonary opacity consistent with pneumoconiosis. Small opacities more likely sarcoidosis or TB.
June 30, 2006	CX 1	Dr. Ahmed, BCR, B	Positive for pneumoconiosis, profusion 2/3, type q opacities, and large Category B opacity consistent with pneumoconiosis. Large opacities greater than 10 mm in both upper lungs. Coalescence of small pneumoconiosis opacities. Emphysema present.
(same)	CX 1	Dr. Miller, BCR, B	Positive for pneumoconiosis, profusion 3/2, type q/r opacities, and large Category B opacity consistent with pneumoconiosis. 4 x 5cm large opacity in right upper lung and 4 x 6 cm large opacity in left upper lung. Coalescence of small pneumoconiosis opacities.
(same)	EX 4	Dr. Wheeler, BCR, B	Negative for pneumoconiosis and large pulmonary opacity consistent with pneumoconiosis. 5 cm mass right apex and ill-defined mass left apex, compatible with conglomerated granulomatous disease, histoplasmosis, or possible TB. Pneumoconiosis ruled out because no symmetrical small nodules in middle and upper lung zones. Recommend biopsy or CT scan for exact diagnosis ¹⁵
July 26, 2006	DX 15	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion 1/1, type t/q opacities. Negative for large pulmonary opacity consistent with pneumoconiosis. Upper lung infiltrates, probably TB or sarcoidosis. Although pneumoconiosis may be present, most of the changes are due to a disease process that is not pneumoconiosis.

In the July 12, 2005 chest x-ray, Dr. Wheeler, a dual qualified radiologist, did not observe a large pulmonary opacity consistent with pneumoconiosis. Dr. D. Patel, also a dual qualified radiologist, noted the presence of large densities that may be PMF or a malignancy. In resolving this conflict, although both physicians are well qualified, Dr. Patel's interpretation has diminished probative value for two reasons. First, Dr. Patel did not present an ILO classification as to the size of large pulmonary opacity. Second, Dr. Patel was equivocal on whether the opacity was associated with pneumoconiosis. As a result, based on Dr. Wheeler's probative assessment, I find the July 12, 2005 chest x-ray negative for a large pulmonary opacity consistent with pneumoconiosis.

After reviewing the February 6, 2006 chest x-ray, Dr. D. Patel and Dr. Scott, a dual qualified radiologist, reached conflicting conclusions. Dr. Patel reported the presence of a large pulmonary opacity consistent with pneumoconiosis. Dr. Scott considered the film negative for

¹⁵Dr. Wheeler also noted that Mr. S. was "quite young" and since the government became more active in controlling coal mine dust in the 1970s, complicated coal workers' pneumoconiosis was more typical in coal mine drillers who worked unprotected before and during WW II.

such a large opacity. Since both doctors are similarly well qualified, their professional standoff renders the February 6, 2006 chest x-ray inconclusive for complicated pneumoconiosis.

Dr. Ahmed, a dual qualified radiologist, and Dr. Miller, a dual qualified radiologist, identified a large pulmonary opacity consistent with pneumoconiosis in the June 30, 2006 chest x-ray. Dr. Wheeler disagreed. Since all three radiologists have the same qualifications, the consensus of Dr. Ahmed and Dr. Miller outweighs Dr. Wheeler's contrary opinion. As a result, the June 30, 2006 chest x-ray is positive for a large pulmonary opacity consistent with pneumoconiosis.

Finally, based on the uncontested interpretation by Dr. Scott, the July 26, 2006 chest x-ray is negative for the presence of a large pulmonary opacity consistent with pneumoconiosis.

In summary, setting aside the inconclusive radiographic study of February 6, 2006, the June 30 2006 chest x-ray is positive for a large pulmonary opacity consistent with pneumoconiosis and the July 12, 2005 and July 26, 2006 chest x-rays are negative for a large pulmonary opacity consistent with pneumoconiosis.¹⁶ Accordingly, Mr. S. is unable to establish the presence of complicated pneumoconiosis through the preponderance of the chest x-rays under 20 C.F.R. § 718.304(a).

B. Biopsy, 20 C.F.R. § 718.304(b)

Mr. S. has not submitted a biopsy report to support his claim. As a result, he is unable to establish complicated pneumoconiosis under 20 C.F.R. § 718.304(b).

C. Other Diagnostic Evidence, 20 C.F.R. § 718.304(c)

In Mr. S.'s case, one type of diagnostic evidence has been presented – a July 22, 2005 CT scan.¹⁷

In the July 22, 2005 CT scan, Dr. Petrozzo observed bilateral upper lobe densities that were irregular in appearance and blended with the surrounding chronic changes (CX 2). Dr. Petrozzo opined that the densities were “most likely due to PMF” although he noted the presence of a possible underlying malignancy.

¹⁶Had Dr. Patel's interpretation been fully probative, the July 12, 2005 chest x-ray would be inconclusive at best due to the conflicting assessments by similarly qualified radiologists. In turn, the remaining two films, June 30, 2006 and July 26, 2006, would offset each other such that the preponderance of the chest x-rays would still not establish the presence of complicated pneumoconiosis.

¹⁷According to Dr. Hippensteel, a CT scan is a specialized radiographic analysis that is more sensitive than a chest x-ray in diagnosing lung disease because it provides greater detail by presenting multiple, sliced images of the lung (EX 8). Dr. Hippensteel indicated that a CT scan is a medically accepted diagnostic tool. Based on Dr. Hippensteel's comments, I find the CT scan is medically acceptable and relevant to the determination of Mr. S.'s entitlement to benefits. See *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.).

When Dr. Hippensteel reviewed the same CT scan, he reported biapical pleural-based densities – a 4 cm density in the left lung and a 2 cm density on the right side. He also observed q size small opacities “separate” from the large lesions (DX 15 and EX 8). In Dr. Hippensteel’s opinion, the large densities were not indicative of complicated pneumoconiosis due to their location in the upper lungs rather than the middle portion and the absence of coalescence of the smaller opacities around the large densities.

Although both physicians appear to have observed the same abnormalities in Mr. S.’s pulmonary CT scan, they reached conflicting opinions as to the cause of the pulmonary changes. Dr. Petrozzo highlighted the irregular shape of the large opacities and blending with the surrounding pulmonary changes to diagnose possible progressive massive fibrosis. Dr. Hippensteel relied on the location of the large opacities and the absence of coalescence of the associated smaller opacities to reach a contrary diagnosis. Although Dr. Petrozzo’s “most likely” diagnosis of PMF with the possibility of a malignancy introduces some ambiguity into his report, I find little viable means to differentiate their opposing opinions such that one is more conclusive than the other. As a result, I consider the July 22, 2005 CT scan inconclusive for complicated pneumoconiosis or the presence of large pulmonary opacities consistent with pneumoconiosis under 20 C.F.R. § 718.304(c).

Conclusion

The preponderance of the chest x-ray evidence is negative for a large pulmonary opacity consistent with pneumoconiosis. The record contains no biopsy evidence of progressive massive fibrosis. And, the other medical diagnostic evidence, a July 22, 2005 CT scan, is inconclusive for the presence of large pulmonary opacity consistent with pneumoconiosis or indicative of complicated pneumoconiosis. Consequently, Mr. S. is unable to prove presence of large pulmonary opacity consistent with pneumoconiosis under 20 C.F.R. § 718.304.

2. Consideration of All Medical Evidence

Although Mr. S. has failed to prove the presence of a large pulmonary opacity consistent with pneumoconiosis, I note that in light of the following medical evidence, especially considering Dr. Hippensteel’s extensive analysis, Mr. S. would not prevail in establishing the presence of complicated pneumoconiosis even if he succeed under the first step.

Pulmonary Function Tests

Exhibit	Date Doctor	Age Height	FEV ₁ pre ¹⁸ post ¹⁹	FVC pre post	MVV pre post	FEV ₁ /FVC pre post	Qualified ²⁰ pre post	Comments
DX 15	Oct. 10, 2005 Dr. Robinette	39 67"	2.98	4.09	---	73%	No	
DX 14	May 15, 2006 Dr. Forehand	39 68"	2.79	3.77	---	74%	No	
DX 15	Jul. 27, 2006 Dr. Hippensteel	39 69"	2.41 2.72	3.44 3.64	68	70% 75%	No No	
EX 1	Oct. 3, 2006 Dr. Patel	40 69"	2.69 2.96	3.68 3.76	88	73% 79%	No No	Mild obstruction
EX 5	Mar. 1, 2007 Dr. Turjman	40 69"	2.55	3.56	---	72%	No No	

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ₂ (rest) pCO ₂ (exercise)	pO ₂ (rest) pO ₂ (exercise)	Qualified
DX 15	Oct. 10, 2005 Dr. Robinette	40	92	No
DX 14	May 15, 2006 Dr. Forehand	37 41	88 72	No No
DX 15	Jul. 27, 2006 Dr. Hippensteel	39.8 42.1	86.8 70.2	No No
EX 1	Oct. 3, 2006 Dr. Patel	37 38.3	94.2 86.3	No No
EX 6	Mar. 1, 2007 Dr. Turjman	38.9 40.4	91.9 95.3	No No

Dr. J. G. Patel
(CX 2)

On July 20, 2005, Dr. J. Patel, Mr. S.'s treating physician, noted that over the past few years, Mr. S. developed increasing shortness of breath with exertion. A July 12, 2005 chest x-ray showed bilateral upper lobe densities suggestive of PMF and pneumoconiosis. Upon physical examination, Dr. Patel noted decreased breath sounds. The pulmonary function tests showed some abnormalities. Dr. Patel diagnosed bilateral pulmonary densities most likely coal workers' pneumoconiosis. He intended to obtain a CT scan and recommended that Mr. S. avoid further coal mine dust exposure.

¹⁸Test result before administration of a bronchodilator.

¹⁹Test result after administration of a bronchodilator.

²⁰Under 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%.

A September 26, 2005 TB test was negative.

On March 3, 2006, Dr. Patel again evaluated Mr. S. for shortness of breath. A recent chest x-ray was positive for complicated coal workers' pneumoconiosis and CT scan revealed mass densities in the lungs' apex "suggestive of progressive massive fibrosis." On examination, Dr. Patel again noted decrease breath sounds. Dr. Patel diagnosed complicated coal workers' pneumoconiosis.

Dr. J. Randolph Forehand
(DX 14)

On May 15, 2006, Dr. Forehand, board certified in allergy and pediatrics, conducted a pulmonary evaluation of Mr. S., a coal miner with more than 15 years mining. Mr. S. never smoked cigarettes. He complained about shortness of breath with exertion.

Upon physical examination, Dr. Forehand noted normal breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests and arterial blood gas studies were near normal. Based on the chest x-ray and Mr. S.'s history of coal mine employment, Dr. Forehand diagnosed clinical simple coal workers' pneumoconiosis. Dr. Forehand further concluded that Mr. S. did not have a totally disabling pulmonary impairment.

Dr. Kirk E. Hippensteel
(DX 15, EX 7, and EX 8)

On July 27, 2006, Dr. Hippensteel, board certified in pulmonary disease and internal medicine, evaluated Mr. S.'s pulmonary condition. Mr. S. was a current coal miner with a mining history of more than 17 years. He never smoked cigarettes. For the past two years, Mr. S. experienced shortness of breath with exertion. A recent TB test was negative.

Upon physical examination, Dr. Hippensteel noted normal chest sounds. The chest x-ray interpretation was positive for pneumoconiosis; however the radiologist believed the noted changes were more likely due to another disease process. The arterial blood gas study indicated mild hypoxemia during exercise. The pulmonary function test showed a partially reversible, mild restriction. A CT scan revealed the presence of two large pulmonary densities of 4 cm on the right upper lung and 2 cm left upper lung and smaller lesions. The large densities were not "typical for complicated pneumoconiosis because of the location." The small lesions may or may not be pneumoconiosis. Dr. Hippensteel also reviewed additional medical evidence, including Dr. Forehand's pulmonary evaluation, several pulmonary function tests, and other radiographic interpretations.

Based on his examination and record review, Dr. Hippensteel diagnosed probable sarcoidosis, a non-infectious granulomatous disease, with possible simple coal workers' pneumoconiosis. Mr. S. did not have complicated coal workers' pneumoconiosis. Dr. Hippensteel presented sarcoidosis rather pneumoconiosis as the primary diagnosis due to the rapid change in Mr. S.' pulmonary function since October 2002 which was inconsistent with the

“gradual change in function over time” associated with pneumoconiosis. Additionally, the noted reversibility in pulmonary function tests was inconsistent with the presence of pneumoconiosis. Mr. S. was not totally disabled.

At a May 3, 2007 deposition, after noting that Mr. S.’s TB test was negative, Dr. Hippensteel explained that a granulomatous disease is an inflammatory process that can be caused by TB infection, a fungal infection, such as histoplasmosis, or a non-infectious disease like sarcoidosis (of an unknown origin). Granulomatous diseases cause nodular opacities similar to pneumoconiosis. For several reasons, Dr. Hippensteel concluded Mr. S. did not have complicated pneumoconiosis. First, a negative TB test does not rule the inflammatory disease of process of sarcoidosis. Second, although the CT scan revealed a 4 cm density in the right lung and a 2 cm density in the left lung, Dr. Hippensteel did not observe a coalescence of the small opacities around the larger opacities. Third, Mr. S.’s large densities were in his upper lungs; whereas, complicated pneumoconiosis usually develops in the central areas of the lungs. Fourth, the smaller lesions associated with the large densities may be either pneumoconiosis or granulomatous disease. Fifth, sarcoidosis can present variable clinical presentations. In contrast, pneumoconiosis causes a fixed, non-variable impairment. Notably, Mr. S.’s pulmonary function tests showed some reversibility and variability indicative of the varying stages of an inflammatory disease process rather than pneumoconiosis. Sixth, Mr. S.’s angiotensin converting enzyme level was at the upper limit of normal. Sarcoidosis causes elevated levels of that enzyme. As a result, the enzyme test result is more consistent with sarcoidosis than pneumoconiosis. In light of the above consideration, although simple coal workers’ pneumoconiosis may be present, Dr. Hippensteel concluded that the large pulmonary opacities were lesions of sarcoidosis. Concerning disability, in light of the pulmonary function tests and arterial blood gas studies, Dr. Hippensteel opined that Mr. S. was not totally disabled from coal mine employment. Dr. Hippensteel acknowledged that Mr. S.’s only significant exposure history was his coal mine employment and some radiologists interpreted his chest x-rays as positive for complicated pneumoconiosis. However, Dr. Hippensteel rendered a “differential” diagnosis based on consideration of all the medical evidence including his CT scan interpretation and the demonstrated variability and reversibility in Mr. S.’s pulmonary function test results.

Discussion

Dr. Forehand did not mention whether Mr. S. had complicated pneumoconiosis. Dr. J. Patel diagnosed complicated pneumoconiosis. Dr. Hippensteel reached a contrary conclusion. Due to this conflict, I must assess the relative probative value of each respective opinion 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.²¹ 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 conclude that Dr. Forehand's assessment has diminished probative value due to incomplete documentation because he did not consider the CT scan evidence and multiple pulmonary function tests in this case.

As Mr. S.'s treating physician, Dr. J. Patel was well positioned to present a well documented and reasoned opinion regarding the presence of complicated pneumoconiosis. However, other than relying on chest x-ray and CT scan evidence "suggestive" of PMF, Dr. Patel provided no other rationale for his finding that Mr. S. "most likely" has complicated pneumoconiosis. In particular, Dr. Patel did not address whether other medical tests supported his complicated pneumoconiosis diagnosis.

Having reviewed all the objective medical evidence in the record, Dr. Hippensteel presented a well documented assessment on whether Mr. S. has complicated pneumoconiosis. During an extensive analysis, in addition to a supportive CT scan review, Dr. Hippensteel relied on variable and reversible pulmonary function test results and elevated enzyme levels to reach a well reasoned conclusion that Mr. S. suffers from sarcoidosis rather than complicated pneumoconiosis.

CONCLUSION

Having failed to prove the presence of a chronic dust disease, complicated pneumoconiosis, under 20 C.F.R. §§ 718.304(a)(b) and (c), Mr. S. is unable to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 that he is totally disabled due to coal workers' pneumoconiosis. Accordingly, in the absence of an irrebuttable presumption of total disability and since Mr. S. continues to work as a coal miner, his claim for black lung disability benefits must be denied.

²¹See *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.)

ORDER

The black lung disability claim of MR. G.E.S. is **DENIED**.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: January 24, 2008
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. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

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

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, 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).