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Case Nos.: 2009-BLA-05773
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BRB Nos.: 11-0367 BLA
11-0440 BLA

In the Matter of

**PATRICIA A. PADAGOMAS o/b/o and Widow of
EDWARD J. PADAGOMAS**
Claimant

v.

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

DECISION AND ORDER ON REMAND

This matter arises from claims for benefits under the Black Lung Benefits Act (the "Act"), 30 U.S.C. §§ 901-945 and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations.¹

Procedural History

The Miner filed a subsequent claim for benefits on September 2, 2008. Director's Exhibit (DX) 3. The Miner filed an initial claim in 2006; the District Director denied the initial claim in February 2007, upon determining that the Miner had not established any of the elements of entitlement. DX 1. The Miner's subsequent claim was pending at the administrative level when the Miner died, on October 16, 2008, at age 75. DX 13. The Miner's widow, the Claimant, filed a claim for survivor's benefits on November 3, 2008. DX 23. The District Director denied benefits in both claims. DX 16, 34. The Claimant timely appealed and requested a hearing. DX 35.

After a consolidated hearing for both claims, held on April 27, 2010, by Decision and Order (D&O) dated February 2, 2011, I denied benefits in both claims. The Claimant appealed to the Benefits Review Board (Board). By Decision and Order dated February 23, 2012 (Board

¹ Citations to regulations herein are to Title 20, Code of Federal Regulations.

D&O), the Board affirmed in part and vacated in part my Decision and Order. The Board remanded the claims for further consideration, consistent with its guidance.

On August 6, 2012, these claims were returned for adjudication, in accordance with the Board's instructions. By Order dated August 15, 2012, I authorized the parties to submit supplemental briefs, which they did.

In this Decision and Order on Remand I have carefully considered the evidence of record and the parties' supplemental arguments. I have also carefully considered the Board's guidance and instructions, as set forth in the Board's Decision and Order.

The Board's Decision

In its Decision and Order, the Board affirmed in part and vacated in part my Decision and Order, and returned the claims to me for further consideration. Board D&O at 12. The Board rejected several of the Claimant's assertions on appeal. Specifically, the Board found no error in my consideration of the Claimant's hearing testimony and the Miner's medical records. Board D&O at 7-8. As well, the Board upheld my determinations regarding the biopsy evidence and Dr. Levinson's opinion as to clinical pneumoconiosis. Board D&O at 8-9.

However, the Board determined that I did not adequately explain my decision to discount positive X-ray evidence and, in particular, found that I erred when I relied on Dr. Spagnolo's opinion to discredit positive X-ray evidence. Board D&O at 9. The Board also found that I did not adequately explain why I found Dr. Spagnolo to be more qualified than Dr. Smith in identifying X-ray changes consistent with pneumoconiosis. Board D&O at 10. Accordingly, the Board determined that I failed to rationally explain credibility determinations, as required under the Administrative Procedure Act. Id.

Issues to be Determined on Remand

On remand, the Board stated, I must first determine, with regard to the Miner's subsequent claim, whether the Claimant established a change in an applicable condition of entitlement under § 725.309. If so, then I must weigh all of the record evidence, including evidence from the Miner's prior claim, relevant to the requisite elements of entitlement. Board D&O at 11.

Additionally, the Board instructed, I must consider whether the Claimant has established the existence of either clinical or legal pneumoconiosis. Id. Regarding the former, the Board specifically stated I should resolve whether the October 9, 2008 X-ray is positive for pneumoconiosis or is unreadable, and must resolve the conflicts in the readings of the October 14, 2008 X-ray and determine whether that X-ray is positive, negative, or in equipoise as to the existence of pneumoconiosis. Id. at n. 15. As necessary, the Board directed me to address whether Dr. Spagnolo offered a reasoned and documented opinion regarding the credibility of the positive X-ray evidence, and whether Dr. Levinson's opinion, that the Miner's pulmonary function studies and oxygenation levels show a disabling impairment consistent with coal dust

exposure, is sufficient to establish the existence of legal pneumoconiosis pursuant to § 718.204(a)(4). Id. at n. 17.

In the event I find the overall weight of the evidence is sufficient to establish the existence of either clinical or legal pneumoconiosis, then I must determine whether the Claimant has established that the Miner was totally disabled due to pneumoconiosis pursuant to § 718.204(b) and (c). Id.

Regarding the Claimant’s survivor’s claim, the Board instructed me to reconsider, as necessary, whether the Claimant has established that the Miner’s death was due to, or substantially contributed to by pneumoconiosis, pursuant to § 718.205(c). Id. at 12.

The X-ray Evidence

As the Board has instructed, I must re-evaluate the X-ray evidence.

My Decision and Order contained the following chart, summarizing the X-ray evidence of record.² D&O at 7.

Date of X-Ray	Date Read	Ex. No.	Physician	Radiological Credentials	Interpretation
10/09/2008	01/06/2009	DX 10	Navani	BCR, B reader	ILO: unreadable X-ray. <i>Comments on ILO form: Underexposed; artifacts; AP supine & poor insp[iration]. “This film is of unreadable quality.”</i>
10/09/2008	03/01/2009	DX 12; DX 31 ³	Smith	BCR, B reader	ILO: 1/0, s/s, 6 lung zones. Additional abnormalities noted: “(aa)”[atherosclerotic] “(co)” [cardiac abnormalities]; “(ef)” [effusion]; “(id)” [ill-defined diaphragm]. Additional hand-written note on ILO form: “suspect CHF [congestive heart failure]/Rt. Pleural effusion. <i>“follow-up suggested to r/o other possible underlying infiltrate.”</i>
10/14/2008	01/06/2009	DX 10	Navani	BCR,	ILO: Negative for

² Italicized portions are added.

³ Dr. Smith’s interpretations of both X-rays are at both locations in the record.

				B reader	pneumoconiosis. Abnormalities noted on ILO form: “(co)” ; “(ef).”
10/14/2008	03/01/2009	DX 12; DX 31	Smith	BCR, B reader	ILO: 1/0, s/p, 6 lung zones. Additional abnormalities noted: “(aa)” ; “(co)” ; “(ef).” Additional handwritten note on ILO form: “Improved from 10/9/2008. Incomplete clearing ? CHF – <i>follow-up suggested until complete resolution.</i> ”

As reflected above, both Dr. Navani and Dr. Smith are dually-qualified (Board-certified radiologists and B-readers). As set out in my initial Decision and Order, regarding the X-ray of 10/09/2008, as indicated above, Dr. Navani determined that the X-ray was unreadable. Id. Dr. Navani stated the following on the interpretation form: “underexposed; artifacts; AP Supine and poor insp.[iration]. This film is of unreadable quality.” DX 10. Dr. Smith, on the other hand, found it to be of sufficient quality to be interpreted. DX 12, 31. He stated that it was of quality 2 and checked the following boxes on the ILO form: “underexposed (light); artifacts; improper position; underinflation.” Id. Dr. Smith also noted the film was “portable” and “scapular overlay.” Id. In addition to the abnormalities listed above, Dr. Smith also noted pleural plaques and pleural thickening. Id.

An X-ray interpretation that reflects that the study is of poor quality or unreadable may be given little or no probative value. Gober v. Reading Anthracite Co., 12 B.L.R. 1-67 (1988). Accordingly, I do not consider Dr. Navani’s interpretation of the X-ray of 10/09/2008. Due to Dr. Smith’s status as a dually-qualified reader, I give some weight to Dr. Smith’s opinion, and accordingly I find that the overall weight of the 10/09/2008 X-ray is positive.⁴

As to the X-ray of 10/14/2008, there is one positive and one negative interpretation, and both readers are dually-qualified. I can discern no reason, from the record, to give greater or lesser weight to either interpretation.⁵ Accordingly, I find that the overall weight of the 10/14/2008 X-ray is in equipoise.

Because there is one positive X-ray and one X-ray in equipoise, I conclude that the overall weight of the X-ray evidence is positive for pneumoconiosis.

⁴ Interestingly, though Dr. Smith interpreted the film of 10/09/2008 as positive for pneumoconiosis, he found the same deficiencies in the film that, in Dr. Navani’s view, made the film unreadable: underexposure, improper positioning, artifacts, and poor lung inflation.

⁵ Dr. Smith did not indicate the film quality. However, because he interpreted the film, I will presume that he found the film of sufficient quality to permit an interpretation to be made. Dr. Navani stated that the film of the 10/14/2008 X-ray was of “3” quality.

The Board also instructed that I consider whether Dr. Smith's interpretations reflect "his belief that the [M]iner was in congestive heart failure, but also had opacities for pneumoconiosis." Board D&O at 10. On review and examination of the record, I find that Dr. Smith's interpretations indicate that he saw indicia of both conditions. Specifically, Dr. Smith's comments regarding partial resolution of congestive heart failure between the X-ray of 10/09/2008 and the X-ray of 10/14/2008, coupled with no significant change in his ILO interpretation for pneumoconiosis between the two films, indicated his determination that the indicia for pneumoconiosis remained stable. This suggests that Dr. Smith observed both conditions in the X-ray.⁶

The Physician Opinions

Because of the Board's many comments and instructions regarding the physician opinion evidence, I find it is necessary for me to re-assess the physician opinion evidence in its entirety.

As noted in my initial Decision and Order, the record contains opinions from two physicians, Dr. Sander Levinson (Claimant's Exhibit (CX) 1) and Dr. Samuel Spagnolo (DX 39, 40). I adopt my summaries of their opinions, as set forth in my initial Decision and Order. D&O at 9-10.

As noted in my initial Decision, Dr. Spagnolo is Board-certified in internal medicine and pulmonary disease. D&O at 9; see DX 39. Dr. Spagnolo's report reflects that he reviewed medical treatment records from the VA Medical Center in Wilkes Barre, Pennsylvania; the Miner's death certificate; and Dr. Smith's X-ray interpretations. DX 40. It does not appear, from the record, that Dr. Spagnolo reviewed Dr. Navani's X-ray interpretations.

Dr. Spagnolo's summation of the VA treatment records reflects that the Miner was diagnosed with congestive heart failure as early as 2006 and had been hospitalized in congestive heart failure on several occasions. Many of the treatment-related CT scans and X-rays Dr. Spagnolo reviewed indicated that the Miner was in congestive heart failure; many also noted pleural effusions and/or infiltrates. See, e.g., DX 30 at 3-46. Some of the items also noted pulmonary "markings" or other abnormalities. See, e.g., DX 30 at 36-38, 41. It was only after addressing the Miner's multiple health conditions, including the Miner's congestive heart failure, that Dr. Spagnolo addressed Dr. Smith's X-ray interpretations. Dr. Spagnolo noted that the treatment radiographs he reviewed "do not demonstrate any consistent evidence of pneumoconiosis, progression of pneumoconiosis or complications of pneumoconiosis." He then commented: "The two chest radiographs reviewed by Dr. Smith dated 10/09/2008 and 10/14/2008 were obtained several days prior to [the Miner's] death and while he was critically ill with heart failure, fluid overload, and endstage renal disease All of these conditions would lead to changes on the radiograph easily confused with changes consistent with pneumoconiosis."

⁶ Dr. Navani also noted unspecified cardiac abnormalities on the film of 10/14/2008.

It appears, from my review of Dr. Spagnolo's opinion, that Dr. Spagnolo's assessment of Dr. Smith's X-ray interpretations was influenced by Dr. Spagnolo's review of medical treatment X-rays and CT scans that did not, overall, indicate the Miner had pneumoconiosis, but did paint a very consistent picture of the Miner's congestive heart failure.⁷ As my initial Decision also reflects, however, I still note that it is uncertain whether Dr. Smith was fully aware of the Miner's long and significant history of congestive heart failure, or knew the Miner had multiple other medical conditions and was critically and terminally ill at the time the X-rays that he interpreted were taken.⁸ D&O at 14. In my initial Decision, I gave Dr. Smith's less weight, for that reason. Id. On remand, I will defer to Dr. Smith's determinations over Dr. Spagnolo's, based on Dr. Smith's superior radiological credentials. Moreover, I find that Dr. Spagnolo did not specifically articulate which changes on radiographs are easily confused with changes consistent with pneumoconiosis.

In conclusion, I find that Dr. Spagnolo's opinion regarding whether the Miner had pneumoconiosis is not well-reasoned and well-documented, and I give it little weight. I reiterate the reasons set out in my initial Decision. D&O at 14. However, I do give some weight to Dr. Spagnolo's opinion regarding the Miner's numerous other medical conditions (such as congestive heart failure) because that opinion is reasoned and documented, and is supported by the Miner's VA medical treatment records.

Though the Board upheld my determination that Dr. Levinson's opinion as to clinical pneumoconiosis was due little weight, because it relied on the biopsy and CT evidence, the Board specifically instructed that I reassess Dr. Levinson's opinion on the issue of legal pneumoconiosis. Board D&O at 8-9, 11 at n. 17. As noted in my initial Decision, Dr. Levinson is Board-certified in internal medicine and pulmonary disease. CX 1 at 6; D&O at 9.

In his written report, Dr. Levinson cited specifically the results of pulmonary function and arterial blood gas tests administered in 2006. CX 1 (Exhibit to Deposition Testimony; hereinafter, Exhibit). These tests were administered in conjunction with the pulmonary evaluation of the Miner's initial claim. See DX 1. In his report, Dr. Levinson stated that these tests indicated the Miner had a "moderate restrictive impairment" and that, based on the report of the examining physician (Dr. Talati), it did not appear the Miner was in congestive heart failure at the time of the pulmonary function test on 09/27/2006. CX 1 (Exhibit). Dr. Levinson noted that an arterial blood gas test administered on 07/19/2006 was not qualifying for disability (with a PO₂ of 72 and PCO₂ of 37), but that an earlier test had showed a PO₂ of 59 millimeters of mercury. Dr. Levinson did not specify the date of the earlier test. Id.

⁷ As noted in my initial Decision, I disregard medical treatment X-ray interpretations on the issue of pneumoconiosis, because they do not use the ILO classification system for pneumoconiosis, as § 718.102 requires. D&O at 6 n. 7.

⁸ Indeed, upon reviewing the X-rays, Dr. Smith commented that follow-up was appropriate for the patient. DX 12, 31 (backs of ILO forms). Clearly, because the Miner died two days after the X-ray of 10/14/2008 was taken, such comments were unnecessary.

Dr. Levinson also opined that the Miner's pulmonary condition was "directly impacted by a chronic pulmonary disease with pulmonary impairment that was significantly related to and substantially aggravated by" the Miner's three years of coal mine employment. CX 1 (Exhibit) Dr. Levinson also stated: "There is no question that [the Miner] had significant pulmonary impairment as documented by his pulmonary function studies and measures of oxygenation. I think the causes of these impairments again was multifactorial but was significantly contributed to and aggravated by his coal mine dust exposure."⁹ Id.

In his deposition testimony, Dr. Levinson stated that results of arterial blood gas and pulmonary function tests "did show impairment in [the Miner's] oxygenation" and cited the fact that the Miner was prescribed oxygen during his lifetime. CX 1 at 15, 17-18. He again cited the test result of 09/27/2006, and stated that a restrictive impairment "could be consistent with an impairment from interstitial lung disease such as coal worker's pneumoconiosis" rather than from smoking. CX 1 at 26. Dr. Levinson acknowledged the Miner had a significant smoking history (25 years at up to two packs per day) but stated that it did not appear the Miner's pulmonary impairment was due to smoking; he did indicate the Miner's smoking history could have played a role in his vascular disease. CX 1 at 27-28. Dr. Levinson also acknowledged that the Miner's coronary artery disease and congestive heart failure would have resulted in complete disability. CX 1 at 34.¹⁰

Other than the tests Dr. Talati administered in 2006 (on 07/19/2006 and 09/27/2006), Dr. Levinson did not specify (for example by date) the pulmonary function and arterial blood gas test results he reviewed that led him to his conclusion regarding the Miner's coal mine employment as a contributing factor in any pulmonary impairment. Notably, the record reflects that the pulmonary function tests conducted under Dr. Talati's aegis were both invalidated due to the Miner's improper performance (coughing/hesitation/closed glottis), as discerned on the flow-volume loops.¹¹ DX 1. Accordingly, it is uncertain whether these test results accurately reflected the Miner's condition. Dr. Levinson did not address that the tests had been invalidated, when he rendered his opinion.

⁹ Regarding the Miner's pulmonary hypertension, Dr. Levinson also commented that he did "not think that it could be dismissed that coal dust inhalation and coal workers' pneumoconiosis would not have contributed some added insult to this degree of pulmonary hypertension in addition to the left ventricular failure." I find this aspect of Dr. Levinson's opinion is speculative, and I give it no weight on the issue of legal pneumoconiosis.

¹⁰ Dr. Levinson also stated that the Miner had multiple comorbidities, but "it's very easy for me to conclude based upon the evidence that his coal worker's pneumoconiosis was a substantially contributing and aggravating cause ..." CX 1 at 16. He then cited the "size of the abnormalities" in the Miner's lungs. CX 1 at 16-17, 18. Because the Board has affirmed my finding regarding Dr. Levinson's opinion, insofar as it was based on biopsy evidence and CT scan evidence, I give no weight to this comment. See Board D&O at 8-9. As well, Dr. Levinson discounted much of Dr. Spagnolo's opinion, because in his view Dr. Spagnolo gave insufficient consideration to the biopsy evidence. CX 1 at 19-20. Because the Board affirmed my determination regarding the biopsy evidence, I disregard Dr. Levinson's conclusion regarding Dr. Spagnolo's opinion.

¹¹ Dr. Spagnolo was the physician who invalidated the tests, in 2006.

As Dr. Levinson noted, the arterial blood gas test Dr. Talati administered on 07/19/2006 was non-qualifying for disability. In his report, Dr. Levinson cited an “earlier” blood gas test with a PO₂ of 59 millimeters of oxygen. Dr. Levinson’s written report reflects that he reviewed “medical records from the Veterans’ Administration Medical Center.” I have, therefore, re-examined these records, which aggregate more than 2,300 pages.¹² See DX 11, 29, 30.

These records contain information about arterial blood gas test results as follows:¹³ DX 30 at 82.

Date	12/23/2002	04/02/2005	08/08/2006	08/28/2006	10/19/2006	02/13/2007	04/14/2007
PCO ₂	42.0	42.0	40.3	33.0	41.4	45.9	34.5
PO ₂	77.0	68.0	74.3	59.1	67.3	54.6	52.6

Presuming an altitude of 2,999 feet or below, at the Veterans Administration facility at Wilkes Barre, Pennsylvania,¹⁴ the tests that are qualifying for disability are the tests dated 08/28/2006, 02/13/2007, and 04/14/2007. The record reflects that all of these tests were administered when the Claimant was hospitalized for a pulmonary condition or exacerbation of congestive heart failure, or both. See, e.g., DX 30 at 1327-1331; DX 30 at 1131-39; DX 30 at 924-27. The test Dr. Levinson specifically cited, with a PO₂ of 59.1, was administered in conjunction with the Miner’s hospitalization for exacerbation of congestive heart failure. DX 30 at 1341. Because the qualifying arterial blood gas tests were administered when the Miner was acutely ill, I find that they do not reflect the Miner’s usual pulmonary condition.¹⁵

On my review of the VA Medical Center records, I did not find any full reports of pulmonary function tests. There were several mentions of the Miner’s FEV₁ values in the records. See, e.g., DX 30 at 892, 1146, 1158, 1209, 1213. However, there were no other corresponding values, such as FVC, FEV₁/FVC ratio, or MVV reported. A qualifying FEV₁ value alone does not establish disability, under the regulation. § 718.204(b)(2)(i).

In sum, the pulmonary function test results on which Dr. Levinson relating to the Miner’s prior claim have been invalidated, and the arterial blood gas test result was non-qualifying. I acknowledge that a physician may diagnose total disability, even where such tests are non-qualifying. See § 718.204(b)(2)(iv). The VA Medical Center’s treatment records reflect that the Miner’s qualifying arterial blood gas tests were taken when he was hospitalized for pulmonary conditions and/or congestive heart failure, and there are no full pulmonary function tests of

¹² The records at DX 30 alone consist of 2, 111 pages: this exhibit begins with approximately 30 unpaginated pages, then is paginated 1-1,385, then is paginated 1-11, and then is paginated 1-302, followed by several hundred unpaginated pages.

¹³ Additional references to some of these tests are scattered throughout the record. See, e.g., DX 30 at 862, 1102, 1006 (test of 4/14/2007); DX 30 at 1343, 1360 (test of 08/28/2006).

¹⁴ Per 29 C.F.R. § 18.201, official notice may be taken of adjudicative facts. The altitude of Wilkes-Barre is about 550 feet. See <http://www.idcide.com/citydata/pa/wilkes-barre.htm>.

¹⁵ For example, the test of 08/08/2006 reflects a PO₂ of 74.3, only three weeks before the test of 08/28/2006 showed a PO₂ of 59.1. A later test, on 10/19/2006, showed a PO₂ of 67.3.

record. It is uncertain whether Dr. Levinson took the Miner's hospitalized status into consideration when rendering his opinion, because he did not acknowledge or discuss the Miner's hospitalization in his opinion.

In light of the foregoing, I find that Dr. Levinson's opinion that the Miner's arterial blood gas and pulmonary function test results showed a disabling impairment consistent with coal mine dust exposure is not well-documented or well-reasoned. Presuming that this opinion constitutes an opinion that the Miner had legal pneumoconiosis, as the Board has indicated, I give the opinion little weight.

Additionally, I find that Dr. Levinson's comment that a restrictive pulmonary impairment could be consistent with pneumoconiosis to be speculative in nature, particularly in light of the fact that Dr. Levinson was aware of the Miner's many other health conditions and did not address why any of these conditions could not have caused or contributed to the Miner's restrictive impairment. An opinion that is speculative may be given little weight. See Barker v. Westmoreland Coal Co., BRB No. 03-0533 BLA (May 28, 2004)(unpub.), slip op. at 5. I also find that, of itself, the fact that the Miner was prescribed oxygen does not indicate that his pulmonary impairment is occupationally-related.¹⁶ In sum, I find that Dr. Levinson's opinion that the Miner's pulmonary condition may be occupationally-related is not well-reasoned and is not well-documented. Accordingly, I give Dr. Levinson's opinion on the issue of legal pneumoconiosis no weight.

In sum, considering all of the evidence on the issue of pneumoconiosis, I find that the overall X-ray evidence is positive for pneumoconiosis. As set forth above, I have found there is no well-reasoned physician opinion as to either clinical or legal pneumoconiosis. Accordingly, considering all of the evidence together, I find that the Claimant has established, by a preponderance of evidence, that the Miner had clinical pneumoconiosis.

Whether the Claimant has Established a Change in Condition of Entitlement

The Board directed that I determine whether the Claimant has established a change in an applicable condition of entitlement. Board D&O at 11. In his prior claim, the Miner did not establish any element of entitlement.¹⁷ DX 1; see also D&O at 3.

¹⁶ In the Miner's case, the medical treatment records indicate that the Miner's oxygen was prescribed in part due to his congestive heart failure. See, e.g., Certification of Medical Necessity, dated 02/22/2007 (DX 30 at unpaginated page).

¹⁷ The X-ray evidence submitted in conjunction with the Miner's prior claim consisted of two interpretations, one positive for pneumoconiosis (from a Board-certified radiologist) and one negative (from a dually-qualified physician). Based on the physicians' credentials, I find the overall X-ray evidence in the prior claim was negative for pneumoconiosis. The physician who conducted the Miner's evaluation under § 725.406 in the prior claim, Dr. Talati, opined that the Miner did not have pneumoconiosis.

Because I find the Claimant to have now established the existence of clinical pneumoconiosis, I also find the Claimant has established a change in condition of entitlement under § 725.309(d).

Whether the Miner's Pneumoconiosis Arose from Coal Mine Employment

Under § 718.203(b), there is a rebuttable presumption that a miner's pneumoconiosis arose from coal mine employment, if the miner had at least 10 years of coal mine employment. In the event the miner had less than 10 years of coal mine employment, a determination that the miner's pneumoconiosis arose from coal mine employment must be based on competent evidence establishing this relationship. § 718.203(c).

In this case, the record establishes that the Miner had three years of coal mine employment. However, there is no evidence of record to indicate any cause, other than the Miner's coal mine employment, for his clinical pneumoconiosis. Moreover, the Director has not asserted any non-occupational cause for the Miner's pneumoconiosis. Accordingly, I will conclude that the Miner's pneumoconiosis arose from his coal mine employment.

Whether the Miner was Totally Disabled

A miner who has pneumoconiosis is entitled to benefits only if he also establishes that he is totally disabled, and that his disability is due to pneumoconiosis. § 718.204.

In my prior Decision, I did not address whether the Miner had established total disability. D&O at 14. The Board has instructed me to make a determination on this issue. Board D&O at 11.

Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment ... requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

The record indicates that the Miner did not undergo a pulmonary evaluation, under § 725.406, in conjunction with his current claim, because he died shortly after he filed this claim.¹⁸

The pulmonary function and arterial blood gas test evidence contained in the VA Medical Center treatment records is summarized above. As discussed above, I cannot make a determination regarding whether any of the pulmonary function tests are qualifying for disability, because only the FEV₁ value was provided. In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume (FEV₁) test and, *in addition*, produce a qualifying value in at least one of the following: the forced vital capacity (FVC) test; the maximum voluntary volume (MVV) test; or the ratio of the FEV₁ value divided by the FVC value that is less than or equal to 55%. § 718.204(b)(2)(i).

Regarding the arterial blood gas test evidence, the table above reflects that the Miner's qualifying arterial blood gas tests were administered when he was hospitalized for pulmonary problems and/or congestive heart failure. Accordingly, I decline to base any determination on the Miner's disability on this data. Additionally, I find that the record is insufficient for me to determine whether any of the arterial blood gas tests were in substantial compliance with § 718.105(a)(b) and (c), as the regulation requires. Thus, I am unable to determine whether any of the tests demonstrate technically valid results. See § 718.105(d).

I summarize the physician opinions on the issue of the Miner's disability, and the cause(s) of any disability, as follows:¹⁹

Dr. Levinson. CX 1.

In his written report, Dr. Levinson stated that the Miner had "significant and severe multiple medical morbidities," as well as a "significant pulmonary impairment as documented by his pulmonary function studies and measures of oxygenation." Dr. Levinson also noted the Miner's pulmonary arterial hypertension. For the reasons set forth above, I gave little weight to Dr. Levinson's conclusion that the Miner's pulmonary impairment is established based on pulmonary function studies and oxygenation [arterial blood gas] tests. CX 1 (Exhibit).

At deposition, Dr. Levinson stated that the Miner was totally disabled, and that pneumoconiosis was a contributing factor in the Miner's disability. CX 1 at 14-17. He acknowledged the Miner had "multiple comorbidities and multiple medical problems." CX 1 at 16. More specifically, Dr. Levinson stated that the Claimant's lung problems contributed to his breathing difficulties, including his impaired oxygenation, and made it more difficult for him to "weather the storm caused by his heart disease." CX 1 at 18. He also admitted that the Miner's

¹⁸ I will not consider the evidence submitted in conjunction with the Miner's prior claim because it dates from 2006, and is too remote to be of significant value on the issue of the Miner's disability. See Coleman v. Ramey Coal Co., 18 B.L.R. 1-9 (1993).

¹⁹ Because my initial Decision did not address the Miner's disability, I did not summarize the physicians' opinions on this issue.

coronary artery disease and congestive heart failure would have resulted in disability. CX 1 at 34.

Dr. Spagnolo. DX 40.

Dr. Spagnolo opined that the Miner did not have cor pulmonale, but did not otherwise address whether the Miner was totally disabled from a respiratory perspective. Dr. Spagnolo listed the Miner's multiple medical problems, based on the VA Medical Center treatment records.

Other evidence.

Under the regulation, lay evidence may be used on the issue of disability if no medical or other evidence exists to address a miner's condition, but a determination cannot be based exclusively on the testimony of an individual who would be eligible for benefits. § 718.204(d)(3). As discussed above, there is medical evidence on the issue of the Miner's disability. Accordingly, I decline to consider the Claimant's testimony on the issue of the Miner's disability.

Discussion

Based on the foregoing, I find that neither of the physicians specifically addressed whether the Miner had a total pulmonary disability, as defined in and required by the regulation. For example, neither of the physicians articulated whether the Miner would be able to perform his last coal mine work (or work of any kind). Both of the physicians recognized that the Miner had multiple major medical conditions at the end of his life.

Assuming arguendo that the evidence establishes the Miner's total disability, as defined in § 718.204, I will, however, address whether the Claimant has established that the Miner's disability was due to pneumoconiosis. The burden is on the Claimant to establish this element of entitlement. See Dir., OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

Whether the Miner was Totally Disabled Due to Pneumoconiosis

This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. In general, the fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. § 718.204(c)(2). A claimant can establish this element through a physician's documented and reasoned medical report. § 718.204(c).

The only medical opinion indicating that the Miner's disability, if any, was due to pneumoconiosis was that of Dr. Levinson. However, in light of the abundant evidence of the Miner's multiple medical problems, particularly his long history of congestive heart failure, I find that Dr. Levinson's opinion does not adequately explain why or how the Miner's condition was exacerbated by pneumoconiosis – he just said his condition made it more difficult for the Miner to “weather the storm” caused by heart problems. Accordingly, I find that Dr. Levinson's opinion on this issue is not well-reasoned, and I give it no weight.

Conclusion: Miner's Claim for Benefits

In light of the foregoing, I find that there is no well-reasoned opinion to establish that the Miner's disability, if any, was due to pneumoconiosis. Accordingly, on remand I must deny the claim for benefits on behalf of the Miner.

The Claimant's Claim for Survivor's Benefits

The Act provides for benefits to eligible survivors of deceased miners whose death was due to pneumoconiosis. § 718.205(a). This provision requires that a claimant must establish three elements, each by a preponderance of the evidence: (1) that the miner had pneumoconiosis; (2) that the miner's pneumoconiosis arose out of coal mine employment; and (3) that the miner's death was due to pneumoconiosis. § 718.205(a)(1) through (3). Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993). The Claimant has the burden to establish each element of entitlement. Dir., OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

In a survivor's claim, it must first be determined whether the miner suffered from coal workers' pneumoconiosis before a finding may be made regarding the etiology of his death. Trumbo, 17 B.L.R. 1-85 (1993). The evidence on the issue of whether the Miner had pneumoconiosis arising out of his coal mine employment is summarized above. As set forth above, I have found that the Miner had clinical pneumoconiosis, arising from his coal mine employment. Thus, the Claimant has established the first two elements of entitlement. What is left to establish is whether the Miner died due to pneumoconiosis.

Section 718.205(c) provides the criteria for determining whether a miner's death is due to pneumoconiosis. This section requires that the Claimant establish one of the following: 1) competent medical evidence establishes that pneumoconiosis was the cause of the miner's death; 2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or death was caused by complications of pneumoconiosis; or 3) that the presumption of § 718.304 [complicated pneumoconiosis] applies.

In this case, there is no evidence that the Miner had complicated pneumoconiosis, as set forth in § 718.304. Therefore, § 718.304 does not apply, and it cannot be presumed that the Miner's death was due to pneumoconiosis. Consequently, the Claimant bears the burden to establish that the Miner's death was due to pneumoconiosis, or that pneumoconiosis was a substantially contributing cause of the Miner's death. The regulation also cautions that survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the

evidence establishes that pneumoconiosis was a substantially contributing cause of death. § 718.205(c)(4). The regulation also states that pneumoconiosis is a substantially contributing cause of death when it hastens the miner's death. § 718.205(c)(5).

The Miner died at the VA Medical Center where he had been treated for several years prior to his death. DX 27, DX 30. The Miner's death certificate states that cardiac arrhythmia due to a myocardial infarction was the immediate cause of death. DX 27. Other causes leading to the immediate cause, as listed on the death certificate, were pleural effusion, renal failure, congestive heart failure, and coronary artery disease. Id. Pneumoconiosis was not listed as a cause of death.

The VA Medical Center records indicate the Miner was in declining health and had been hospitalized on numerous occasions in the months prior to his death. See, e.g., DX 30 at 1327-31 (August 2006); DX 30 at 1131-39 (February 2007); DX 30 at 930-1103 (April 2007); DX 30 at 924-27 (May 2008); DX 30 at 313-415 (June 2008); DX 30 at 170-279 (July 2008). Most of these hospitalizations were for problems related to congestive heart failure or pulmonary problems, or both. When the Miner was hospitalized in July 2008, it was noted that he also had chronic renal insufficiency and worsening renal function. DX 30 at unpaginated page.

The Miner's final hospitalization, in October 2008, is most succinctly recounted in the Discharge Summary. DX 30 at unpaginated page; see also DX 30 at 1-135. The Miner was hospitalized after sustaining a fall and passing out. His significant medical conditions were listed. The Miner's EKG showed atrial fibrillation; he was identified as being in renal failure, with hyperkalemia, and he also had cellulitis of both lower extremities. The Miner's chronic congestive heart failure and pleural effusion were noted, but he was not in severe congestive heart failure at the time of his admission. The Discharge Summary noted the Miner had no shortness of breath. There was an indication of internal bleeding in the gastrointestinal tract. The Miner's condition continued to worsen, with low blood pressure. The Miner died about a week after his hospital admission. The discharge diagnoses were: Status Post [S/P] syncope with right side pleural effusion; End Stage Renal Disease [ESRD] with diabetic neuropathy and hypertensive nephrosclerosis. The physician who co-signed the Discharge Summary, Dr. Vinay Desai, also signed the Miner's death certificate.

In his report, Dr. Spagnolo stated that the Miner's death was "caused by his ischemic cardiomyopathy resulting in diastolic heart failure complicated by long standing diabetes mellitus and diabetic nephropathy leading to end stage renal failure." DX 40. He also stated there was no objective evidence to indicate the Miner had either clinical or legal pneumoconiosis, so, therefore, there was no objective evidence that pneumoconiosis played any role in the Miner's death.

Dr. Levinson, in his initial written report, stated that he totally agreed with Dr. Spagnolo that the Miner's death was caused by ischemic cardiomyopathy resulting in heart failure with recurrent pleural effusion, renal failure underlying long standing diabetes mellitus. CX 1 (Exhibit). He stated, in addition, he was also "strongly of the opinion" that the Miner's pulmonary condition was directly impacted by chronic pulmonary disease substantially related to

and aggravated by his coal mine employment. Id. In his written report, Dr. Levinson did not directly link the Miner's death to his coal mine employment.

At his deposition, Dr. Levinson testified that pneumoconiosis contributed to the Miner's death, and cited the pulmonary function study and arterial blood gas tests (discussed above), as well as the Miner's reliance on oxygen. CX 1 at 17-18. Dr. Levinson also indicated that, had the Miner not had coal dust accumulation in the upper lobes, he would have been better able to "weather the storm" caused by his heart disease. CX 1 at 18. He also acknowledged that the Miner's death was multifactorial. CX 1 at 22. In his addendum report, Dr. Levinson's opinion regarding the Miner's death was as follows: "I also feel that while [the Miner's] death was caused by ischemic cardiomyopathy resulting in heart failure with recurrent pleural effusion, renal failure and underlying longstanding diabetes mellitus[,] I am also of the direct opinion that this pneumoconiosis was a significant contributing and aggravating factor in the occurrence of his death." CX 1 (Exhibit).

As indicated above, the VA Medical Center treatment records indicate the Miner had multiple health problems, and that at the time of his death he had kidney failure as well as chronic heart failure. Neither physician denied the precipitating causes of the Miner's death. Where they differ is on the role, if any, that the Miner's pneumoconiosis played.

Dr. Spagnolo denied that the Miner had pneumoconiosis, which is contrary to my finding. Accordingly, I give his opinion that the Miner's death was not related to pneumoconiosis no weight. See generally Toler v. Eastern Associated Coal Co., 43 F.3d 109 (4th Cir. 1995) (it is appropriate to give little weight to a physician's opinion that is based on a conclusion regarding the existence of pneumoconiosis at odds with the administrative law judge's determination).

I find that Dr. Levinson's opinion is quite conclusory. Dr. Levinson did not explain at all what aspect of the Miner's clinical pneumoconiosis played a role in bringing about, or hastening, the Miner's death.²⁰ Additionally, I note that Dr. Levinson's conclusion appears to be at odds with the VA Medical Center records, which indicate that respiratory problems (such as shortness of breath) did not play a significant role in the Miner's final hospitalization.

I find that there is no well-reasoned or well-documented physician opinion to establish that pneumoconiosis played any role in the Miner's death. Based on the foregoing, and mindful that the burden is on the Claimant to establish that the Miner died due to pneumoconiosis, I find that the Claimant is unable to sustain that burden. Indeed, I find that the overwhelming preponderance of the evidence is that the Miner died due to the conditions described in the voluminous VA Medical Center records, including the records pertaining to his final hospitalization.

²⁰ As set forth above, I found Dr. Levinson's conclusion about legal pneumoconiosis not to be well-reasoned, and I did not find the Miner to have legal pneumoconiosis. Accordingly, I give no weight to Dr. Levinson's conclusion regarding any contributory element of legal pneumoconiosis in the Miner's condition in his final illness, and will presume that Dr. Levinson's opinion relates to clinical pneumoconiosis.

Conclusion: Claimant's Claim for Survivor's Benefits

Because I find that the Claimant is unable to establish that the Miner died due to pneumoconiosis, as defined in the regulation, on remand I must deny the Claimant's claim for survivor's benefits.

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

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).