U.S. Department of Labor

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

BRB Nos. 20-0256 BLA
and 20-0256 BLA-A

HENRY LEE DAWSON

Claimant-Petitioner
Cross-Respondent

v.

GRIFFITH CONSTRUCTION COMPANY

and

BRICKSTREET MUTUAL INSURANCE COMPANY

Employer/Carrier-
Respondents and
Cross-Petitioners

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR

Party-in-Interest

DATE ISSUED: 07/29/2021

DECISION and ORDER

Appeal and Cross-Appeal of the Decision and Order Denying Benefits of Timothy J. McGrath, Administrative Law Judge, United States Department of Labor.

Henry Lee Dawson, Raysal, West Virginia.

Ashley M. Harman and Lucinda L. Fluharty (Jackson Kelly, PLLC), Morgantown, West Virginia, for Employer and its Carrier.

Before: BOGGS, Chief Administrative Appeals Judge, ROLFE and JONES, Administrative Appeals Judges.

PER CURIAM:

Claimant appeals, without the assistance of counsel,[1] and Employer and its Carrier (Employer) cross-appeal the Decision and Order Denying Benefits (2011-BLA-06348) of Administrative Law Judge Timothy J. McGrath rendered on a claim filed pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2018) (Act). This case involves a miner's claim filed on August 27, 2010.

The administrative law judge credited Claimant with 6.91 years of coal mine employment.[2] Because he found the evidence did not establish complicated pneumoconiosis, Claimant 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. Based on the parties' stipulation that Claimant is not totally disabled, the administrative law judge also found Claimant could not establish entitlement to benefits under 20 C.F.R. Part 718, and denied benefits.

On appeal, Claimant generally challenges the denial of benefits. Employer responds in support of the denial. In its cross-appeal, Employer argues the administrative law judge erred in finding Claimant established clinical pneumoconiosis. The Director, Office of Workers' Compensation Programs, has not filed a response brief.

In an appeal filed by a claimant without the assistance of counsel, the Board addresses whether substantial evidence supports the Decision and Order below. *Hodges v. BethEnergy Mines, Inc.*, 18 BLR 1-84 (1994). We must affirm the administrative law

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[1] On Claimant's behalf, Vickie Combs, a benefits counselor with Stone Mountain Health Services of Vansant, Virginia, requested that the Benefits Review Board review the administrative law judge's decision, but she is not representing Claimant on appeal. *See Shelton v. Claude V. Keen Trucking Co.*, 19 BLR 1-88 (1995) (Order).

[2] Section 411(c)(4) of the Act provides a rebuttable presumption that a miner is totally disabled due to pneumoconiosis if he has at least fifteen years of underground or substantially similar surface coal mine employment and a totally disabling respiratory or pulmonary impairment. 30 U.S.C. §921(c)(4) (2018); *see* 20 C.F.R. §718.305. Because Claimant established fewer than fifteen years of coal mine employment, and the parties stipulated that he is not totally disabled, Claimant is unable to invoke the Section 411(c)(4) presumption. Hearing Transcript at 7; Joint Exhibit 1.

judge's Decision and Order if it is rational, supported by substantial evidence, and in accordance with applicable law.[3] 33 U.S.C. §921(b)(3), as incorporated by 30 U.S.C. §932(a); *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

Section 411(c)(3) Presumption – Complicated Pneumoconiosis

Section 411(c)(3) of the Act provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he suffers from a chronic dust disease of the lung which: (a) when diagnosed by x-ray, yields one or more large 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, is a condition which would yield results equivalent to (a) or (b). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. The administrative law judge must determine whether the evidence in each category tends to establish the existence of complicated pneumoconiosis, and then must weigh together the evidence at subsections (a), (b), and (c) before determining whether Claimant has invoked the irrebuttable presumption. *See Westmoreland Coal Co. v. Cox*, 602 F.3d 276, 283 (4th Cir. 2010); *E. Assoc. Coal Corp. v. Director, OWCP* [*Scarbro*], 220 F.3d 250, 255-56 (4th Cir. 2000); *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33 (1991) (en banc).

The X-ray Evidence at 20 C.F.R. §718.304(a)

The administrative law judge considered seven readings of three x-rays.[4] 20 C.F.R. §718.304(a). Dr. Forehand, a B reader, read the October 20, 2010 x-ray as showing "bilateral upper lobe densities" consistent with complicated pneumoconiosis, Category B. Director's Exhibit 12. He commented that malignancy and infection should be ruled out. *Id*. Dr. Miller, dually qualified as a B reader and Board-certified radiologist, noted "bilateral upper lung large opacities with a combined size less than five centimeters" compatible with complicated pneumoconiosis, Category A. Director's Exhibit 28. Dr. Meyer, also dually qualified, read the film as showing large opacities present in both lung

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[3] This case arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit because Claimant performed his coal mine employment in West Virginia. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Director's Exhibit 5; Hearing Transcript at 31.

[4] Dr. Gaziano reviewed this x-ray for quality purposes only. Director's Exhibit 12.

zones, Category B. Employer's Exhibit 4. Dr. Meyer indicated the opacities could also represent sarcoidosis.[5] *Id.*

Dr. Meyer read the May 3, 2011 x-ray as positive for complicated pneumoconiosis, again stating "sarcoidosis is favored." Director's Exhibit 26. Dr. Alexander, also a dually-qualified radiologist, read the film as positive for complicated pneumoconiosis, Category A. Employer's Exhibit 6. Dr. Miller read the April 4, 2012 x-ray as positive for a Category B large opacity but commented he suspected sarcoidosis and recommended pathological confirmation. Dr. Meyer read the same x-ray as positive for complicated pneumoconiosis, Category C. Claimant's Exhibit 1; Employer's Exhibit 7. He also commented that he suspected sarcoidosis and recommended pathological confirmation. Employer's Exhibit 7.

After considering the physicians' qualifications and their associated comments, the administrative law judge found the designated x-rays supported a finding of complicated pneumoconiosis.[6] 20 C.F.R. §718.304(a); Decision and Order at 43-44. He explained that "taken alone and on this record, [the physician's comments suggesting the identified opacities could be due to other causes] do not undermine the affirmative x-ray readings." *Id.* at 44. Because it is supported by substantial evidence, we affirm the administrative law judge's determination that the x-ray evidence supports a finding of complicated pneumoconiosis. 20 C.F.R. §718.304(a); *Compton v. Island Creek Coal Co.*, 211 F.3d 203, 207-08 (4th Cir. 2000); Decision and Order at 42.[7]

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[5] Dr. Meyer commented, "given the patient's young age and associated conglomerate fibrosis and symmetric adenopathy, sarcoidosis is favored." Employer's Exhibit 4.

[6] The administrative law judge noted all the physicians identified simple pneumoconiosis, with opacities ranging in size from 2/1, 2/2, 2/3, or 3/2, as reported on the ILO forms. Decision and Order at 43-44; Director's Exhibits 12, 26, 28; Claimant's Exhibit 1; Employer's Exhibits 4, 6, 7.

[7]The administrative law judge's explanation with respect to why the notations of the physicians did not detract from an affirmative finding of complicated pneumoconiosis on the x-rays is conclusory; however, any error due to his failure to provide an adequate explanation for his finding ultimately is harmless in view of his determination that complicated pneumoconiosis is not established by the evidence as a whole, as discussed *infra*. *See Larioni v. Director, OWCP*, 6 BLR 1-1276, 1-1278 (1984).

The Biopsy Evidence at 20 C.F.R. §718.304(b)

Claimant underwent a bronchoscopy on March 1, 2010. The gross description noted "focal deposition of anthrasilicotic material" and "minute flecks of red-black tissue, the largest measuring 1mm," but no changes of coal workers' pneumoconiosis were identified. Director's Exhibit 26. Bronchial washings obtained from both right and left lobes identified "no malignant cells" and indicated "no yeast or fungal elements." *Id*.

Dr. Groten conducted a computed tomography (CT) guided lung biopsy on July 5, 2011. Employer's Exhibit 19. The purpose of the biopsy was to "rule out sarcoidosis versus pneumoconiosis" regarding an apparent "bilateral upper lobe lung mass." *Id*. Dr. Pardasani reviewed pathology tissue from the lung biopsy and reported "diffuse granulomatous process" with no evidence of malignancy or coal workers' pneumoconiosis. *Id*. He diagnosed "non-caseous granuloma" and noted "a strong possibility of sarcoidosis." *Id*.

The administrative law judge found that none of the physicians interpreting the biopsy evidence diagnosed complicated pneumoconiosis, and they did not describe any lesions attributable to coal workers' pneumoconiosis, or describe massive lesions.[8] 20 C.F.R. §718.304(b); Decision and Order at 45. Because it is supported by substantial evidence, we affirm the administrative law judge's finding that the biopsy evidence does not support a finding of complicated pneumoconiosis. 20 C.F.R. §718.304(b); *Compton*, 211 F.3d at 207-208; Decision and Order at 45.

Other Medical Evidence at 20 C.F.R. §718.304(c)

Lastly, the administrative law judge considered other medical evidence, including x-ray readings, CT scan reports, and physicians' notes, along with the parties' designated medical opinion evidence.

Treatment X-rays

The administrative law judge considered readings of four x-rays contained in the treatment records or designated as other medical evidence pursuant to 20 C.F.R. §718.107.

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[8] Although Dr. McKinney, one of Claimant's treating physicians, referred to the bronchoscopy findings as "supportive of coal workers' pneumoconiosis," the administrative law judge permissibly discounted her opinion in light of the pathologist's failure to identify "changes of coal workers' pneumoconiosis." Decision and Order at 44; Director's Exhibit 26; *see Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 949 (4th Cir. 1997).

Dr. Powers interpreted a March 1, 2010 x-ray as failing to exclude an "underlying lung mass/adenopathy/neoplasm." Director's Exhibit 26. The administrative law judge found this x-ray did not establish complicated pneumoconiosis because Dr. Powers did not classify the results in ILO format. Decision and Order at 42.

Dr. Forehand read a March 30, 2010 x-ray as positive for Category A large opacities; however, he further clarified his reading by noting "bilateral upper lobe masses," under which he wrote, "r/o [rule out] TB [tuberculosis], malignancy[, and] other granulomatous diseases." Director's Exhibit 26. Dr. Subramaniam interpreted the same x-ray as showing Category A large opacities and noted "bilateral large opacities in the upper lobes." *Id*. He commented that it is "somewhat unusual to see this degree of pneumoconiotic change in a patient with [twelve] years of occupational history" and recommended further CT scan examination to rule out sarcoidosis. *Id*. Dr. Meyer also interpreted the March 30, 2010 x-ray as positive for Category B large opacities in the upper lobes, but commented that sarcoidosis is suspected. Employer's Exhibit 10. The administrative law judge acknowledged the comments by Drs. Subramaniam and Meyer, but found the x-ray positive for complicated pneumoconiosis, without any specific explanation for that finding. Decision and Order at 42-43.

Dr. Castle read the March 23, 2011 x-ray as positive for complicated pneumoconiosis, Category B.[9] Director's Exhibit 21. He stated that the etiology of the bilateral upper lung zone masses is "uncertain" with "differential diagnoses including sarcoidosis, lymphoma, [and] granulomatous disease." *Id*. Dr. Meyer also interpreted this x-ray as positive for a Category B large opacity but stated that "[g]iven this patient's young age, sarcoidosis is suspected." Employer's Exhibit 11. The administrative law judge found "[g]iven that both experts appear less than certain about alternative diagnoses to account for the large opacities, I find their comments do not detract from the weight of their ILO interpretations[,]" which support a finding of complicated pneumoconiosis. Decision and Order at 43.

Dr. Seaman interpreted a December 5, 2011 x-ray as showing scattered mass-like and small nodular opacities, and commented that the differential diagnosis includes sarcoidosis and "could also represent coal workers['] pneumoconiosis given the clinical history." Claimant's Exhibit 10 at 16. The administrative law judge found this x-ray

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[9] This x-ray was taken in conjunction with Dr. Castle's March 23, 2011 exam. Director's Exhibit 21. Dr. Castle interpreted the analog copy of a digital film. *Id*. Because it is originally a digital film, Employer designated it as other medical evidence pursuant to 20 C.F.R. §718.107. *See* Decision and Order at 43.

insufficient to establish complicated pneumoconiosis because Dr. Seaman relied on an incorrect clinical history of coal mine dust exposure. Decision and Order at 44.

CT Scans

The administrative law judge considered twelve interpretations of seven CT scans taken on February 16, 2010, June 15, 2010, May 13, 2011, January 16, 2012, July 5, 2012, July 9, 2013, and November 25, 2014. Decision and Order at 28-33; Director's Exhibit 26; Claimant's Exhibits 2, 3, 6, 7; Employer's Exhibit 8. Dr. Ramakrishnan interpreted the February 16, 2010 CT scan as showing coalescing masses in both upper lobes "consistent with possible advanced coal workers' pneumoconiosis." Director's Exhibit 26. He noted Claimant's young age of thirty-one and determined he did not have enough information to make an intelligent diagnosis. *Id.* Dr. Meyer interpreted the same scan as showing "upper lobe predominant perilymphatic nodules with coalescence in association with symmetric mediastinal and hilar lymphadenopathy." Employer's Exhibit 8. He "strongly favored" a diagnosis of sarcoidosis given Claimant's age, but agreed coal workers' pneumoconiosis may result in similar appearance although typically only after several decades of significant exposure. *Id.*

Dr. Knapp interpreted the June 15, 2010 CT scan as showing "[s]evere pneumoconiosis stable from previous examination." Director's Exhibit 26.

Dr. Shahan interpreted the May 13, 2011 CT scan as showing symmetrical reticulonodular interstitial disease with bilateral irregular lung masses. Claimant's Exhibit 2. He stated that sarcoidosis or other granulomatous disease "would appear to be more likely etiologies," but could possibly be coal workers' pneumoconiosis "despite [Claimant's] young age." *Id.*

Dr. Coleman interpreted the January 16, 2012 CT scan as showing:

> Areas of airspace consolidation in the upper lobes and in the superior segments of the lower lobe associated with random ground-glass nodules throughout the lungs are present representing [Claimant's] known pneumoconiosis. This appears to have worsened petechial in the right upper lobe with enlarged areas of airspace consolidation and loss of lung volume.

Claimant's Exhibit 3. Dr. Meyer read the same scan as showing:

> Diffuse perilymphatic nodules with bilateral areas of conglomerate fibrosis which have changed significantly over less than [two] years. Symmetric mediastinal and hilar lymphadenopathy is also slightly decreased. This

> pattern of evolution is not consistent with coal workers pneumoconiosis and in this young patient strongly favors sarcoidosis.

Employer's Exhibit 8.

Dr. Knapp interpreted a July 5, 2012 CT scan as showing "[s]table findings consistent with pneumoconiosis. [Claimant] has upper lobe predominant massive pulmonary fibrosis with reticular nodular pattern present." Claimant's Exhibit 7. Dr. Meyer interpreted the same scan as showing:

> Upper lobe predominant perilymphatic nodules with conglomerate fibrosis and symmetric mediastinal and hilar lymphadenopathy. Serial chest CT's demonstrate interval resolution of lymphadenopathy and improvement in perilymphatic nodules and conglomerate fibrosis. *The evolution of these findings is not compatible with coal workers' pneumoconiosis and characteristic of sarcoidosis.*

Employer's Exhibit 23 (emphasis added).

Dr. Mendrek interpreted the July 9, 2013 CT scan as showing:

> Significant improvement in bilateral mass-like consolidations described in prior examination. The findings suggest a more acute process in prior study such as a pneumonia-like process which has mostly resolved. The massive progressive fibrosis felt to be present in prior study appears less conspicuous, but there is persistent fibrosis seen in both lung fields. The diffuse reticulonodular pattern described in prior studies persists or may show slight improvement. Again a superimposed infectious or inflammatory process in prior study is not excluded.

Employer's Exhibit 13. Dr. Meyer read the same scan as showing:

> Overall improvement in perilymphatic nodules with decrease in size of conglomerate masses and mediastinal lymphadenopathy. The evolution of these findings is not consistent with coal workers' pneumoconiosis and in this young patient is almost certainly due to sarcoidosis.

Employer's Exhibit 8.

Lastly, Dr. Fish interpreted the November 25, 2014 CT scan as showing:

> 1. Continued marked improvement of multifocal interstitial reticulonodular opacities as well as marked improvement of upper lobe consolidative changes. Findings are most consistent with appropriate response to therapy. No indication of acute intrathoracic process.
> 2. Minimal residual air space scarring and architectural changes are present in the upper lobes, which may relate to underlying history of pneumoconiosis.

Claimant's Exhibit 6.

The administrative law judge found that "[t]he CT scans show the regression in the lung masses" with the earliest scans from 2010 diagnosing complicated pneumoconiosis, but later CT scans, read by various physicians, indicating sarcoidosis or another granulomatous disease was more likely and the massive fibrosis appeared to be less conspicuous. Decision and Order at 46-47, *referencing* Claimant's Exhibit 2; Employer's Exhibit 13.

Treatment Notes

On February 24, 2010 Dr. Hoskere saw Claimant for a follow-up visit after a February 16, 2010 CT scan revealed masses in his upper lobe, which he noted were suggestive of possible coal workers' pneumoconiosis. Director's Exhibit 26. He decided to "proceed with bronchoscopy to rule out any other types of atypical infections versus and [sic] cancers." *Id.* The bronchoscopy, discussed above, was performed on March 1, 2010. Director's Exhibit 26. On March 9, 2010, Dr. McKinney saw Claimant as a follow-up to his March 1, 2010 bronchoscopy and noted all the findings were consistent with coal workers' pneumoconiosis. Director's Exhibit 26.

In a March 20, 2010 "Initial History and Physical Form" from Tug River Health Association, Dr. Hoskere notes bronchoscopy results consistent with silicosis and chronic obstructive pulmonary disease (COPD). Director's Exhibit 26.

On June 23, 2010, Dr. McKinney noted Claimant's February 16, 2010 and June 15, 2010 CT scans "show severe pneumoconiosis, but stable from previous examination with mediastinal lymph nodes present that appear to be stable as well." Director's Exhibit 26. She diagnosed "advanced progressive massive pneumoconiosis." *Id.* On July 16, 2010, Dr. McKinney saw Claimant for epigastric chest pain of unknown origin, and wrote under "Impression" that he had diagnosed "COPD with advanced progressive massive pneumoconiosis." *Id.*

On October 28, 2010, Dr. Kosseifi saw Claimant for difficulty breathing, and diagnosed COPD and coal workers' pneumoconiosis with progressive massive fibrosis (PMF) based on radiographic findings. Director's Exhibit 26.

On February 15, 2011, Dr. Patel examined Claimant for complaints of "lung mass, shortness of breath" and noted the lung mass was "most probably secondary to pneumoconiosis." Director's Exhibit 26. Dr. Patel performed a lung biopsy on July 5, 2011, as discussed *supra*, Employer's Exhibit 19. In a July 12, 2011 treatment note, Dr. Patel indicated that he saw Claimant for chest pain, noting Claimant had a past medical history of "anxiety, sarcoidosis: proven by CT guided biopsy, caseating granuloma, and bronchoscopy." His diagnostic impression was sarcoidosis. Employer's Exhibit 18.

On September 15, 2011, Dr. McKinney-Smith reviewed Dr. Patel's bronchoscopy report, noting the biopsy "apparently was consistent with sarcoidosis." Employer's Exhibit 14. She provided a diagnosis of "[p]rogressive coal workers['] pneumoconiosis" and "[p]ossible sarcoidosis[,]" noting that a larger biopsy may be needed or a trial of steroids, given Claimant's worsening symptoms. *Id*.

On November 22, 2011, Dr. Hoskere noted he did not have the official results of the July 5, 2011 biopsy so he wanted to have a CT scan taken in two to three months. Claimant's Exhibit 5. If there was worsening of the PMF, he noted Claimant may need a trial of steroids. *Id*. He diagnosed PMF with coal workers' pneumoconiosis and possible sarcoidosis. *Id*. On January 24, 2012, Dr. Hoskere stated Claimant was not an eligible candidate for lung transplant, and a CT scan revealed stable bilateral reticular disease. *Id*. He found no "urgent pressing issues to start steroids." *Id*. On April 3, 2012, Dr. Hoskere diagnosed "[s]arcoidosis with [PMF] and coal worker's disease[,]" and noted Claimant "has some worsening cough; I suspect he probably has sarcoid induced [disease]." He indicated he would start Claimant on steroids at this time. *Id*.

On November 25, 2014, Dr. Zaietta saw Claimant for his shortness of breath. He noted the "CT scan today shows improvement in the nodular density compared to previous ones[; n]o massive fibrosis." Claimant's Exhibit 6.

On July 17, 2015, Dr. Hoskere saw Claimant for treatment of coal workers' pneumoconiosis, indicating he was doing better with less shortness of breath and occasional wheezes but could not tolerate steroids. Claimant's Exhibit 6. He noted Claimant's November 25, 2014 CT scan was"[s]table and actually improved." *Id*. On February 3, 2016, Dr. Hoskere saw Claimant for a follow-up concerning his COPD and noted Claimant's "advanced coal workers' pneumoconiosis" which he reported was stable on the last CT scan (unidentified). *Id*. at 12. On March 30, 2016, Dr. Hoskere saw Claimant for sleep apnea and COPD, which was"[s]table at this time." *Id*. at 17. On

October 11, 2016, Dr. Hoskere again saw Claimant for complicated coal workers' pneumoconiosis, COPD, hypoxemia, tachycardia, and sleep apnea. *Id*. at 36. On June 28, 2017, Dr. Hoskere noted a prior CT scan (unidentified) showed significant but residual scarring; he listed coal workers' pneumoconiosis, COPD, and sleep apnea as ongoing problems. *Id*. at 42. Dr. Hoskere saw Claimant on December 19, 2017, and noted he had coal workers' pneumoconiosis, but the CT scans were showing improvement of the conglomerate bilateral masses, COPD, and sleep apnea. *Id*. at 47.

Medical Opinion Evidence

The administrative law judge also considered the reports of Drs. Forehand, Steele, Hoskere, Castle, and Spagnolo.[10] Decision and Order at 11-26; Director's Exhibits 12, 21; Claimant's Exhibits 9, 10; Employer's Exhibits 3, 12, 15, 16, 21. Dr. Forehand diagnosed Claimant with "complicated pneumoconiosis with PMF" based on his 2010 examination and x-ray, but suggested additional testing to rule out malignancy and infection. Director's Exhibit 12; Employer's Exhibit 3.

Dr. Steele evaluated Claimant for a possible lung transplant on December 5, 2011, and reviewed various x-rays and CT scans. Claimant's Exhibit 10. He opined Claimant most likely has complicated coal workers' pneumoconiosis and PMF given his fifteen to twenty years of coal dust exposure and latency period despite his young age. *Id*. He stated it would be extremely hard for him to make a diagnosis of sarcoidosis, but Caplan syndrome could be a possible explanation for his PMF at a young age. *Id*.

Dr. Hoskere, one of Claimant's treating physicians, authored three "to whom it may concern" letters dated June 28, 2016, October 10, 2016, and August 29, 2017, opining that Claimant has complicated coal workers' pneumoconiosis, "which was evident on his last lung biopsy in 2011." Claimant's Exhibit 9.

Dr. Castle examined Claimant on March 23, 2011. While he indicated it was impossible to determine with any certainty the etiology of Claimant's pulmonary problem, he provided a differential diagnosis that included sarcoidosis, lymphoma, or granulomatous disease such as fungal disease, tuberculosis, or Wegener's granulomatosis. Director's Exhibit 21. He stated coal workers' pneumoconiosis could not be totally excluded but "the CT scan appearance of these masses does not look like [PMF]." *Id*. After reviewing

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[10] Although the administrative law judge found good cause to admit Dr. Meyer's report and depositions, he "found that this evidence is unnecessary for the resolution of this case." Decision and Order at 7, 48; Employer's Exhibits 9, 17, 22.

additional medical notes and CT scan evidence,[11] Dr. Castle testified in 2016 that Claimant did not have complicated pneumoconiosis but rather has sarcoidosis. Employer's Exhibit 15 at 40-41, 52-53. In reaching this diagnosis, he relied on the CT scan evidence showing regression of Claimant's lung masses, including the November 25, 2014 CT scan showing "there were no longer any masses present." *Id*. at 35. He also noted Claimant had normal pulmonary function[12] and responded "amazingly well to therapy for sarcoidosis; namely with steroids." *Id*. at 43. Further, Dr. Castle relied on Dr. Patel's biopsy showing noncaseating granulomas, which he stated is "what we expect to find in an individual with sarcoidosis." *Id*.

In a report dated January 4, 2014, Dr. Spagnolo indicated the interpretations of Claimant's x-rays were compatible with sarcoidosis and the CT guided lung biopsy also provided "sufficient pathologic support for a clinical, laboratory, radiological diagnosis of

[11] Dr. Castle reviewed the following material: Dr. Powers's March 1, 2010 x-ray interpretation; Dr. Forehand's March 30, 2010 x-ray interpretation; Dr. Meyer's March 30, 2010 x-ray interpretation; Dr. Miller's October 20, 2010 x-ray interpretation; Dr. Meyer's October 20, 2010 x-ray interpretation; Dr. Meyer's May 3, 2011 x-ray interpretation; Dr. Alexander's May 3, 2011 x-ray interpretation; Dr. Meyer's March 23, 2011 x-ray interpretation; Dr. Groten's July 5, 2011 x-ray interpretation; Dr. Meyer's April 4, 2012 x-ray interpretation; Dr. Miller's April 4, 2012 x-ray interpretation; the March 1, 2010 bronchoscopy report; Dr. Ramakrishnan's February 16, 2010 CT scan report; Dr. Knapp's June 15, 2010 CT scan report; Dr. Shahan's May 13, 2011 CT scan report; Dr. Coleman's January 16, 2012 CT scan report; Dr. Patel's October 24, 2013 deposition; Dr. Miller's October 24, 2013 deposition; Dr. Forehand's November 5, 2013 deposition; Dr. Meyer's report containing his interpretations of the February 16, 2010, January 16, 2012, and July 9, 2013 CT scans; Dr. Meyer's July 19, 2014 medical report; Dr. Spagnolo's January 4, 2014 medical report; Dr. Hoskere's select treatment records from March 1, 2010 through March 3, 2016; Dr. Hoskere's November 22, 2011, January 24, 2012, and April 3, 2012 office visit notes; notes from office visits on November 24, 2012, June 17, 2015, February 3, 2016, March 30, 2016, October 10, 2016, June 28, 2017, and December 18, 2017 with Drs. Hoskere and Zaietta, including a November 15, 2014 CT scan read by Dr. Fish; Bradshaw Medical Clinic medical records; Tug River Medical Center medical records; Dr. Patel's medical records; and Abingdon Medical Associates medical records, including Dr. McKinney's post bronchoscopy report. Director's Exhibits 26, 28; Claimant's Exhibits 1-6; Employer's Exhibits 1-4, 6-14.

[12] Dr. Castle acknowledged that some of the studies showed very minimally reduced total lung capacity, but he indicated "that's typical of sarcoid[osis] and that's what you see in sarcoidosis is a reduced total lung capacity and FVC." Employer's Exhibit 15 at 46.

sarcoidosis." Employer's Exhibit 12. At his 2016 deposition, Dr. Spagnolo reviewed additional records[13] and reiterated his diagnosis of sarcoidosis, as opposed to complicated pneumoconiosis, based on Claimant's short coal dust exposure, normal lung function, x-ray picture "classic for sarcoid," and response to treatment for sarcoidosis. Employer's Exhibit 16 at 28-29. In a supplemental report dated March 30, 2018, Dr. Spagnolo reviewed additional records, including the biopsy reports, and noted they provided additional support for his diagnosis of sarcoidosis. Employer's Exhibit 21.

Weighing the treatment evidence and medical reports, the administrative law judge permissibly accorded less weight to the opinions of Drs. Forehand, Steele, Hoskere, and McKinney that Claimant has complicated pneumoconiosis. As the administrative law judge noted, Dr. Forehand did not review the biopsy results or the CT scans demonstrating regression of the large opacities. Decision and Order at 45; *see* Director's Exhibit 12; Employer's Exhibit 3. He therefore permissibly found that Dr. Forehand's opinion was less credible because it was based on limited evidence. *See Harman Mining Co. v. Director, OWCP* [*Looney*], 678 F.3d 305, 316-17 (4th Cir. 2012); *Sellards v. Director, OWCP*, 17 BLR 1-77, 1-80-81 (1993); *Bobick v. Saginaw Mining Co.*, 13 BLR 1-52, 1-54 (1988); Decision and Order at 45.

Regarding Dr. Steele's December 5, 2011 opinion, the administrative law judge found that he based his diagnosis of complicated pneumoconiosis, in part, on Claimant's

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[13] Dr. Spagnolo reviewed the following material: Dr. Meyer's March 30, 2010 x-ray interpretation; Dr. Meyer's October 20, 2010 x-ray interpretation; Dr. Meyer's May 3, 2011 x-ray interpretation; Dr. Meyer's March 23, 2011 x-ray interpretation; Dr. Groten's July 5, 2011 x-ray interpretation; Dr. Meyer's April 4, 2012 x-ray interpretation; Dr. Shahan's May 13, 2011 CT scan report; Dr. Coleman's January 16, 2012 CT scan report; Dr. Forehand's November 5, 2013 deposition; Dr. Meyer's report containing his interpretations of the February 16, 2010, January 16, 2012, and July 9, 2013 CT scans; Dr. Meyer's July 19, 2014 medical report; Dr. Hoskere's select treatment records from March 1, 2010 through March 3, 2016; Dr. Hoskere's November 22, 2011, January 24, 2012, and April 3, 2012 office visit notes; notes from office visits on November 24, 2012, June 17, 2015, February 3, 2016, March 30, 2016, October 10, 2016, June 28, 2017, and December 18, 2017 with Drs. Hoskere and Zaietta, including a November 15, 2014 CT scan read by Dr. Fish; Dr. McKinney-Smith's September 15, 2011 treatment note. Employer's Exhibit 16 at 9-10; *see* Claimant's Exhibits 2-6; Employer's Exhibits 3-4, 6-11, 13-14.

description of having been exposed to coal mine dust for fifteen to twenty years[14] and "significant cold [sic] dust exposure lifelong, which began when he was a young child working with his father in various activities related to coal including transportation of coal and shoveling coal." Decision and Order at 45, *quoting* Claimant's Exhibit 10. But the administrative law judge observed that Claimant did not describe the same history at the hearing and therefore permissibly discredited Dr. Steele's opinion for relying on an inaccurate coal mine employment history.[15] *See Sellards*, 17 BLR at 1-80-81; *Bobick*, 13 BLR at 1-54; Decision and Order at 45. Additionally, the administrative law judge permissibly found "the accuracy of Dr. Steele's report is questionable in light of the more recent results of the CT scans and the 2011 biopsy, the results of which, according to the pathologist, pointed towards a diagnosis of sarcoidosis, and which did not substantiate a

[14] The administrative law judge quoted Dr. Steele's statement that "the patient is describing cold [sic] dust exposure 15-20 years previous to today" and found "[i]t is unclear whether Claimant told [Dr. Steele] his exposure commenced 15 to 20 years before, or whether that figure constituted the duration of such exposure." Decision and Order at 45; Claimant's Exhibit 10.

[15] The administrative law judge found that aside from the years which show a full year of employment with Employer, the record does not establish the beginning and ending dates of Claimant's employment with the other coal mine companies. Decision and Order at 40. Thus, he applied the formula at 20 C.F.R. §725.101(a)(32)(iii) to calculate the number of days Claimant worked in coal mine employment for each year from 1998 through 2009. *Id.* at 40-41. He divided Claimant's yearly earnings as reported in his Social Security Administration earnings records by the coal mine industry's average daily earnings, as reported in Exhibit 610 of the *Coal Mine (Black Lung Benefits Act) Procedure Manual*, to find Claimant had a total of 6.91 years of coal mine employment (based on a 125-day work-year). *Id.* at 40-41. In doing so, it appears he erroneously relied on United States Court of Appeals for the Sixth Circuit law. *See Shepherd v. Incoal, Inc.*, 915 F.3d 392, 405-06 (6th Cir. 2019); Decision and Order at 40-41. Error, if any, is harmless, however, as using this calculation would overstate the length of Claimant's coal mine employment. *Larioni*, 6 BLR at 1-1278. Further, at the hearing, the parties agreed Claimant had fewer than fifteen years of coal mine employment. Hearing Transcript at 7. Claimant additionally testified that he had eight to ten years of coal mine employment, beginning in 1998 and ending in 2020 with some periods of unemployment between those times. *Id*. at 23. He acknowledged that he listed approximately thirteen years in his Department of Labor application for benefits but "after thinking about that some[,]" felt it was between eight to ten years. *Id*. at 23-24. Claimant did not discuss any other coal dust exposure at the hearing aside from his coal mine employment.

diagnosis of complicated pneumoconiosis." Decision and Order at 45; *see Looney*, 678 F.3d at 316-17; *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 528 (4th Cir. 1998).

Similarly, the administrative law judge found that while Dr. Hoskere was Claimant's treating physician since 2010, his opinion that Claimant suffers from complicated pneumoconiosis and progressive massive fibrosis was not persuasive as his "letter reports have no analysis or examination of their underlying documentation." Decision and Order at 45-46. Dr. Hoskere also stated the pathology evidence showed complicated pneumoconiosis but failed to address Dr. Pardasani's pathology diagnosis of non-caseous granuloma with no evidence of coal workers' pneumoconiosis. Decision and Order at 46; *see* Claimant's Exhibit 9; Employer's Exhibit 19. The administrative law judge therefore permissibly found:

> On the whole Dr. Hoskere's conclusions over a period of time appear to build upon the early results of x-rays and CT scans that suggested complicated pneumoconiosis and progressive massive fibrosis. His later opinions do not account for, or address, the changes in the more recent CT scans, or the pathology report of the 2011 biopsy that undermines the early diagnoses of complicated pneumoconiosis and progressive massive fibrosis.

Looney, 678 F.3d at 316-17; *Parsons v. Wolf Creek Collieries*, 23 BLR 1-29, 1-34-35 (2004) (en banc); Decision and Order at 45-46; Claimant's Exhibit 9.

Further, the administrative law judge permissibly found unpersuasive treating physician Dr. McKinney's September 15, 2011 diagnosis of PMF and complicated pneumoconiosis because she "allowed for a diagnosis of possible sarcoidosis" and admitted she was unsure "how much [of] these radiographic abnormalities are from coal workers' pneumoconiosis versus sarcoidosis." Decision and Order at 46, *quoting* Employer's Exhibit 14; *see U.S. Steel Mining Co. v. Director, OWCP* [*Jarrell*], 187 F.3d 384, 389 (4th Cir. 1999); *Hicks*, 138 F.3d at 533; Director's Exhibit 26.

In contrast, the administrative law judge gave more weight to the opinions of Drs. Castle and Spagnolo that Claimant has sarcoidosis. Decision and Order at 46-47. He permissibly found they are better reasoned and documented because they are supported by the CT scans showing regression in the size of the lung masses; the biopsy results indicating that coal workers' pneumoconiosis or malignancy was not present; and Dr. Patel's eventual opinion that Claimant has sarcoidosis based on the 2011 pathology results. *Looney*, 678 F.3d at 316-17; Decision and Order at 46-47; Director's Exhibits 21, 26; Employer's Exhibits 12, 15, 16, 19, 22. The administrative law judge also permissibly determined that even assuming the opinions of Claimant's treating physicians are well documented and reasoned, "their conclusions are outweighed by the contrary opinions of Dr. Castle, as

supported by the CT scan evidence and treatment opinions of Dr. Patel." Decision and Order at 46; *see Looney*, 678 F.3d at 316-17. We therefore affirm, as supported by substantial evidence, the administrative law judge's finding that the medical opinion and other relevant evidence does not support a finding of complicated pneumoconiosis. 20 C.F.R. §718.304(c); *Compton*, 211 F.3d at 207-08.

Weighing all evidence together, the administrative law judge found that although the x-ray evidence demonstrates the presence of complicated pneumoconiosis based on the ILO classifications, the record as a whole more persuasively establishes that Claimant does not suffer from complicated pneumoconiosis. Decision and Order at 47. He permissibly found the doubts expressed by the radiologists in their x-ray comments that the masses could be due to some disease other than complicated pneumoconiosis, most likely sarcoidosis, were clearly substantiated by the biopsy results and the record evidence as a whole and, thus, were not speculative. Decision and Order at 47-48, *citing Cox*, 602 F.3d at 287;[16] *see Looney*, 678 F.3d at 316-17. Because it is supported by substantial evidence, we affirm the administrative law judge's finding that the evidence as a whole did not establish complicated pneumoconiosis. *See Cox*, 602 F.3d at 283; *Lester v. Director, OWCP*, 993 F.2d 1143, 1145 (4th Cir. 1993); *Melnick*, 16 BLR at 1-33-34; Decision and Order at 47-48. Consequently, we affirm the administrative law judge's finding that Claimant failed to invoke the irrebuttable presumption of total disability due to pneumoconiosis. 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304.

As the parties agreed Claimant has not proven he has a totally disabling respiratory or pulmonary impairment,[17] an essential element of entitlement, we affirm the

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[16] In *Westmoreland Coal Co. v. Cox*, 602 F.3d 276, 287 (4th Cir. 2010), the court found the evidence "consisted of speculative alternative diagnoses that were not based on evidence [the miner] suffered from any of the diseases suggested." Thus, the court affirmed that the administrative law judge did not err in rejecting the physicians' opinions who attributed the cause of the identified opacities to factors other than complicated pneumoconiosis. *Id.* Unlike *Cox*, the administrative law judge found the record evidence in this case included credible evidence and diagnoses that Claimant in fact suffers from sarcoidosis and not complicated pneumoconiosis and therefore concluded Claimant did not satisfy his burden of proof.

[17] At the hearing, Claimant was represented by a lay representative from Stone Mountain Health Services. Hearing Transcript at 4-5. As the administrative law judge confirmed at the hearing, Claimant and Employer, in their Joint Pre-Hearing Statement, agreed that Claimant's "pulmonary function and [arterial blood gas] testing fails to prove that he suffers from a pulmonary or respiratory impairment or condition to prevent him

administrative law judge's findings that Claimant did not invoke the rebuttable presumption of total disability due to pneumoconiosis under Section 411(c)(4) or establish entitlement to benefits under 20 C.F.R. Part 718.[18] *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989). We therefore affirm the denial of benefits.[19]

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from performing his usual coal mining work, or similar substantial gainful employment." *Id.* at 7; *see* Joint Exhibit 1.

[18] Without the benefit of the Section 411(c)(3) and (c)(4) presumptions, Claimant must establish disease (pneumoconiosis); disease causation (it arose out of coal mine employment); disability (a totally disabling respiratory or pulmonary impairment); and disability causation (pneumoconiosis substantially contributed to the disability). 30 U.S.C. §901; 20 C.F.R. §§718.3, 718.202, 718.203, 718.204.

[19] In view of our affirmance of the administrative law judge's denial of benefits, we need not address the arguments raised in Employer's cross-appeal. *See Larioni*, 6 BLR at 1-1278.

Accordingly, the administrative law judge's Decision and Order Denying Benefits is affirmed.

SO ORDERED.

JUDITH S. BOGGS, Chief
Administrative Appeals Judge

JONATHAN ROLFE
Administrative Appeals Judge

MELISSA LIN JONES
Administrative Appeals Judge