No. 11-4298

IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

DIXIE FUEL CO. LLC, and BITUMINOUS CASUALTY CORP.,

Petitioners

v.

ARLIS HENSLEY and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,

Respondents

On Petition for Review of an Order of the Benefits Review Board, United States Department of Labor

BRIEF FOR THE FEDERAL RESPONDENT

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BRIEF FOR THE FEDERAL RESPONDENT

STATEMENT OF APPELLATE AND SUBJECT MATTER JURISDICTION

Dixie Fuel Company, LLC, and its insurance carrier, Bituminous Casualty Corporation, (Dixie) petition this Court for review of a Benefits Review Board decision affirming an administrative law judge's award of Arlis Hensley's claim for benefits under the Black Lung Benefits Act (BLBA), 30 U.S.C. §§ 901-944, as

amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1556, 124 Stat. 119, 260 (2010).

On February 9, 2010, the ALJ awarded Mr. Hensley federal black lung benefits. Appendix (App.) 20. Dixie's timely appeal to the Benefits Review Board on March 3, 2010, gave the Board jurisdiction to review the ALJ's decision. Certified Case Record (R.) 73-80. *See* 33 U.S.C. §§ 921(a) and (b)(3), as incorporated by 30 U.S.C. § 932 (a) (providing thirty-day period for appealing ALJ decisions to the Board).

On March 30, 2011, the Board issued a final order affirming the ALJ's award of benefits. R. 14-30; App. 4. Dixie timely sought reconsideration of the Board order on April 26, 2011. R. 3-13. *See* 20 C.F.R. § 802.407 (providing a thirty day period for seeking reconsideration of a final Board order). The Board denied Dixie's motion for reconsideration on September 30, 2011. R. 1-2. App. 3.

On November 23, 2011, Dixie timely petitioned this Court to review the Board's order and Reconsideration order. App.1. *See* 33 U.S.C. § 921(c), as incorporated by 30 U.S.C. § 932(a) (providing a sixty-day period for appealing Board decisions); 20 C.F.R. § 802.406 (a timely motion for reconsideration to the Board tolls the sixty-day period for a party to seek appellate review in the appropriate federal court).

This Court has jurisdiction over Dixie's petition for review under 33 U.S.C. § 921 (c), as incorporated by 30 U.S.C. § 932(a). The injury contemplated by 33 U.S.C. § 921(c) - Mr. Hensley's exposure to coal dust - occurred in the Commonwealth of Kentucky, within the jurisdictional boundaries of this Court. *See Danko v. Director, OWCP,* 846 F.2d 366, 368 (6th Cir. 1988).

STATEMENT OF THE ISSUE

Whether the ALJ improperly found pneumoconiosis established based solely on X-ray evidence, rather than considering "all relevant evidence" of the disease as mandated by the BLBA.

STATEMENT OF THE CASE

Mr. Hensley (the miner) filed his current claim for black lung benefits on December 4, 2006.[1] Director's Exhibit No. (DX) 4.[2] Following a hearing in April 2009, ALJ Kenneth A. Krantz, determined that Dixie, the miner's last coal mine

[1] The miner filed two prior claims for federal black lung benefits. The first, filed August 24, 1990, was denied by the district director on January 25, 1991. The district director also denied the second claim, filed October 1, 2003, on September 9, 2004. DX 1, DX 2.

[2] The Index of Documents in the Certified Case Record (CCR), submitted December 28, 2011, by Board Clerk Thomas O. Shepherd, does not contain separate entries for the hearing exhibits, hearing transcript, or administrative proceedings occurring before the February 9, 2010 award of benefits. The Director therefore has not provided separate references to the Certified Case Record for these documents.

employer, was responsible for the payment of benefits and issued an award. R. 73-80; App. 47-55.

On appeal to the Board, Dixie challenged the ALJ's determination that the miner suffered from pneumoconiosis, asserting that the ALJ had failed to weigh together all relevant medical evidence of the disease. Dixie further argued that the ALJ erred in weighing the evidence of disability causation. R. 33-60.

The Board affirmed the award, finding that the ALJ's weighing of the evidence regarding the existence of pneumoconiosis and disability causation was proper. R. 14-30; App. 6-18. The Board then denied Dixie's motion for reconsideration. R. 1-3; App 3. This appeal followed. App. 1.

STATEMENT OF THE FACTS

The miner was employed in coal mine work for thirteen years, ending in January 1988. App. 22. He worked for approximately ten years as a continuous mine operator at the face of the mine, where he was exposed to extensive coal dust. ALJ hearing transcript (HT) 14, 23. He subsequently worked as a pinner-helper at the mine face. While working as pinner-helper, he injured his hand and arm when they were caught in a belt head. Upon his doctor's advice, he left coal mine employment several months later. HT 13, 16, 19. The miner smoked cigarettes for 10-12 years, quitting approximately 21-22 years prior to the hearing. He described the daily amount he smoked as one-half pack. HT 15,18.

A. Relevant Medical Evidence

The Director is responding only to Dixie's challenge to the finding of pneumoconiosis. This statement summarizes the evidence relevant to that issue.

Chest X-ray Interpretations

Exhibit Number	X-ray Date	Physician/ Qualifications[3]	Interpretation
DX 1-25	9/10/90	Dahhan B reader	Small opacities 0/1 [negative] s/q, mid and lower zones. No pleural abnormalities consistent with pneumoconiosis
DX 1-24	9/10/90	Gordonson BCR/B-reader	0/1 [negative] s/t, all zones no pleural abnormalities consistent with pneumoconiosis
DX 1-23	9/10/90	Sargent B/BCR	1/0 [positive] t/s, all zones
DX 2-91	2/23/04	Baker B-reader	2/1 [positive] t/s mid and lower zones. No pleural abnormalities consistent with pneumoconiosis Pleural thickening of an interlobar fissure
DX 2-105	2/23/04	Barrett BCR/B-reader	Quality reading only Definite emphysema Scarring in right lower lung

[3] In this column, "BCR" denotes a radiologist who is certified "in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association." 20 C.F.R. § 718.202(a)(1)(ii)(C). A "B-reader" is "a physician who has demonstrated proficiency in evaluating chest roentgenograms for roentgenographic quality and in the use of the ILO-U/C classification [required by section 20 C.F.R. § 718.102(b)] for interpreting chest roentgenograms for pneumoconiosis and other diseases." 20 C.F.R. § 718.202(a)(1)(ii)(E).

DX 2-24	2/23/04	Halbert BCR/B-reader	No parenchymal abnormalities consistent with pneumoconiosis No pleural abnormalities consistent with pneumoconiosis
CX 1	11/1/06	Alexander BCR/B-reader	2/2 [positive] p/s, all zones right diaphragm elevated and ill-defined. Scarring or atelectasis in rt lower zone
EX 7	11/1/06	Wheeler BCR/B-reader	No parenchymal abnormalities consistent with pneumoconiosis No pleural abnormalities consistent with pneumoconiosis Obesity contributes to minimal hypoinflation and crowded lower lung markings. Accentuated underexposure on both views and a broad band of discoid atelectasis in RML more likely than scar. Increased lung markings in bases and lateral periphery mid and upper lungs are probably pulmonary vascular prominence but early linear and irregular interstitial lung disease could be present possibly mixed with a few tiny nodules. Possible 8-9 mm nodule in lateral right upper lung overlying anterolateral right rib2 compatible with granuloma or tiny tumor
DX 16	1/5/07	Baker B-reader	2/1 [positive] q/p all zones no pleural abnormalities consistent with pneumoconiosis
DX 17	1/5/07	Barrett BCR/B-reader	Quality reading Right basal scar

DX 38/39	1/5/07	Wheeler BCR/B-reader	[negative] No pleural abnormalities consistent with pneumoconiosis Hypoinflation with broad discoid atelectasis more likely than scar right lower lateral lung involving pleura. Pulmonary vascular prominence more likely than interstitital lung disease lower lung accentuated hypoinflation and underexposure.
CX 4	1/5/07	Ahmed BCR/B-reader	1/2 [positive] q/t, all zones minute soft irregular and rounded parenchymal densities scattered throughout both lungs pleural abnormalities consistent with pneumoconiosis very poor inspiratory effort, infiltrate in the right lower lunch that could be atelectasis no evidence of localized pneumonia
DX 33/34	4/12/07	Dahhan B-reader	1/1 [positive] q/q upper and middle zones no pleural abnormalities consistent with pneumoconiosis opacities in mid and upper zones consistent with Category 1 simple coal workers' pneumoconiosis coalescence in right lower lobe with thickening of the major fissure
EX 4/CX 8	7/28/08	Rosenberg B-reader	No pleural abnormalities consistent with pneumoconiosis Linear scarring in the mid and lower lung zones with some atelectasis or infiltrate in right

			lower lung zone
CX 3	7/28/08	Alexander BCR/B-reader	2/2 [positive] t/p, all zones Category A large opacities No pleural abnormalities consistent with coal workers' pneumoconiosis 20 mm large opacity in the right lower zone consistent with complicated CWP (follow-up recommended)
CX 2	1/16/09	Miller BCR/B-reader	2/3 t,q, all zones diffuse, small, predominantly irregular opacities compatible with pneumoconiosis scarring or atelectasis at the right lung base
EX 10	1/16/09	Wheeler BCR/B-reader	No pleural abnormalities consistent with pneumoconiosis Moderate linear and irregular interstitial infiltrate or interstitial fibrosis lower half lungs involving pleura and possibly mixed with few nodules in lateral periphery and possible subtle interstitial infiltrate or fibrosis in lower lateral upper lobes involving pleura compatible with interstitial lung disease; usual interstitial pneumonitis, autoimmune disease or possible lymphatic spread of cancer with possible few small granulomata from histoplasmosis Transverse band of discoid atelectasis or scar between lower right hilum and lateral pleura

Biopsy evidence

On March 24, 2008, a needle core biopsy was performed on the miner to evaluate a lung mass in his lower right lung. The specimen lacked normal lung tissue and consisted of "granulomatous inflammatory process characterized by areas of geographic caseous necrosis." The pathologic diagnosis was "caseating granulomatous pneumonitis."[4] CX 6.

Dr. Everett Oesterling evaluated four slides and a cytologic preparation obtained from the needle core biopsy. Dr. Oesterling concluded that there was evidence of coal mine dust inhalation but the specimens did not include sufficient interstitial tissue to permit a diagnosis of interstitial lung disease or to relate the lung changes to coal dust exposure. EX 11.[5]

[4] Caseous necrosis is a morphological change indicative of cell death "in which the tissue becomes a soft, dry crumbly mass resembling cheese." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 303 (30th ed. 2003). Granulomatous pneumonitis is an inflammation of the lungs with "granulomas, usually resulting from an infection or inhalation of organic dust." *Id*. at 1465.

[5] Dixie states that a second biopsy was performed on March 5, 2009. Pet. Br. 7. It appears that Dixie is confusing Dr. Oesterling's review of slides taken from the March 24, 2008 biopsy with a second biopsy. *Compare* EX 11 (photographs of slides bearing S-08-2823 identification) *with* CX 6 (biopsy pathology report number KPS-08-02823); *see also* Dixie's post-hearing brief to ALJ at 10 (describing only one biopsy, which was reviewed by Dr. Oesterling).

CT scans

Three CT scans of the miner's chest were conducted at the request of his treating physician, Dr. William Powers. CX 6. The first scan, conducted on February 19, 2008, revealed, *inter alia*, a possible neoplastic or inflammatory mass and a moderate amount of infiltrates in the left lung base. CX 6.

A second CT scan, conducted on July 22, 2008, revealed numerous non-calcified nodules or masses scattered throughout the lungs and a dominant mass in the right lower lobe (previously biopsied). The concluding diagnosis was pulmonary fibrosis, primarily basilar, with multiple nodules, including the mass in the right lower lung lobe. CX 6. A comparison of the two CT-scans provided limited correlation but nonetheless showed the development of multiple pulmonary nodules, most non-calcified, and possible diffuse granulomatous disease or early neoplasm, and possible slightly increased interstitial changes. CX 6.

A third CT scan, taken January 27, 2009, showed a soft tissue mass at the right lung base, irregular parenchymal density at the left lung base, and small pulmonary nodules scattered throughout both lungs. The doctor's impression was multiple pulmonary nodules and masses and adenopathy, as well as scattered scarring, atelectasis, and inflammatory changes. It was also noted that there was no significant change from the November 4, 2008 scan.[6] CX 6.

[6] The record does not contain a report of the November 4, 2008 CT scan.

Medical Opinions[7]

Dr. A. Dahhan, a Board-certified internist and pulmonologist and B-reader, examined the miner on April 12, 2007.[8] App. 71. He noted a history of rheumatoid arthritis and read an X-ray as positive for simple category 1 pneumoconiosis. *Id.* Dr. Dahhan opined that the miner's rheumatoid arthritis could very well be responsible for the changes on X-ray, explaining that rheumatoid arthritis can variously affect the lungs, including causing pulmonary fibrosis and nodules. He further opined that the miner's pulmonary disability resulted from his rheumatoid lung disease and possibly his smoking habit. App. 71-73.

In his deposition, Dr. Dahhan stated, consistent with his medical report, that the effects of rheumatoid arthritis mimic those of pneumoconiosis and that the X-ray markings of the two conditions could not be distinguished with certainty. App. 81-82. When asked if rheumatoid arthritis was the likely cause of the miner's

[7] The record also contains two medical opinions from Dr. Baker, one from the miner's second claim, DX 2, and one from the current claim. DX 16. The miner also submitted short reports from his treating physicians, Drs. Powers, Stolfutz, and Augustine. CX 6, 7. Although these doctors all found pneumoconiosis, the ALJ accorded little weight to their diagnoses. According to the ALJ, Dr. Powers' opinion was equivocal, Dr. Stolfutz's unexplained, and Drs. Baker and Augustine's opinions lacked critical information about the miner's medical condition, *i.e.*, his rheumatoid disease, and thus were insufficiently reasoned. App. 48-49.

[8] Dr. Dahhan also examined the miner in 1990 in connection with his first claim. DX 1. He determined that the miner did not have pneumoconiosis or a respiratory disability.

pulmonary problems, Dr. Dahhan stated that there was "a very high diagnosis on the differential." App. 82. Dr. Dahhan noted that the miner's pulmonary condition had significantly changed between his exam in September, 1990, and the April, 2007 exam, as evidenced by increased spots on his lung, deteriorating pulmonary function results, and increasing degenerative joint disease. App. 84. Although he acknowledged that the medical literature indicates that coal dust can have a latent effect on pulmonary conditions, he opined that because the miner had no coal dust exposure after 1987-88, it should not have accounted for any of the pulmonary changes. App. 85. Dr. Dahhan concluded that rheumatoid arthritis accounted for some of the miner's pulmonary impairment. App. 85.

Dr. David M. Rosenberg, a Board-certified internist and pulmonologist and B-reader, examined the miner in July, 2008 at Dixie's request. App. 58. He noted the miner's history of rheumatoid arthritis and administered an X-ray, which he read as negative for pneumoconiosis. Dr. Rosenberg commented that the X-ray did not reveal micronodularity in the upper lung zones, which results from past coal mine dust exposure, but rather showed linear interstitial scarring in the mid- and lower lung zones, which is associated with rheumatoid arthritis. App. 62.

Dr. Rosenberg also discussed the relationship between coal dust exposure and linear interstitial scarring. He noted that there are many types of interstitial lung disease that can lead to interstitial scarring. App. 62. He further criticized

several medical references purporting to demonstrate a relationship between coal dust and linear interstitial lung disease because the studies failed to control for known risk factors, particularly smoking. By contrast, he approvingly cited several studies indicating that rheumatoid arthritis "classically causes interstitial pulmonary fibrosis and thus linear parenchymal changes on chest X-ray or CT." App. 62.

Specific to the miner, Dr. Rosenberg pointed out that his decreased pO_2[9] after exercise correlated with his scarring on X-ray, which he had determined to be related to "RA [rheumatoid arthritis] or multiple other disorders, but not past coal mine dust exposure." App. 62. Dr. Rosenberg thus concluded that the miner was disabled from his linear interstitial lung disease, and not from any past coal mine dust exposure. App. 62.

Dr. Rosenberg's subsequent review of an additional chest X-ray reading, CT scan reports, and the treatment records of Drs. Powers and Stoltzfus, confirmed his view that the miner's pulmonary impairment was in no way attributable to coal dust exposure, but rather was caused by linear interstitial changes from rheumatoid arthritis and newly-developing granulomas from an unidentified inflammatory process. App. 68.

[9] PO2 is defined as "oxygen partial pressure." DORLANDS MEDICAL ILLUSTRATED DICTIONARY at 1347.

B. Relevant Decisions Below

Decision and Order Awarding Benefits, February 9, 2010 (App. 20)

ALJ Kenneth A. Krantz issued a decision awarding benefits on February 9, 2010. App. 20. Because this was a subsequent claim, the ALJ first determined, based on the newly-submitted medical reports, that the miner was totally disabled, an element of entitlement previously decided against him.[10] App. 44.

The ALJ then considered the entirety of the medical evidence of record to determine whether it established entitlement to benefits. Of the seven chest X-rays, the ALJ found two positive for pneumoconiosis (dated April 2007 and July 2008), one negative (dated February 2004), and four in equipoise (dated September 1990, November 2006, January 2007, and January 2009). App. 47. Recognizing the progressive and irreversible nature of pneumoconiosis, the ALJ accorded greater weight to the two positive readings because they were more recent than the negative reading. (They were taken three and four years later). The ALJ accordingly found pneumoconiosis established by X-ray under section 718.202(a)(1). App. 47.

[10] Under 20 C.F.R. § 725.309(d), a miner may file a subsequent claim for benefits if the earlier claim has been finally denied and over a year has passed. Before the subsequent claim may be considered on its merits, however, the claimant must demonstrate that "one of the applicable conditions of entitlement . . . has changed since the date upon which the order denying the prior claim became final." *Id.*

The ALJ then considered the biopsy and medical opinion evidence and determined that it did not establish pneumoconiosis under 20 C.F.R. §§ 718.202(a)(2) and (a)(4). App. 47-50.

The ALJ concluded that pneumoconiosis was established based solely on the X-ray evidence. App. 50. In doing so, he relied on Board precedent permitting a claimant in a case arising in the Sixth Circuit to establish pneumoconiosis by satisfying any one of the alternate methods found in 20 C.F.R. § 718.202(a). App. 50.

The ALJ went on to consider whether the pneumoconiosis arose out of coal mine employment. Because the miner had 13 years of qualifying coal mine employment and had established pneumoconiosis by X-ray evidence, the ALJ found that the miner was entitled to the § 718.203 rebuttable presumption that his pneumoconiosis arose from coal mine employment. App. 50-51.

The ALJ then determined that the negative biopsy of the right lung mass and the medical opinions of Drs. Rosenberg and Dahhan failed to rebut that presumption. With respect to the biopsy evidence, the ALJ recognized in accordance with 20 C.F.R. § 718.106 that negative biopsy evidence does not constitute conclusive proof of the absence of pneumoconiosis. More important, the biopsy, which examined the mass in the lower right lung, failed to "rebut the presumption that the *other* abnormalities noted on X-ray, which were found to be

consistent with pneumoconiosis, were caused by coal mine employment." App. 51-52.

Regarding Drs. Dahhan's and Rosenberg's opinions that the linear interstitial changes seen on X-ray were unrelated to coal dust exposure, the ALJ found that Dr. Dahhan inadequately explained why, given its latent and progressive nature, pneumoconiosis "'should not' have had a latent impact on [the miner's] respiratory system." App. 52. With respect to Dr. Rosenberg's opinion, the ALJ concluded that he had improperly criticized scientific studies linking interstitial X-ray changes to coal dust exposure. App. 53. Specifically, the ALJ determined that Dr. Rosenberg misrepresented or did not specify the alleged absence of controls used by the studies' authors. App. 52-53.

Having found pneumoconiosis arising out of coal mine employment, the ALJ then determined that the pneumoconiosis contributed to the miner's undisputed totally disabling pulmonary impairment and awarded benefits. App 54-55.

Board Decision and Order, March 30, 2011 (A.4)

On appeal to the Board, Dixie challenged the ALJ's finding of pneumoconiosis based solely on the X-ray evidence, asserting that the ALJ erred in not weighing together all relevant evidence regarding the existence of the disease. Rejecting this contention, the Board stated that because this case arises within the

jurisdiction of the Sixth Circuit, it would decline to apply Third and Fourth Circuit law, namely *Penn Allegheny Coal Co. v. Williams,* 114 F.3d 22 (3d Cir. 1997), and *Island Creek Coal Co. v. Compton,* 211 F.3d 203 (4th Cir. 2000), and instead would continue to hold in cases arising within the Sixth Circuit, that a miner can establish pneumoconiosis under any of the alternate methods listed in 20 C.F.R. § 718.202(a). App. 10 n. 7.

On the merits, the Board found that the ALJ permissibly credited the positive reading by a dually qualified radiologist (Dr. Alexander) of the July 2008 X-ray (one of the most recent of record) in finding pneumoconiosis established. It further observed that the ALJ performed both a "qualitative and quantitative analysis" of the X-ray evidence and explained his resolution of the conflicting readings. The Board thus upheld the ALJ's determination as supported by substantial evidence. App. 10.

The Board also affirmed the ALJ's finding that the negative biopsy evidence and medical opinions were insufficient to rebut the § 718.203 presumption that the pneumoconiosis arose out of coal mine employment. App. 12. The Board agreed with the ALJ that the negative biopsy of the right lower lung mass did not conclusively establish the absence of pneumoconiosis or address the etiology of *other* X-ray abnormalities (which had been found to be consistent with pneumoconiosis). App. 11-12. In addition, the Board held that it was within the

ALJ's discretion to find Dr. Dahhan's opinion insufficiently reasoned because he failed to account for the progressive nature of pneumoconiosis. App. 12-13. Likewise, the Board affirmed the ALJ's discrediting of Dr. Rosenberg's opinion that the X-ray changes were unrelated to coal mine employment because the ALJ reasonably rejected Dr. Rosenberg's premise that linear interstitial fibrosis, in general, is not related to coal dust exposure. App. 14-15. In particular, the Board found that the ALJ permissibly reviewed the medical studies referenced by Dr. Rosenberg, and ruled that his rejection of Dr. Rosenberg's criticism of these studies did not constitute an impermissible substitution of his opinion for Dr. Rosenberg's. App. 15-16.[11]

Last, the Board affirmed the ALJ's finding that the medical opinions established that the miner's total disability was due to pneumoconiosis. App. 17-18. It accordingly affirmed the award of benefits.

Dixie timely sought reconsideration of the Board's decision, which the Board summarily denied. R. 1-13.

SUMMARY OF THE ARGUMENT

Under section 718.202(a), pneumoconiosis may be established by X-ray, autopsy or biopsy, application of presumption, or medical opinion. Contrary to the

[11] The Board also concluded that, contrary to Dixie's assertion, the ALJ had properly considered the CT scan evidence when he addressed Dr. Rosenberg's opinion.

holdings below, proof by one method does not mean that pneumoconiosis is automatically established. Rather, the ALJ must weigh together all relevant evidence—including the evidence identified in the remaining sections of 718.202(a), as well as "medically acceptable" evidence not directly addressed in section 718.202(a). The ALJ must do this because the Act mandates that "all relevant evidence" be considered. Further, section 718.202(a) by its terms in no way mandates that satisfaction of one method precludes consideration of contrary evidence, and the Director, whose interpretation is entitled to deference, has not interpreted section 718.202(a) in this manner.

In the instant case, the ALJ reasonably found that the weight of the X-ray evidence was positive for pneumoconiosis, but he did not consider this finding in light of other credible evidence of record, specifically, the CT scan and biopsy reports. Accordingly, the case must be remanded for the ALJ to properly weigh all of the relevant evidence pertaining to the existence of pneumoconiosis.

ARGUMENT

REMAND IS REQUIRED FOR THE ALJ TO WEIGH TOGETHER ALL RELEVANT EVIDENCE REGARDING THE EXISTENCE OF PNUEMOCONIOSIS.

A. Standard of Review

The Court exercises plenary review with respect to questions of law. *Caney Creek Coal Co. v. Satterfield*, 150 F.3d 568, 571 (6th Cir. 1998). Absent an error

of law, the ALJ's findings and conclusions must be affirmed if supported by substantial evidence. *Peabody Coal Co. v. Hill*, 123 F.3d 412, 415 (6th Cir. 1997).

B. Statutory and Regulatory Background

In order to be entitled to benefits under the BLBA, a miner must establish, *inter alia*, that he suffers from pneumoconiosis. 30 U.S.C. § 901(a); 20 C.F.R. § 725.202(d)(2)(i). Compensable pneumoconiosis takes two forms, "clinical" and "legal." 20 C.F.R. § 718.201(a). "Clinical pneumoconiosis" refers to a cluster of diseases recognized by the medical community as fibrotic reactions of lung tissue to the "permanent deposition of substantial amounts of particulate matter in the lungs," 20 C.F.R. § 718.201(a), and is generally diagnosed by chest X-ray, biopsy or autopsy, 20 C.F.R. §§ 718.102, 718.106, 718.202(a)(1)-(2). In contrast, "legal pneumoconiosis" is a broader category referring to "any chronic lung disease or impairment . . . arising out of coal mine employment," 20 C.F.R. § 718.201(a)(2), and is diagnosed "notwithstanding a negative X-ray," 20 C.F.R. § 718.202(a)(4). The Act further provides that, in determining the validity of a claim, "all relevant evidence shall be considered, including, where relevant, medical tests such as blood gas studies, X-ray examination, electrocardiogram, pulmonary function studies, or physical performance tests…" 30 U.S.C. § 923(b).[12]

[12] Notwithstanding this statutory requirement, the Secretary has promulgated regulations placing limits on the *amount* of evidence a party may submit in a claim under the BLBA, thereby determining the quantity of medical evidence that is

The Secretary's Part 718 regulations contain criteria for evaluating whether a miner suffers from pneumoconiosis (both clinical and legal). Section 718.202(a) provides four methods by which pneumoconiosis can be demonstrated. These methods are 1) X-ray readings; 2) biopsy or autopsy evidence; 3) invocation of certain presumptions (inapplicable in this case); and 4) a "reasoned medical opinion." 20 C.F.R. § 718.202(a)(1)-(a)(4) respectively. [13]

Finally, when the Department promulgated section 718.202(a) it was aware that its four listed methods of establishing pneumoconiosis might not be sufficiently inclusive. 65 Fed. Reg. 79945 (December 20, 2000). To remedy this and meet the statute's "all relevant evidence" command, the Secretary allowed

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generally relevant in a black lung claim. *See* 20 C.F.R. § 725.414 (establishing evidence limits); *Elm Grove Coal Co. v. Director, OWCP*, 480 F.3d 283-85 (4th Cir. 2007) (upholding evidence limits); *National Mining Ass'n v. Dep't of Labor*, 292 F.3d 849, 873-74 (D.C. Cir. 2002) (same).

[13] Section 718.202(a) provides in relevant part:

> (a) A finding of the existence of pneumoconiosis may be made as follows:
>
> (1) A chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of pneumoconiosis.
> (2) A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis;
> (3) If the presumptions described in §§ 718.304. 718.305, or 718.306 are applicable, it shall be presumed that the miner is or was suffering from pneumoconiosis.
> (4) A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201.

consideration of "the results of any medically acceptable test or procedure reported by a physician" not addressed by the regulations. 20 C.F.R. § 718.107. Consequently, an ALJ may consider CT scan results if "medically acceptable."

C. Argument

1. Under the Act "all relevant evidence" must be considered when determining the existence of pneumoconiosis.

Refusing to apply Third or Fourth Circuit law in this Sixth Circuit case, the ALJ and the Board held that section 718.202(a)'s four methods of proving pneumoconiosis were alternative, and that satisfaction of one method established the disease. App. 10 n.7. In its opening brief, Dixie asserts that the Board is wrong, and that all relevant evidence regarding the existence of the disease must be weighed together before a finding of pneumoconiosis is made. The Director agrees.

In our view, although section 718.202(a) enumerates four distinct methods of establishing pneumoconiosis, all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease. This interpretation of section 718.202(a) is consistent with the regulatory text, comports with the plain meaning of the BLBA, and promotes the legislative goal to compensate miners disabled by pneumoconiosis. As such, the Director's interpretation of his own regulation is controlling. *Auer v. Robbins,* 519 U.S. 452,

461 (1997) (agency's interpretation of own regulation is controlling "unless plainly erroneous or inconsistent with the regulation").

First, there is nothing in the text of section 718.202(a) that *precludes* weighing relevant evidence together, or conversely, that *requires* a finding of pneumoconiosis based on only one type of evidence. The two courts of appeals to have considered the issue have reached the same conclusion. In *Penn Allegheny Coal Co. v. Williams,* 114 F.3d 22 (3d Cir. 1997), the Third Circuit rejected the Board's alternative-method approach and held that, "although section 718.202(a) enumerates four distinct methods of establishing pneumoconiosis, all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." *Id.* at 25 (quoting the Director's brief). In support, the court cited the Act's provision that "all relevant evidence shall be considered," and the fact that section 718.202(a) does not list its proof methods in the disjunctive. 114 F.3d at 25.

The Fourth Circuit followed suit in *Island Creek Coal Co. v. Compton,* 211 F.3d 203 (4th Cir. 2000). Based on the plain statutory directive that all relevant evidence be considered, and simple common sense, the court held that "there is nothing in the language of 718.202(a) to support a conclusion that satisfaction of the requirements of one subsection conclusively proves the existence of pneumoconiosis even in the face of conflicting evidence." *Id.* at 209. The court

explained that it read the regulation "as giving claimants flexibility in proving their claims, but not as establishing mutually exclusive bases for demonstrating the existence of pneumoconiosis." *Id.; Consolidation Coal Co. v. Brown,* 230 F.3d 1351 (4th Cir. 2000).[14]

Moreover, as noted by the Third Circuit, the Director's interpretation is consistent with the BLBA. It provides that "all relevant evidence" must be considered in determining the validity of claims. 30 U.S.C. § 923(b); *see also Mullins Coal Co.v. Director, OWCP*, 484 U.S. 135, 139 (1989); *Bosco v. Twin Pines Coal Co.,* 892 F.2d 1473, 1479 (10th Cir. 1989) ("resolving a claim for benefits under a procedure that does not ensure consideration of all relevant evidence is expressly prohibited under the Act"). Thus, for instance, if a record contains X-ray interpretations, CT scans, and biopsy reports relevant to the question, the Act prohibits the conclusion that the miner did or did not have pneumoconiosis based on the X-ray evidence alone. The CT scans and the biopsy evidence must also be weighed. Further extending this analysis, if the X-ray and biopsy evidence prove negative for "clinical" pneumoconiosis under section

[14] Significantly, the Fourth Circuit found guidance in this Court's decision in *Gray v. SLC Coal Co.,* 176 F.3d 382 (6th Cir. 1999). In *Gray*, this Court considered section 411(c)(3) of the Act, 30 U.S.C. 921(c)(3), which provides four methods for proving the existence of complicated pneumoconiosis. This Court concluded that, even though the methods were alternative, satisfaction of one method did not automatically establish the condition. Rather, the Court held that the Act's mandate to consider all relevant evidence required that evidence within one category must be weighed against evidence in the others. 176 F.3d at 389.

718.201(c)(1), the Act requires that the record must then be evaluated for the adequacy of the physicians' opinions that the miner suffered from the broader category of "legal" pneumoconiosis under section 718.201(c)(2); *see* 20 C.F.R. § 718.202(a)(4); *Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350, 356 (6th Cir. 2007); *Jericol Mining, Inc. v. Napier*, 301 F.3d 703, 713 (6th Cir. 2002)

Last, our construction of section 718.202(a) to include consideration of all relevant evidence also advances the intent of Congress to compensate the victims of disabling pneumoconiosis caused by coal dust exposure. For example, the X-ray readings in a case may be uniformly read as negative, but a biopsy, CT scan, or autopsy may nevertheless demonstrate the presence of clinical pneumoconiosis. *See* S. Rep. No. 743, 92d Cong. 2d Sess. (1972), reprinted in 1972 U.S.C.C.A.N. 2305, 2315-16 (recognizing the relative fallibility of X-rays vis-à-vis autopsy results). Conversely, a pathology report may reveal some other disease process after a diagnosis of clinical pneumoconiosis on X-ray. *Cf. Lester v. Director, OWCP*, 993 F.2d 1143, 1144-5 (4th Cir. 1993) (affirming the denial of benefits where the ALJ found X-ray positive for complicated pneumoconiosis outweighed by biopsy and autopsy evidence demonstrating the presence of simple pneumoconiosis only).

In sum, it is the Director's position that all the evidence relevant to the pneumoconiosis diagnosis must be weighed together when considering whether a

claimant suffers from the disease under section 718.202(a). The Board ruled otherwise, and the Board's contrary interpretation of section 718.202(a) should be rejected. *See Sharondale Corp. v. Ross*, 42 F.3d 998, 999 (6th Cir. 1994) (court defers to Director's reasonable interpretation of own regulation); *Robbins v. Cyprus Cumberland Coal Co.*, 146 F.3d 425, 427 (6th Cir. 1998) (Board interpretation entitled to no special deference).

2. Remand is necessary for the ALJ to weigh together all relevant evidence concerning the presence of pneumoconiosis.

The ALJ here found pneumoconiosis established solely by X-ray. The record contains, however, additional probative evidence—a negative biopsy and CT scans, CX 6, EX 11, that must be considered before concluding the disease is present. In particular, the ALJ must carefully consider and address the CT scan reports in the miner's treatment records. CX 6. On the one hand, they make no mention of pneumoconiosis and could be interpreted as negative for the disease. *See Marra v. Consolidation Coal Co.*, 7 Black Lung Rep. (MB) 1-216 (Ben. Rev. Bd. 1984). On the other hand, the scan reports note, *inter alia*, pulmonary nodules and interstitial opacities, which arguably are "tangentially supportive" of the positive finding by X-ray. *Cannelton Indus., Inc. v. Frye*, 93 Fed. App. 551, 2004 WL 720254, *5 (4th Cir. 2004). Or, the ALJ could simply find the CT scans inconclusive. In any event, it is the ALJ's call to make as fact-finder on remand.

Wolf Creek Collieries v. Director, OWCP, 298 F.3d 511, 519, 522 (6th Cir. 2002) (ALJ's job is to weigh and assess credibility of evidence).

That said, it is important to stress that the ALJ need not reconsider on remand Drs. Dahhan's and Rosenberg's opinions regarding the existence of pneumoconiosis. Although Dixie is correct (Pet. Br. 18) that the ALJ improperly evaluated their opinions regarding the *existence* of pneumoconiosis in his discussion of the *etiology* of the disease, App. 50-54, that error was harmless. As explained below, the ALJ reasonably rejected their explanation that the X-ray and CT scan abnormalities were caused by rheumatoid disease.

In the first place, Dr. Dahhan never made a definitive diagnosis to that effect. He read the April 12, 2007 X-ray as showing "opacities in the mid and upper zones consistent with Category I simple coal workers' pneumoconiosis." App 72. And although his medical report and later deposition testimony cast some doubt on that reading, App. 73, App. 82-85 (suggesting rheumatoid disease could have caused the X-ray abnormalities), Dr. Dahhan never disavowed his positive X-ray reading. At most his doubts are just that -- qualified and equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184, 186 (6th Cir. 1995) (ALJ may reject opinion that is stated in qualified or equivocal language). In any event, the ALJ reasonably rejected as "inadequately explain[ed]" Dr. Dahhan's intimation that rheumatoid arthritis caused the X-ray abnormalities. App. 52. The doctor, despite

acknowledging literature on the latent and progressive nature of pneumoconiosis, did not cite to any medical evidence or otherwise explain to the ALJ's satisfaction why "coal mine dust 'should not have had a latent impact on [the miner's] respiratory system.'" App. 52.

The ALJ likewise reasonably discredited Dr. Rosenberg's opinion that the linear interstitial lung disease shown on X-ray was not pneumoconiosis or otherwise related to coal mine dust exposure. The ALJ permissibly rejected Dr. Rosenberg's criticism of several scientific studies linking interstitial scarring to coal mine employment because the doctor misrepresented or failed to specify the absence of controls in the studies. App. 53. *See Wolf Creek Collieries*, 298 F.3d at 522 (whether a medical opinion is sufficiently reasoned is "essentially a credibility matter" within the ALJ's domain).

Dixie's assertion, Pet. 19-22, that the ALJ could not review the same scientific studies that its own doctor relied on is plainly wrong. The ALJ's examination of the underlying scientific literature did not, as alleged, constitute a substitution of his own medical judgment for the doctor's, but rather was a permissible exercise of the ALJ's power to ascertain whether the medical opinion was sufficiently documented and reasoned. As this Court explained in *Director, OWCP v. Rowe*, 710 F.2d 251 (6th Cir. 1983), "the mere fact that an opinion is asserted to be based upon medical studies cannot by itself establish as a matter of

law that it is documented and reasoned." 710 F.2d at 255. "Instead, the fact-finder [must] . . . examine the validity of the reasoning of a medical opinion in light of the studies conducted and the objective indications upon which the medical opinion or conclusion is based." *Id.* That is all the ALJ did here and his discrediting of Dr. Rosenberg's opinion regarding the existence of pneumoconiosis should therefore be affirmed.

CONCLUSION

The Court should vacate the Board's affirmance of the award of benefits and remand for further consideration.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I certify that this brief is proportionally-spaced, using Times New Roman 14-point typeface, and contains 5,306 words, as counted by Microsoft Office Word 2003.

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CERTIFICATE OF SERVICE

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