U.S. Department of Labor

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

BRB No. 20-0465 BLA

CHERYL A. LIGHT (Widow of MARK A. LIGHT) Claimant-Petitioner v. POWELL MOUNTAIN COAL COMPANY, INCORPORATED and PROGRESS FUELS/DUKE ENERGY Employer/Carrier-Respondents DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR Party-in-Interest	)	DATE ISSUED: 12/29/2021 DECISION and ORDER

Appeal of the Decision and Order Denying Benefits of Jonathan C. Calianos, Administrative Law Judge, United States Department of Labor.

Cheryl A. Light, Dryden, Virginia.

Kendra R. Prince (Penn Stuart & Eskridge), Abingdon, Virginia, for Employer and its Carrier.

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

PER CURIAM:

Claimant,[1] without the assistance of counsel,[2] appeals Administrative Law Judge (ALJ) Jonathan C. Calianos's Decision and Order Denying Benefits (2018-BLA-05587) rendered on a survivor's claim filed on January 16, 2017, pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2018) (Act).

The ALJ accepted the parties' stipulation that the Miner had 11.6 years of coal mine employment, and therefore Claimant could not invoke the Section 411(c)(4) presumption that the Miner's death was due to pneumoconiosis.[3] 30 U.S.C. §921(c)(4) (2018). He further found the evidence did not establish the existence of complicated pneumoconiosis, and Claimant therefore could not invoke the irrebuttable presumption of death due to pneumoconiosis provided at Section 411(c)(3) of the Act. 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. Considering Claimant's entitlement under 20 C.F.R. Part 718, the ALJ accepted the parties' stipulation that the Miner had clinical pneumoconiosis and found the disease arose out of coal mine employment. However, he found the evidence did not establish the Miner's death was due to pneumoconiosis and denied benefits.

On appeal, Claimant generally challenges the ALJ's denial of benefits. Employer responds in support of the denial of benefits. 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 considers whether the Decision and Order below is supported by substantial evidence.

[1] Claimant is the widow of the Miner, who died on March 19, 2016. Director's Exhibit 9. Because there is no evidence the Miner was receiving benefits at the time of his death or "determined to be eligible to receive benefits" on a claim filed prior to his death, Claimant is not eligible for derivative survivor's benefits at Section 422(*l*) of the Act, 30 U.S.C. §932(*l*) (2018); Pretrial Conference Transcript at 4-5.

[2] On Claimant's behalf, Diane Jenkins, a benefits counselor with Stone Mountain Health Services of St. Charles, Virginia, requested the Board review the ALJ's decision, but she is not representing Claimant on appeal. *See Shelton v. Claude V. Keene Trucking Co.*, 19 BLR 1-88 (1995) (Order).

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

McFall v. Jewell Ridge Coal Co., 12 BLR 1-176, 1-177 (1989); *Stark v. Director, OWCP*, 9 BLR 1-36, 1-37 (1986). We must affirm the ALJ's findings if they are 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 Assocs., Inc.*, 380 U.S. 359 (1965).

The Section 411(c)(4) Presumption – Length of Coal Mine Employment

Although Claimant alleged at least fifteen years of coal mine employment, Director's Exhibit 5, Hearing Transcript at 9, at the hearing she stipulated to 11.6 years of coal mine employment based upon the district director's calculations. Hearing Transcript at 6; Pretrial Conference Transcript at 7. In light of Claimant's stipulation, which is supported by substantial evidence in the form of the Miner's Social Security Administration earnings record, we affirm the ALJ's determination that Claimant could not invoke the Section 411(c)(4) presumption. 30 U.S.C. §921(c)(4); 20 C.F.R. §718.305(b)(i); Decision and Order at 3 n.2; Director's Exhibits 7, 8.

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

Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), as implemented by 20 C.F.R. §718.304, provides an irrebuttable presumption of death due to pneumoconiosis if the miner suffered 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(a)-(c). The ALJ 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); *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993); *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33-34 (1991) (en banc).

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

The ALJ considered two interpretations of an x-ray dated February 18, 2013. Decision and Order at 15-16. Dr. Alexander, a dually-qualified Board-certified radiologist

[4] The Board will apply the law of the United States Court of Appeals for the Fourth Circuit, as the Miner performed his last coal mine employment in Virginia. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Director's Exhibit 5.

and B reader, interpreted the x-ray as positive for simple pneumoconiosis, but negative for complicated pneumoconiosis. Director's Exhibit 10. Dr. Miller, also dually qualified, interpreted the x-ray as positive for simple pneumoconiosis and noted an area of coalescence "just shy of meeting the criteria for a large opacity of complicated pneumoconiosis." Claimant's Exhibit 1. Consequently, the ALJ rationally found the x-ray evidence did not establish the existence of complicated pneumoconiosis. *See Director, OWCP v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 281 (1994); *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992); 20 C.F.R. §718.304(a); Decision and Order at 26.

20 C.F.R. §718.304(b) – Biopsy and Autopsy Evidence

A biopsy of a cavitary lung nodule in the left upper lung was performed on August 3, 2012. Director's Exhibit 12. Dr. Costello opined the biopsy was negative for malignancy and showed "[f]ibrous tissue and histocytes with abundant anthracotic particles; consistent with coal workers' pneumoconiosis." *Id.* at 7. Dr. Caffrey, who reviewed the slide, opined it showed lesions of simple coal workers' pneumoconiosis. Director's Exhibit 19.

The record also contains a report from a second biopsy, as well as a report following a bronchial lavage. Director's Exhibit 17. Dr. Helms opined a September 3, 2015 biopsy of the right upper lung was negative for fungi, acid fast bacilli, and malignancy, but showed subepithelial granulomatous inflammation. *Id.* at 47-48. Dr. Kulbacki opined a March 18, 2016 bronchial lavage of the left upper lung was consistent with Aspergillus pneumonia. Employer's Exhibit 1; Director's Exhibit 17 at 49.

Dr. Helms conducted the Miner's autopsy. She found regions of fibrosis with scattered anthracotic pigment-laden macrophages measuring up to 8 mm in the left lower lung and 1.1 cm in the right upper lung, which she opined are compatible with coal worker's pneumoconiosis. Director's Exhibit 13. Dr. Helms further noted bilateral pleural effusion, bilateral pleural adhesions, bilateral acute bronchopneumonia, bronchial Aspergillosis in the left lung, a right hilar lymph node with silicoanthracotic nodules, and plasmacytomas of the rib. *Id.* Dr. Caffrey, who reviewed the slides and treatment records, opined the slides showed simple but not complicated pneumoconiosis. Director's Exhibit 19. Dr. Caffrey disagreed with Dr. Helms's description of a 1.1 cm nodule in the right lung, opining Dr. Helms's macroscopic description of the lungs as showing "No significant regions of black discoloration or macules" indicates she saw no mass lesions or nodules and her description of "scattered anthracotic pigment-laden macrophages" describes only an area of dust deposit and not a lesion of simple or complicated pneumoconiosis. Employer's Exhibit 4 at 14. He also found bilateral pleural effusion, bilateral diffuse acute bronchopneumonia with focal abscess, focal Aspergillosis of the left lung, acute pulmonary congestion, bronchiolar metaplasia and dysplasia, a right hilar lymph node with an

anthracotic nodule, and plasmacytomas of the rib tissue. *Id.* Dr. Fino, who reviewed the autopsy reports and treatment records, opined the autopsy evidence would not support a finding of complicated pneumoconiosis because it did not show a lesion of at least two cm and the lesion Dr. Helms described would not appear as greater than one centimeter on a chest x-ray. Employer's Exhibits 3, 5. The ALJ found the autopsy evidence was not sufficient to establish complicated pneumoconiosis because Drs. Fino and Caffrey offered persuasive opinions based on the entirety of the record that the Miner did not suffer from the disease; moreover, Dr. Helms did not diagnose progressive massive fibrosis or opine the 1.1 cm mass would appear on an x-ray as greater than one centimeter. Decision and Order at 26.

As the trier-of-fact, the ALJ has discretion to assess the credibility of the medical opinions based on the experts' explanations for their diagnoses, and to assign those opinions appropriate weight. *See Mingo Logan Coal Co. v. Owens*, 724 F.3d 550, 558 (4th Cir. 2013); *Westmoreland Coal Co. v. Cochran*, 718 F.3d 319, 324 (4th Cir. 2013). The ALJ permissibly credited the opinions of Drs. Fino and Caffrey that the autopsy evidence does not support a diagnosis of complicated pneumoconiosis. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 949 (4th Cir. 1997). Moreover, while the absence of a specific statement of equivalency by a physician is not a bar to establishing complicated pneumoconiosis, the mere existence of a 1.1 cm mass at autopsy is not sufficient to establish complicated pneumoconiosis. *See Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 244 (4th Cir. 1999) (Evidence of a 2 to 3 cm mass diagnosed as "massive fibrosis" and a 1.3 cm nodule was insufficient evidence to determine whether the Miner had complicated pneumoconiosis); *see also Clinchfield Coal Co., v. Fultz*, 61 F. App'x 866, 871 (4th Cir. 2003) ("While there may be lesions so large that it is self-evident that they would have shown as opacities greater than one centimeter on x-ray, we cannot presume that lesions of 1.2 centimeters are so large that there need be no further testimony or evidence.").

In this case, the record is devoid of any diagnosis of complicated pneumoconiosis, progressive massive fibrosis, or massive lesions of pneumoconiosis. Decision and Order at 25. Moreover, the experts' opinions conflict as to whether any large masses exist, and the only evidence relevant to an equivalency determination is Dr. Fino's opinion that a 1.1 cm mass would not appear as greater than one centimeter on an x-ray. Director's Exhibits 13, 19; Employer's Exhibits 4-6. Consequently, substantial evidence supports the ALJ's determination that the autopsy evidence is not sufficient to establish massive lesions that

would measure as greater than one centimeter on x-ray.[5] 20 C.F.R. §718.304(b); *Blankenship*, 177 F.3d at 244; Decision and Order at 26.

We therefore affirm the ALJ's determination that the evidence does not establish complicated pneumoconiosis at 20 C.F.R. §718.304(b).

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

The ALJ further considered the Miner's treatment records, including x-ray and computed tomography (CT) scan readings, as well as the medical opinions of Drs. Fino and Caffrey.

X-Rays

Dr. DePonte read a January 21, 2013 x-ray as showing chronic interstitial lung disease with no focal area of consolidation or pneumothorax. Director's Exhibit 20 at 30. She also read a January 29, 2013 x-ray as showing prominent interstitial markings. *Id*. at 31. Dr. Chung read a March 5, 2013 x-ray as revealing diffuse bilateral interstitial infiltrates and no evidence of pneumothorax. Director's Exhibit 20 at 40. Dr. Rao read a March 25, 2015 x-ray as revealing large bilateral lower lobe consolidations suspicious for multilobal pneumonia. Employer's Exhibit 4. The March 17, 2016 x-ray was read by Dr. Culp as revealing patchy airspace disease involving the left lung with suspected layered pleural effusions due to pneumonia, asymmetric edema, or pulmonary hemorrhage. Director's Exhibit 14 at 6. Dr. Grover noted a March 18, 2016 x-ray showed infiltrate in the mid left lung. Director's Exhibit 17 at 36.

CT Scans

Dr. Reynolds read a June 26, 2012 CT scan as showing a stable 1.5 x 1.6 cm mass in the left upper lobe consistent with malignancy, infiltrates in the lower lung consistent with pneumonia, and bilateral nodules with infiltrates consistent with metastatic foci. Director's Exhibit 20 at 17. Dr. Lull read the August 3, 2012 CT scan as showing improved bibasilar ground glass opacities, a 1.4 x 1.3 cm nodule in the left upper lung, a 0.8 x 1.2 cm nodule in the left lower lobe, and nodules measuring up to one centimeter in the right middle lung, which he opined are suspicious for malignancy and metastatic disease. Director's Exhibit 12 at 6. Dr. Jernigan read a November 2, 2012 CT scan as showing a

[5] Moreover, while the ALJ did not independently evaluate the biopsy evidence, it suffers from the same flaws as the autopsy evidence; therefore, the ALJ's failure to explicitly consider this evidence is harmless. *See Larioni v. Director, OWCP*, 6 BLR 1-1276, 1-1278 (1984).

1.5 x 1.3 mm nodule in the left upper lung and multiple other nodules throughout the lungs consistent with metastatic disease. Director's Exhibit 20 at 22.

Dr. DePonte interpreted a February 8, 2013 CT scan as showing fine nodular interstitial lung disease, a 1.9 x 1.6 cm nodule in the left upper lung that "may" be carcinoma or an atypical conglomerate mass of coal workers' pneumoconiosis, three noncalcified opacities in the right middle lobe measuring up to one centimeter consistent with neoplasm or a conglomerate mass of coal workers' pneumoconiosis, and small nodules in the lower lungs bilaterally measuring up to 1.2 cm. Director's Exhibit 12 at 13-14. Dr. Chung read a February 25, 2013 CT scan as revealing diffuse metastatic bone disease, bilateral metastatic lung disease, and mediastinal adenopathy. Director's Exhibit 20 at 37-38. Dr. Jernigan read the June 25, 2013 CT scan as showing generally stable pulmonary nodules with a slightly increased cluster of nodules in the right medial lung base. Director's Exhibit 20 at 41-44.

Dr. Ramakrishnan read a December 22, 2014 scan as revealing a 3 x 1.3 cm nodular density in the right lung base and extensive bilateral pulmonary infiltrates. Director's Exhibit 12 at 22. A March 25, 2015 scan revealed dense confluent airspace opacities within most lung fields suggestive of multilobular pneumonia. Director's Exhibit 12 at 23. Dr. Thurman read the April 9, 2015 CT scan as showing significantly improved parahilar and bilateral lower lobe interstitial densities, patchy nodular opacities in the left upper and right lower lungs consistent with a residual infectious/inflammatory process, and a possible component of underlying interstitial lung disease. Director's Exhibits 12 at 24-25. Dr. Creasy read the June 2, 2015 CT scan as revealing persistent multifocal reticular nodular and ground glass opacities, and a consolidative area in the right lower lobe measuring 4.2 cm consistent with a progressive inflammatory/infectious process. Director's Exhibit 12 at 19. The August 10, 2015 CT scan was read by Dr. Vittori as revealing no significant change in the basilar nodules, or the ground glass and reticular opacities observed in both lungs. Director's Exhibits 12 at 20-21. According to Dr. Ramakrishnan, an August 11, 2015 positron emission tomography (PET)/CT scan displayed active noncalcified nodules, primarily in the lower lung zones, with a mildly metabolically active 3.1 x 1.9 cm dominant nodule in the right lower lung. Director's Exhibit 12 at 26-27. Dr. Siner read the March 18, 2016 CT scan as revealing extensive bilateral pneumonia and diffuse multiple myeloma, with no pneumoconiosis seen. Director's Exhibit 14 at 32.

Dr. Fino opined the autopsy evidence does not support a finding of complicated pneumoconiosis because it did not show a lesion of at least 2 cm and the lesion described by the prosector would not appear as greater than 1cm on a chest x-ray. Employer's Exhibits 3, 5. He further opined the treatment records do not support a finding of complicated pneumoconiosis as the lesions on the CT scans were not always observed, no biopsy was consistent with complicated pneumoconiosis, and the left upper lung nodule

resolved while the right upper lung abnormality was not consistent with complicated pneumoconiosis. *Id*. Similarly, as discussed above, Dr. Caffrey opined there was no evidence of complicated pneumoconiosis or progressive massive fibrosis. Director's Exhibit 19; Employer's Exhibit 4.

The ALJ found that, while the treatment records include numerous mentions of pneumoconiosis and black lung, these diagnoses were based primarily upon the Miner's medical history rather than the objective testing. Decision and Order at 25. He further accurately found that, while the CT scans contain observations of large nodules, they do not contain diagnoses of progressive massive fibrosis or any indication of how they would appear on an x-ray. *Id*. at 26. Finally, he found credible the opinions of Drs. Caffrey and Fino, who reviewed all of the records, including the CT scans and autopsy reports, that the Miner did not have complicated pneumoconiosis. *Id*. Consequently, the ALJ found the other medical evidence does not establish complicated pneumoconiosis. *Id*.; 20 C.F.R. §718.304(c).

The record is devoid of any diagnosis of complicated pneumoconiosis, progressive massive fibrosis, or massive lesions of pneumoconiosis, and the only equivalency determination is Dr. Fino's opinion that the large nodule Dr. Helms described would not appear as greater than one centimeter on x-ray.[6] *Blankenship*, 177 F.3d at 244; *Fultz*, 61 F. App'x at 871. The ALJ further permissibly credited the opinions of Drs. Fino and Caffrey that the treatment records do not support a diagnosis of complicated pneumoconiosis. *Compton*, 211 F.3d at 211; *Underwood*, 105 F.3d at 949. Because it is supported by substantial evidence, we affirm the ALJ's determination that the other medical evidence does not establish complicated pneumoconiosis. 20 C.F.R. §718.304(c); *Blankenship*, 177 F.3d at 233; *Compton*, 211 F.3d at 211; Decision and Order at 26. We therefore affirm the ALJ's determination that the evidence as a whole does not establish complicated pneumoconiosis. 20 C.F.R. §718.304; Decision and Order at 26.

[6] While Dr. DePonte opined the February 8, 2013 CT scan showed a possible atypical conglomerate mass of coal workers' pneumoconiosis in the left upper lung, she did not opine this was complicated pneumoconiosis or indicate that it would appear as greater than one centimeter on an x-ray. Director's Exhibit 12 at 13-14. Moreover, an x-ray taken ten days later was read by Drs. Miller and Alexander as negative for complicated pneumoconiosis, with Dr. Miller opining there was an area of coalescence too small to be complicated pneumoconiosis. Decision and Order at 24; Director's Exhibit 12 at 16; Claimant's Exhibit 1. Further, neither Dr. Helms nor Dr. Caffrey noted a nodule in the left upper lung. Director's Exhibits 13, 19.

Part 718 Entitlement – Death Due to Pneumoconiosis

Because the Section 411(c)(3) and Section 411(c)(4) statutory presumptions do not apply, Claimant must establish the Miner had pneumoconiosis arising out of coal mine employment, and that his death was due to pneumoconiosis. *See* 20 C.F.R. §§718.202(a), 718.203, 718.205(a); *Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-87-88 (1993). Death is considered due to pneumoconiosis if pneumoconiosis or complications of pneumoconiosis cause a miner's death, or if pneumoconiosis was a substantially contributing cause of his death. 20 C.F.R. §718.205(b)(1), (2). Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. 20 C.F.R. §718.205(b)(6); *see Collins v. Pond Creek Mining Co*., 751 F.3d 180, 184 (4th Cir 2014). Failure to establish any one of the required elements precludes entitlement. *See Trumbo*, 17 BLR at 1-87-88.

The ALJ accurately noted the only evidence that the Miner's death was due to pneumoconiosis is the death certificate.[7] Decision and Order at 26-28. Dr. Nakhala listed septic shock due to pneumonia, bacteremia, and acute renal failure as the immediate cause of death and multiple myeloma and pneumoconiosis as other significant contributing conditions. Director's Exhibit 11. The ALJ rationally accorded little weight to this diagnosis because the physician provided no rationale for his findings, he did not attribute the Miner's death to pneumoconiosis on the final discharge summary or diagnose the disease during prior hospitalizations, and the physician's previous notations that the Miner had a history of pneumoconiosis were based solely on Claimant's statements,. *Bill Branch Coal Co. v. Sparks*, 213 F.3d 186, 192 (4th Cir. 2000); Decision and Order at 27; Director's Exhibits 12, 13. Because there is no other evidence that the Miner's death was due to pneumoconiosis, we affirm the ALJ's determination that Claimant did not establish the Miner's death was due to pneumoconiosis. 20 C.F.R. §718.205(b). As Claimant failed to establish an essential element of entitlement, we affirm the denial of survivor's benefits under 20 C.F.R. Part 718. *Trumbo*, 17 BLR at 1-87-88.

[7] Both Drs. Caffrey and Fino diagnosed simple coal workers' pneumoconiosis that did not cause or contribute to the Miner's death. Director's Exhibit 17; Employer's Exhibits 3, 4. Dr. Helms's autopsy report listed simple coal workers' pneumoconiosis, but it did not address whether the disease contributed to the Miner's death. Director's Exhibit 12.

Accordingly, the ALJ'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