

BRB No. 05-0643 BLA

FRED R. JENKINS)
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 Claimant-Petitioner)
)
 v.)
)
 PEABODY COAL COMPANY)
)
 and) DATE ISSUED: 05/10/2006
)
 OLD REPUBLIC INSURANCE COMPANY)
)
 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 of Richard A. Morgan, Administrative Law Judge, United States Department of Labor.

Larry L. Rowe, Charleston, West Virginia, for claimant.

Laura Metcoff Klaus (Greenberg Traurig LLP), Washington, D.C., for employer.

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

PER CURIAM:

Claimant appeals the Decision and Order (03-BLA-6713) of Administrative Law Judge Richard A. Morgan denying benefits 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). This case involves a claim filed on December 14, 2001. After crediting claimant with at least fifteen years of coal mine employment, the administrative law judge found that the evidence was insufficient to establish the existence of

pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1)-(4). Although the administrative law judge found that the evidence was sufficient to establish total disability pursuant to 20 C.F.R. §718.204(b), he found that the evidence was insufficient to establish that claimant's total disability was due to pneumoconiosis pursuant to 20 C.F.R. §718.204(c). Accordingly the administrative law judge denied benefits. On appeal, claimant contends that the administrative law judge erred in finding the medical opinion evidence insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). Claimant also contends that the evidence is sufficient to establish that the administrative law judge erred in finding the evidence insufficient to establish that his total disability is due to pneumoconiosis pursuant to 20 C.F.R. §718.204(c). Employer responds in support of the administrative law judge's denial of benefits. The Director, Office of Workers' Compensation Programs, has not filed a response brief.¹

The Board must affirm the findings of the administrative law judge if they are supported by substantial evidence, are rational, and are in accordance with applicable law. 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).

Claimant argues that the administrative law judge erred in finding that the medical opinion evidence is insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). A finding of either clinical pneumoconiosis, *see* 20 C.F.R. §718.201(a)(1), or legal pneumoconiosis, *see* 20 C.F.R. §718.201(a)(2),² is sufficient to support a finding of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4).

Claimant contends that the administrative law judge erred in finding the medical opinion evidence insufficient to establish the existence of clinical pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). The administrative law judge found that Drs. Rasmussen, Gaziano, Vidal and Zaldivar diagnosed clinical pneumoconiosis based upon the x-ray evidence. Decision and Order at 25; Director's Exhibit 13; Claimant's Exhibits 1, 6-9; Employer's Exhibits 8, 13. The administrative law judge, however, permissibly questioned these physicians' reliance upon positive x-ray interpretations in light of the administrative law judge's earlier finding that the x-ray evidence of record is insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1).

¹Because no party challenges the administrative law judge's findings that the evidence is insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1)-(3), these findings are affirmed. *Skrack v. Island Creek Coal Co.*, 6 BLR 1-710 (1983).

²“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).

Decision and Order at 25; *see Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162 (4th Cir. 2000). The administrative law judge, therefore, found that these opinions are insufficient to support a finding of clinical pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). *Id.* Because it is supported by substantial evidence, we affirm the administrative law judge's finding that the medical opinion evidence is insufficient to establish the existence of clinical pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4).

Claimant next argues that the administrative law judge committed numerous errors in finding the medical opinion evidence insufficient to establish the existence of legal pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). As previously noted, "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 administrative law judge found that the diagnoses of legal pneumoconiosis rendered by Drs. Rasmussen and Gaziano were outweighed by the opinions of Drs. Zaldivar and Branscomb, who attributed claimant's pulmonary problems to his smoking history and heart disease. Decision and Order at 25. The administrative law judge found that the opinions of Drs. Zaldivar and Branscomb were "more aligned with the objective medical data." *Id.* The administrative law judge also found the discounting of claimant's heart afflictions by Drs. Rasmussen and Gaziano detracted from the worth of their opinions. *Id.* The administrative law judge, therefore, found that the medical opinion evidence was insufficient to establish the existence of legal pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4). *Id.*

The administrative law judge initially noted that both Drs. Rasmussen and Gaziano attributed the miner's chronic obstructive pulmonary disease (COPD) to his cigarette smoking and coal dust exposure. Decision and Order at 25. In addition to diagnosing coal workers' pneumoconiosis (clinical pneumoconiosis), Dr. Rasmussen diagnosed COPD due to coal dust exposure and cigarette smoking. *See* Director's Exhibit 13. This diagnosis, if credited, is sufficient to support a finding of legal pneumoconiosis. In addition to diagnosing coal workers' pneumoconiosis (clinical pneumoconiosis), *see* Claimant's Exhibit 1, Dr. Gaziano diagnosed, *inter alia*, mild emphysema, bronchitis and "obstruction of an asthmatic type." *See* Claimant's Exhibit 8 at 25, 30-31. The administrative law judge, however, did not address whether Dr. Gaziano attributed any of these diagnoses to claimant's coal dust exposure. Although the administrative law judge found that Dr. Gaziano attributed claimant's COPD to his coal dust exposure and cigarette smoking, the administrative law judge did not provide any support for this finding. Consequently, the administrative law judge, on remand, is instructed to provide a basis for his finding that Dr. Gaziano rendered a diagnosis sufficient to constitute a finding of legal pneumoconiosis.

Claimant argues that the administrative law judge erred in not recognizing the conflict between the opinions of Drs. Zaldivar and Branscomb. Claimant specifically contends that the administrative law judge failed to note the significance of the fact that while Drs. Zaldivar and Branscomb agreed that claimant's pulmonary impairment was not attributable to his coal dust exposure, they disagreed as to the etiology of claimant's pulmonary conditions. *See* Claimant's Brief at 37. Claimant's contention has merit. While Dr. Zaldivar attributed claimant's pulmonary impairment to bronchiolitis and pulmonary fibrosis caused by cigarette smoking, *see* Employer's Exhibit 8, Dr. Branscomb opined that claimant was totally disabled due to his cardiac condition.³ Employer's Exhibit 11. In weighing the medical opinion evidence, the administrative law judge improperly treated the opinions of Drs. Zaldivar and Branscomb as though each physician opined that claimant's pulmonary problems were attributable to cigarette smoking and heart disease.

Claimant also argues that the administrative law judge failed to provide a basis for crediting Dr. Branscomb's finding that claimant suffered from significant heart disease. The record contains evidence supportive of a finding of heart disease. For example, claimant was hospitalized from June 30, 2003 through July 4, 2003. In the discharge summary from this hospitalization, Dr. Vidal diagnosed, *inter alia*, congestive heart failure, and noted that claimant was "status post coronary artery bypass graft."⁴ Claimant's Exhibit 5.

The record, however, also contains evidence that calls into question the existence and/or the severity of claimant's cardiac disease. For example, on September 3, 2002, Dr. Rasmussen took claimant's medical history. At that time, claimant reported that he had been hospitalized for chest pain in 2002. Director's Exhibit 13. Claimant also reported that he had undergone cardiac catheterization which he characterized as "not too

³In a deposition taken on August 3, 2004, Dr. Branscomb opined that claimant did not suffer from a coal mine dust induced lung disease. Employer's Exhibit 11 at 15. Dr. Branscomb opined that claimant's February 3, 2003 CT scan was "entirely negative" and did not support a diagnosis of coal workers' pneumoconiosis. *Id.* at 27. Dr. Branscomb opined that claimant's pulmonary function study results were not consistent with the effect of coal dust exposure. *Id.* at 41. Dr. Branscomb opined that claimant's results "coincide[d] with the development of his coronary disease and heart failure." *Id.* at 42. Dr. Branscomb did not believe that claimant's pulmonary function study results supported the presence of any occupational lung disease. *Id.*

⁴Dr. Vidal's discharge summary does not reflect any discussion of the diagnosis of congestive heart failure or provide any background information regarding claimant's coronary artery bypass graft surgery. In a subsequent letter dated August 3, 2003, Dr. Vidal did not mention any heart condition and/or surgery. *See* Claimant's Exhibit 6.

bad.” *Id.* Claimant indicated that his primary problem was an irregular heart beat. *Id.* On physical examination, Dr. Rasmussen noted that claimant’s heart rhythm was regular with no murmurs, gallops or clicks. *Id.* An electrocardiogram revealed non-specific ST-T wave changes. *Id.* In his October 4, 2002 report, Dr. Rasmussen did not diagnose any type of cardiac disease. *Id.*

In a subsequent report dated August 2, 2004, Dr. Rasmussen addressed Dr. Branscomb’s opinion that claimant’s impairment is attributable to cardiovascular disease. Dr. Rasmussen stated that:

Dr. Branscomb...indicates cardiovascular disease as the cause of [claimant’s] abnormalities. He may, in part, have gained support by a report of a hospitalization at St. Francis Hospital June 30-July 4, 2003. At this time a diagnosis of congestive heart failure was made and a statement was made that the patient had had a prior CABG. There was no clinical evidence to support the diagnosis of congestive heart failure. He had an echocardiogram, which revealed normal left ventricular size and function with a normal left ventricular ejection fraction. There was a report given to me and in Dr. Branscomb’s review of cardiac catheterization having been performed in 2002, which showed no remarkable coronary insufficiency. It is also noteworthy there is nothing to suggest that [claimant] exhibited impaired cardiac function when he was evaluated by Dr. Zaldivar including no electrocardiographic changes and no evidence of early anaerobic metabolism. I therefore reject Dr. Branscomb’s assertion that cardiovascular disease played a role.

Claimant’s Exhibit 7.⁵

Dr. Gaziano examined claimant on March 8, 2004. At this time, Dr. Gaziano did not list a history of cardiac disease or surgery.⁶ *See* Claimant’s Exhibit 1. Claimant indicated that he had never been told that he suffered from cardiac disease. *Id.* On physical examination, Dr. Gaziano noted that claimant’s “[h]eart was regular without murmur, thrill, gallop or cardiac enlargement.” *Id.* During a July 20, 2004 deposition, Dr. Gaziano also questioned Dr. Branscomb’s diagnoses. Dr. Gaziano stated that:

⁵In a report dated November 10, 2004, Dr. Rasmussen opined that Dr. Branscomb’s assertion that there was “plenty of evidence of congestive heart failure” was not supported by the record. *See* Claimant’s Exhibit 9.

⁶Dr. Gaziano noted that claimant had “rheumatic fever with valvular heart disease treated with penicillin until age 10.” Claimant’s Exhibit 1.

[Dr. Branscomb is] assuming a lot of things that the records don't allow you to assume. When I examined [claimant], he didn't show any sign of heart failure or left ventricular failure. He was hospitalized once for possibility of heart failure, but that hospitalization included chronic obstructive lung disease with acute problems, so I didn't see the evidence clinically or radiographically, on x-ray, at the time of my examination to support a degree of heart disease that would affect [claimant's] tests in the way [Dr. Branscomb] described it.

Claimant's Exhibit 8 at 33-34.⁷

Dr. Zaldivar examined claimant on May 26, 2004. At that time, Dr. Zaldivar did not record any history of heart disease or surgery. *See* Employer's Exhibit 8. On physical examination, Dr. Zaldivar noted that claimant heart revealed "S1 equal to S2 without murmurs or gallops."⁸ *Id.*

⁷Dr. Gaziano explained that the CT scan readings by Drs. Wheeler and Scott would have shown left ventricular failure if it were present. Claimant's Exhibit 8 at 34. Dr. Gaziano explained that:

You could have some left ventricular decreased function that may not show up [on the CT scans], but it would certainly show failure, which he did not have. He's not had it on any examination. The only reference to it was in a hospitalization once sometime before so I don't think that that's a reasonable explanation, congestive heart failure.

Claimant's Exhibit 8 at 34.

⁸In a report dated September 29, 2004, Dr. Zaldivar stated that:

Dr. Rasmussen downplayed the opinion of Dr. Branscomb who was cited by him as stating that there was cardiac disease present. However, Dr. Rasmussen was unaware that there was a hospitalization at St. Francis Hospital from June 30th to July 4th of 2003 with a diagnosis of congestive heart failure and previous coronary bypass surgery. I personally am not aware of this particular admission to St. Francis Hospital, but Dr. Rasmussen cited the exercise test performed under my direction as proof that no cardiac dysfunction existed in the year 2003 and this is blatantly incorrect. The study of 2002 could not predict what would happen the following year. Moreover, an individual may certainly have congestive heart failure with fluid overload even if the systolic function of the left

Claimant accurately notes that Dr. Branscomb himself, at times, questioned the sufficiency of the cardiac data upon which he based his opinion.⁹ Although the

ventricle is reported as normal by echocardiogram. The reason for this is that the left ventricle may fail either through systolic dysfunction where it is unable to pump toward sufficient blood, or diastolic dysfunction; which means that it is not relaxing well enough to accept the blood coming to it from the lungs. Either one of these two abnormalities will result in flooding of the lungs and either one of these abnormalities are diagnostic of cardiac dysfunction, which will certainly affect the blood gases, both at rest and during exercise.

Employer's Exhibit 13.

Dr. Zaldivar, however, did not change his previous opinion, *i.e.*, that claimant's pulmonary impairment was attributable to bronchiolitis and pulmonary fibrosis resulting from his smoking habit. *See* Employer's Exhibit 8. Thus, unlike Dr. Branscomb, Dr. Zaldivar did not attribute claimant's pulmonary impairment to heart disease.

⁹For example, in a report dated July 8, 2004, Dr. Branscomb stated that:

On 4/10/02 the oxygen tension fell significantly during exercise. Five months later it was down to 57.8 at rest, corrected for the altitude of the laboratory of Dr. Rasmussen. I note that these reductions in gas transfer occurred simultaneously with a change in the lung volume tests. Whereas they had previously shown a large TLC and some gas trapping the volumes rather abruptly went down coincident with change in gas transfer. The *probable explanation* for this is the presence of left ventricular failure with increased pulmonary congestion and reduced air space. This would explain the lung volumes and the blood gas findings. *The medical records are insufficient to determine precisely the cause of these more recent changes because of the lack of sufficient data.* For example, has a CABG operation been done or not? What are the indices of cardiovascular function? What is the recent overall history of pulmonary and cardiovascular findings?

I can conclude with a reasonable degree of probability or certainty that these changes are not the effect of CWP. Although CWP can cause certain obstructive manifestations and there are certain forms and manifestations of CWP which can demonstrate latency there are no published findings showing coal dust can cause with the pulmonary function values seen in [claimant] a subsequent deterioration in blood gas transfer with reducing

administrative law judge acknowledged this fact, *see* Decision and Order at 25 n.18, he did not explain how it affected the weight that he accorded to Dr. Branscomb's opinion.

The administrative law judge thus failed to provide a basis for his finding that the "records clearly demonstrate that [claimant] had significant heart disease." Decision and Order at 25. In making this finding, the administrative law judge failed to consider and address all of the relevant evidence of record.

The administrative law judge also did not explain the basis for his finding that the opinions of Drs. Zaldivar and Branscomb are "more aligned with the objective medical data." Decision and Order at 25. Consequently, the administrative law judge's analysis of whether the medical opinion evidence is sufficient to establish the existence of legal pneumoconiosis does not comply with the requirements of the Administrative Procedure Act (APA), specifically 5 U.S.C. §557(c)(3)(A), which provides that every adjudicatory decision must be accompanied by a statement of findings of fact and conclusions of law and the basis therefor on all material issues of fact, law or discretion presented in the record. 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 5 U.S.C. §554(c)(2), 33 U.S.C. §919(d) and 30 U.S.C. §932(a); *see Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162 (1989).

lung volumes and with no change in ventilation. However, this could readily happen with heart disease.

[Claimant] is totally disabled from his last coal mine work as a result of cardiovascular disease with blood gas transfer problems. The latter are *probably the result of cardiovascular disease but could be the result of variations in the severity of chronic asthmatic bronchitis*. He did not have a disabling level of gas exchange problems prior to 2002. He also has familial asthma or asthmatic bronchitis which is not caused or aggravated by coal dust which does not disable him from his last coal mine work.

If I assume CWP is present I would still conclude his respiratory impairment is not the result of CWP.

Employer's Exhibit 9 (emphasis added).

Dr. Branscomb was sometimes more definitive regarding the existence of heart disease. For example, during his September 30, 2004 deposition, Dr. Branscomb stated that there was "plenty of clinical evidence of heart failure." Employer's Exhibit 12 at 17. Dr. Branscomb stated that "the diffusing capacity and the dropping of oxygen is highly characteristic of patients who have congestive heart failure." *Id.*

In light of the above-referenced errors, we vacate the administrative law judge's finding that the medical opinion evidence is insufficient to establish the existence of legal pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4) and remand the case for further consideration. On remand, should the administrative law judge find the medical opinion evidence sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4), he must weigh all of the relevant evidence together pursuant to 20 C.F.R. §718.202(a), before determining whether the evidence is sufficient to establish the existence of pneumoconiosis. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162 (4th Cir. 2000); *see also Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 BLR 2-104 (3d Cir. 1997).

Because the administrative law judge must reevaluate whether the medical evidence is sufficient to establish the existence of pneumoconiosis, an analysis that could affect his weighing of the evidence on the issue of disability causation, we also vacate the administrative law judge's findings pursuant to 20 C.F.R. §718.204(c).

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.

NANCY S. DOLDER, Chief
Administrative Appeals Judge

ROY P. SMITH
Administrative Appeals Judge

BETTY JEAN HALL
Administrative Appeals Judge