BRB No. 09-0419 BLA

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| DANNY G. HERNDON | ) | |
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| Claimant-Petitioner | ) | |
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| v. | ) | |
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| CK COAL CORPORATION | ) | |
| | ) | |
| and | ) | |
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| BRICKSTREET MUTUAL INSURANCE COMPANY | ) | DATE ISSUED: 02/22/2010 |
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| Employer/Carrier-Respondents | ) | |
| | ) | |
| DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR | ) | |
| | ) | |
| Party-in-Interest | ) | DECISION and ORDER |

Appeal of the Decision and Order – Denying Benefits of Daniel L. Leland, Administrative Law Judge, United States Department of Labor.

Leonard Stayton, Inez, Kentucky, for claimant.

Paul E. Frampton (Bowles, Rice, McDavid, Graff & Love LLP), Charleston, West Virginia, for employer/carrier.

Before: DOLDER, Chief Administrative Appeals Judge, SMITH and HALL, Administrative Appeals Judges.

PER CURIAM:

Claimant appeals the Decision and Order - Denying Benefits (2007-BLA-5336) of Administrative Law Judge Daniel L. Leland rendered on a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C.§901 *et seq*. (the Act). The administrative law judge credited

claimant with forty-three years of qualifying coal mine employment, and adjudicated this claim, filed on March 28, 2006, pursuant to the regulations contained in 20 C.F.R. Part 718. The administrative law judge found the evidence of record insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1)-(4). Accordingly, benefits were denied.

On appeal, claimant contends that the administrative law judge erred in his evaluation of the CT scan evidence under Section 718.202(a), and erred in determining that the medical opinion evidence failed to establish legal pneumoconiosis at Section 718.202(a)(4). Employer responds, urging affirmance of the administrative law judge's denial of benefits. The Director, Office of Workers' Compensation Programs, has declined to respond in this appeal.[1]

The Board's scope of review is defined by statute. The administrative law judge's Decision and Order must be affirmed if it is rational, supported by substantial evidence, and in accordance with applicable law.[2] 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).

To be entitled to benefits under the Act, claimant must demonstrate by a preponderance of the evidence that he is totally disabled due to pneumoconiosis arising out of coal mine employment. 30 U.S.C. §901; 20 C.F.R. §§718.3, 718.202, 718.203, 718.204. Failure to establish any one of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

Claimant challenges the administrative law judge's finding that the weight of the evidence did not establish the existence of clinical or legal pneumoconiosis under Section 718.202(a). Claimant argues that, because the administrative law judge determined that a numerical preponderance of the x-ray evidence was positive for pneumoconiosis under Section 718.202(a)(1), he was obligated to find the existence of clinical pneumoconiosis

[1] The administrative law judge's findings with regard to the length of coal mine employment, and his finding that claimant failed to establish the existence of clinical pneumoconiosis at 20 C.F.R. §718.202(a)(2)-(3), are affirmed, as unchallenged on appeal. *See Skrack v. Island Creek Coal Co.*, 6 BLR 1-710 (1983); Decision and Order at 7.

[2] This case arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit, as claimant was employed in the coal mining industry in West Virginia. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*); Director's Exhibit 3.

established, and that he "erred in considering the CT scan evidence against the chest x-ray evidence pursuant to 20 C.F.R. §718.202(a)(1)." Claimant's Brief at 9. Claimant also contends that the administrative law judge incorrectly evaluated the medical opinions of Drs. Rasmussen, Zaldivar, and Rosenberg, and should have found legal pneumoconiosis established pursuant to Section 718.202(a)(4), based on Dr. Rasmussen's opinion, that claimant's chronic obstructive pulmonary disease (COPD) was due to both coal dust exposure and smoking. Claimant's arguments are without merit.

Considering all of the evidence relevant to the existence of pneumoconiosis together pursuant to *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162 (4th Cir. 2000), the administrative law judge permissibly found that the most probative evidence of record failed to establish either clinical or legal pneumoconiosis. First, contrary to claimant's assertion, the administrative law judge did not consider the CT scan evidence under Section 718.202(a)(1), nor did his finding under Section 718.202(a)(1), that the x-ray evidence was predominantly positive for pneumoconiosis, preclude his subsequent consideration of the CT scan evidence of record.[3] Decision and Order at 7-8. Rather, the administrative law judge acknowledged that CT scans are properly considered as "other medical evidence" under 20 C.F.R. §718.107, and must be evaluated for probative value and relevance. 20 C.F.R. §718.107. He concluded, based on the deposition testimony of Drs. Zaldivar and Rosenberg, that the CT scan evidence was relevant to the determination of the existence of pneumoconiosis, and was more reliable than the x-ray evidence. In particular, the administrative law judge noted Dr. Zaldivar's testimony, that a CT scan shows the lungs in greater detail and is superior to a chest x-ray for determining the presence or absence of coal workers' pneumoconiosis.[4] Accordingly, the administrative law judge chose to credit the negative CT scan interpretations of record over the predominantly positive x-ray evidence, and concluded

[3] The CT scans of April 8, 2008, and April 24, 2008, were read as negative by Dr. Willis, a Board-certified radiologist and B reader, who stated that "overall the primary pathology demonstrated [in the CT scans] is emphysema and the findings do not support a diagnosis of occupational pneumoconiosis." Decision and Order at 3; Employer's Exhibit 6. Dr. Zaldivar, a B reader, found no evidence of pneumoconiosis based on the CT scan of July 30, 2008, and Dr. Anderson also found no pneumoconiosis based on his review of the July 30, 2008 CT scan. Decision and Order at 7; Employer's Exhibit 4.

[4] Dr. Zaldivar explained that a conventional CT scan will slice the lungs in five millimeter segments and a high resolution CT scan will slice the lungs in one millimeter segments, which are very close to what a pathologist would see under a microscope. Employer's Exhibit 11 at 12; Decision and Order at 6. The administrative law judge noted that the April 24, 2008 CT scan was high resolution. Decision and Order at 3.

that the weight of the evidence failed to establish the existence of clinical pneumoconiosis. Decision and Order at 8.

In considering whether legal pneumoconiosis was established at Section 718.202(a)(4), the administrative law judge accurately summarized the conflicting opinions of Drs. Rasmussen,[5] Zaldivar,[6] and Rosenberg,[7] noting that Dr. Rasmussen

[5] Evaluating claimant for the Department of Labor, Dr. Rasmussen diagnosed: 1) coal workers' pneumoconiosis based on a positive x-ray classified as 1/0, p/p, and the miner's forty-four years of coal mine employment; and 2) COPD/emphysema caused by coal mine dust exposure and cigarette smoking. Director's Exhibit 11; Decision and Order at 4. Dr. Rasmussen stated:

> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has coal workers' pneumoconiosis, which arose from his 44 years of coal mine employment. Both the patient's cigarette smoke and his coal mine dust exposure are responsible for his disabling lung disease. Either could be the exclusive cause of his impairment, but it is extremely unlikely. It has long been recognized that coal mine dust exposure can cause COPD/emphysema/interstitial fibrosis. Cigarette smoke causes identical forms of COPD including emphysema, bronchitis and small airways disease. They cause identical forms of centriacinar, paracinar, cicatricial and bullous emphysema. Both toxic substances (in about 15% of heavy smokers and 15% of heavily exposed coal miners who are susceptible to those effects) stimulate phagocytic cells, which in turn release chemicals causing a cascade of cellular and enzymatic processes, which are identical. Coal mine dust in contrast to cigarette smoke also causes interstitial fibrosis. Some authorities believe that a combination of fibrosis and emphysema can result in impaired oxygen transfer with preservation of ventilatory capacity. …It is quite apparent that both smoking and coal mine dust have contributed perhaps equally in causing [claimant's] disabling lung disease. … [Claimant] has clinical pneumoconiosis, which clearly is a material contributing factor to his disabling lung disease. Director's Exhibit 11 at 13-17.

[6] Dr. Zaldivar performed a pulmonary evaluation of claimant on April 4, 2007, and was deposed twice following his review of additional medical evidence. Dr. Zaldivar found a moderate irreversible airway obstruction; normal lung volumes; high carboxyhemoglobin levels typical of a current smoker; a moderate diffusion impairment; and no radiographic evidence of pneumoconiosis. He opined that claimant's lifelong cigarette smoking caused emphysema, affecting his airway obstruction and diffusing

opined that both smoking and coal dust exposure caused claimant's disabling lung condition, although the physician admitted that it was possible that either exposure could be the exclusive cause of the impairment. The administrative law judge then observed:

> [Dr. Rasmussen] asserted that coal mine dust exposure and cigarette smoking cause identical forms of chronic pulmonary disease, but failed to provide a specific explanation as to how he was able to decide that the miner's lung disease is due to coal mine dust exposure rather than exclusively due to cigarette smoking.

Decision and Order at 8. Finding that Dr. Rasmussen's opinion was poorly reasoned, the administrative law judge accorded it little weight on the issue of legal pneumoconiosis, and credited the contrary medical opinions of Drs. Zaldivar and Rosenberg, that claimant's respiratory impairment was due solely to smoking.

We conclude that the administrative law judge's evaluation and weighing of the medical opinions of record was proper, and within his discretion as fact-finder. Initially, we reject claimant's position that the administrative law judge was obligated to accept Dr. Rasmussen's opinion, that because pneumoconiosis and cigarette smoking "cause the same type of airflow limitations in a miner's lungs," claimant's pulmonary impairment in this case was caused, at least in part, by his coal dust exposure. Claimant's Brief at 14. While Dr. Rasmussen opined that both smoking and coal dust exposure were contributing causes of claimant's COPD and emphysema, the administrative law judge found that the physician "failed to provide a specific explanation as to how he was able to decide that

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capacity through damage to the capillary beds of the lungs. Dr. Zaldivar concluded that claimant has neither clinical nor legal pneumoconiosis, and that his pulmonary impairment results from smoking, but is unrelated to coal dust exposure. Decision and Order at 4-6; Employer's Exhibits 4, 9, 11.

[7] After reviewing the medical records, Dr. Rosenberg diagnosed COPD and diffuse emphysema caused by smoking, and concluded that claimant does not have clinical or legal pneumoconiosis. Dr. Rosenberg attributed claimant's disabling oxygenation abnormality to COPD, based on the absence of micronodularity or any form of interstitial disease on x-ray, and claimant's decreased breath sounds with airflow obstruction. He found that claimant's reduced $FEV_1$ levels, and decreased oxygenation in association with exercise, point to an emphysematous process related to claimant's long and continued smoking, and not coal dust exposure. He testified that the characteristic patterns of pulmonary abnormalities seen in smokers differ from the characteristic patterns seen in coal miners. Decision and Order at 5, 6; Employer's Exhibits 5, 10.

the miner's lung disease is due to coal mine dust exposure rather than exclusively due to cigarette smoking." Decision and Order at 8. Moreover, although Dr. Rasmussen conducted various objective tests and related his findings, he did not specifically discuss how the results of these tests supported his opinion that the pulmonary impairment he observed was due to a combination of coal mine dust exposure and cigarette smoking in this particular individual, rather than to smoking alone. An administrative law judge is not compelled to accept any particular medical theory, but must resolve conflicts in the evidence, and assign probative weight. *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 21 BLR 2-34 (4th Cir. 1997). In the present case, the administrative law judge permissibly concluded that Dr. Rasmussen's opinion was entitled to little weight because it was inadequately explained or supported. *See Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 BLR 2-323 (4th Cir. 1998); *see also Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186, 22 BLR 2-251 (4th Cir. 2000); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(*en banc*); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). By comparison, the administrative law judge found that Drs. Rosenberg and Zaldivar "provided detailed and well-reasoned explanations supporting their conclusion that the miner's oxygenation impairment is due entirely to cigarette smoking." Decision and Order at 8. In particular, the administrative law judge observed that Dr. Rosenberg "strongly disagreed with Dr. Rasmussen's assertion that coal mine dust exposure and cigarette smoking cause identical forms of pulmonary abnormalities because the characteristic patterns seen in cigarette smokers differ from the characteristic patterns demonstrated by those exposed to coal mine dust." *Id*. The administrative law judge noted Dr. Rosenberg's interpretation of the objective evidence, including "the decline in $FEV_1$%, the marked decrease in the diffusing capacity, the abnormal $pO_2$ with exercise, and the minimally abnormal or negative chest x-rays" as supporting his opinion that this claimant's pulmonary impairment was "caused by cigarette smoking as opposed to coal mine dust exposure." Decision and Order at 9. With respect to the opinion of Dr. Zaldivar, the administrative law judge noted that the physician "relied on the location of the lung damage and the fact that most of the chest x-rays were classified as no higher than 1/0" for his conclusion that claimant's impairment is due exclusively to cigarette smoking. *Id*.

Claimant's argument, that the credited medical opinions of Drs. Rosenberg and Zaldivar are contrary to the Act and the medical literature, finds no support in the record. Further, we reject claimant's assertion that the administrative law judge erred in characterizing the opinions of Drs. Rosenberg and Zaldivar as well-reasoned. Whether a medical opinion is well-reasoned is essentially a credibility determination, which will not be disturbed if supported by substantial evidence. *See Wolf Creek Collieries v. Director, OWCP* [*Stephens*], 298 F.3d 511, 522, 22 BLR 2-494, 2-512 (6th Cir. 2002); *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 762 n.10, 21 BLR 2-587, 2-603 n. 10 (4th Cir. 1999). We conclude that the administrative law judge validly identified the bases upon which he found the opinions of Drs. Zaldivar and Rosenberg to be more persuasive and better reasoned than that of Dr. Rasmussen and, in so doing, permissibly exercised his

discretion to resolve evidentiary conflicts. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85 (1993); *Clark*, 12 BLR at 1-149. Consequently, we affirm the administrative law judge's finding that the weight of the medical opinion evidence was insufficient to establish legal pneumoconiosis at Section 718.202(a)(4), and his finding that the weight of the evidence as a whole did not establish the existence of clinical or legal pneumoconiosis under Section 718.202(a). *See Compton*, 211 F.3d 203, 22 BLR 2-162. As claimant has failed to establish the existence of pneumoconiosis, an essential element of entitlement under 20 C.F.R. Part 718, we affirm the administrative law judge's finding that claimant is precluded from entitlement to benefits. *See Anderson*, 12 BLR at 1-112.

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

SO ORDERED.

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NANCY S. DOLDER, Chief
Administrative Appeals Judge

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ROY P. SMITH
Administrative Appeals Judge

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BETTY JEAN HALL
Administrative Appeals Judge