U.S. Department of Labor

Benefits Review Board
P.O. Box 37601
Washington, DC 20013-7601

BRB No. 14-0100 BLA

EARVIN R. HALL	)	
	)	
Claimant-Respondent	)	
	)	
v.	)	
	)	
BIZWIL, INCORPORATED	)	DATE ISSUED: 04/30/2015
	)	
and	)	
	)	
OLD REPUBLIC INSURANCE COMPANY	)	
	)	
Employer/Carrier-Petitioners	)	
	)	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR	)	
	)	
Party-in-Interest	)	DECISION and ORDER

Appeal of the Decision and Order on Remand – Award of Benefits of Richard T. Stansell-Gamm, Administrative Law Judge, United States Department of Labor.

John C. Collins (Law Office of John C. Collins), Salyersville, Kentucky, for claimant.

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

Before: HALL, Chief Administrative Appeals Judge, McGRANERY and BOGGS, Administrative Appeals Judges.

HALL, Chief Administrative Appeals Judge:

Employer/carrier (employer) appeals the Decision and Order on Remand – Award of Benefits (2008-BLA-5896) of Administrative Law Judge Richard T. Stansell-Gamm, rendered on claimant's request for modification of the denial of his subsequent claim, filed on February 8, 2001, pursuant to the provisions of the Black Lung Benefits Act, as

amended, 30 U.S.C. §§901-944 (the Act).[1] This case is before the Board for the second time.[2] In his initial Decision and Order, dated July 7, 2011, the administrative law judge determined that claimant worked ten years in surface coal mine employment. The administrative law judge further determined that the evidence was insufficient to establish the existence of complicated pneumoconiosis pursuant to 20 C.F.R. §718.304(a), (b). However, based on Dr. Mitchell's July 13, 2007 bronchoscopy/mediastinoscopy report, the administrative law judge found that claimant established the existence of complicated pneumoconiosis pursuant to 20 C.F.R. §718.304(c), and that he was entitled to invocation of the irrebuttable presumption of total disability due to pneumoconiosis. The administrative law judge further concluded that claimant established a change in an applicable condition of entitlement under 20 C.F.R. §725.309, a basis for modification under 20 C.F.R. §725.310, and he awarded benefits accordingly.

In consideration of employer's appeal, the Board vacated the award of benefits. The Board held that the administrative law judge erred by mischaracterizing the conclusions of Dr. Mitchell and in determining that claimant established the existence of complicated pneumoconiosis, based solely on Dr. Mitchell's report. *Hall v. Bizwil, Inc*., BRB No. 11-0731 BLA, slip op. at 8 (Aug. 23, 2012) (unpub.). The Board instructed the administrative law judge on remand to reconsider whether Dr. Mitchell's report, "standing on its own," satisfied the requisite criteria for establishing complicated pneumoconiosis at 20 C.F.R. §718.304(c). *Id*.

On remand, the administrative law judge determined that claimant satisfied his burden to establish the existence of complicated pneumoconiosis. The administrative law judge also determined that claimant established a change in an applicable condition of entitlement under 20 C.F.R. §725.309, and a basis for modification pursuant to 20 C.F.R. §725.310. Accordingly, the administrative law judge awarded benefits.

On appeal, employer asserts that the administrative law judge's finding of complicated pneumoconiosis is legally and factually flawed. Specifically, employer contends that the administrative law judge: failed to properly resolve whether a diagnosis of anthracosis in claimant's lymph nodes supports a finding that claimant has a chronic dust disease of the lung; did not accurately describe the biopsy findings of Dr. Jansen;

[1] The amendments to the Black Lung Benefits Act, which became effective on March 23, 2010, do not apply to this subsequent claim, based on its filing date. 30 U.S.C. §921(c)(4), as implemented by 20 C.F.R. §718.305(a); Director's Exhibit 2.

[2] We incorporate the procedural history of the case, as set forth in *Hall v. Bizwil, Inc*., BRB No. 11-0731 BLA, slip op. at 2-3 (Aug. 23, 2012) (unpub.).

improperly discredited Dr. Wheeler's x-ray interpretations; erred in finding complicated pneumoconiosis established in the absence of a specific equivalency determination by Dr. Mitchell or Dr. Jansen; and failed to properly weigh all of the relevant evidence, prior to concluding that claimant suffers from complicated pneumoconiosis. Claimant responds, urging affirmance of the award of benefits. The Director, Office of Workers' Compensation Programs, has declined to file a substantive response, unless specifically requested to do so by the Board.

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.[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) of the Act, implemented by 20 C.F.R. §718.304 of the regulations, provides that there is an irrebuttable presumption of total disability due to pneumoconiosis if the miner suffers from a chronic dust disease of the lung which, (a) when diagnosed by chest x-ray, yields one or more large opacities (greater than one centimeter in diameter) classified as Category A, B, or C; (b) when diagnosed by biopsy yields massive lesions in the lung; or (c) when diagnosed by other means, is a condition that would yield results equivalent to (a) or (b). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. The introduction of legally sufficient evidence of complicated pneumoconiosis does not automatically qualify a claimant for the irrebuttable presumption. The administrative law judge must first 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 invocation of the irrebuttable presumption pursuant to 20 C.F.R. §718.304 has been established. *See Gray v. SLC Coal Co.*, 176 F.3d 382, 387, 21 BLR 2-616, 624 (6th Cir. 1999); *see also Westmoreland Coal Co. v. Cox*, 602 F.3d 276, 287, 24 BLR 2-269, 2-286 (4th Cir. 2010). *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46, 17 BLR 2-114, 2-117-18 (4th Cir. 1993); *Gollie v. Elkay Mining Corp.*, 22 BLR 1-306, 1-311 (2003); *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33-34 (1991) (en banc).

Pursuant to 20 C.F.R. §718.304(a), the administrative law judge considered two readings of one analog x-ray dated March 24, 2010. This x-ray was read as positive for simple and complicated coal workers' pneumoconiosis, Category B, by Dr. Alexander, dually qualified as a Board-certified radiologist and B reader, and as negative for simple

[3] Because claimant's last coal mine employment was in Kentucky, the Board will apply the law of the United States Court of Appeals for the Sixth Circuit. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Director's Exhibit 1.

and complicated coal workers' pneumoconiosis by Dr. Wheeler, also a dually qualified radiologist. Decision and Order on Remand at 6; Claimant's Exhibit 2; Employer's Exhibit 3. Dr. Alexander indicated on the ILO form that there was a six centimeter opacity in the left upper lung zone and a four centimeter opacity in the right upper lung zone. Claimant's Exhibit 2. Dr. Wheeler also indicated on the ILO form that there were two bilateral six centimeter masses in the upper lobes, "compatible with conglomerate granulomatous disease: histoplasmosis or mycobacterium avium complex (MAC) more likely than [tuberculosis]." Employer's Exhibit 3. He further identified a one centimeter oval "calcified granuloma" in the "right mid lung," compatible with histoplasmosis. *Id*. Because the administrative law judge considered Dr. Alexander and Dr. Wheeler to be equally qualified, he determined that the x-ray readings were in equipoise and that claimant was unable to establish the existence of complicated pneumoconiosis, based on the x-ray evidence under 20 C.F.R. §718.304(a). Decision and Order on Remand at 6.

Pursuant to 20 C.F.R. §718.304(b), the administrative law judge considered a biopsy report by Dr. Jansen, a Board-certified clinical and anatomic pathologist. Claimant's Exhibit 7. Dr. Jansen examined two tissue samples obtained during claimant's July 13, 2007 bronchoscopy and mediastinoscopy, performed by Dr. Mitchell. *Id*. Dr. Jansen stated in the "Intraoperative Consult" section of his biopsy report:

> Frozen Section #1: Peritracheal node – negative for tumor or granulomatous disease. (DGD)
> Frozen Section #2: Negative for tumor, fibrotic granuloma. (DGD)

Id. The gross description of specimen number one indicated that it was a section from the right peritracheal node. *Id*. The microscopic description identified "sinus histiocytosis" and "some small non-necrotizing granulomas consisting of collections of histiocytes with an occasional intermixed giant cell." *Id*. The following diagnosis was provided: "Lymph node with sinus histiocytosis and non-necrotizing granulomatous inflammation . . . ." *Id*.

The gross description of specimen number two, labeled subcarinal node, indicated that it "consist[ed] of a 1.0 [centimeter] in greatest dimension aggregate of black anthracotic soft tissue." Claimant's Exhibit 7. The microscopic description identified "dense sclerosing fibrosis with pigmented histiocytes," but "no granulomatous inflammation or evidence of neoplasm." *Id*. The following diagnosis was stated for specimen two, the subcarinal lymph node: "Dense sclerosing fibrosis with scant background lymphoid tissues." *Id*. Both specimens were said to show "no AFB [tuberculosis] or fungus." *Id*.

In considering whether claimant established the existence of complicated pneumoconiosis, based on the biopsy evidence, the administrative law judge initially determined:

> Since Dr. Jansen observed a one centimeter aggregate of black anthracotic tissue that contained dense fibrosis associated with the pigmentation upon microscopic examination, and eliminated granulomatous disease, neoplasm, and bacteria/fungal infection, his pathology report is positive for pneumoconiosis.

Decision and Order on Remand at 7. The administrative law judge also found, however, that "Dr. Jansen did not additionally address whether his pathology observations represented a finding of a 'massive lesion' or indicate whether the noted one centimeter mass would appear as a large radiographic pulmonary opacity." *Id.* Thus, the administrative law judge concluded that Dr. Jansen's pathology findings of a one centimeter "anthracotic mass containing dense fibrosis obtained from the subcarnial lymph node is insufficient alone to establish the presence of complicated pneumoconiosis[.]" *Id.*

Pursuant to 20 C.F.R. §718.304(c), in accordance with the Board's remand instruction, the administrative law judge reconsidered the July 18, 2007 report of Dr. Mitchell, which was prepared in conjunction with the bronchoscopy and cervical mediastinoscopy performed on July 13, 2007. Decision and Order on Remand at 8-9; Claimant's Exhibit 7. Dr. Mitchell indicated in his report that claimant underwent surgery because a preliminary CT scan showed "bilateral [6.0] centimeter pulmonary masses with mediastinal adenopathy with one 3.5 centimeter subcarinal node." Claimant's Exhibit 7. Dr. Mitchell described the course of surgery as follows:

> Bronchoscopy was performed. There was some increased clear mucus in the right main stem, but there was no evidence of masses intraluminally in the bronchi on either side. In addition, there was no evidence of external compression of the bronchi. After sterile prep and drape a cervical mediastinoscopy was performed. There was excellent visualization of the mediastinum. A right paratracheal node was benign by frozen section with granulomatous tissue present. I was able to identify the subcarinal node which was 3[.0] centimeters, very distinct and large. A biopsy of this showed only granulomatous material and anthracosis.

Id. In a subsequent letter dated September 19, 2007, Dr. Mitchell stated, "[a]ll biopsies demonstrated only granulomatous disease and no evidence of malignancy." *Id.*

The administrative law judge acknowledged that Dr. Mitchell "neither diagnosed progressive massive fibrosis or complicated pneumoconiosis upon completion of his mediastinoscopy procedure which included a review of Dr. Jansen's pathology." Decision and Order on Remand at 9. However, the administrative law judge considered Dr. Mitchell's surgical report to be supportive of a finding that claimant has complicated pneumoconiosis, insofar as Dr. Mitchell observed a 3.0 centimeter subcarinal node, and reported that "the biopsy of [the] 1.0 centimeter mass that he obtained from that 3.0 centimeter mass was positive for anthracosis." *Id*. The administrative law judge explained:

> [A]lthough Dr. Mitchell also did not render a specific equivalency determination, the above two diagnostic results establish the presence of a 3.0 centimeter pulmonary mass containing anthracosis, which as clearly demonstrated by the radiographic evidence in this case, would appear greater than one centimeter on chest x-ray.

Id. (footnotes omitted). The administrative law judge concluded that claimant established a large pulmonary opacity consistent with complicated pneumoconiosis "through other diagnostic evidence" at 20 C.F.R. §718.304(c).[4] Decision and Order at 9.

Weighing all of the evidence together, the administrative law judge concluded that claimant satisfied his burden to establish complicated pneumoconiosis, by a preponderance of the record evidence as a whole. The administrative law judge based his determination on the following evidence:

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[4] The administrative law judge also noted that Dr. Sola read a January 7, 2008 digital x-ray as showing "rounded densities in both upper lobes with pleural reaction" along with "extensive changes of emphysema [raising] suspicion for silicosis." Director's Exhibit 58. Dr. Wheeler read this same digital x-ray as negative for simple and complicated pneumoconiosis. Employer's Exhibit 1. Dr. Wheeler identified a five and one-half centimeter mass in the lower central left upper lung involving the "upper lateral left hilum," a five centimeter mass in the lower central right upper lung "involving upper lateral right hilum" and a two centimeter mass in the "upper border in subapical [right upper lung]," all compatible with "conglomerate granulomatous disease, mycobacterium avium complex (MAC) or histoplasmosis more likely than [tuberculosis]." *Id*. The administrative law judge concluded that the January 7, 2008 digital x-ray was negative for complicated pneumoconiosis because Dr. Sola's credentials were not contained in the record, and because Dr. Wheeler is a dually qualified radiologist. Decision and Order on Remand at 8.

> Dr. Jansen's findings of a) anthracotic pneumoconiosis, b) the absence of granulomatous inflammation, and c) no bacterial or fungal infection, in the 1.0 centimeter tissue sample, and Dr. Mitchell's diagnosis of anthracosis in the same specimen that was obtained from the 3.0 centimeter subcarinal node, diminishes the probative value of Dr. Wheeler's conclusions that none of the large pulmonary opacities in the March 24, 2010 chest x-ray and the January 7, 2008 digital chest x-ray were consistent with pneumoconiosis in light of his comments that the large masses [were] consistent with conglomerate granulomatous disease, myocobaterium avium complex, or histoplasmosis.

Decision and Order on Remand at 10. Accordingly, the administrative law judge found that claimant invoked the irrebuttable presumption and awarded benefits.

In challenging the award of benefits, employer maintains that Dr. Jansen's biopsy report and Dr. Mitchell's surgical report are legally insufficient to establish that claimant has complicated pneumoconiosis, because they address lymph node tissue and not lung tissue. Employer specifically argues that Dr. Mitchell's diagnosis of anthracosis in the subcarinal lymph node fails to show that claimant has a chronic dust disease of the lung for purposes of invocation of the irrebuttable presumption. Employer further states that "a biopsy of the lymph node alone, *without any other medical evidence establishing a connection between the disease process in the lymph node and a disease in the lungs,* cannot establish complicated pneumoconiosis." Employer's Brief in Support of Petition for Review at 10 (emphasis added).

Contrary to employer's characterization, the administrative law judge did not base his finding of complicated pneumoconiosis *solely* on the biopsy evidence pertaining to a subcarinal lymph node. Employer's argument is essentially identical to the argument rejected by the United States Court of Appeals for the Fourth Circuit in *Cox*:

> [C]ontrary to Westmoreland's assertion, it is clear from the [administrative law judge's] opinion that her conclusion was based not on the 2005 biopsy, but rather on an evaluation of all of the evidence before her. This approach was legally proper under *Scarbro*. *See* [*E. Associated Coal Corp. v. Director, OWCP*] *Scarbro*, 220 F.3d [250,] 256, [22 BLR 2-93, 2-101 (4th Cir. 2000)](explaining that, in the [administrative law judge's] analysis of whether the claimant established the § 921(c)(3) presumption, "*all of the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities of greater than one centimeter in diameter on x-ray*").

Cox, 602 F.3d at 285, 24 BLR at 2-284. The administrative law judge in this case properly determined that claimant established the existence of complicated pneumoconiosis, based on his consideration of all the relevant evidence, and his specific crediting of a positive x-ray reading for pneumoconiosis, Category B. Decision and Order on Remand at 10. As noted by the administrative law judge, Dr. Alexander found bilateral masses measuring 6.0 and 4.0 centimeters on the March 24, 2010 x-ray in "the same location as the two masses identified by Dr. Mitchell during the mediastinoscopy"[5] and opined that it was complicated pneumoconiosis, Category B. Decision and Order at 9 n.12; Claimant's Exhibit 2. Dr. Wheeler also observed large bilateral masses measuring 6.0 centimeters on the March 24, 2010 x-ray, but opined that it was negative for both simple and complicated pneumoconiosis. Employer's Exhibit 3. Because each doctor is a dually qualified radiologist, the administrative law judge initially considered the x-ray evidence, standing alone, to be inconclusive. Decision and Order on Remand at 10. However, after consideration of other relevant evidence in the record, the administrative law judge concluded that Dr. Alexander's positive reading for complicated pneumoconiosis was more persuasive. *Id.* Contrary to the argument of employer and our dissenting colleague, the administrative law judge was not mistaken when he considered the lymph node biopsies obtained during a bronchoscopy and mediastinoscopy as evidence relevant to identification of the lung masses seen on x-ray. The reason those procedures were performed was to diagnose precisely the large masses in claimant's lungs shown on CT scan. Claimant's Exhibit 7. Since medical doctors relied upon those findings to diagnose masses in claimant's lungs, the administrative law judge properly considered them relevant to his determination of which x-ray interpretations to credit. Although the administrative law judge's medical terminology was not as precise as our dissenting colleague would like, any error he made in this regard was harmless, because his legal determination that the biopsy findings were relevant to a diagnosis of the opacities in claimant's lungs was well-supported by the medical opinion evidence. We conclude that the administrative law judge drew permissible inferences in this case based

[5] Dr. Mitchell included a preoperative diagnosis of bilateral pulmonary masses. In the section of his surgical report entitled "Indications for Procedure," Dr. Mitchell referenced a CT scan that showed "bilateral 6.0 centimeter pulmonary masses with mediastinal adenopathy with one 3.5 centimeter subcarinal node." Claimant's Exhibit 7. Dr. Mitchell indicated that claimant was a coal miner and a non-smoker. *Id.* The mediastinoscopy and bronchoscopy were performed in order to obtain an exact diagnosis of the bilateral masses in the lungs by means of a less invasive procedure than a lung biopsy. *Id.* Dr. Mitchell biopsied the 3.5 centimeter subcarinal node, identified on the CT scan, and also a paratracheal node. *Id.* The administrative law judge's inference that claimant's enlarged lymph nodes in the mediastinum were related to a disease process occurring in the lungs was rational in light of claimant's treatment history and Dr. Mitchell's surgical report.

on the evidence that was before him, and properly considered all of the relevant evidence in finding that claimant has complicated pneumoconiosis. *See Gray*, 176 F.3d at 389, 21 BLR at 2-629 ("all relevant evidence means just that – all evidence that assists the [administrative law judge] in determining whether a miner suffers from complicated pneumoconiosis.); *Cox*, 602 F.3d at 287, 24 BLR at 2-286; *Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162 (1989).

We also reject employer's contention that the administrative law judge erred in his treatment of Dr. Wheeler's opinion. The administrative law judge rationally explained that Dr. Mitchell's finding of anthracosis in claimant's subcarinal lymph node lent support to Dr. Alexander's diagnosis of simple and complicated pneumoconiosis in claimant's lungs and "diminished the probative value of Dr. Wheeler's conclusions that none of the large pulmonary opacities in the March 24, 2010 chest x-ray and the January 7, 2008 digital chest x-ray were consistent with pneumoconiosis . . . ." Decision and Order on Remand at 10; *see Wolf Creek Collieries v. Director, OWCP* [*Stephens*], 298 F.3d 511, 522, 22 BLR 2-494, 2-512 (6th Cir. 2002). *Peabody Coal Co. v. Groves*, 277 F.3d 829, 836, 22 BLR 2-320, 2-325 (6th Cir. 2002), *cert. denied*, 537 U.S. 1147 (2003); *Director, OWCP, v. Rowe*, 710 F.2d 251, 255, 5 BLR 2-99, 2-103 (6th Cir. 1983). The administrative law judge also stated correctly that Dr. Jansen's pathology review of the tissue sample from the subcarinal lymph node found anthracotic pneumoconiosis and the absence of granulomatous inflammation. Decision and Order on Remand at 9, n.11; Director's Exhibit 69. Thus, the administrative law judge permissibly determined that the biopsy findings detracted from the credibility of Dr. Wheeler's opinion.[6] *See Stephens*, 298 F.3d at 522, 22 BLR at 2-512.

[6] The administrative law judge acknowledged that there were contradictory statements in the biopsy reports regarding the presence of granulomatous disease but permissibly resolved the conflict as follows:

> I have considered that Dr. Mitchell also stated the 1.0 centimeter mass contained "granulomatous material" as well. However, the actual biopsy report establishing anthracotic pneumoconiosis in the 1.0 centimeter mass specifically indicated the absence of granulomatous inflammation. I have also considered Dr. Mitchell's subsequent September 19, 2007 report in which he stated that all the biopsies from his July 13, 2007 procedure demonstrated "only granulomatous disease and no evidence of malignancy." In assessing this discrepancy, I give greater probative weight to Dr. Mitchell's diagnosis of anthracosis on the day he conducted his procedure, which was supported by actual biopsy findings by Dr. Jansen of the 1.0 centimeter pulmonary tissue sample.

Review of the record reveals that the administrative law judge in the instant case, like the administrative law judge in *Cox*, properly found that the x-ray evidence, when considered in light of the other evidence, including CT scans, medical interpretations and a biopsy, was sufficient to establish statutory complicated pneumoconiosis under §921(c)(3), as implemented by 20 C.F.R. §718.304. *Cox*, 602 F.3d at 285, 24 BLR at 2-284. We consider employer's arguments on appeal to be no more than a request that the Board reweigh the evidence, which we are not empowered to do. *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113 (1989). Because the administrative law judge discussed in detail all of the relevant evidence presented in the record, and he acted within his discretion in crediting Dr. Alexander's positive reading for a large opacity, Category B, on the March 24, 2010 x-ray, we affirm the administrative law judge's finding that claimant established the existence of complicated coal workers' pneumoconiosis by a preponderance of the evidence. *See Groves*, 277 F.3d at 836, 22 BLR at 2-325; *Rowe*, 710 F.2d at 255, 5 BLR at 2-103. Thus, we affirm the administrative law judge's finding that claimant is entitled to the irrebuttable presumption at 20 C.F.R. §718.304. *See Gray*, 176 F.3d at 387, 21 BLR at 2-624; *Gollie*, 22 BLR at 1-311; *Melnick*, 16 BLR at 1-33-34.

Accordingly, the administrative law judge's Decision and Order on Remand – Award of Benefits is affirmed.

SO ORDERED.

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BETTY JEAN HALL, Chief
Administrative Appeals Judge

Decision and Order on Remand at 9 n. 11; *Wolf Creek Collieries v. Director, OWCP* [*Stephens*], 298 F.3d 511, 522, 22 BLR 2-494, 2-512 (6th Cir. 2002).

I concur.

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REGINA C. McGRANERY
Administrative Appeals Judge

BOGGS, Administrative Appeals Judge, dissenting:

I respectfully dissent from my colleagues' decision to affirm the administrative law judge's finding that claimant is entitled to the irrebuttable presumption of total disability due to pneumoconiosis. I agree with employer that the administrative law judge misstated and mischaracterized Dr. Jansen's biopsy report; applied an incorrect legal analysis in finding that Dr. Mitchell's surgical report established the existence of complicated pneumoconiosis; selectively analyzed the evidence in reaching his conclusions; failed to identify specific evidentiary support for his findings; and did not rationally explain the basis for his findings of fact and conclusions of law, as required by the Administrative Procedure Act (APA).[7]

These errors arose largely because the administrative law judge analyzed the lymph node tissue evidence as lung tissue evidence without setting forth any rational basis for doing so; considered Dr. Mitchell's statement regarding anthracosis as a credible medical diagnosis of pneumoconiosis without evaluating whether it was a reasoned and documented medical opinion; and overlooked the biopsy evidence of granulomatous disease in reaching his conclusions. As the administrative law judge's factual and legal errors directly affected his determination that claimant established complicated pneumoconiosis, they are not harmless. Consequently, the case should be remanded for further consideration.

Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), as implemented by 20 C.F.R. §718.304(a), provides that there is an irrebuttable presumption of total disability due to pneumoconiosis if the miner suffers from a chronic dust disease of the lung which, (a) when diagnosed by chest x-ray, yields one or more large opacities (greater than one

[7] The Administrative Procedure Act requires that every adjudicatory decision be accompanied by a statement of "findings and conclusions, and the reasons or basis therefor, on all the material issues of fact, law, or discretion presented on the record." 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 30 U.S.C. §932(a).

centimeter in diameter) 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 that would yield results equivalent to (a) or (b). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304 (emphasis added). The introduction of legally sufficient evidence of complicated pneumoconiosis, however, does not automatically qualify a claimant for the irrebuttable presumption found at 20 C.F.R. §718.304. The administrative law judge must examine all the evidence on this issue, i.e., evidence of simple and complicated pneumoconiosis, as well as evidence that pneumoconiosis is not present, resolve any conflict, and make a finding of fact. *Gray v. SLC Coal Co.*, 176 F.3d 382, 21 BLR 2-615 (6th Cir. 1999); *Lester v. Director, OWCP*, 993 F.2d 1143, 17 BLR 2-114 (4th Cir. 1993); *Gollie v. Elkay Mining Corp.*, 22 BLR 1-306, 1-311 (2003); *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33-34 (1991) (en banc). Further, the administrative law judge must explain the basis for all of his findings of fact and conclusions of law in accordance with the APA.

Review of the Evidence and the Administrative Law Judge's Decision

Pursuant to 20 C.F.R. §718.304(a), relating to the diagnosis of complicated pneumoconiosis by x-ray, the administrative law judge considered one positive reading for simple and complicated pneumoconiosis, Category B, of an analog x-ray dated March 24, 2010, by Dr. Alexander, dually qualified as a Board-certified radiologist and B reader, and one negative reading for simple and complicated pneumoconiosis of the same x-ray by Dr. Wheeler, also a dually qualified radiologist. Decision and Order on Remand at 6; Claimant's Exhibit 2; Employer's Exhibit 3. On the ILO form, Dr. Alexander identified a six centimeter opacity in the left upper lung zone and a four centimeter opacity in the right upper lung zone. Claimant's Exhibit 2. Dr. Wheeler also indicated on the ILO form that there were two bilateral six centimeter masses in the upper lobes of the lung, "compatible with conglomerate granulomatous disease: histoplasmosis or mycobacterium avium complex (MAC) more likely than [tuberculosis]." Employer's Exhibit 3. Additionally, Dr. Wheeler identified a "probable [one centimeter] calcified granuloma in right mid lung," compatible with histoplasmosis. *Id*. The administrative law judge concluded that the x-ray evidence was in equipoise because he considered Drs. Alexander and Wheeler to be equally qualified. Therefore, he found that claimant was unable to establish the existence of complicated pneumoconiosis at subsection (a).

Relevant to 20 C.F.R. §718.304(b), relating to diagnosis of massive lesions in the lungs by biopsy or autopsy evidence, the administrative law judge considered a pathology report by Dr. Jansen of tissue samples from two lymph nodes. The lymph node tissue was obtained by Dr. Mitchell during a bronchoscopy and cervical mediastinoscopy performed on July 13, 2007. Claimant's Exhibit 7. Under the heading "Intraoperative Consult," Dr. Jansen's biopsy report stated:

> Frozen Section #1: Peritracheal node – negative for tumor or granulomatous disease. (DGD)
> Frozen Section #2: Negative for tumor, fibrotic granuloma. (DGD)

Id. The gross description of specimen number one indicated that it was a section from the right peritracheal node. *Id*. The microscopic description identified "sinus histiocytosis" and "some small non-necrotizing granulomas consisting of collections of histiocytes with an occasional intermixed giant cell." *Id*. The following diagnosis was provided: "Lymph node with sinus histiocytosis and non-necrotizing granulomatous inflammation . . . ." *Id*.

The gross description of specimen number two, labeled subcarinal node, indicated that it "consist[ed] of a 1.0 [centimeter] in greatest dimension aggregate of black anthracotic soft tissue." Claimant's Exhibit 7. The microscopic description identified "dense sclerosing fibrosis with pigmented histiocytes," but "no granulomatous inflammation or evidence of neoplasm." *Id*. The following diagnosis was stated for specimen two, the subcarinal lymph node: "Dense sclerosing fibrosis with scant background lymphoid tissues." *Id*. Both specimens were said to show "no AFB [tuberculosis] or fungus." *Id*.

In evaluating the biopsy evidence, the administrative law judge set forth the definition of clinical pneumoconiosis[8] at 20 C.F.R. §718.201(a)(1). He observed that "because the regulatory definition of clinical pneumoconiosis requires both a deposit of coal dust matter and lung tissue reaction to the deposit, a biopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis." Decision and Order on Remand at 7. However, the administrative law judge concluded:

> Since Dr. Jansen observed a one centimeter aggregate of black anthracotic tissue that contained dense fibrosis associated with the pigmentation upon microscopic examination, and eliminated granulomatous disease, neoplasm, and bacteria/fungal infection, his pathology report is positive for pneumoconiosis. However, Dr. Jansen did not additionally address whether his pathology observations represented a finding of a "massive lesion" or indicate whether the noted one centimeter mass would appear as a large

[8] Clinical pneumoconiosis consists of "those diseases recognized by the medical community as pneumoconioses, 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).

> radiographic pulmonary opacity. Consequently, standing alone, Dr. Jansen's pathology findings of a one centimeter anthracotic mass containing dense fibrosis obtained from the subcarinal lymph node is insufficient alone to establish the presence of complicated pneumoconiosis under 20 C.F.R. §718.304([b]). At the same time, I find that Dr. Jansen's pathology report does establish the presence of 1.0 [centimeter] pulmonary mass containing anthracotic pneumoconiosis that was obtained from the 3.0 [centimeter] subcarinal lymph mass by Dr. Mitchell for pathological assessment.

Id.

Pursuant to 20 C.F.R. §718.304(c), which relates to diagnosis of complicated pneumoconiosis by means other than x-ray, biopsy or autopsy,[9] the administrative law judge considered two readings of a January 7, 2008 digital x-ray and Dr. Mitchell's surgical report. Decision and Order on Remand at 8-9; Claimant's Exhibit 7. The administrative law judge credited Dr. Wheeler's negative reading of the January 7, 2008 digital x-ray over the positive reading by Dr. Sola, as Dr. Wheeler is a dually qualified radiologist and Dr. Sola's qualifications were not of record.

Dr. Mitchell explained in his report that claimant underwent surgery because a preliminary CT scan showed "bilateral [6.0] centimeter pulmonary masses with mediastinal adenopathy with one 3.5 centimeter subcarinal node." Claimant's Exhibit 7. Dr. Mitchell wrote under "Description of Procedure" the following:

> Bronchoscopy was performed. There was some increased clear mucus in the right main stem, but there was no evidence of masses intraluminally in the bronchi on either side. In addition, there was no evidence of external compression of the bronchi. After sterile prep and drape a cervical mediastinoscopy was performed. There was excellent visualization of the mediastinum. A right paratracheal node was benign by frozen section with granulomatous tissue present. I was able to identify the subcarinal node which was 3[.0] centimeters, very distinct and large. A biopsy of this showed only granulomatous material and anthracosis. Incision was closed with two layers of Vicyrl suture. I discussed this further with Dr. Lee

[9] Diagnosis of complicated pneumoconiosis by means other than x-ray, biopsy or autopsy must accord with acceptable medical procedures and the condition diagnosed must be one that "could reasonably be expected to yield the results" described for diagnosis of massive lesions by biopsy or autopsy, or diagnosis based on large opacities shown on x-ray. 20 C.F.R. §718.304(c).

> Hicks from Oncology and felt that a CT guided lung biopsy may be the next best option.

Id. In a subsequent letter dated September 19, 2007, Dr. Mitchell advised Dr. Kousa, claimant's treating physician, that he had seen claimant for a post-surgical visit. He stated that "[a]ll biopsies demonstrated only granulomatous disease and no evidence of malignancy." *Id*. Dr. Mitchell related that claimant complained of shortness of breath and was requesting "to see a medical lung specialist." *Id*. Dr. Mitchell indicated that he referred claimant to Dr. Thompson in Lexington, Kentucky.[10] *Id*.

The administrative law judge acknowledged that Dr. Mitchell did not diagnose complicated pneumoconiosis, but found that "the entirety of Dr. Mitchell's operative report is sufficient to establish, under Section 718.304(c), the presence of a large pulmonary mass consistent with pneumoconiosis." Decision and Order on Remand at 9. The administrative law judge explained:

> First, during the course of his mediastinoscopy procedure *into the tracheal area of the lungs*, Dr. Mitchell observed a 3.0 centimeter, subcarinal node. Second, Dr. Mitchell reported that the biopsy of [the] 1.0 centimeter mass that he obtained from the 3.0 centimeter pulmonary mass was positive for anthracosis. Third, although Dr. Mitchell also did not render a specific equivalency determination, the above two diagnostic results establish the presence of a 3.0 centimeter pulmonary mass containing *anthracosis*, which as clearly demonstrated by the radiographic evidence in this case, would appear greater than one centimeter on chest x-ray.

Id. (footnotes omitted) (emphasis added). The administrative law judge concluded therefore that claimant established complicated pneumoconiosis pursuant to 20 C.F.R. §718.304(c). Weighing all of the evidence together, the administrative law judge further concluded:

> Dr. Jansen's findings of a) anthracotic pneumoconiosis, b) the absence of granulomatous inflammation, and c) no bacterial or fungal infection, in the 1.0 centimeter tissue sample, and Dr. Mitchell's diagnosis of anthracosis in the same specimen that was obtained from the 3.0 centimeter subcarinal node, diminishes the probative value of Dr. Wheeler's conclusions that none of the large pulmonary opacities in the March 24, 2010 chest x-ray and the January 7, 2008 digital chest x-ray were consistent with

[10] There is no evidence in the record pertaining to claimant's treatment subsequent to the surgery.

> pneumoconiosis in light of his comments that the large masses [were] consistent with conglomerate granulomatous disease, mycobacterium avium complex, or histoplasmosis. As a consequence, the interpretations of the March 24, 2010 chest x-ray no longer stand in equipoise, such that the remaining probative finding by Dr. Alexander of a large pulmonary opacity consistent with pneumoconiosis also actually establishes the presence of a large pulmonary opacity consistent with pneumoconiosis under 20 C.F.R. §718.304(a). Additionally, the January 7, 2008 digital chest x-ray becomes inconclusive based on the remaining probative interpretation by Dr. Sola. Accordingly, [claimant] has proven the presence of complicated pneumoconiosis under 20 C.F.R. §718.304, thereby invoking that irrebuttable presumption that he is totally disabled due to pneumoconiosis.

Decision and Order on Remand at 10.

Analysis of the Administrative Law Judge's Decision

I would vacate the administrative law judge's award of benefits because he mischaracterized the biopsy evidence. Although the administrative law judge observed correctly that Dr. Jansen did not identify massive lesions sufficient to establish complicated pneumoconiosis pursuant to Section 718.304(b), he stated that "Dr. Jansen's pathology report does establish the presence of 1.0 [centimeter] *pulmonary mass* containing *anthracotic pneumoconiosis* that was obtained from the 3.0 [centimeter] subcarinal lymph mass . . . ." Decision and Order on Remand at 7. However, Dr. Jansen did not diagnose anthracosis, pneumoconiosis, or anthracotic pneumoconiosis. Dr. Jansen states only that the subcarinal lymph node "consist[ed] of a 1.0 [centimeter] in greatest dimension aggregate of black anthracotic soft tissue." Claimant's Exhibit 7. Under the regulations, anthracotic pigmentation does not qualify as pneumoconiosis. 20 C.F.R. §718.202(a)(2); *see Hapney v. Peabody Coal Co.*, 22 BLR 1-104, 1-111 (2001) (en banc) (Dolder & Smith, JJ., concurring and dissenting). Moreover, based on his microscopic examination, Dr. Jansen diagnosed "dense sclerosing fibrosis with scant background of lymphoid tissue." *Id*. Dr. Jansen did not associate the fibrosis he diagnosed with his gross finding of anthracotic tissue. I believe that the administrative law judge erred in selectively analyzing portions of Dr. Jansen's report, and in misstating Dr. Jansen's conclusions, to support his finding of clinical pneumoconiosis. *See Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 BLR 2-84 (7th Cir. 1983); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 BLR 1-606 (1983).

Furthermore, the regulations specifically require a "chronic dust disease of the lung" in order to establish clinical pneumoconiosis, either simple or complicated. *See* 20 C.F.R. §§718.201, 718.304. Clinical pneumoconiosis consists of "those diseases recognized by the medical community as pneumoconioses, 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) (emphasis added). The tissue specimens obtained by Dr. Mitchell and then examined by Dr. Jansen were from two lymph nodes located in the *mediastinum*.[11] Neither Dr. Jansen nor Dr. Mitchell described the tissue specimens as lung tissue. Further Dr. Jansen did not indicate that there was any connection between the tissue he examined and the lungs or any condition or disease of the lungs. Claimant's Exhibit 7. Thus, because the administrative law judge failed to address that Dr. Jansen's statements regarding anthracotic tissue and fibrosis on specimen two pertain to a subcarinal lymph node, and the administrative law judge provided no rationale for treating this tissue as lung tissue, I would vacate his finding of clinical pneumoconiosis under 20 C.F.R. §718.201(a)(1), based on Dr. Jansen's report.

I also agree with employer that the administrative law judge erred in finding that claimant established complicated pneumoconiosis, based on Dr. Mitchell's report, at 20 C.F.R. §718.304(c). The administrative law judge improperly concluded that the "diagnostic results of Dr. Mitchell's July 13, 2007 mediastinoscopy establishes the *presence of a large pulmonary opacity* consistent with pneumoconiosis."[12] Decision and Order on Remand at 10. In his surgical report, Dr. Mitchell indicated that the mediastinoscopy was necessary because a preliminary CT scan showed "bilateral 6 centimeter pulmonary masses with mediastinal adenopathy with one 3.5 centimeter subcarinal node." Director's Exhibit 69; Claimant's Exhibit 7. During his surgical procedure, Dr. Mitchell observed and removed tissue from two enlarged lymph nodes in the mediastinum, the area between the lungs as discussed *supra*.[13] The administrative law judge, however, described Dr. Mitchell's surgical procedure as involving the "tracheal area *of the lungs.*" Decision and Order on Remand at 9 (emphasis added). The administrative law judge further erred by misstating that a one centimeter tissue specimen was obtained from a "3.0 centimeter *pulmonary* mass" and, without proper foundation, by equating the three-centimeter subcarinal lymph node with one of the bilateral lung

[11] The mediastinum is defined as "the region in mammals between the pleural sacs of the lungs, containing all of the thoracic viscera *except the lungs."* *The American Heritage Medical Dictionary* 2007 (emphasis added).

[12] Pulmonary is defined as "pertaining to the *lungs*." *The American Heritage Medical Dictionary* 2007 (emphasis added).

[13] He identified one node as the right paratracheal node and identified the other node as a subcarinal node. Claimant's Exhibit 7.

masses identified by Drs. Alexander and Wheeler on the March 24, 2010 x-ray.[14] Decision and Order on Remand at 9, n.12 (emphasis added). Thus, the administrative law judge's finding of complicated pneumoconiosis was based on characterizing the tissue from the subcarinal node in the mediastinum as lung tissue, and equating the subcarinal node with a pulmonary mass seen on x-rays, but the administrative law judge provided no proper bases for doing so.

Additionally, employer makes a valid argument that the administrative law judge did not properly consider the credibility of Dr. Mitchell's description of anthracosis in his report. Although Dr. Mitchell stated that the biopsy revealed anthracosis, Dr. Jansen did not diagnose anthracosis.[15] To the extent that Dr. Mitchell rendered his own diagnosis of anthracosis, the administrative law judge must address whether it is a diagnosis of anthracosis under 20 C.F.R. §718.201(a)(1) and is sufficiently explained and credible. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85 (1993). The administrative law judge must determine if a physician's opinion is reasoned and documented, prior to relying on it to support a finding that claimant established simple or complicated

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[14] The administrative law judge stated that "although Dr. Mitchell also did not render a specific equivalency determination, the . . . diagnostic results establish the presence of a 3.0 centimeter mass containing anthracosis, *which as clearly demonstrated by the radiographic evidence in this case*, would appear greater than one centimeter on a chest x-ray." Decision and Order on Remand at 9 (emphasis added). His footnote reference for the radiographic evidence states, "[i]n the March 24, 2010 chest x-ray Dr. Alexander found 6.0 and 4.0 centimeter pulmonary masses in both upper lung zones (the same location as the two masses identified by Dr. Mitchell during the mediastinoscopy) . . . ." Decision and Order on Remand at 9 n.12. The administrative law judge thus equated the subcarinal node seen by Dr. Mitchell with the two bilateral pulmonary masses seen by Dr. Alexander. However. Dr. Mitchell's report references a pre-operative CT scan, which clearly differentiates the subcarinal node from the bilateral pulmonary masses. Claimant's Exhibit 7.

[15] Dr. Mitchell wrote under "Description of Procedure" the following:

> Bronchoscopy was performed . . . I was able to identify the subcarinal node which was 3[.0] centimeters, very distinct and large. *A biopsy of this showed only granulomatous material and anthracosis* . . . I discussed this further with Dr. Lee Hicks from Oncology and felt that a CT guided *lung biopsy* may be the next best option.

Claimant's Exhibit 7 (emphasis added).

pneumoconiosis.[16] *See* 20 C.F.R. §718.202(a)(4); *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 BLR 2-323 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 BLR 2-269 (4th Cir. 1997).

> Whether a diagnosis of anthracosis in a miner's lymph nodes can be considered a diagnosis of clinical pneumoconiosis is a question of fact to be resolved by the administrative law judge, in accordance with the regulatory definition of the disease, and based on medical evidence establishing that the disease process found in the lymph nodes relates to, or is diagnostic of, a chronic dust disease of the lung.[17] *See Daugherty v. Dean Jones Coal Co.*, 895 F.2d 130, 13 BLR 2-134 (4th Cir. 1989); *Hapney*, 22 BLR at 1-114. In this case, the administrative law judge has failed to consider whether the diagnosis of anthracosis in the lymph node is credible as a diagnosis of clinical pneumoconiosis under 20 C.F.R. §§718.201(a)(1), 718.202, and, to also identify evidence in the medical record that establishes a diagnostic connection between the disease process identified in claimant's subcarinal lymph node and the bilateral lung masses identified on x-ray.[18] Thus, the administrative law judge's

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[16] Employer argues that Dr. Mitchell's diagnosis of anthracosis is not credible because the doctor "relied on a work history that was twice the amount that was established in the record" and it inaccurately reflects the biopsy evidence. Employer's Brief in Support of Petition for Review at 14.

[17] In *Van Dyke v. Beatrice Pocahontas Coal Co.*, BRB No. 05-0249 BLA (Dec. 29, 2005) (unpub.), the Director, Office of Workers' Compensation Programs, filed a brief in support of a denial of benefits, based on the administrative law judge's finding that a biopsy diagnosing anthracosilicosis in the miner's lymph nodes was insufficient to establish clinical pneumoconiosis, pointing out that the 2001 regulations clearly contemplate that biopsy evidence be of lung tissue. *Id*.; *see* 20 C.F.R. §718.106(a) ("A report of an autopsy or biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of the lung). The 2001 regulations which were promulgated after *Daugherty v. Dean Jones Coal Co.*, 895 F.2d 130, 13 BLR 2-134 (4th Cir. 1989) was decided, added language describing pneumoconiosis more specifically as "the conditions characterized by deposition of substantial amounts of particulate matter *in the lungs* and the fibrotic reaction *of the lung tissue* to that deposition caused by dust in coal mine employment." 20 C.F.R. §718.201(a)(1) (emphasis added).

[18] Although the weighing of the evidence is for the administrative law judge, the interpretation of medical data is for the medical experts. *Marcum v. Director, OWCP*, 11 BLR 1-23 (1987); *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131 (1986); *Bogan v. Consolidation Coal Co.*, 6 BLR 1-1000 (1984). Accordingly, it is error for an administrative law judge to interpret medical tests and thereby substitute an adjudicator's

finding of complicated pneumoconiosis, based on Dr. Mitchell's surgical report, is not rationally explained. *See Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162, 1-165 (1989); *Clark v. Karst-Robbins Coal Co*., 12 BLR 1-149 (1989) (en banc). I would therefore vacate the administrative law judge's finding at 20 C.F.R. §718.304(c).

Lastly, I agree with employer that the administrative law judge erred in his treatment of Dr. Wheeler's opinion, and in concluding that claimant established complicated pneumoconiosis, based on a weighing of all the relevant evidence. The administrative law judge specifically rejected Dr. Wheeler's x-ray reading on the ground that Dr. Jansen's biopsy report showed "the absence of granulomatous inflammation." Decision and Order on Remand at 10. The administrative law judge again mischaracterized and selectively analyzed Dr. Jansen's findings. Contrary to the administrative law judge's analysis, the "Intraoperative Consult" section of Dr. Jansen's report pertaining to specimen one, indicates it was "negative for tumor or granulomatous disease," but the microscopic description notes "small non-necrotizing granulomas," and the diagnosis is "*non-necrotizing granulomatous inflammation.*" Claimant's Exhibit 7 (emphasis added). In addition, Dr. Mitchell also noted "granulomatous material" in his July 13, 2007 operative report, and later stated in his September 19, 2007 letter that "all biopsies demonstrated *only granulomatous disease* and no evidence of malignancy." *Id*. (emphasis added). As employer observes, "the finding of no granulomatous inflammation on one specimen does not negate the finding of granulomas on the other." Employer's Brief in Support of Petition for Review at 14.

Under these facts, I would vacate the administrative law judge's rejection of Dr. Wheeler's negative x-ray reading on the stated ground that the biopsy evidence "showing an absence of granulomatous inflammation" detracted from Dr. Wheeler's opinion. *See Wright v. Director, OWCP*, 7 BLR 1-475 (1984); *Hess*, 7 BLR at 1-295. An administrative law judge is permitted to discredit alternate explanations for large masses on x-rays if there is no evidence in the record to show that a miner had any of the diseases suggested by the physician. *See generally Westmoreland Coal Co. v. Cox*, 602 F.3d 276, 287, 24 BLR 2-269, 2-286 (4th Cir. 2010). The administrative law judge, however, has failed to consider relevant evidence of granulomatous disease that supports Dr. Wheeler's opinion regarding the etiology of claimant's masses seen on x-ray. *Akers*, 131 F.3d at 441, 21 BLR at 2-275-76; *McCune v. Central Appalachian Coal Co.*, 6 BLR 1-996, 1-998 (1984).

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conclusions for those of the physician. *See Scott v. Mason Coal Co.*, 14 BLR 1-37 (1990) (recon en banc).

Contrary to the majority's suggestion, the administrative law judge's determination in this case is not at all like that of the administrative law judge in *Cox*. In *Cox*, the administrative law judge considered all of the relevant evidence and properly characterized it. *Cox*, 602 F.3d at 285, 24 BLR at 2-284. Because the administrative law judge did not do so here, remand is required.

In conclusion, the administrative law judge misstated and mischaracterized the biopsy findings and Dr. Jansen's report; applied an incorrect legal analysis in finding that Dr. Mitchell's surgical report established the existence of complicated pneumoconiosis at 20 C.F.R. §718.304(c); failed to consider all of the evidence relevant to granulomatous disease; and has not adequately explained the evidentiary bases for his findings of complicated pneumoconiosis, in accordance with the APA and the regulatory criteria. These errors are not harmless, as they comprised an integral part of the administrative law judge's determination that claimant invoked the irrebuttable presumption of total disability due to pneumoconiosis at 20 C.F.R. §718.304, and his ultimate determination that claimant is entitled to benefits. *See Shinseki v. Sanders*, 556 U.S. 396, 413 (2009) (an error is not harmless if it could have made a difference in the outcome.); *Larioni v. Director, OWCP*, 6 BLR 1-1276, 1-1278 (1984). Consequently, I would vacate the administrative law judge's determination that claimant is entitled to the irrebuttable presumption, vacate the award of benefits, and remand the case for further consideration of whether claimant has satisfied his burden of proof pursuant to 20 C.F.R. §718.304. *See Cox v. Benefits Review Board*, 791 F.2d 445, 447, 9 BLR 2-46, 2-48 (6th Cir. 1986); *Director, OWCP v. Congleton*, 793 F.2d 428, 7 BLR 2-12 (6th Cir. 1984); *Wojtowicz*, 12 BLR at 1-165; *Mabe v. Bishop Coal Co.*, 9 BLR 1-67 (1986). As an additional matter, because the administrative law judge repeated many of the same errors on remand as he did in his initial decision with regard to the biopsy evidence and Dr. Mitchell's report, I would instruct that the case be reassigned to a different administrative law judge for a fresh look at the evidence.

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JUDITH S. BOGGS
Administrative Appeals Judge