U.S. Department of Labor

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

BRB No. 17-0424 BLA

MANUEL RAY STAFFORD	)	
	)	
Claimant-Petitioner	)	
	)	
v.	)	
	)	
CRYSTAL SPRINGS, INCORPORATED	)	
	)	
and	)	
	)	
TRAVELERS INDEMNITY COMPANY	)	DATE ISSUED: 06/20/2018
	)	
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 Alan L. Bergstrom, Administrative Law Judge, United States Department of Labor.

Leonard Stayton, Inez, Kentucky, for claimant.

James M. Kennedy (Baird and Baird, P.S.C.), Pikeville, Kentucky, for employer.

Before: HALL, Chief Administrative Appeals Judge, GILLIGAN and ROLFE, Administrative Appeals Judges.

PER CURIAM:

Claimant appeals the Decision and Order Denying Benefits (2013-BLA-05513) of Administrative Law Judge Alan L. Bergstrom rendered on a claim filed pursuant to the provisions of the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2012) (the Act). This case involves a miner's claim filed on February 23, 2012.

Because the administrative law judge credited claimant with 13.32 years of coal mine employment, he found that claimant could not invoke the rebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(4) of the Act.[1] 30 U.S.C. §921(c)(4) (2012). The administrative law judge also found that the evidence did not establish complicated pneumoconiosis under 20 C.F.R. §718.304, and thus claimant could not invoke the irrebuttable presumption of total disability due to pneumoconiosis under Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3). Turning to whether claimant could establish entitlement without the benefit of a presumption, the administrative law judge found that claimant failed to establish the existence of clinical or legal pneumoconiosis[2] pursuant to 20 C.F.R. §718.202(a) and, therefore, he denied benefits.

On appeal, claimant argues that the administrative law judge erred in finding that the evidence did not establish the existence of legal pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). Employer responds in support of the denial of benefits. The

[1] Section 411(c)(4) of the Act provides a rebuttable presumption that a miner is totally disabled due to pneumoconiosis in cases where fifteen or more years of underground coal mine employment, or coal mine employment in conditions substantially similar to those in an underground mine, and a totally disabling respiratory impairment are established. 30 U.S.C. §921(c)(4) (2012); *see* 20 C.F.R. §718.305.

[2] Clinical pneumoconiosis" consists of "those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment." 20 C.F.R. §718.201(a)(1). "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. 20 C.F.R. §718.201(a)(2). The definition includes "any chronic pulmonary disease or respiratory or pulmonary impairment that is significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b).

Director, Office of Workers' Compensation Programs, did not file a response brief in this appeal.[3]

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.[4] 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).

Existence of Legal Pneumoconiosis

To establish entitlement to benefits under the Act without the benefit of the Section 411(c)(3) or Section 411(c)(4) presumptions, claimant must establish the existence of pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, a totally disabling respiratory or pulmonary impairment, and that the totally disabling respiratory or pulmonary impairment is due to pneumoconiosis. 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 an award of benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 BLR 1-26, 1-27 (1987); *Perry v. Director, OWCP*, 9 BLR 1-1, 1-2 (1986) (en banc).

To establish the existence of legal pneumoconiosis, claimant must show that he suffers from a chronic lung disease or impairment "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §§718.201(a)(2), (b). The administrative law judge considered the opinions of Drs.

[3] We affirm, as unchallenged on appeal, the administrative law judge's findings that claimant established 13.32 years of coal mine employment and, therefore, is not entitled to the rebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(4). *See Skrack v. Island Creek Coal Co.*, 6 BLR 1-710, 1-711 (1983); Decision and Order at 16-18, 20. We further affirm, as unchallenged, the administrative law judge's findings that the evidence did not establish the existence of complicated pneumoconiosis, pursuant to 20 C.F.R §718.304, or simple pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1)-(3), and that the medical opinion evidence did not establish the existence of clinical pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). *See Skrack*, 6 BLR at 1-711; Decision and Order at 18-23

[4] The record reflects that claimant's coal mine employment was in Kentucky. Decision and Order at 3, 18; Director's Exhibit 6. Accordingly, this case arises within the jurisdiction of the United States Court of Appeals for the Sixth Circuit. *See Shupe v. Director, OWCP*, 12 BLR 1-200 (1989) (en banc).

Rasmussen, Cohen, Rosenberg and Jarboe. Decision and Order at 9-15, 20-23. Drs. Rasmussen and Cohen opined that claimant suffers from legal pneumoconiosis in the form of a reduced diffusing capacity impairment that is due, in part, to coal mine dust exposure. Dr. Rosenberg opined that claimant does not suffer from a reduced diffusing capacity impairment, but that, if he did, it would not be due to coal mine dust exposure. Dr. Jarboe also opined that claimant does not suffer from any coal mine dust-related disease or impairment.

The administrative law judge discredited the opinions of Drs. Rasmussen and Cohen as based on the incorrect premise that claimant has a reduced diffusing capacity impairment and, therefore, he found them insufficient to carry claimant's burden of establishing legal pneumoconiosis. Decision and Order at 22-23. Claimant asserts that the administrative law judge misinterpreted the evidence in doing so. Claimant's Brief at 17. We agree.

Dr. Rasmussen examined claimant on May 15, 2012 and performed objective testing including diffusing capacity testing. He opined that claimant has a moderate reduction in single breath diffusing capacity of 53% to 55% of predicted,[5] and he attributed the impairment in part to coal mine dust exposure.[6] Decision and Order at 9-10; Director's Exhibit 9.

On September 12, 2012, Dr. Rosenberg examined claimant and performed objective testing. He recorded claimant's diffusing capacity at 65% to 70% of predicted,[7] which he stated was mildly reduced, but when corrected for lung volumes, was normal at 93% of predicted. Director's Exhibit 10 at 3. Dr. Rosenberg acknowledged that Dr. Rasmussen's diffusing capacity measurement was reduced at 53% to 55% of predicted,

[5] Dr. Rasmussen's testing reflects an actual diffusing capacity of 53% of predicted, which rises to 55% of predicted when adjusted for carboxyhemoglobin. Director's Exhibit 9 at 20; Claimant's Exhibit 1 at 9, 11, 14.

[6] Dr. Rasmussen initially opined that claimant's reduced diffusion capacity was "at least minimally" caused by coal dust exposure, although his smoking and his "extensive" chemotherapy treatment could be contributing factors. Decision and Order at 9-10, 20, 22; Director's Exhibit 9 at 26-27. Subsequently, Dr. Rasmussen clarified that coal mine dust exposure significantly contributed to claimant's reduced diffusing capacity. Decision and Order at 20; Director's Exhibit 9 at 21.

[7] Dr. Rosenberg's testing reflects an actual diffusing capacity of 65% of predicted, which rises to 70% of predicted when adjusted for carboxyhemoglobin. Director's Exhibit 10 at 13.

but questioned the accuracy of Dr. Rasmussen's results. He noted that the test was difficult to do and commonly yielded variable measurements, and that claimant has no clinical pneumoconiosis or emphysema to correlate physically with a reduced diffusing capacity.[8] Employer's Exhibit 4 at 9. Dr. Rosenberg further opined that, even if Dr. Rasmussen's reduced diffusing capacity measurement is correct, the fact that both the baseline values and the values corrected for lung volumes had improved between Dr. Rasmussen's testing and his own indicated that the reduced diffusing capacity is not related to coal mine dust exposure. Decision and Order at 10-11; Employer's Exhibit 4 at 8, 10, 11-12. Rather, Dr. Rosenberg contended that other factors, including anemia, elevated carboxyhemoglobin levels, and chemotherapeutic agents used in claimant's cancer treatment could cause a reduction in diffusing capacity. Decision and Order at 21; Employer's Exhibits 4 at 10; 9.

Dr. Jarboe reviewed the medical evidence, including the opinions of Drs. Rasmussen and Rosenberg. He authored a report dated February 22, 2014, and testified by deposition. Decision and Order at 12-13; Employer's Exhibits 3, 5. He initially noted that Dr. Rasmussen's diffusing capacity was moderately reduced at 53% of predicted, and when corrected for lung volumes was only mildly reduced at 70% of predicted.[9] Employer's Exhibits 3 at 2; 5 at 7. By contrast, Dr. Rosenberg's diffusing capacity was 70% of predicted, and when corrected for lung volumes was normal at 93% of predicted. Employer's Exhibits 3 at 4; 5 at 8. Dr. Jarboe stated that because Dr. Rosenberg's testing was "entirely different," he had "serious doubts" about the validity of Dr. Rasmussen's testing. Employer's Exhibit 5 at 14. He added, however, that if Dr. Rasmussen's test was valid, then there was little evidence to support Dr. Rasmussen's conclusion the reduction was due to coal mine dust exposure, as claimant has no significant restriction or obstruction, no gas exchange impairment on resting blood gas studies, and no evidence of fibrosis on x-ray.[10] *Id*. at 13-14, 19-20.

[8] Dr. Rosenberg stated that claimant does not have significant restriction because his lung capacity is 81% of predicted, and he has no obstruction on pulmonary function testing. *See* Employer's Exhibit 4 at 7-8, 10.

[9] Dr. Jarboe stated that it is important to correct diffusing capacity results for lung volumes in order to obtain more accurate results. Employer's Exhibit 5 at 12.

[10] Dr. Jarboe stated that in addition to the lack of evidence of coal mine dust-induced disease in this case, medical research indicated that coal mine dust does not cause significant reductions of diffusing capacity. Employer's Exhibit 3 at 8-9.

On cross-examination, however, Dr. Jarboe acknowledged that Drs. Rasmussen and Rosenberg used different predicted values to calculate the percentage of predicted results they obtained on diffusing capacity testing. *Id.* at 16. Dr. Jarboe conceded that when looking at the raw data of 19.2 millimeters of mercury per minute obtained by Dr. Rasmussen and 19.14 millimeters of mercury per minute obtained by Dr. Rosenberg, rather than at the percentage of predicted, the results are "almost identical." Employer's Exhibit 5 at 18-19. Thus, Dr. Jarboe further conceded that it was likely that both diffusing capacity studies were valid. Dr. Jarboe emphasized, however, that he still did not attribute the reduced diffusing capacity to coal mine dust exposure. *Id.* at 22.

Finally, Dr. Cohen reviewed the medical opinions of Drs. Rasmussen, Rosenberg, and Jarboe, and testified by deposition on September 27, 2016. Dr. Cohen diagnosed legal pneumoconiosis based on the low diffusing capacity results obtained "on two occasions" by Dr. Rasmussen and Dr. Rosenberg.[11] Claimant's Exhibit 1 at 7. He acknowledged that Dr. Rosenberg's results appeared higher, but explained that because Dr. Rosenberg used a different predicted value for reference, his percentage of predicted was necessarily higher.[12] *Id.* at 9-10. Dr. Cohen explained that when the data is examined, however, Dr. Rasmussen obtained 19.2 millimeters of mercury per minute and Dr. Rosenberg obtained nearly "the exact same measurement" of 19.14 millimeters of mercury per minute. *Id.* at 10-11. Thus, Dr. Cohen noted that when the same predicted normal values are used for reference the results of Drs. Rasmussen and Rosenberg are "essentially the same" at 55% to 56% of predicted, and both demonstrate a moderate impairment.[13] Claimant's Exhibit 1 at 11.

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[11] Dr. Cohen stated that he did not use the diffusing capacity values adjusted for lung volumes, because it was not recommended by the American and European Thoracic Societies, but instead compared the values adjusted for carboxyhemoglobin only. Claimant's Exhibit 1 at 8-9, 14.

[12] Dr. Rasmussen used a predicted normal value of 35.2 millimeters of mercury per minute for reference. He obtained an adjusted result of 19.2 millimeters of mercury per minute which, when compared to the reference value, is 55% of predicted normal. Director's Exhibit 9 at 20. Dr. Rosenberg used a reference value of 27.16 millimeters of mercury per minute. He obtained an adjusted result of 19.14 millimeters of mercury per minute which, when compared to his reference value is 70% of predicted normal. Director's Exhibit 10 at 13. *Id.* at 11.

[13] For this reason, Dr. Cohen explained that values calculated as a percentage of predicted should not be used unless the same predicted normal values were used for reference. Claimant's Exhibit 1 at 9-10.

With respect to the cause of the impairment, Dr. Cohen stated that both coal mine dust and smoking damage the alveolar-capillary membranes through similar methods, by causing scarring and impeding gas transfer from the lungs to the blood vessels. Thus, Dr. Cohen explained, coal mine dust and smoking produce the same pattern of impairment on lung function testing, and one cannot distinguish between the two causes. Decision and Order at 21; Claimant's Exhibit 1 at 7-8, 13. Dr. Cohen disagreed with Dr. Jarboe that the absence of significant restriction or obstruction pointed to a non-coal mine dust-related cause, noting that diffusing capacity commonly signals a gas exchange problem before obstruction or restriction develops. Decision and Order at 21-22; Claimant's Exhibit 1 at 15. Further, Dr. Cohen asserted that the studies cited by Dr. Jarboe concluding that coal mine dust does not cause a significant reduction in diffusing capacity are deficient. *Id.*

Considering these medical opinions, the administrative law judge found that the only medical evidence of record that supports a finding of legal pneumoconiosis "relies on the results of one value" on Dr. Rasmussen's diffusing capacity test. Decision and Order at 23. Further, he noted that both Dr. Rosenberg and Dr. Jarboe opined that claimant's reduced diffusing capacity, as measured by Dr. Rasmussen, had improved to normal at the time of Dr. Rosenberg's testing, only four months later. Decision and Order at 21-22. The administrative law judge acknowledged "Dr. Cohen['s] conten[tion] that reference values should not be compared" but noted that "[c]laimant still showed an improvement in his diffusing capacity between Dr. Rasmussen's and Dr. Rosenberg's test[s]."[14] *Id.* Specifically, he noted that "the DLCO value in Dr. Rasmussen's test was 53[%] of the predicted value prior to being adjusted for lung volumes, while the value on Dr. Rosenberg's test was 70[%] of the predicted value." *Id.* The administrative law judge stated, "[c]onsidering the irreversible nature of pneumoconiosis, [c]laimant's condition should not have substantially improved on Dr. Rosenberg's subsequent testing if Dr. Rasmussen's test was valid and the cause of his reduced diffusing capacity was coal mine dust exposure." *Id.* Thus, the administrative law judge found that the

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[14] The administrative law judge summarized the test results as follows:

> On Dr. Rasmussen's test, claimant's single breath diffusing capacity was 53 percent of the predicted value and 55[%] of the predicted value when adjusted for lung volumes. His 'DLCO/VA' adjusted was 70[%] of the predicted value . . . . However, on Dr. Rosenberg's test, performed four months later, Claimant's diffusing capacity was 70[%] of the predicted value and, when adjusted, it was 93[%] of predicted.

Decision and Order at 22 (internal citations omitted).

improvement on Dr. Rosenberg's subsequent testing undermined the credibility of Dr. Rasmussen's testing and, therefore, undermined the opinions of Drs. Rasmussen and Cohen who relied on that testing. Noting further that the medical evidence established that the reduced diffusing capacity could be due to a variety of causes, the administrative law judge concluded that claimant failed to establish the existence of legal pneumoconiosis by a preponderance of the evidence. Director's Exhibit 9 at 21; Decision and Order at 22.

We agree with claimant that substantial evidence does not support the administrative law judge's finding that claimant's diffusing capacity testing showed a "marked improvement" in his impairment, which is inconsistent with the irreversible nature of pneumoconiosis, and undermines the opinions of Drs. Rasmussen and Cohen. Claimant's Brief at 17-18.

The administrative law judge erred in stating that the only evidence supporting a finding of legal pneumoconiosis "relies on the results of one value" on Dr. Rasmussen's pulmonary function test. As claimant correctly notes, Dr. Cohen emphasized that he diagnosed legal pneumoconiosis based on the low diffusing capacity results obtained by both Dr. Rasmussen and Dr. Rosenberg. Claimant's Brief at 11; Claimant's Exhibit 1 at 7. Also, it appears the administrative law judge misinterpreted a portion of Dr. Cohen's opinion. Claimant's Brief at 17-18. In stating that "reference values" should not be compared, Dr. Cohen was referring to test results expressed as a percentage of a predicted normal reference value, e.g. 55% of predicted. *Compare* Claimant's Exhibit 1 at 9-10 *with* Decision and Order at 22. Dr. Cohen explained that results expressed as a percentage of a predicted normal reference value should not be compared unless the same predicted normal reference values are used for the calculations. Claimant's Exhibit 1 at 9-10. Here, Dr. Cohen explained that Drs. Rasmussen and Rosenberg obtained almost "exactly the same" results, but calculated the "percent of predicted" value using different predicted normal values for reference. *Id.* at 10. This caused Dr. Rosenberg's results to be expressed as a higher percentage of predicted normal and, thus, to appear improved over Dr. Rasmussen's results.[15] Moreover, Dr. Jarboe agreed that the physicians' use of

[15] Dr. Rosenberg relied on the fact that claimant's diffusing capacity "improved over time" to conclude that the impairment measured by Dr. Rasmussen's values may not be "real" or, if "real" are not due to coal mine dust exposure. Employer's Exhibit 4 at 8-10. Dr. Rosenberg did not address, however, the difference between the predicted normal values used by Rasmussen and himself. Employer's Exhibit 4 at 8-10. Further, while Dr. Rosenberg reviewed Dr. Cohen's deposition testimony, he did not address Dr. Cohen's opinion regarding the significance of the physicians' use of different predicted normal values. Employer's Exhibit 9.

different predicted normal reference values caused Dr. Rosenberg's results to appear higher, or improved, when the results obtained by Drs. Rasmussen and Rosenberg are actually "nearly identical." Employer's Exhibit 5 at 16-19. Dr. Jarboe further stated that the similarity between the results obtained by Drs. Rasmussen and Rosenberg supported the conclusion that both tests are valid.[16] *Id.* at 19.

Thus, contrary to the administrative law judge's characterization, and as claimant asserts, the medical evidence does not establish that the reduced diffusing capacity measured by Dr. Rasmussen improved over time. Decision and Order at 22-23; Claimant's Brief at 17-18. Therefore, we agree with claimant that the administrative law judge's basis for concluding that claimant does not have legal pneumoconiosis is in error. *See Tackett v. Director, OWCP*, 7 BLR 1-703, 1-706 (1985); Claimant's Brief at 17-18. We thus vacate the administrative law judge's finding that the weight of the medical opinion evidence fails to support a finding of legal pneumoconiosis, pursuant to 20 C.F.R. §718.204(b)(2)(iv). On remand, the administrative law judge should address the physicians' explanations for their conclusions and the validity of their reasoning in light of the evidence. *See Director, OWCP v. Rowe*, 710 F.2d 251, 255, 5 BLR 2-99, 2-103 (6th Cir. 1983); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149, 1-155 (1989) (en banc).

If the administrative law judge determines that claimant did not establish that he has legal pneumoconiosis, he must deny benefits based on claimant's failure to establish an essential element of entitlement. *See Anderson*, 12 BLR at 1-112; *Trent*, 11 BLR at 1-27; *Perry*, 9 BLR at 1-2. If, on the other hand, the administrative law judge finds that claimant suffers from legal pneumoconiosis, he must determine whether claimant has also established that he is totally disabled due to pneumoconiosis, pursuant to 20 C.F.R. §718.204(b), (c).

[16] The administrative law judge noted that Dr. Jarboe "did *not* think the diffusing capacity result of Dr. Rasmussen's test was valid because Dr. Rosenberg would have seen a similar result." Decision and Order at 21 (emphasis added).

Accordingly, the administrative law judge's Decision and Order Denying Benefits is affirmed in part and vacated in part, and the case is remanded to the administrative law judge for further consideration consistent with this opinion.

SO ORDERED.

BETTY JEAN HALL, Chief
Administrative Appeals Judge

RYAN GILLIGAN
Administrative Appeals Judge

JONATHAN ROLFE
Administrative Appeals Judge