

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 June 2011

In the Matter of:

DAVID A. VIERS, JR.,
Claimant,

CASE NO: 2008-BLA-5945

v.

BANNER BLUE COAL COMPANY,
Employer,

and

AMERICAN MINING INSURANCE
COMPANY,
Carrier,

and

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

Appearances: Mr. Jerry Murphree
Stone Mountain Health Services
For Claimant

John R. Sigmond, Esq.
Michael F. Blair, Esq.
Penn, Stuart & Eskridge
For Employer

Before: Paul C. Johnson, Jr.
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations provide, *inter alia*, compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents.

I conducted a hearing on this claim on March 23, 2010, in Abingdon, Virginia. The parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18. The Director of the Office of Workers Compensation Programs (“OWCP”) was not represented at the hearing. ALJ Exhibits 1-2, Director’s Exhibits (“DX”) 1-37, Claimant’s Exhibits (“CX”) 1-8, and Employer’s Exhibits (“EX”) 1-16 were admitted into evidence. Employer objected to CX 1 and 8, which I overruled. Claimant objected EX 1 and DX 12, which I also overruled. The record was held open after the hearing to allow the parties to submit written argument. Both parties submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

Procedural History

Mr. Viers filed his claim on August 20, 2007. [DX 2.] On June 6, 2008, the District Director issued a Proposed Decision and Order awarding benefits. [DX 26.] Employer disagreed with that determination and requested a formal hearing. [DX 28.] On August 28, 2008 the matter was forwarded to this Office for formal hearing. [DX 37.]

Applicable Standards

This claim was filed after the effective date of the current regulations; thus, the current regulations at 20 C.F.R. Parts 718 and 725 apply. 20 C.F.R. §§ 718.2 and 725.2. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 C.F.R. §§ 718.1, 718.202, 718.203, 718.204, and 725.103. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1556 (2010) (PPACA) revives the 15-year presumption at 30 U.S.C. § 921(c)(4), as implemented at 20 C.F.R. § 718.305.

Issues

The issues contested by the Employer are:

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;
2. Whether his pneumoconiosis arose out of coal mine employment;
3. Whether he is totally disabled from a pulmonary or respiratory standpoint; and
4. Whether his disability is due to pneumoconiosis.

[DX 35; Tr. 5.]

The parties stipulated to 28.52 years of coal mine employment. It is not contested and is supported by Claimant’s social security records. [Tr. 5-6.]

Findings of Fact and Conclusions of Law

A. Personal, Employment, and Smoking History

Claimant was born on October 25, 1956. [DX 2.] He married his current wife on August 7, 1976, and has no other dependents. [DX 2, 8.]

Based on Claimant's Social Security earnings records and the employment history he listed on his Form CM-911, Claimant began working in the nation's coal mines in 1975 at Smith Branch Coal Company, and worked at several different coal mines until September of 2005, when he was injured. [DX 4-6, Transcript of formal hearing ("Tr.") 20.] His jobs included: roof bolter, general inside miner, foreman, scoop operator, shuttle car operator, miner helper, loader helper, and car coupler. [DX 4.]

Claimant testified that his most recent employment was at Banner Blue Coal Company, which was formerly called Apollo Mining, where he worked for three years as a roof bolter. [Tr. 16.] In this position, he installed bolts to support and keep together the mine's roof and keep it from falling in. [Tr. 16-19.] Working at the face of the mine, he was exposed to rock dust, which would fall on him while he was drilling in the bolts. [Tr. 19.] He also ran the scoop, cutting machines, and bridges, and worked a jack setter. [Tr. 20.] Claimant quit working in the mines in 2005, when he was injured. [Tr. 20.]

Claimant testified that he went to Dr. Forehand for his Department of Labor examination and he is still seeing him on a regular basis. [Tr. 21.] He reported that he is extremely short of breath and that any exertion at all causes him to be completely out of breath. [Tr. 22.] He uses two inhalers – QVAR and Combivent – which were prescribed by Dr. Forehand. [Tr. 22.]

Claimant testified that he smoked for approximately twenty years, from 1978 to 1998. [Tr. 26.] He stated that he started smoking when he was 22 and smoked about a pack a day. [Tr. 27.] In Dr. Fino's medical report, he stated that Claimant smoked 1 pack a day for 15 years from 1974 until 1989. [EX 4.] Dr. Forehand and Dr. Rosenberg noted that Claimant smoked for 20 pack years. [CX 2, EX 3.] Since Claimant's testimony was under oath and with a full appreciation of its consequences, and Dr. Forehand and Dr. Rosenberg also noted that he smoked for 20 pack years, I find that Claimant has a smoking history of approximately 20 pack years, from 1978 to 1998.

B. Medical Evidence

1. X-Ray Evidence

The x-ray evidence in the record consists of the following:

Date of Study	Exhibit #	Date of Reading	Physician/Credentials	Film Quality	Reading
6/28/07	DX 22	7/24/07	Ahmed/B, BCR	1	r/q, 2/2 in six zones, large A opacities
	EX 14	5/12/08	Scatarige/B, BCR	2 (light)	r/q, 1/1 in five zones
10/01/07	DX 10	10/01/07	Forehand/B	1	r/q, 2/1 in six zones, large B opacities
	DX 11	10/19/07	Navani/B, BCR	3 (overexposed)	Quality only
	DX 12	11/06/07	Wheeler/B, BCR	1	q/t, 0/1 in six zones
	CX 5	7/08/08	Miller/B, BCR	2 (improper position)	r/q, 3/2 in six zones, large B opacities
	EX 13	5/12/08	Scott/B, BCR	1	r/u, 1/1 in four zones
10/20/08	CX 7	2/22/09	Alexander/B, BCR	1	r/q, 2/2 in six zones, large B opacities
	EX 3	10/31/08	Wheeler/B, BCR	1	q/q, 0/1 in four zones

2. Medical Opinion

The medical opinion evidence includes the opinions of the following physicians:

J. Randolph Forehand, MD

Dr. Forehand examined Claimant on behalf of the Department of Labor on October 1, 2007. [DX 14; CX 1-2.] He is board certified in pediatrics and in allergy and immunology, and is board eligible in pediatric pulmonary medicine. He is a B reader. Dr. Forehand took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He asserted that although Mr. Viers smoked cigarettes for 20 years, his spirogram had a FEV1 of 82% of predicted, thus he concluded that Mr. Viers' complaints of shortness of breath were not coming principally from

cigarette smoking. Dr. Forehand found that Claimant has complicated coal workers' pneumoconiosis, rapidly progressive massive fibrosis, and a totally and permanently disabling respiratory impairment from severe damage to his lungs. Further, he stated that there is no clinical evidence of TB, histoplasmosis or cancer and that there is no other medically reasonable explanation for Mr. Viers' complaint and findings. Additionally, Dr. Forehand did some diagnostic tests on January 7, 2008, and found that Mr. Viers tested negative for tuberculosis and histoplasmosis. [CX 3-4.]

Dr. Forehand refers to medical records from Dr. Byers, who performed a bronchoscopy on Claimant, making a preoperative diagnosis of conglomerate masses secondary to coal worker's pneumoconiosis (CWP). Dr. Forehand also refers to an exam performed by Dr. Gregory Fino on Mr. Viers on March 13, 2008 and explains that he finds it medically implausible that Dr. Fino categorically refuses to consider complicated coal worker's pneumoconiosis (CCWP) and progressive massive fibrosis (PMF) in his list of possible causes of Mr. Viers' lung disease after admitting earlier in his report that he was concerned about CCWP and PMF.

Dr. Forehand supplemented his medical report with letters dated January 22, 2008 and November 2, 2008 [CX 2, CX 1.] In the January 22, 2008 letter he addressed, at the request of OWCP, certain additional medical information with which he was provided. He disagreed with Dr. Wheeler's opinion that the large opacities on the x-ray of October 1, 2007 did not represent complicated pneumoconiosis, but were more likely granulomatous disease, tuberculosis, or histoplasmosis. He stated that a TB test with a positive candida control that he had performed showed that Mr. Viers did not have tuberculosis, and a blood test for histoplasmosis was negative. He also stated that Dr. Wheeler had co-written a peer-review article in April 1973 in which he said that pneumoconiosis is a disease characterized by the development of granulomatous nodules, and that Dr. Wheeler noted that Mr. Viers' x-ray changes were consistent with granulomatous disease. Dr. Forehand also stated that a CT scan is better than an x-ray in demonstrating coal workers' pneumoconiosis, because in complicated pneumoconiosis, the background profusion of small opacities may be low and not easily seen on x-ray. Dr. Forehand also stated that the medical literature showed that masses of complicated pneumoconiosis can appear centrally or in the periphery of the lung involving the pleura, and therefore the fact that conglomerate masses are in the periphery does not make complicated pneumoconiosis less likely. Dr. Forehand also disagrees with Dr. Wheeler's observation that Mr. Viers is "young" for developing complicated pneumoconiosis, citing a NIOSH study showing that complicated pneumoconiosis is on the rise among younger coal miners in the area where Mr. Viers worked.

In his letter dated November 2, 2008, Dr. Forehand addressed whether the large opacities were caused by sarcoidosis, histoplasmosis, tuberculosis, or lung cancer. He stated that he considered those alternative diagnoses, but was able to exclude them with a very high degree of medical certainty. Sarcoidosis appears in patients at age 20-35, while complicated pneumoconiosis is unusual in patients under age 40; Mr. Viers was 51 at the time of the letter. Additionally, there are significant differences in the appearance of sarcoidosis and the appearance of complicated pneumoconiosis on x-ray, and the opacities are more consistent with complicated pneumoconiosis. Sarcoidosis rarely forms the large opacities seen in the x-ray,

causes significant enlargement of hilar lymph nodes (not present on Mr. Viers' x-ray), is associated with calcification of the lung tissue and lymph nodes (not present on Mr. Viers' x-ray), and commonly involves other organs such as the eye, skin, liver, and other lymph nodes (no such findings on examination). Additionally, sarcoidosis causes an elevated level of angiotensin-converting enzyme in the blood, but Mr. Viers' was not elevated. Histoplasmosis also has a different appearance on x-ray from complicated pneumoconiosis, and causes an elevated antibody in the blood, while Mr. Viers' x-ray is not consistent with the appearance of histoplasmosis and his blood test was negative for histoplasmosis. Likewise, tuberculosis can be distinguished by appearance from complicated pneumoconiosis; it is usually found in one lung, while Mr. Viers' disease appears in both lungs. Additionally, tuberculosis causes a unilateral, rounded mass or apical scar, while Mr. Viers' upper-lobe masses are bilateral and oblong, not round. Finally, the blood test he performed ruled out tuberculosis, because the combination of a negative tuberculin skin test and a positive control skin test for candida rules out a tuberculosis infection. Dr. Forehand stated that Mr. Viers displayed none of the symptoms of lung cancer, and his carcinoembryonic antigen and erythrocyte sedimentation are not elevated, as they would be if he had cancer. Attached to Dr. Forehand's letter is a letter from David N. Weissman, MD, Director of the NIOSH Division of Respiratory Disease Studies, which criticized Dr. Wheeler's November 6, 2007 x-ray interpretation [DX 12.] Two NIOSH B readers, who were not informed of Claimant's history, interpreted the x-ray as showing a background of small opacities and either category B or category C large opacities.¹ Dr. Weissman cited studies that he said showed that Dr. Wheeler's were not consistent with a "considerable body of scientific information by NIOSH about the lung diseases of coal workers, including the reports of rapidly progressive disease and advanced disease among young miners." He stated that progressive massive fibrosis is frequently located in the lateral peripheral areas of the upper and mid-lung, and the profusion of small opacities is frequently reduced due to the accretion of the smaller opacities into the massive lesion.

Paul S. Wheeler, M.D.

Dr. Wheeler examined Claimant on behalf of the Employer and interpreted chest x-rays from October 1, 2007 and October 20, 2008. He is a B reader and is board certified in radiology. He responded to Dr. Forehand's letter of January 22, 2008 in a letter dated October 10, 2008. [EX 1.] Dr. Wheeler opined that Mr. Viers has granulomatous disease, and explained that there are many types and histoplasmosis is the most common. He disagreed with Dr. Forehand's diagnosis, and explained that the CT scan is not a histologic tool and the final diagnosis depends on histology and microbiology. Dr. Wheeler asserted that for an exact diagnosis, Claimant needs a biopsy of his right upper lobe mass evaluated by an experienced pathologist.

David M. Rosenberg, M.D.

Dr. Rosenberg examined Claimant on the Employer's behalf on October 20, 2008. [EX 3.] He is B reader and is board certified in internal medicine and pulmonary disease. In making a diagnosis, Dr. Rosenberg reviewed numerous evaluations, medical records, chest x-rays, CAT

¹ The ILO classification forms for these readings are not in the record, and have not been designated by either party as x-ray evidence. I consider the letter from NIOSH only for the purpose of evaluating the various medical opinions and radiological interpretations.

scans, pulmonary function tests, and blood gas studies, as well as took Claimant's occupational, social, family and medical histories, and conducted a physical examination. Based on his review, he found that Claimant has a normal total lung capacity, without restriction, and a normal diffusing capacity. Dr. Rosenberg found that Mr. Viers' chest x-ray revealed findings of granulomatous disorder, as described by Dr. Wheeler, and not abnormalities related to past coal mine dust exposure. He stated that Claimant's condition was more consistent with inflammatory changes related to chronic infection or sarcoidosis, not coal workers' pneumoconiosis.

Subsequently, by letter dated April 30, 2010, Dr. Rosenberg addressed the issue of whether his conclusions remain intact after reviewing Dr. Forehand's report from November 2, 2008. Dr. Rosenberg stated that Dr. Forehand has no pathologic confirmation for his diagnosis. He argued that while large nodule formation in relationship to sarcoidosis is not the usual presentation of this disorder, the clinical entity of nodular sarcoidosis is well described. He further asserted that large nodule formation can occur in association with various infections such as histoplasmosis and coccidiomycosis, as well as other microbial agents. Dr. Rosenberg asserted that his previously reached conclusions remain intact and that further diagnostic testing should be performed to establish the definite cause for his x-ray findings.

Gregory J. Fino, M.D.

Dr. Fino examined Claimant on behalf of the Employer on March 13, 2008. [EX 4.] He is a B reader. Dr. Fino took occupational, social, family and medical histories, and conducted a physical examination, blood gas studies, pulmonary function testing, and performed a two-view digital chest x-ray. Having viewed this chest x-ray, he stated that he was concerned with respect to complicated coal worker's pneumoconiosis, thus he requested other radiographic studies. Dr. Fino reviewed several x-rays and tests results and found that in slightly more than two years, huge bilateral masses occurred. He reported that Claimant's shortness of breath has been present for 22 years and is getting worse and noted that Mr. Viers complained of a daily cough, mucous production, and wheezing. He explained that such a change is an unlikely result of complicated pneumoconiosis and indicated that he would seek other diagnosis such as sarcoidosis, tuberculosis or histoplasmosis. Dr. Fino stated that he believes simple coal worker's pneumoconiosis is present, but that he didn't find that the pneumoconiosis resulted in any respiratory impairment.

Dr. Fino followed up on March 6, 2009, after reviewing additional medical evidence. [EX 15.] He stated that the additional evidence did not cause him to change his opinion on Mr. Viers' diagnosis. Subsequently, by letter dated May 4, 2010, Dr. Fino addressed Dr. Forehand's medical letters and records and any impact they might have on his findings. [EX 18.] Dr. Fino stated that he agrees with Dr. Forehand that the positive Candida skin test and a negative PPD skin test rule out tuberculosis, but that his main concern is sarcoidosis. He asserted that the additional evidence does not change any of his opinion and that he recommends an open lung biopsy.

3. Biopsy

On January 18, 2006, John G. Byers, MD performed a fiberoptic bronchoscopy, with preoperative indications of biapic conglomerate masses secondary to CWP, rule out indolent infection or neoplasm. [DX 14, CX 4.] He obtained bronchial washings from the right lung for cytology and for gram stain culture and sensitive, and acid fast smear and culture. He also conducted bronchoalveolar lavage from the right upper lobe for acid fast and fungal smears and cultures. The final cytologic diagnosis was "Negative, no malignant cells identified." There was no mycobacterium isolated or acid fast bacilli seen, and no infection observed.

4. Hospitalization Records/Treatment Notes

John G. Byers, M.D.

On January 11, 2006, Dr. Byers performed a pulmonary consultative evaluation of Claimant's abnormal x-ray and found that he had radiologic evidence consistent with conglomerate CWP. [DX 22, CX 8.] Dr. Byers is board certified in internal and pulmonary medicine. He noted that Claimant complained of coughing, wheezing, shortness of breath when walking 100 yards, and production of about a fourth of a cup of white sputum per day. Dr. Byers stated that Claimant has a medical history positive for CWP, arthritis and diabetes. His impressions were that Claimant has CWP with an element of COPD with reversible obstructive airways disease based on his pulmonary function test. He rules out the possibility of a concomitant indolent infection such as atypical tuberculosis.

On March 14, 2006, Dr. Byers did a physical exam of Claimant and noted that his breath sounded somewhat diminished but remained clear and his vital signs were stable. [DX 22, CX 8.] He said that his impressions were that Mr. Viers has conglomerate pneumoconiosis, mild asthma and a dry cough with intermittent wheezing and some related dyspnea.

On June 13, 2006, Dr. Byers did a follow-up checkup on Claimant and again found conglomerate CWP, noting that his chest x-ray was unchanged from the previous one. [DX 22, CX 8.] He also noted that Mr. Viers had increased exertional dyspnea and a heart murmur. On December 4, 2006, Dr. Byers did another follow-up with Claimant and found that he had a fixed wheeze on forced exhalation and again noted conglomerate CWP. Dr. Byers did another routine follow-up on June 12, 2007, and found no changes.

5. Other Medical Evidence

CT Scans

John G. Byers, M.D.

On December 14, 2005, Dr. Byers read Claimant's CT scan and found multiple reticular nodular densities in the upper, mid and lower lung zones with an increase in interstitial lung markings, which he determined to be most likely related to pneumoconiosis. [DX 22.] He also found mild enhancement of moderate size noncalcified spiculated densities in the upper lobes

bilaterally. His impression was that the particular nodular densities in Claimant's chest were most likely due to complicated pneumoconiosis.

Basim Antoun, M.D.

Dr. Antoun, who is board certified in radiology,² interpreted a CT scan taken on January 7, 2008. [DX 14.] He found bilateral multiple apical pulmonary masses, some of which are pleural based ranging in size from 2-3.5 cm in diameter, each associated with significant and wide areas of surrounding interstitial fibrosis most compatible with CWP. [DX 14.] In addition, he noted that there are a few small pleural based nodularities in the upper lung fields. Based thereon, and on his understanding that Mr. Viers had a 29-year history of coal mining, he determined that the findings were most consistent with coal workers' pneumoconiosis.

William W. Scott, Jr., M.D.

Dr. Scott interpreted the January 7, 2008 CT scan and found peripheral masses on both upper lungs 4 cm in diameter with mid-upper lung 1-2 mm focal scars and linear scarring. [EX 5.] He said that the masses have increased in size over the past two years and reported that the changes are most compatible with tuberculosis.

Physical Exams

Judy Walton, F.N.P.

Ms. Walton did a physical exam of Claimant on October 5, 2006 on the Employer's behalf. [EX 6.] She reported that Mr. Viers has diabetes type I, hypertension and hyperlipidemia.

Matthew D. Beasey, M.D.

Dr. Beasey did a physical exam of Claimant on July 7, 2006 on behalf of the Employer. [EX 7.] He stated that Claimant has diabetes type I, hypertension, high cholesterol and recent disc surgery. Dr. Beasey (or an associate) did a follow-up visits on January 17, 2007, April 17, 2007 August 9, 2007, and November 7, 2007 and found no new problems or worsened conditions. [EX 8-11.]

Digital x-ray Interpretations

3/13/08	CX 6	3/07/09	Ahmed/ B, BCR	2 (scapula overlay)	r/q, 3/2 in six zones, large B opacities
	EX 2	10/07/08	Wheeler/B, BCR	4	"NIOSH does not allow classification

² See www.abms.org. I informed the parties at the hearing that I would take official notice of physicians' credentials, and there were no objections. [Tr. 6.]

					of digital x-rays”
	EX 4	3/13/08	Fino/B	Not indicated	2/2, q/q in Six zones. Large mass in upper zones

C. Complicated Pneumoconiosis

Under 20 CFR § 718.304(a), complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under Section 718.304. Its existence may also be established under Section 718.304(b) by biopsy or autopsy or under Section 718.304(c), by an equivalent diagnostic result reached by other means. The United States Court of Appeals for the Fourth Circuit has held that complicated pneumoconiosis is established if “(A) an x-ray of the miner’s lungs shows at least one opacity greater than one centimeter in diameter; (B) a biopsy or autopsy reveals ‘massive lesions’ in the lungs; or (C) a diagnosis by other means reveals a result equivalent to (A) or (B).” *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000).³ The three methods of showing complicated pneumoconiosis “describe a single, objective condition,” *ibid.*, and therefore “regardless of which diagnostic technique is used, the same underlying condition triggers the underlying condition.” *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 244 (4th Cir. 1999). In other words, a “massive lesion” under prong (B) is sufficient to show complicated pneumoconiosis when, on x-ray, it would show as an opacity greater than one centimeter. *Scarbro*, 220 F.3d at 258. Positive x-ray evidence alone, however, does not necessarily establish the existence of complicated pneumoconiosis; “[E]ven where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) [biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray.” *Id.* at 256.

I find first that the evidence under prongs (B) and (C) does not establish the existence of pneumoconiosis. Prong (B) is not established because the biopsy evidence does not mention the presence of pneumoconiosis. Prong (C) is not established because, although some interpretations of the CT scans and digital x-rays indicate the existence of large masses, there is no evidence from any source that those masses would appear as large opacities greater than one centimeter in diameter on a chest x-ray. Likewise, the medical opinions of Drs. Forehand and Fino that Claimant has complicated pneumoconiosis do not make such an equivalency determination.

Whether Claimant has complicated pneumoconiosis, then, depends on whether the x-ray evidence establishes under Prong (A) that he does. Here, there are eight interpretations of three

³ Claimant’s last coal-mine employment was in Virginia [EX 11 at 4:13-5:11; DX 3]; thus, the law of the U.S. Court of Appeals for the Fourth Circuit governs this claim. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

x-rays.⁴ Seven of the interpretations are by physicians who are both board-certified radiologists and B readers, and one is by a physician who is a B reader but not a radiologist. Two of the seven interpretations by dually-qualified physicians indicate the presence of category B large opacities; one indicates category A large opacities; and four indicate that there are no opacities on the chest x-ray. The one interpretation by a B reader is positive for category B large opacities. The x-ray of June 28, 2007 was interpreted by one dually-qualified physician as negative for complicated pneumoconiosis, and by one dually-qualified physician as showing category A large opacities. The x-ray of October 1, 2007 was interpreted by one dually-qualified physician as negative for complicated pneumoconiosis, and by one dually-qualified physician and one B reader as showing category B large opacities. The x-ray of October 20, 2008 was interpreted by one dually-qualified physician as negative for complicated pneumoconiosis, and by one dually-qualified physician as showing category B large opacities. I find that the x-ray of October 1, 2007 is positive for complicated pneumoconiosis in light of the superior credentials of the physician so finding, while the remaining x-rays are indeterminate in light of the equivalent qualifications of the interpreting physicians. Thus, the x-ray evidence, standing alone, is indeterminate on the issue of whether Mr. Viers has complicated pneumoconiosis. However, under *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must consider all of the relevant evidence, including biopsy, medical opinions, and other medical evidence, together to determine whether Mr. Viers can establish the presence of complicated pneumoconiosis.

The comments of the interpreting physicians are of assistance in determining whether the x-ray evidence establishes the existence of complicated pneumoconiosis. Four doctors found complicated pneumoconiosis: Dr. Forehand, Dr. Miller, Dr. Ahmed, and Dr. Alexander. Dr. Forehand indicated that he found marked distortion of the intrathoracic organs and Dr. Ahmed found an atherosclerotic aorta, bullae, distortion of the intrathoracic organs, and emphysema. Dr. Miller assessed that the chest x-ray showed bilateral upper lung opacities with a combined size greater than five centimeters that are typical of complicated pneumoconiosis. He also found hyperexpansion consistent with COPD. Dr. Alexander found bilateral upper zone large opacities with a summed diameter greater than 50 mm, indicating category B complicated coal worker's pneumoconiosis.

Dr. Wheeler found a 9x5 cm mass in the central right upper lung and upper right hilum, a 10x3 cm mass on the lateral left upper lung and lower left apex involving pleura, and a probable 2 cm mass on the left lower lung, and determined that that the large masses were compatible with conglomerate granulomatous disease, tuberculosis or histoplasmosis. He noted that CWP was very unlikely because nodular infiltrates were mainly in the lateral periphery of the lungs involving pleura. He explained that the masses are not large opacities of CWP because they also are peripheral and in the lower left hilum involving pleura, and background nodules near them show very low profusion. He also noted that the patient is young and that large opacities were typically found in drillers working unprotected during and before World War II.

After carefully considering all the evidence, I find the reasons given by Dr. Wheeler for his negative interpretations to be unpersuasive. Dr. Wheeler identified tuberculosis or histoplasmosis as possible causes of the large masses; however, both tuberculosis and

⁴ Dr. Navani's review of the October 1, 2007 x-ray was for quality purposes only, thus I will not consider it in evaluating the x-ray evidence.

histoplasmosis have been eliminated by testing. Additionally, Dr. Wheeler's argument that large opacities are unlikely simply because he is young and such opacities were typically found before World War II is unfounded. A sweeping generalization such as this should not be included in an analysis as to whether the patient has large opacities when this can be determined from analyzing the patient's chest x-ray, and Dr. Weissman of NIOSH has stated that the medical literature is contrary to Dr. Wheeler's opinion. I therefore give little weight to Dr. Wheeler's x-ray interpretations.

Dr. Scatarige found that there were peripheral apical and upper lobe infiltrates, which had increased since 2006, and said this asymmetry favored tuberculosis or histoplasmosis rather than CWP or silicosis. Again, those diseases have been eliminated by testing. Thus, for the same reasons discussed above for discounting Dr. Wheeler's opinion, I discount Dr. Scatarige's opinion as well.

Similarly, Dr. Scott noted that he found mid and upper linear and small nodular infiltrates/fibrosis with a large peripheral component and peripheral marks, which he said are probably due to unknown activity and are not components of silicosis or CWP. Like Dr. Scatarige, Dr. Scott found infiltrates and fibrosis but claimed that they are not a result of CWP. Dr. Scott dismisses CWP, but he makes no diagnosis, asserting that the infiltrates and fibrosis which appear on the x-ray are "probably due to unknown activity." I find Dr. Scott's interpretation to be speculative and equivocal, and find that it is unconvincing.

The CT scans, digital x-ray, medical opinions, and the bronchoscopy are relevant in evaluating whether the large opacities show complicated pneumoconiosis or something else. The CT scan evidence is supportive of a finding of complicated pneumoconiosis. Two of the physicians who interpreted the CT scans found that they showed the existence of complicated pneumoconiosis. Dr. Scott observed large masses and determined that they are most compatible with tuberculosis; however, tuberculosis has been ruled out. Additionally, Dr. Scott made no explicit findings on the existence of complicated (or simple) pneumoconiosis. Thus, the CT scans are positive for the existence of complicated pneumoconiosis.

The bronchoscopy does not address the existence of simple or complicated pneumoconiosis, but rules out a malignancy.

The digital x-ray was interpreted by three physicians, each of whom observed large opacities. Dr. Ahmed found them to be category B large opacities of pneumoconiosis. Dr. Wheeler again found that they were more likely conglomerate granulomatous disease or histoplasmosis than pneumoconiosis. Dr. Fino was initially concerned that they showed complicated pneumoconiosis, so he compared it with earlier studies; he concluded that, because the large opacities developed rapidly over a two-year period, they do not represent complicated pneumoconiosis. For the reasons previously stated, I discount Dr. Wheeler's interpretation of the digital x-ray. I additionally discount Dr. Fino's opinion that the opacities are not complicated pneumoconiosis, because he has not adequately explained why the condition cannot appear over a two-year period. Further, Dr. Weissman of NIOSH has disputed Dr. Fino's belief that Claimant's rapid development of large opacities would be inconsistent with the progress of complicated pneumoconiosis.

Based on the totality of the evidence, I find that the existence of complicated pneumoconiosis is established under Prong (A). Under the law of the Fourth Circuit, that evidence is sufficient to invoke the irrebuttable presumption under 20 CFR § 725.304 unless other evidence shows that the large opacities are not present or are not what they seem to be. *Scarbro, supra*, 220 F.3d at 256. Here, there is no evidence that the masses are not present – every physician who reviewed an analog or digital x-ray or a CT scan observed the presence of large masses. Additionally, I reject the opinion evidence that the masses are something other than opacities of complicated pneumoconiosis for the reasons set forth above. Accordingly, Claimant is entitled to the irrebuttable presumption that he is disabled from pneumoconiosis.

Conclusion

Taking into account the x-ray interpretations, the interpretations of the digital x-rays and CT scans, the comments of the interpreting physicians, and the medical opinion evidence, I find that Claimant has met his burden to show the existence of complicated pneumoconiosis.⁵

D. Entitlement to Benefits

For the reasons set forth above, I find that Claimant has established the existence of complicated pneumoconiosis. A miner who has ten or more years of coal-mine employment and a Category A, B, or C opacity on chest x-ray is entitled to a rebuttable presumption that his complicated pneumoconiosis arose out of coal-mine employment. 20 CFR § 718.203; *The Daniels Co. v. Director, OWCP [Mitchell]*, 479 F.3d 321 (4th Cir. 2007). Claimant has established 28.52 years of coal-mine employment and is therefore entitled to the presumption. Employer has presented no evidence or argument to overcome the presumption, and I therefore find that Claimant has established that his complicated pneumoconiosis arose out of his coal-mine employment.

In addition, having established the existence of complicated pneumoconiosis, Claimant is entitled to the irrebuttable presumption under 20 CFR § 725.304 that he is totally disabled from pneumoconiosis. He is therefore entitled to benefits under the Act.

E. Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2007); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006) (en banc). Here, Claimant filed his application in August of 2007; however, the first

⁵ Because I find that the Claimant has shown the existence of complicated pneumoconiosis, he is entitled to benefits and I need not address the presumption at Section 1556 of the Patient Protection and Affordable Care Act.

evidence of complicated pneumoconiosis (and therefore total disability) was June 28, 2007. Accordingly, I find that he is entitled to benefits commencing in June of 2007.

F. Representative's Fees

The regulations address non-attorney representatives' fees at 20 CFR §§ 725.362, 365 and 366. The Claimant's representative has not yet filed an application for fees. The Claimant's representative is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties (including the Claimant) have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

Based on the foregoing, IT IS ORDERED:

1. The claim for benefits filed by Claimant David A. Viers, Jr. on August 20, 2007, is hereby GRANTED;
2. Employer shall pay Claimant benefits under the Act commencing in June 2007 and continuing, augmented for one dependent;
3. Employer shall reimburse the Black Lung Disability Trust Fund for all payments made to Claimant;
4. Counsel for

SO ORDERED.

A

PAUL C. JOHNSON, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("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).