U.S. Department of Labor

Benefits Review Board
200 Constitution Ave. NW
Washington, DC 20210-0001

BRB No. 21-0226 BLA

MARY CALTAGARONE (Widow of WILLIAM M. CALTAGARONE) Claimant-Petitioner v. KNISELEY COAL COMPANY, INCORPORATED and AMERICAN MINING INSURANCE COMPANY Employer/Carrier-Respondents DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR Party-in-Interest	)	DATE ISSUED: 12/19/2022 DECISION and ORDER

Appeal of the Decision and Order - Denying Request for Modification on Remand of Drew A. Swank, Administrative Law Judge, United States Department of Labor.

Heath M. Long and Matthew A. Gribler (Pawlowski, Bilonick & Long), Ebensburg, Pennsylvania, for Claimant.

Sean B. Epstein (Thomas, Thomas & Hafer, LLP), Pittsburgh, Pennsylvania, for Employer and its Carrier.

Before: BUZZARD, ROLFE and GRESH, Administrative Appeals Judges.

PER CURIAM:

Claimant[1] appeals Administrative Law Judge (ALJ) Drew A. Swank's Decision and Order - Denying Request for Modification on Remand (2017-BLA-05999) rendered on a miner's claim filed on April 22, 2013, pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2018) (Act). This case is before the Benefits Review Board for a second time.[2]

In his initial Decision and Order Denying Benefits, the ALJ credited the Miner with 30.74 years of coal mine employment but found Claimant did not establish he had a totally disabling respiratory or pulmonary impairment. 20 C.F.R. §718.204(b)(2); Director's Exhibit 28. Thus Claimant could not invoke the presumption of total disability due to pneumoconiosis at Section 411(c)(4) of the Act,[3] 30 U.S.C. §921(c)(4) (2018). The ALJ also found Claimant established simple coal workers' pneumoconiosis based on the Miner's autopsy evidence, 20 C.F.R. §718.202(a), but did not establish he had complicated pneumoconiosis and therefore could not invoke the irrebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(3) of the Act. 30 U.S.C. §921(c)(3)(2018); 20 C.F.R. §718.304; Director's Exhibit 28. Because Claimant failed to establish total disability, an essential element of entitlement, the ALJ denied benefits. Director's Exhibit 28. The ALJ subsequently issued a Decision and Order Denying Request for Modification because Claimant failed to establish a mistake in a determination of fact.[4] 20 C.F.R. §725.310; Director's Exhibit 29.

In consideration of Claimant's appeal, the Board affirmed the ALJ's finding that Claimant failed to establish complicated pneumoconiosis through x-ray or "other" medical evidence at 20 C.F.R. §718.304(a), (c). *Caltagarone v. Kniseley Coal Co., Inc.*, BRB No. 18-0383 BLA, slip op. at 4 n.6 (Sept. 20, 2019) (unpub.). However, the Board held the

[1] Claimant is the widow of the Miner, who died on January 15, 2014. Director's Exhibit 33. She is pursuing the claim on behalf of his estate. *Id.*

[2] We incorporate the procedural history of the case as set forth in *Caltagarone v. Kniseley Coal Co.*, BRB No. 18-0383 BLA, slip op. at 2 (Sept. 20, 2019) (unpub.).

[3] Section 411(c)(4) of the Act provides a rebuttable presumption that a miner was totally disabled due to pneumoconiosis if he had at least fifteen years of underground or substantially similar surface coal mine employment and a totally disabling respiratory impairment at the time of his death. 30 U.S.C. §921(c)(4) (2018); *see* 20 C.F.R. §718.305.

[4] The ALJ determined that because the Miner is deceased, Claimant cannot establish modification based on a change in condition. 20 C.F.R. §725.310; Decision and Order on Modification at 2.

ALJ erred in finding Claimant failed to establish complicated pneumoconiosis through the Miner's autopsy evidence at 20 C.F.R. §718.304(b). *Caltagarone*, BRB No. 18-0383 BLA, slip op. at 3-5. The Board explained the ALJ did not render necessary credibility findings with respect to the autopsy reports or explain his basis for resolving the conflict in this evidence. *Id.* In addition, the Board held that he did not explain why the negative x-rays, CT scans, the Miner's treatment records, and the medical reports are more credible than the autopsy evidence. *Id.* Because his Decision and Order did not comply with the Administrative Procedure Act (APA),[5] the Board vacated his finding that Claimant did not invoke the irrebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), and therefore the denial of benefits, and remanded the case for reconsideration. *Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162, 1-165 (1989); *Caltagarone*, BRB No. 18-0383 BLA, slip op. at 3-5.

In his Decision and Order - Denying Request for Modification on Remand that is the subject of this appeal, the ALJ again found Claimant failed to establish complicated pneumoconiosis and thus did not invoke the Section 411(c)(3) presumption. He thus again denied Claimant's request for modification as she failed to establish a mistake in a determination of fact. 20 C.F.R. §725.310.

On appeal, Claimant contends the ALJ did not properly weigh the autopsy reports of Drs. Perper and Oesterling. Employer and its carrier (Employer) urge the Board to affirm the denial of Claimant's modification request. The Director, Office of Workers' Compensation Programs (the Director), agrees the ALJ committed a number of errors in finding the autopsy evidence insufficient to establish complicated pneumoconiosis but "takes no position as to whether these errors affected the outcome in this case." Director's Letter Response at 1 n.1.

The Board's scope of review is defined by statute. We must affirm the ALJ's Decision and Order if it is rational, supported by substantial evidence, and in accordance with applicable law.[6] 33 U.S.C. §921(b)(3), as incorporated by 30 U.S.C. §932(a); *O'Keeffe v. Smith, Hinchman & Grylls Assocs., Inc.*, 380 U.S. 359 (1965).

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[5] The Administrative Procedure Act, 5 U.S.C. §§500-591, provides that every adjudicatory decision must include "findings and conclusions and the reasons or basis therefor, on all the material issues of fact, law, or discretion presented . . . ." 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 30 U.S.C. §932(a); *see Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162, 1-165 (1989).

[6] The Board will apply the law of the United States Court of Appeals for the Third Circuit because the Miner performed his last coal mine employment in Pennsylvania. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Director's Exhibit 6, 7.

Invocation of the Section 411(c)(3) Presumption – Complicated Pneumoconiosis

Section 411(c)(3) of the Act provides an irrebuttable presumption that a miner's total disability was due to pneumoconiosis if he suffered from a chronic dust disease of the lung which: (a) when diagnosed by x-ray, yields one or more opacities greater than one centimeter in diameter that would be classified as Category A, B, or C; (b) when diagnosed by biopsy or autopsy, yields massive lesions in the lung; or (c) when diagnosed by other means, would be a condition that could reasonably be expected to reveal a result equivalent to (a) or (b). *See* 20 C.F.R. §718.304. In determining whether Claimant has invoked the irrebuttable presumption, the ALJ must consider all evidence relevant to the presence or absence of complicated pneumoconiosis. 30 U.S.C. §923(b); *Truitt v. North Am. Coal Corp.*, 2 BLR 1-199 (1979), *aff'd sub nom. Director, OWCP v. North Am. Coal Corp.*, 626 F.2d 1137 (3d Cir. 1980); *see Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33 (1991) (en banc).

We agree with Claimant's and the Director's arguments that the ALJ committed several errors in weighing the autopsy evidence on remand.[7] 20 C.F.R. §725.304(b); Decision and Order on Remand at 3-26; Claimant's Brief at 8-10; Director's Letter Response at 1 n.1.

Dr. Perper reviewed forty-three autopsy slides and issued a report dated September 9, 2014. Director's Exhibit 26 (internally Claimant's Exhibit 2). He stated slide twenty-nine reveals a "[s]ilico-anthracotic micronodule exceeding [one centimeter]" that is "too large to be included in a single microphotograph, even at the lowest magnification [of] 16x." *Id.* Moreover, he concluded this nodule is "consistent with complicated coal workers' pneumoconiosis, on the background of mild simple coal workers pneumoconiosis with macules, micronodules, and foci of interstitial broanthracosis." *Id.*

Dr. Oesterling also reviewed the autopsy slides along with Dr. Perper's report and issued his own report on May 10, 2015. Director's Exhibit 25 (internally Employer's

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[7] The ALJ also summarized and weighed the report of Dr. Qian, the autopsy prosector. Dr. Qian set forth a "final antatomic diagnosis" that the Miner had moderate simple coal workers' pneumoconiosis with moderate chronic interstitial pneumonitis. Director's Exhibit 26 (internally Claimant's Exhibit 1). Although the ALJ found Dr. Qian diagnosed progressive massive fibrosis, there is no indication Dr. Qian made such a diagnosis. Decision and Order at 7, 22-23. Nonetheless the ALJ assigned little probative weight to Dr. Qian's report because, among other reasons, it is contradicted by the other pathology and radiologic evidence of record. *Id.* No party challenges this finding. Thus we affirm it. *Skrack v. Island Creek Coal Co*., 6 BLR 1-710, 1-711 (1983).

Exhibit 2). He concluded the slides reveal "evidence of minimal macular and focal micronodular interstitial coal workers' pneumoconiosis." *Id.* at 6. Regarding slide twenty-nine, he stated it reveals a "linear segment" that measured one centimeter in length and four millimeters in diameter. *Id.* He concluded this is "not a lesion purely due to coal dust, is not in the interstitium, and does not fulfill the criteria for a diagnosis of progressive massive fibrosis Dr. Perper has diagnosed." *Id.* Specifically, he explained his rationale based on his observations of the nodule on slide twenty-nine at different magnification levels:

> [A]t 30x [magnification] . . . the underlying lung appears normal while the enlarged structure shows a compartmentalized pattern. The extreme pole shows a slightly swirled area of pink tissue containing black pigment. By contrast the tissue on the right shows elongate pink fibers, [but] they do not have a swirled pattern. Photo 16 at 60x through the midportion of the larger area again clarifies the fact that these are arranged in a linear fashion, not in a swirled fashion as is typical in coal workers' pneumoconiosis and the nodules found thereon in. . . . Photo 20 at 150x shows the central portion of the swirled nodule with black pigment at 600x in photo 21 this is easily visualized. With partial polarized light photo 22 shows elongate pale golden tan birefringence in the collagen fibers of the lymph node while the adjacent tissues do contain black pigment with a scattering of modest numbers of silicate and silica crystals. This structure becomes critical for in examining it (sic), it has a pole which does appear secondary to coal dust and it produces a small micronodule that measures [two millimeters] in its greatest dimension. The remainder of this structure has a totally different architecture for we see the elongate parallel collagen fibers that are arranged in a basket weave pattern typical of reactive pleural fibrosis and is not the pattern seen in coal dust nodules. Therefore this would appear to be an entrapped area of pleura and indeed the far pole shows an area of pleura leading into the upper pole of this fibrotic component. Again reactive fibrosis in the pleura, not progressive massive fibrosis as Dr. Perper has opined.

Id.

In his June 30, 2015 deposition, Dr. Oesterling again stated there was "an area that comes close to being large enough [in] one dimension to say this is complicated coal workers' pneumoconiosis, but in looking at that histologically, two-thirds of that lesion are normal reactive fibrotic process and are unrelated to the dust that has produced a small micronodule on the one pole." Director's Exhibit 25 (Internally Employer's Exhibit 1) at 15. He stated that one pole is a "micronodule of coal workers' disease" but the "remainder of [the lesion] is a basket-weave pattern of fibrosis [] that is reactive pleural fibrosis [and]

not coal workers' pneumoconiosis." *Id.* at 17. But he could not identify the cause of the reactive pleural fibrosis, other than stating it is not due to coal dust. *Id.* at 19. He also testified the lesion is not complicated pneumoconiosis because it measures 1.1 centimeters in length but 0.4 millimeters in depth, and that is "nowhere near enough fibrosis to qualify for a diagnosis of progressive fibrosis." *Id.* at 18. In this regard, he stated that a one-centimeter lesion "has to be one-centimeters in every direction" to constitute complicated pneumoconiosis. *Id.* at 30.

Thereafter, Dr. Perper testified by deposition on July 9, 2015, and issued a supplemental report dated June 2, 2016. Director's Exhibits 26 (internally Claimant's Exhibit 4), 31. In both his deposition and supplemental report, he disputed Dr. Oesterling's rationale for excluding complicated pneumoconiosis. *Id.*

He reiterated slide twenty-nine "showed a lesion which exceeded one centimeter and it was basically a silicotic, anthracotic or highly anthracotic nodule[,] and such nodules which exceed one centimeter are diagnostic of complicated coal workers' pneumoconiosis/progressive massive fibrosis." Director's Exhibit 26 (internally Claimant's Exhibit 4) at 13. Moreover, he challenged Dr. Oesterling's opinion that the nodule has to be one-centimeter in all directions to constitute complicated pneumoconiosis, that the structure of the nodule is inconsistent with complicated pneumoconiosis, and that the lesion is not complicated pneumoconiosis because it involves the pleura. *Id.* 13-17. He concluded the lesion of complicated pneumoconiosis would appear on x-ray measuring at least one centimeter. *Id.* at 18-21. Furthermore, he explained why negative x-ray or CT scan evidence does not undermine his diagnosis of complicated pneumoconiosis because autopsy results are the "gold standard" for diagnosing the disease. *Id.* at 24-25, 40-41. He also opined the Miner's autopsy revealed a background of mild simple coal workers pneumoconiosis with macules and multiple micronodules, further supporting a diagnosis of complicated pneumoconiosis, and set forth why Dr. Oesterling was inconsistent in discussing this issue. *Id.* at 21-23.

The ALJ found Dr. Oesterling's conclusions "are detailed and well-documented, consistent with the medical literature explaining the development and composition of lesions of progressive massive fibrosis, and well-reasoned." Decision and Order on Remand at 23-24. He found the doctor's medical criteria for diagnosing progressive massive fibrosis is consistent with the medical literature he cited and judicial precedent. *Id.* Further, he found Dr. Oesterling's measurement of the lesion on slide twenty-nine is consistent with the autopsy prosector's report. *Id.*

In contrast, the ALJ determined Dr. Perper's opinion is "not as well documented and reasoned as those of Dr. Oesterling and [] entitled to much less probative weight on the issue" of complicated pneumoconiosis. Decision and Order at 24-25. He found Dr. Perper "failed to specifically identify the examined slides to the specific sections from

which they were obtained[.]" *Id.* Further, he found Dr. Perper did not address the lesion's basket-weave pattern that Dr. Oesterling identified at 600x magnitude on slide twenty-nine, nor "comment on Dr. Oesterling's finding that the only presence of coal dust reaction was a single micronodule at one end of the lesion and without heavy pigmentation present in the lesion." *Id.* He found Dr. Perper "misstated" the legal standard for establishing complicated pneumoconiosis through autopsy evidence. *Id.* Finally, he found Dr. Perper "failed to address the CT scan by Dr. Wolfe that he reviewed except to say the CT scan did not show one centimeter lesions." *Id.* Thus he found the autopsy evidence does not establish complicated pneumoconiosis. *Id.* at 25-26.

First, the ALJ erred by failing to follow the Board's remand instructions. The Board previously instructed him to "consider [C]laimant's argument that Dr. Oesterling's opinion is based in part on a diagnostic criterion that is contrary to the regulations." *Caltagarone*, BRB No. 18-0383 BLA, slip op. at 5-6. The Board specifically identified:

> Dr. Oesterling espoused the belief that a pleural lesion must be 1 cm in all directions in order to qualify as complicated pneumoconiosis. Director's Exhibit 25 (Dr. Oesterling's Deposition) at 18, 30. As the Department of Labor has declined to adopt a specific numerical criterion for the pathological diagnosis of complicated pneumoconiosis, Dr. Oesterling's diagnostic medical criteria are not controlling under the regulations. *See Scarbro*, 220 F.3d at 258; *see also The Pittsburg & Midway Coal Mining Co.* [*Cornelius*], 508 F.3d 975, 984 (observing that neither the Act nor the regulations defines the term "massive lesions"). Notably, the ILO classification form used for the interpretation of x-rays defines Category A opacities as those "[h]aving a greatest diameter exceeding about 10 mm . . . ." *See* Form CM-933 (emphasis added).

Caltagarone, BRB No. 18-0383 BLA, slip op. at 6, n.9.

When the Board remands a case, the ALJ must comply with its instructions and "implement both the letter and spirit of the . . . mandate." *See Scott v. Mason Coal Co.*, 289 F.3d 263, 267 (4th Cir. 2002), *quoting United States v. Bell*, 5 F.3d 64, 66 (4th Cir. 1993). Because the ALJ did not comply with our remand instructions, we must vacate his finding that Dr. Oesterling's opinion is reasoned and documented. Decision and Order on Remand at 24.

The ALJ also erred in discrediting Dr. Perper's opinion on the basis that the doctor did not explain why he disagreed with Dr. Oesterling. Decision and Order on Remand at 25. Specifically, the ALJ found:

> [Dr. Perper] disagreed with Dr. Oesterling opinion [that the lesion] was not complicated pneumoconiosis because the slide only provides a two

> dimensional measurement with no way to evaluate the third dimension and referred to the cited medical article to say complicated pneumoconiosis has a haphazard and irregular pattern not a twirled or whorled pattern so Dr. Oesterling was incorrect to say it was not complicated pneumoconiosis. However, Dr. Perper did not examine Slide 29 at 600x magnitude to determine whether or not the bulk of the lesion was a basket-weave pattern reported by Dr. Oesterling, which is not a haphazard and irregular pattern endorsed by Dr. Perper as complicated pneumoconiosis. He also did not comment on Dr. Oesterling's finding that the only presence of coal dust reaction was a single micronodule at one end of the lesion and without heavy pigmentation present in the lesion.

Id. This credibility finding is not supported by substantial evidence.

Dr. Perper set forth in detail his basis for disagreeing with Dr. Oesterling's opinion. In his deposition, Claimant's counsel asked Dr. Perper to address Dr. Oesterling's opinion that the lesion is not one of complicated pneumoconiosis because it was not one centimeter "in all directions." Director's Exhibit 26 (internally Claimant's Exhibit 4) at 13-14. In response, he stated Dr. Oesterling is "incorrect because [] no pathologist can see lesions of coal workers pneumoconiosis, [or] any kind of lung lesion, in three dimension" as "the slides which are under the examination by the pathologist are only two dimensions. They are very thin slides and only two dimension really could be evaluated." *Id.* He stated "[t]here is no way to evaluate the third dimension because there is no third dimension and basically the dimensions which are on the slides are length and width, but not depth." *Id.*

Dr. Perper also disputed Dr. Oesterling's opinion that the absence of a swirled patterned on a portion of the lesion undermines a diagnosis of complicated pneumoconiosis. He explained:

> Dr. Oesterling creates a requirement which is non-existent. Not only is it non-existent, but it is also diametrically opposed to the accepted pathology standards. There is a classic paper, original paper or classic paper of pathology and this paper is called Pathology Standards for Coal Workers Pneumoconiosis. It was published in the Archive of Pathology of Laboratory Medicine in 1979, the Volume 103 by Kleinerman, Green, Harley Taylor and others, and in this classical pathology standards defines complicated coal workers pneumoconiosis as having haphazard and the irregular kind of pattern and specifically it specified that it doesn't have a whorled or twirled pattern and therefore is totally contrary and opposed to the claim of Dr. Oesterling. So, Dr. Oesterling's claim that the lesion of coal workers pneumoconiosis has to be whorled or twirled is properly incorrect. Thus he

stated the lesion not having a swirled pattern "to its fibrous tissue" is actually consistent with complicated pneumoconiosis.[8]

Director's Exhibit 26 (internally Claimant's Exhibit 4) at 14-16.

Dr. Perper further addressed Dr. Oesterling's opinion that the lesion is not complicated pneumoconiosis because it involves the pleura. Director's Exhibit 26 (internally Claimant's Exhibit 4) at 17. He testified that the Kleinerman, Green, Harley Taylor article "specifies that [it is] typical for complicated coal workers pneumoconiosis is to have pleural based lesions." *Id.* But he noted "this particular lesion [does not involve] only the pleura" and "is clearly bordered on the side by the pleura, and therefore, it is pleural based[.]" *Id.* He explained "the pleura is a very thick membrane which covers the lung and if [the lesion] would be thicker and it would be just in the pleura, then it could not have border lines on any part of it and the photographs clearly show such bordering by alveolar tissue indicating that this is a lesion which involves both the pleura and the lung tissue, the alveolar tissue beneath the pleura." *Id.*

Finally, in a supplemental report, Dr. Perper reiterated that "Dr. Oesterling unreasonably and artificially separated the components of the macronodule in a pneumoconiotic fibro-anthracotic nodule, failing to photographically document the entire macronodule, and unreasonably segregating a more pigmented region and dismissing the remainder as non-specific fibrosis." Director's Exhibit 31 at 3. Dr. Perper stated his own "microscopic description and the photographs of the entire macronodular lesion (in 2 segments with micrometer measurements attached) clearly document a single fibro-anthracotic macronodule."[9] *Id.*

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[8] Dr. Perper reviewed Dr. Oesterling's entire report, and thus was aware of his identification of a basket-weave pattern on slide twenty-nine at 600x magnitude. Director's Exhibits 26 (internally Claimant's Exhibit 4), 31. He nonetheless concluded Dr. Oesterling based his opinion on a non-existent requirement and opined that a haphazard and irregular pattern is consistent with complicated pneumoconiosis based on the medical literature. Director's Exhibit 26 (internally Claimant's Exhibit 4) at 14-16. To the extent the ALJ concluded that a basket-weave pattern is not haphazard or irregular, he has not supported his determination with any medical evidence. *See Marcum v. Director, OWCP*, 11 BLR 1-23, 1-24 (1987) (the interpretation of objective data is a medical determination and an ALJ may not substitute his opinion for that of a physician).

[9] As discussed above, Dr. Perper stated slide twenty-nine "showed a lesion which exceeded one centimeter and it was basically a silicotic, anthracotic or highly anthracotic

Thus the ALJ erred in failing to consider the entirety of Dr. Perper's opinion when he discredited it. 30 U.S.C. §923(b) (ALJ must consider all relevant evidence); *Wensel v. Director, OWCP*, 888 F.2d 14, 17 (3d Cir. 1989)*; Sea "B" Mining Co. v. Addison*, 831 F.3d 244, 253-54 (4th Cir. 2016); *Director, OWCP v. Rowe*, 710 F.2d 251, 255 (6th Cir. 1983); *McCune v. Central Appalachian Coal Co*., 6 BLR 1-996, 1-998 (1984).

The ALJ also erroneously criticized Dr. Perper for failing to "specifically identify the examined [autopsy] slides to the specific [lung] sections from which they were obtained" or "identify the [lung] site from which slide [twenty-nine] was obtained . . . ." Decision and Order on Remand at 24-25. As discussed in the Board's prior decision, Drs. Oesterling and Perper both agree that autopsy slide twenty-nine reveals a lesion in the Miner's lungs which measures more than one centimeter in length. Director's Exhibit 25 (internally Employer's Exhibit 1 at 3, 4 at 31) and 26 (internally Claimant's Exhibit 2 at 5, 4 at 13). The disagreement between the two doctors is whether the lesions is complicated pneumoconiosis. *See Caltagarone*, BRB No. 18-0383 BLA, slip op. at 3-4. The ALJ has not explained why Dr. Perper's failure to correspond each autopsy slide with a location in the lung, or indicate the location of the lung from which slide twenty-nine emanates, undermines the credibility of his opinion. *Wensel*, 888 F.2d at 17; *Wojtowicz*, 12 BLR at 1-165.

The ALJ further erred in discrediting Dr. Perper's opinion for misstating the regulatory standard for establishing complicated pneumoconiosis based on autopsy evidence at 20 C.F.R. §718.304(b). The ALJ stated as follows:

> Dr. Perper misstated the requirements of progressive massive fibrosis when he testified 'Currently the standard for coal workers' pneumoconiosis is one centimeter or more on pathological slide … because lesions observed on the tissue when they are seen radiologically can only be the same size or larger, never smaller … because there is some distance in the body between the lesion and the … radiological plate. This lesion exceeded one centimeter, therefore, the radiological image of this lesion of tissue would certainly be the same size or larger."

Decision and Order on Remand at 25, *quoting* Director's Exhibit 26 (internally Claimant's Exhibit 4).

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nodule[,] and such nodules which exceed one centimeter are diagnostic of complicated coal workers' pneumoconiosis/progressive massive fibrosis." Director's Exhibit 26 (internally Claimant's Exhibit 4) at 13.

First, we note Dr. Perper was addressing the medical standard for diagnosing complicated pneumoconiosis and not any particular legal standard. In his deposition, he stated that, based on his medical opinion, the lesion seen "pathologically [is] a lesion of complicated coal workers pneumoconiosis." Director's Exhibit 26 (internally Claimant's Exhibit 4) at 18-19. He indicated older medical articles required a lesion to measure two centimeters to constitute complicated pneumoconiosis, but the medical standard "underwent a number of changes and some of the changes involved new types of coal workers pneumoconiosis, such as interstitial fibrosis type of coal workers pneumoconiosis." *Id.* In addition, he noted newer medical sources, such as textbooks published by the Armed Forces Institute of Pathology and some universities," reflect that the current standard for complicated pneumoconiosis "is one centimeter or more on pathological slide and such a slide of one [c]entimeter or more is equivalent to radiological image of one centimeter or more." *Id.* He explained why a lesion measuring one centimeter on autopsy would appear on x-ray measuring at least one centimeter, noting "lesions observed on the tissue when they are seen radiologically can be only the same size or larger and never smaller, and this is because of the physical law which directs the spread of the rays of light." *Id.* He concluded the lesion he identified on autopsy would appear at least one centimeter on x-ray. *Id.* at 18-21. Thus the ALJ erroneously mischaracterized Dr. Perper's deposition testimony. *Wensel*, 888 F.2d at 17; *Addison*, 831 F.3d at 253-54.

Further, Dr. Perper's opinion is not contrary to applicable law. The term progressive massive fibrosis is generally considered to be equivalent to the term complicated pneumoconiosis and when there is a diagnosis of progressive massive fibrosis, it equates to a diagnosis of massive lesions, sufficient to establish the existence of complicated pneumoconiosis under 20 C.F.R. §718.304(b). *See Perry v. Mynu Coals, Inc.*, 469 F.3d 360, 365 n.4 (4th Cir. 2006); *Lisa Lee Mines v. Director, OWCP* [*Rutter*], 86 F.3d 1358, 1359, 20 BLR 2-227, 2-228 (4th Cir. 1996) (noting that complicated pneumoconiosis is known "by its more dauntingly descriptive name, 'progressive massive fibrosis.'"); *Gray v. SLC Coal Co.*, 176 F.3d 387 (6th Cir. 1999). As the Director correctly argues, the ALJ incorrectly applied precedent from the United States Court of Appeals for the Third Circuit, within whose jurisdiction this case arises, when he stated this circuit requires an equivalency finding for autopsy evidence diagnosing complicated pneumoconiosis. Decision and Order on Remand at 5-6, 22; Director's Letter Response at 1 n.1. Contrary to the ALJ's analysis, the Third Circuit in *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14 (3d Cir. 1981) did not address whether an equivalency finding is necessary for evidence under 20 C.F.R. §718.304(b) and only held that an equivalency finding is necessary for evidence under 20 C.F.R. §718.304(c). *See Bridger Coal Co. v. Dir., OWCP*, 669 F.3d 1183,1193 n.9 (10th Cir. 2012).

The ALJ next erred in finding Dr. Perper "failed to address the CT scan by Dr. Wolfe that he reviewed except to say the CT scan did not show one-centimeter lesions." Decision and Order on Remand at 25. Contrary to the ALJ's analysis, Claimant's counsel

asked Dr. Perper about the negative CT scans and x-rays, and he explained this type of evidence does not undermine a diagnosis of complicated pneumoconiosis based on pathology evidence.

Dr. Perper explained autopsy findings are the "gold standard" for identifying coal workers' pneumoconiosis because "radiological findings are basically shadows of lesions and the lesion can be lesions of coal workers pneumoconiosis" or lesions of other conditions, such as cancer or fungal infection. Director's Exhibit 26 (internally Claimant's Exhibit 4) at 24-25. He stated that, "after reviewing hundreds of cases of coal workers who died with coal workers' pneumoconiosis, [he] found very commonly that radiologists . . . mistakenly diagnose . . . nodules of coal workers pneumoconiosis as being granuloma and after the fact the autopsies clearly show that there is no [] granuloma present[.]" *Id.* Identifying the same problem with CT scans, he explained that "more than [thirty] percent [of these tests] miss lesions of coal workers pneumoconiosis and other lesions. Lesions of coal workers pneumoconiosis, even complicated coal workers pneumoconiosis, have been totally missed or sometimes thought to be granuloma, in other cases thought to be cancer." *Id.* at 39. He conceded he did not review a number of CT scans of record and the CT scans he did review did not show one-centimeter lesions, but, as noted, he considered diagnosis by autopsy to be the gold standard and reiterated that both x-rays and CT scans frequently misidentify "lesions of coal workers pneumoconiosis, including complicated, [for a variety of [other] things."[10] *Id.* at 40-41. Thus the ALJ erred in failing to discuss this aspect of Dr. Perper's testimony. 30 U.S.C. §923(b); *Wensel*, 888 F.2d at 17; *Addison*, 831 F.3d at 253-54; *Rowe*, 710 F.2d at 255; *McCune*, 6 BLR at 1-998.

Based on the foregoing errors, we vacate the ALJ's finding that Claimant failed to establish complicated pneumoconiosis through autopsy evidence. 20 C.F.R. §718.304(b). We further vacate his finding that Claimant did not establish complicated pneumoconiosis based on consideration of the evidence as a whole[11] and therefore the denial of benefits. 20 C.F.R. §718.304.

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[10] On redirect examination, Dr. Perper further refuted Dr. Wolfe's observations of granulomas measuring 0.6 and 0.4 centimeters when he opined that "in the comparison of radiological and pathological finding[s], the pathological finding get [sic] the upper hand, and in this case none of the three pathologists observed any granulomas for the very reason that none was present." Director's Exhibit 26 (internally Claimant's Exhibit 4) at 52.

[11] In instructing the ALJ to explain why "the negative x-rays, CT scan, treatment records, and medical reports are more credible than the autopsy evidence," the Board instructed the ALJ to weigh Dr. Go's opinion that the absence of positive x-ray and CT scan evidence does not undermine the autopsy evidence of complicated pneumoconiosis. *Caltagarone*, BRB No. 18-0383 BLA, slip op. at 4-5, n.8. The ALJ discredited Dr. Go's

Reassignment

Finally, in light of the Board's previous remand of this case and the ALJ's failure to follow the Board's instructions and repetition of numerous errors, we conclude that "review of this claim requires a fresh look at the evidence . . . ." *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 537 (4th Cir. 1998) (instructing that review of the claim required a fresh look at the evidence, unprejudiced by the various outcomes of the ALJ, where he made several errors of law including failing to consider all of the relevant evidence and to adequately explain his rationale for crediting certain evidence); *see* 20 C.F.R. §§802.404(a), 802.405(a); *see also Cochran v. Consolidation Coal Co.*, 16 BLR 1-101, 1-107 (1992). Thus, we direct the case be reassigned to a different ALJ on remand.

Remand Instructions

On remand, the new ALJ must reconsider whether the autopsy evidence establishes complicated pneumoconiosis. 20 C.F.R. §718.304(b). The new ALJ must critically examine all the relevant medical evidence, resolve the conflict in the physicians' opinions, and explain his or her weighing of the evidence in accordance with the requirements of the APA. 5 U.S.C. §557(c)(3)(A); *Wojtowicz*, 12 BLR at 1-165. In addition, he or she should address the comparative credentials of the physicians, the explanations for their conclusions, the documentation underlying their medical judgments, and the sophistication of, and bases for, their diagnoses. *Wensel*, 888 F.2d at 17; *Addison*, 831 F.3d at 253-54; *Rowe*, 710 F.2d at 255. He or she must weigh together all of the evidence relevant to the presence or absence of complicated pneumoconiosis. *Melnick*, 16 BLR 1-31, 1-33-34. If the new ALJ determines that the evidence does not establish complicated pneumoconiosis, he or she may reinstate the denial of Claimant's request for modification. If he or she determines Claimant has established complicated pneumoconiosis, thus invoking the irrebuttable presumption of total disability due to pneumoconiosis, the new ALJ must determine whether Employer has established the Miner's complicated pneumoconiosis did not arise out of his coal mine employment and thus whether Claimant is entitled to an award of benefits. 20 C.F.R. §718.203, 718.304.

Accordingly, the ALJ's Decision and Order - Denying Request for Modification on Remand is affirmed in part and vacated in part, and the case is remanded to the Office of

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opinion based, in part, on his discrediting of Dr. Perper's autopsy opinion. Decision and Order on Remand at 21-22. Because the ALJ erred in discrediting Dr. Perper's autopsy findings, we vacate his discrediting of Dr. Go's medical opinion and instruct the new ALJ to reweigh it on remand as necessary.

Administrative Law Judges for reassignment to a different ALJ for further consideration in accordance with this opinion.

SO ORDERED.

GREG J. BUZZARD
Administrative Appeals Judge

JONATHAN ROLFE
Administrative Appeals Judge

DANIEL T. GRESH
Administrative Appeals Judge