No. 11-3574

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

LITTLE DAVID COAL COMPANY;
OLD REPUBLIC INSURANCE COMPANY

Petitioners

v.

BILLY COLLINS;
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

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BRIEF FOR THE FEDERAL RESPONDENT

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BRIEF FOR THE FEDERAL RESPONDENT

STATEMENT OF JURISDICTION

Little David Coal Mining Company and its insurance carrier (collectively, Little David or employer) petition this Court for review of a Benefits Review Board's decision affirming the award of Billy Collins's claim for benefits under the Black Lung Benefits Act (the BLBA), 30 U.S.C. § 932(a). Appendix (App.) 1. This Court has both appellate and subject matter jurisdiction over Little David's petition for review pursuant to section 21(c) of the Longshore and Harbor

Workers' Compensation Act ("Longshore Act"), 33 U.S.C. § 921(c), as incorporated by section 422(a) of the Act, 30 U.S.C. § 932(a).

On May 31, 2011, Little David petitioned this Court for review of the Board's March 30, 2011, Order on Motion for Reconsideration and its September 30, 2010, Decision and Order, within the sixty-day time limit set forth in section 21(c). 33 U.S.C. § 921(c); Fed. R. App. P. 26(a)(3) (when the last day of the period falls on a Sunday, time for filing a paper in court is extended until the next day the clerk's office is open). The injury contemplated by section 21(c)—Collins's exposure to coal mine dust—occurred in Tennessee, within the jurisdictional boundaries of this Court.[1] 33 U.S.C. § 921(c).

The Board had jurisdiction to review the administrative law judge's decision pursuant to section 21(b)(3) of the Longshore Act. 33 U.S.C. § 921(b)(3), as incorporated by 30 U.S.C. § 932(a). Little David appealed the administrative law

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[1] Although the overwhelming majority of his years of exposure to coal mine dust occurred while working in Virginia, a state within the Fourth Circuit's jurisdiction, Collins's most recent exposure occurred in Tennessee, a state within the jurisdiction of this Circuit. App. 45. When a claimant is exposed to coal dust in more than one circuit, section 21(c) does not specify which forum is the proper one. 33 U.S.C. § 921(c). Thus, Little David's selection of this Circuit is a proper forum as it was a location of Collins's occupational exposure to coal mine dust. *Hon v. Director, Office of Workers' Compensation Programs*, 699 F.2d 441, 443-44 (8th Cir. 1983) ("appeal lies in any circuit in which the claimant worked and was exposed to the danger, prior to the manifestation of the injury."); *Consolidation Coal Co. v. Chubb*, 741 F.2d 968, 970-71 (7th Cir. 1984) (same).

judge's July 22, 2009, decision to the Board on August 21, 2009, within the thirty-day period prescribed by section 21(a) of the Longshore Act. 33 U.S.C. § 921(a), as incorporated by 30 U.S.C. § 932(a).

STATEMENT OF THE ISSUES

1. Does the Administrative Procedure Act forbid an ALJ from discounting expert testimony in a BLBA case that contradicts the Department of Labor's evaluation of scientific and medical literature in the preamble to the BLBA's implementing regulations?

2. Are the ALJ's assessments of the conflicting expert testimony and ultimate decision awarding BLBA benefits to Collins supported by substantial evidence?

STATEMENT OF THE CASE

1. Legal framework.

Former coal miners who are totally disabled by pneumoconiosis, a respiratory or pulmonary impairment arising out of coal mine employment, are entitled to BLBA benefits. It is undisputed that claimant/respondent Billy Collins suffers from chronic obstructive pulmonary disease (COPD) that totally disables

him from performing his former work as a miner.[2] The disputed issue in this case is whether Collins's disabling COPD is "legal pneumoconiosis" as defined by 20 C.F.R. § 718.201.

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)(1); *see also Eastover Mining Co. v. Williams*, 338 F.3d 501, 509 (6th Cir. 2003) ("Clinical or medical pneumoconiosis is a lung disease caused by fibrotic reaction of the lung tissue to inhaled dust that is generally visible on chest x-ray films." (citing *Usery v. Turner-Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976))). This cluster of diseases includes, but is not limited to, "coal workers' pneumoconiosis" as that term is commonly used by doctors. 20 C.F.R. § 718.201(a)(1). Clinical pneumoconiosis is generally diagnosed by chest x-ray,

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[2] Chronic obstructive pulmonary disease, commonly abbreviated "COPD," is a lung disease characterized by airflow obstruction. THE MERCK MANUAL 568 (17th ed. 1999). COPD "includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema, and asthma." 65 Fed. Reg. 79939 (Dec. 20, 2000). The medical experts variously described or categorized Collins's COPD as, *e.g.*, "COPD/Emphysema" (Dr. Rasmussen, App. 138), "severe pulmonary emphysema" (Dr. Fino, App. 147), and "bullous emphysema" (Dr. Hippensteel, App. 190). For the reader's convenience, this brief generally replaces these various terms with the umbrella category, COPD.

biopsy or autopsy. 20 C.F.R. §§ 718.102, 718.106, 718.202(a)(1)-(2).

"Legal pneumoconiosis" refers to "any chronic lung disease or impairment … arising out of coal mine employment" and specifically includes "any chronic restrictive or obstructive pulmonary disease." 20 C.F.R. § 718.201(a)(2); *see Eastover Mining*, 338 F.3d at 509 ("Legal pneumoconiosis includes all lung diseases meeting the regulatory definition of any lung disease that is significantly related to, or aggravated by, exposure to coal dust."); *Richardson v. Director, OWCP*, 94 F.3d 164, 166 n. 2 (4th Cir. 1996) ("COPD, if it arises out of coal-mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis."). A disease arises out of coal mine employment if it is "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). Moreover, pneumoconiosis is "recognized as a latent and progressive disease which may first become detectable only after cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c).

2. Course of the proceedings below.

Billy Collins filed his claim for federal black lung benefits in 1991. App. 22. Initially, his claim was denied. Within a year of the denial becoming final, Collins requested modification on the ground of a mistake in a determination of

fact or a change in conditions.[3] *Id.* After an ALJ denied his claim, Collins filed another modification request. This cycle was repeated several times until Collins filed a modification request in 2004. App. 23.

Following the hearing, an ALJ granted Collins's modification petition on the ground that the evidence established his condition had changed and that he was now totally disabled due to pneumoconiosis. App. 62. Little David appealed to the Board, which vacated an aspect of the decision and remanded for further consideration by the ALJ. App. 42.

On July 22, 2009, the ALJ issued his decision on remand granting modification and awarding benefits. App. 22. Little David again appealed to the Board, which affirmed the award[4] and denied Little David's subsequent motion for reconsideration. App. 20, 10. Little David then petitioned this Court for review. App. 1.

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[3] Modification is an unusual procedure available in BLBA and Longshore Act proceedings. It allows any party to re-litigate an award or denial "on the ground of a change in conditions or because of a mistake in a determination of fact." 33 U.S.C. § 922, as incorporated by 30 U.S.C. § 932(a); *see also* 20 C.F.R. § 725.310 (implementing regulation).

[4] The Board modified a clerical error in the ALJ's remand order so that compensation commenced as of October 2004, not 2002. App. 20; *see* App. 61.

STATEMENT OF THE FACTS

1. Collins's work and smoking histories.

Collins worked as a coal miner intermittently between 1974 and 1991. App. 51. The ALJ credited Collins with a total of seven years of coal mine employment and this finding has not be challenged. App. 53. His last mining job was as a roof bolter, one of the dustiest jobs in the mine. App. 130. He also was a cigarette smoker from approximately 1958 until 1996. App. 126, 143, 189. The intensity of his smoking was between one-half to three-quarters of a pack per day. *Id*.

2. The relevant medical evidence.[5]

This appeal centers on the ALJ's evaluation of testimony by three medical experts: Dr. Rasmussen, who testified that Collins's COPD arose, in part, out of his coal mine employment, and Drs. Fino and Hippensteel, who attributed Collins's COPD solely to smoking. Pet. br. at 27-31.

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[5] Much of the medical evidence in the record is not directly relevant on appeal. There is no current contention that Collins suffers from clinical pneumoconiosis. Because X-ray readings are primarily used to diagnose clinical pneumoconiosis, *see* 20 C.F.R. §§ 718.201, 718.202(a)(1), that evidence is not separately summarized here. Likewise, it is not disputed that Collins is totally disabled by COPD in the form of emphysema. Consequently, the results of pulmonary function tests and arterial blood gas studies results, which are primarily used to determine whether a claimant is totally disabled rather than the etiology of any impairment, are not discussed except within the context of a physician's narrative opinion.

a. Dr. Rasmussen.

Dr. D.L. Rasmussen examined Collins in October 2004.[6] App. 135. Dr. Rasmussen recorded a 15-year work history of underground coal mining as a roof bolter ending in 1991, and a 36-year smoking history at a rate of three-quarters of a pack of cigarettes a day ending in 1996. App. 135-36. He conducted medical testing and reported that the chest x-ray showed pneumoconiosis "as well as COPD with bilateral bullous changes," the pulmonary function test results revealed a "very severe, minimally reversible obstructive ventilatory pattern," and the arterial blood gas study results demonstrated "marked resting hypoxemia." App. 133, 137. Based on these results, his examination, and Collins's occupational and smoking histories, Dr. Rasmussen diagnosed "COPD/Emphysema" that was very severe and totally disabling. App. 138. The doctor attributed the cause of the disabling lung disease to a combination of coal dust exposure and smoking. *Id.* Dr. Rasmussen noted that Collins's "bullous changes are not inconsistent with emphysema secondary to coal mine dust exposure." App. 134.

In a supplemental report, Dr. Rasmussen considered a coal-mine-work history of only 9 years and determined that Collins's disabling lung disease was

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[6] This examination was provided by the Department to fulfill its statutory duty to provide a claimant-miner with "an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation." 30 U.S.C. § 923(b).

still a result of both smoking and coal dust exposure because his mining job was particularly dusty:

> Nine years of coal mine employment, especially as a roof bolter, which is the most hazardous underground job so far as dust is concerned, is quite sufficient to cause coalworkers' pneumoconiosis and disabling lung disease in a susceptible host. Mr. Collins is obviously a susceptible individual both to cigarette smoke and to coal mine dust.

App. 130.

Dr. Rasmussen reexamined Collins on February 14, 2006. App. 125. The ventilatory testing revealed very severe irreversible obstructive ventilatory impairment. App. 127. Dr. Rasmussen again concluded that Collins's totally disabling respiratory impairment arose in part as a result of his coal mine employment. 127-28. [7]

b. Dr. Fino.

Dr. Gregory Fino first examined Collins in June 2005 at Little David's request. He recorded a 15-year coal-mine-work history and a 40-year three-quarters pack per day cigarette smoking history. App. 143. Based on a chest x-ray

[7] In addition to Dr. Rasmussen, two physicians retained by the claimant—Drs. Nida and Agarwal—opined that Collins's disabling pulmonary impairment had been caused, in part, by his exposure to coal dust. The ALJ found the opinions lacked any probative value because each was undocumented and poorly explained. App. 57-58. The ALJ's determination to accord these opinions no weight was never challenged below (*see* App. 36 n.7); therefore, a detailed discussion of either is unwarranted.

that he found was negative for pneumoconiosis but consistent with severe pulmonary emphysema, and pulmonary function tests showing a severe obstructive ventilatory defect, Dr. Fino diagnosed "severe pulmonary emphysema due to smoking." App. 147. He explained that it was "possible to distinguish the effects of smoking from the effects of coal mine dust when evaluating a patient with emphysema." *Id*. Citing studies that established a correlation between the severity of clinical pneumoconiosis and the amount of emphysema, Dr. Fino stated it was "possible to determine in a given miner whether or not coal mine dust inhalation was a clinically significant contributing factor in impairment or disability." App. 151. Dr. Fino concluded that there was "insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis"; therefore, pneumoconiosis did not contribute to Collins's respiratory impairment. App. 152.

In a July 11, 2006, supplemental report, Dr. Fino reviewed Collins's medical records from 2005 and 2006. After reviewing these additional records, Dr. Fino reiterated his original diagnosis that Collins has severe pulmonary emphysema directly related to smoking, that he does not have simple coal workers' pneumoconiosis and that coal mine dust played no role in his disabling respiratory impairment. App. 139, 142.

c. Dr. Hippensteel.

In May 2006, Dr. Kirk Hippensteel, at Little David's request, provided a

written opinion based on his March 1, 2006, examination of Collins and his review of Collins's available medical records. He recorded a 15-year coal mine work history, of which 10 years were underground as a roof bolter, and a 35-year smoking history of less than one pack per day. App. 188, 189. Like Drs. Rasmussen and Fino, he diagnosed a severe obstructive pulmonary impairment. App. 190. Dr. Hippensteel noted the chest x-ray showed evidence of bullous emphysema but was not suggestive of coal workers' pneumoconiosis. App. 189. He said bullous emphysema "is a congenital problem that has been aggravated by cigarette smoking." App. 190. Dr. Hippensteel disagreed with Dr. Rasmussen's statement that bullous emphysema could be associated with simple coal workers' pneumoconiosis. He noted bullous emphysema can be associated with complicated coal workers' pneumoconiosis, a more advanced form of the disease, which Collins does not have. App. 196. Dr. Hippensteel concluded that Collins is totally disabled from a pulmonary standpoint; however, "this impairment is distinguishable and separate from that caused from his coal mine dust exposure." App. 196.

When deposed in June 2006, Dr. Hippensteel reiterated his opinion that Collins is disabled by congenital bullous emphysema that was worsened by his cigarette smoking but not by his coal mine dust exposure. App. 168.

3. Summary of the decisions below.

a. Decisions prior to 2007.

Prior to Collins's most recent modification petition, his claim for benefits was denied. In these earlier reviews, the ALJs found Collins proved he had a totally disabling pulmonary impairment but had not shown that he suffered from pneumoconiosis or that pneumoconiosis was a contributing cause of his total disability. App. 89, 110, 123.

b. ALJ Solomon's April 12, 2007, Decision and Order Granting Modification and Awarding Benefits.

The ALJ considered Collins's 2004 modification request.[8] Based on his review of Collins's employment records, he credited Collins with seven years of coal mine employment. App. 51-53. Considering the medical evidence to determine if there had been a mistake in a prior determination of fact or a change in Collins's condition since the prior denial of benefits, the ALJ determined that the weight of the x-ray evidence failed to establish the presence of clinical pneumoconiosis but that the medical opinion evidence established the presence of legal pneumoconiosis. App. 57. Assessing the opinions of five physicians, the

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[8] Collins filed a new benefits claim on July 26, 2004, within one year of when the denial of his prior modification request became final; therefore, the ALJ properly treated the 2004 filing as a timely request for modification. App. 53-54. The Board affirmed the ALJ's finding that Collins's modification request was timely. App. 33-34. Little David is no longer challenging the timeliness of this request.

ALJ concluded:

- Dr. Rasmussen credibly diagnosed COPD/emphysema due to both smoking and nine years of coal mine dust exposure as a roof bolter (App. 58);
- Dr. Hippensteel credibly diagnosed bullous emphysema, which the doctor explained was congenital and worsened with age and smoking but not with coal dust exposure (App. 58);
- Dr. Nida's diagnosis of coal workers' pneumoconiosis and COPD was poorly reasoned and of little probative value (App. 57);
- Dr. Agarwal's diagnosis of COPD and severe coal workers' pneumoconiosis lacked adequate foundation because the doctor did not mention Collins's smoking history or any recent x-rays or objective tests (App. 57-58); and
- Dr. Fino's diagnosis of emphysema and pulmonary impairment due to Collins's extensive smoking history based on an absence of clinical pneumoconiosis merited little weight because the doctor failed to account for the presence of legal pneumoconiosis, which may exist in the absence of clinical pneumoconiosis (App. 58).

Weighing the two credible opinions, the ALJ determined that the qualifications of Dr. Rasmussen and Dr. Hippensteel in the field of pulmonary medicine were not significantly different to warrant dissimilar treatment. App. 59. However, the ALJ gave less weight to Dr. Hippensteel's opinion because he failed to adequately

explain the possible aggravating factor that coal dust exposure could have had on Collins's respiratory impairment. App. 58-59. Based on Dr. Rasmussen's more persuasive opinion, the ALJ found Collins established that he now has pneumoconiosis. App. 59.

Collins was previously found to have a totally disabling respiratory impairment and the ALJ found the newly submitted evidence confirmed this finding. App. 59-60. Addressing the cause of that disabling respiratory impairment, the ALJ discounted Dr. Fino's and Dr. Hippensteel's causation opinions because, contrary to the ALJ's finding, neither concluded that Collins has legal pneumoconiosis. App. 60. Accordingly, based on Dr. Rasmussen's reports diagnosing total disability due to pneumoconiosis, the ALJ concluded that Collins established his entitlement to benefits. App. 61.

c. The Benefits Review Board's November 26, 2008, Decision.

The Board affirmed the ALJ's findings that the claim was a timely modification request; that no mistake in a prior determination of fact was proved; that Collins did not have clinical pneumoconiosis; and that he did suffer from a totally disabling pulmonary impairment. App. 33-34. The Board affirmed, as within the ALJ's discretion, the ALJ's determination to give less weight to Dr. Fino's opinion because his opinion was based on the absence of clinical pneumoconiosis and did not account for the possible presence of legal

pneumoconiosis. App. 37, n.8.

But the Board found merit in Little David's assertions of error concerning the weighing of Dr. Hippensteel's and Dr. Rasmussen's medical opinions. The Board noted the ALJ accorded Dr. Rasmussen's opinion more weight because he examined Collins more recently than Dr. Hippensteel; however, the ALJ erroneously stated that Dr. Hippensteel last saw Collins in 1997 when, in fact, Dr. Hippensteel examined him in 2006, subsequent to Dr. Rasmussen's 2004 examination. App. 36. While the ALJ correctly noted that Dr. Hippensteel stated bullous emphysema was not associated with simple pneumoconiosis, the Board determined that the ALJ erred in finding that Dr. Hippensteel's opinion was contrary to the BLBA's underlying premises without first considering the doctor's deposition testimony, which acknowledged that coal dust exposure could cause the type of severe obstruction seen in Collins's case. App. 36-37. The Board also held that the ALJ inconsistently evaluated the medical opinions of Drs. Rasmussen and Hippensteel. Therefore, the Board vacated and remanded for further consideration of the ALJ's legal pneumoconiosis finding and, if necessary, whether Collins's total disability is due to pneumoconiosis. App. 37-38. The Board also directed the ALJ on remand to address whether granting modification rendered justice under the BLBA. App. 38 n.9.

d. ALJ Solomon's July 22, 2009, Decision and Order on Remand.

Reconsidering the medical opinions relevant to establishing legal pneumoconiosis, the ALJ noted that Dr. Rasmussen asserted that Collins's impairment was significantly related to, or aggravated by, both smoking and coal mine dust exposure while Dr. Hippensteel stated Collins's bullous emphysema was aggravated by smoking but not coal mine dust exposure. App. 26. The ALJ found the concept of legal pneumoconiosis, as set forth in the amended regulation, was not discussed by Dr. Hippensteel in his report or testimony, and was not addressed by Little David in its argument. App. 26. The ALJ determined that Dr. Hippensteel did not directly refute that mining exposure is competent to aggravate bullous emphysema. *Id*. The ALJ found more rational Dr. Rasmussen's explanation that "cigarette smoking and coal mine dust cause identical forms of emphysema using identical cellular and enzymatic processes to destroy lung tissue." App. 26. He noted that Dr. Rasmussen's opinion was more consistent than Dr. Hippensteel's with the regulatory materials that found "dust-induced and smoke induced emphysema occur through similar mechanisms, and '[e]ven in the absence of smoking, coal mine dust is clearly associated with clinically significant airways obstruction and chronic bronchitis. The risk is additive with cigarette smoking.' 65 Fed. Reg. at 79943, 79940 (Dec. 20, 2000)." App. 26. The ALJ also found Dr. Rasmussen's credentials as a congressionally acknowledged

authority on pneumoconiosis who had published articles on the topic more recently than Dr. Hippensteel compelling. Therefore, the ALJ found legal pneumoconiosis established through Dr. Rasmussen's reasoned opinion. *Id*. The ALJ noted that the pneumoconiosis finding also established a change in Collins's condition for the purpose of pursuing modification. App. 28.

As neither Dr. Fino nor Dr. Hippensteel found legal pneumoconiosis, the ALJ accorded little weight to their opinions on disability causation. App. 27. Crediting Dr. Rasmussen's opinion, the ALJ found Collins proved his disabling pulmonary impairment is due to pneumoconiosis. App. 28. Accordingly, the ALJ found Collins entitled to benefits.

e. The Benefits Review Board's September 30, 2010, Decision.

Little David challenged the ALJ's failure to consider whether granting Collins's modification petition would render justice under the BLBA and the ALJ's weighing of the medical opinion evidence on the issues of pneumoconiosis and disability causation. App. 16. The Board held that the ALJ permissibly concluded "that Dr. Rasmussen's opinion was consistent with claimant's work history, medical history, objective testing, and the discussion of prevailing medical science in the preamble to the revised regulations." App. 18. Likewise, the Board ruled the ALJ acted within his discretion in finding that the opinion of Dr. Hippensteel "merited less weight because the doctor did not discuss the effects that

claimant's coal dust exposure had on [his COPD/bullous emphysema], or whether claimant's bullous emphysema was aggravated by his coal dust exposure, as well as by his smoking." App. 18. The Board held that

> the administrative law judge could properly examine whether medical rationales are consistent with the conclusions contained in the medical literature and scientific studies relied upon by the Department of Labor (DOL) in drafting the definition of legal pneumoconiosis. Thus, we reject employer's assertion that the administrative law judge's review of the medical opinions in light of such studies constituted use of non-record evidence, an untimely evidentiary ruling or a denial of due process.

App. 18.

The Board also upheld the ALJ's determination that Dr. Rasmussen is an acknowledged expert in the field of pulmonary impairments in coal miners and that it was permissible to accord greater probative weight to his opinion based, in part, on his expertise. App. 18. Having affirmed the ALJ's credibility determinations as supported by substantial evidence, the Board affirmed the ALJ's finding that Collins established the existence of legal pneumoconiosis and a change in his condition since the prior denial of benefits. App. 19.

On the disability-causation question, the Board held the ALJ permissibly discounted Drs. Hippensteel and Fino's opinions that Collins's disability is unrelated to pneumoconiosis because they did not diagnose legal pneumoconiosis, contrary to the ALJ's finding, in the first instance. App. 19. Instead, the Board affirmed the ALJ's reliance on Dr. Rasmussen's opinion that coal dust

"contributed significantly" to Collins's disability. App. 19.

Finally, the Board affirmed the ALJ's award of benefits, "notwithstanding his failure to consider employer's argument that granting modification would not render justice under the Act." App. 19. The Board noted that a modification petition cannot be denied solely on the number of times modification has been requested and Little David had not shown that Collins's prior actions were egregious; therefore, the Board concluded that "a determination that granting modification renders justice under the Act is implicit in the administrative law judge's finding that new evidence established claimant's entitlement to benefits." App. 19.

The Board summarily denied Little David's subsequent motion for reconsideration. App. 10.

SUMMARY OF THE ARGUMENT

Little David's lead argument is that the ALJ violated the Administrative Procedure Act by discrediting its medical expert on the ground that his opinion contradicted the Department of Labor's conclusions on certain medical and scientific issues as expressed in the preamble to the BLBA's implementing regulations. Little David produces no authority for this remarkable claim, which is contrary to established practice in the federal black lung program and administrative law generally.

The remainder of Little David's brief presents only substantial evidence issues. Little David challenges the ALJ's interpretation of its experts' opinions and the ALJ's decision to credit Dr. Rasmussen's opinion over its experts. But such credibility determinations are the ALJ's to make. Perhaps a different fact finder might have interpreted the opinions of Little David's experts as more consistent with the Department's views and found them to be more persuasive than Dr. Rasmussen's. That, however, does not change the fact that this ALJ's reading of the expert opinions is supported by substantial evidence and should be affirmed.

ARGUMENT

The ALJ's Ruling That Collins Suffers From A Totally Disabling Pulmonary Disease Caused, In Part, By His Exposure To Coal Mine Dust Is In Accord With The APA And Supported By Substantial Evidence.

1. Standard of Review.

While Little David's brief is primarily dedicated to challenging the ALJ's credibility determinations and weighing of the medical opinion evidence, to the extent that it challenges the ALJ's reliance on the preamble, Little David presents a question of law. The Court reviews that de novo. *Caney Creek Coal Co. v. Satterfield*, 150 F.3d 568, 571 (6th Cir. 1998). The Director's interpretation of the BLBA and its implementing regulations is entitled to deference. *Gray v. SLC Coal Co.*, 176 F.3d 382, 386-87 (6th Cir. 1999); *Sharondale Corp. v. Ross*, 42 F.3d 993, 998 (6th Cir. 1994).

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), "even if the facts permit an alternative conclusion," *Youghiogheny & Ohio Coal Co. v. Webb*, 49 F.3d 244, 246 (6th Cir. 1995). Substantial evidence means evidence that a reasonable mind might accept as adequate to support a conclusion. *Id.*

2. In considering the credibility of a medical expert's testimony, an ALJ is permitted to consider the preamble to the BLBA's implementing regulations, which provides the Department of Labor's rationale for the regulations and evaluation of the medical and scientific literature on black lung disease.

Little David's primary argument is that an ALJ cannot discount a medical expert's testimony that is contrary to the Department of Labor's evaluation of relevant scientific and medical issues in the preamble to the BLBA's implementing regulations without violating the Administrative Procedure Act. Pet. br. at 20-24. Little David argues that the ALJ arbitrarily created a "consistency with the preamble" rule to diminish the credibility of its physicians and, thus, violated its due process rights and the Administrative Procedure Act, 5 U.S.C. § 556(d). But the ALJ created no such rule, and committed no error in considering the preamble when assessing the credibility of the various medical opinions.

Using full notice-and-comment procedures, the Department employed its rulemaking authority to resolve the scientific question whether coal dust exposure

can cause obstructive impairment. 30 U.S.C. § 936(a); *Midland Coal Co. v. Director, OWCP*, 358 F.3d 486, 490 (7th Cir. 2004); *National Min. Ass'n v. Department of Labor*, 292 F.3d 849, 863 (D.C. Cir. 2002). The answer, yes, is plainly reflected on the face of the regulation defining legal pneumoconiosis, which "includes, but is not limited to, any chronic restrictive *or obstructive* pulmonary disease arising out of coal mine employment." 20 C.F.R. § 718.201(a)(2) (emphasis added). Any medical expert who testifies that coal dust exposure cannot cause obstructive disease is expressing an opinion contrary not only to the regulatory preamble, but also to the regulation itself.

The regulatory preamble presents and assesses the medical and scientific literature supporting the Department's conclusion that exposure to coal mine dust can cause COPD. 65 Fed. Reg. 79937-45 (Dec. 20, 2000). Moreover, it identifies the Department's reliance on a comprehensive study by the National Institute for Occupational Safety and Health (NIOSH) as support for the proposed revision to clarify that the definition of "pneumoconiosis" encompasses obstructive lung disorders arising from occupationally-related pathologies. 62 Fed. Reg. 3343 (Jan. 22, 1997) (citing National Institute for Occupational Safety and Health, *Criteria for a Recommended Standard, Occupational Exposure to Respirable Coal Mine*

Dust § 4.2.2. *et seq*. (1995)).[9] NIOSH, the statutory advisor to the black lung benefits program, 30 U.S.C. § 902(f)(1)(D), and an expert in the analysis of occupational disease research, reviewed the Department's proposed revisions and concluded that "NIOSH scientific analysis supports the proposed definitional changes." 64 Fed. Reg. 54978-79 (Oct. 8, 1999).

In addition to explaining the basis for the Department's position, the preamble responds to commenters, including Dr. Fino, who denied the possibility that coal dust can cause COPD. 65 Fed. Reg. at 79938-42. The preamble also addresses medical literature on the interrelationship between coal dust exposure and smoking as causes of COPD, crediting studies finding the risks of smoking and dust exposure to be additive. *Id.* at 79939-41. Again, the Department relied on NIOSH's comprehensive review of the available medical and scientific evidence published in 1995 and on NIOSH's favorable response to the Department's proposed revisions to support its position. 65 Fed. Reg. at 79939, 79943.

It is perfectly reasonable for an ALJ to consult the preamble as an authoritative statement of the Department's evaluation of conflicting medical and scientific literature on these issues. And it is similarly reasonable for an ALJ to

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[9] The complete referenced NIOSH publication is available on its website at http://www.cdc.gov/niosh/95-106.html.

give less weight to the testimony of medical experts who contradict, or rely on sources that contradict, that evaluation. That is all the ALJ did in this case. App. 25, 26.

Little David claims that this violates the APA, but the Seventh and Third Circuit Courts of Appeals have approved of using the preamble in this manner, as has the Benefits Review Board. *Consolidation Coal Co. v. Director, OWCP*, 521 F.3d 723, 726 (7th Cir. 2008) (describing ALJ's "sensible" decision to discredit physician's opinion conflicting with scientific consensus on clinical significance of coal dust-induced COPD, as determined by Department of Labor in preamble); *Helen Mining Co. v. Director OWCP*, 650 F.3d 248, 257 (3d Cir. 2011) ("The ALJ's reference to the preamble to the regulations, 65 Fed. Reg. 79941 (Dec. 20, 2000), unquestionably supports the reasonableness of his decision to assign less weight to Dr. Renn's opinion"); *Ethel Groves v. Island Creek Coal Company*, 2011 WL 2781446 at *3, BRB No. 10-0592 BLA (DOL Ben. Rev. Bd. June 23, 2011) ("an administrative law judge has the discretion to examine whether a physician's reasoning is consistent with the conclusions contained in medical literature and scientific studies relied upon by DOL in drafting the definition of legal pneumoconiosis.").

These cases reflect the well-established principle that a reviewing court must generally be at its most deferential when examining an administrative agency's

determination of scientific or technical matters within its area of expertise. *See Baltimore Gas & Elec. Co. v. Natural Resources Defense Council*, 462 U.S. 87, 103 (1983); *Marsh v. Oregon Natural Resources Council*, 490 U.S. 360, 377 (1989). The Supreme Court has recognized that this principle applies to the federal black lung program, "a complex and highly technical regulatory program," in which the identification and classification of relevant "criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991); *accord*, *Midland Coal Co.*, 358 F.3d at 490 ("we see no reason to substitute our scientific judgment, such as it is, for that of the responsible agency"). Little David's position—which would positively forbid an ALJ from considering the Secretary of Labor's evaluation of the scientific literature on black lung disease—turns this well-established principle on its head.

The case Little David primarily relies upon for its view that the preamble is off limits, *Home Concrete & Supply, LLC v. United States*, 634 F.3d 249 (4th Cir. 2011), stands for nothing of the sort. In *Home Concrete*, the Fourth Circuit rejected the IRS's attempt to rely on a policy position set forth in the preamble to a regulation to extend the statutorily-set six-year limitations period. 634 F.3d at 257-58. First, setting a statute of limitations is hardly akin to evaluating conflicting medical and scientific literature on the various effects of coal dust exposure. It is

therefore not entitled to the same heightened deference that an agency's evaluation of scientific or technical matters is. Second, and more fundamentally, the statement in the IRS preamble at issue in *Home Concrete* was contrary to the language of the statute. As Judge Wilkerson stated in his concurrence, "What the IRS seeks to do in extending the statutory limitations period goes against what I believe are the plain instructions of Congress, which have not been changed, and the plain words of the Court, which have not been retracted." 634 F.3d at 259. In contrast, the preamble at issue here does not conflict with the BLBA, which defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

Little David's reliance on *Wyeth v. Levine*, 555 U.S. 555, 129 S.Ct. 1187 (2009), founders on the same shoals. Like *Home Concrete*, the preamble in question in *Wyeth* addressed a legal issue—the preemptive effect of FDA regulations on state law remedies—rather than a scientific or technical one. 129 S.Ct. at 1201 ("agencies have no special authority to pronounce on pre-emption absent special delegation by Congress"). It was also, again like *Home Concrete*, "at odds with what evidence we have of Congress's purposes" and, to top it off, "revers[ed] the FDA's own longstanding position without providing a reasoned explanation[.]" *Id.* None of these facts are true of the regulatory preamble at issue

in this case.

Little David briefly argues that the ALJ's consideration of the preamble violated the APA because the preamble was not part of the formal case record. Pet. br. at 24-25. Little David cites no authority for the proposition that considering a regulatory preamble published in the Federal Register violates the APA. As explained above, at least two courts of appeals have approved of ALJ decisions using the preamble in just this way. *Consolidation Coal Co.*, 521 F.3d at 726; *Helen Mining Co.*, 650 F.3d at 257. *See also Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473, 483 n.7 (7th Cir. 2001) ("During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino [denying that coal dust inhalation causes significant obstructive lung disease] and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'" (quoting 65 Fed. Reg. 79,939)). The ALJ's consideration of the preamble in this case was similarly appropriate.

3. Substantial evidence supports the ALJ's award of benefits.

In evaluating whether there is substantial evidence to support the ALJ's finding, "an appellate tribunal may not reweigh the evidence or make credibility determinations" or "evaluate and resolve conflicting medical evidence." *Adams v. Peabody Coal Co.*, 816 F.2d 1116, 1120-21 (6th Cir.1987). When an ALJ explains

his reasoning and does not rely on an impermissible basis, this Court must defer to his discretion and judgment in assessing the conflicts in the evidence. *See Director, Office of Workers' Compensation Programs v. Rowe,* 710 F.2d 251, 255 (6th Cir. 1983). When medical testimony conflicts, the question "'of whether a physician's report is sufficiently documented and reasoned is a credibility matter left to the trier of fact.'" *Tennessee Consol. Coal Co. v. Crisp*, 866 F.2d 179, 185 (6th Cir.1989) (quoting *Moseley v. Peabody Coal Co.*, 769 F.2d 357, 360 (6th Cir.1985)). The ALJ must, however, adequately explain the reasons for his decision. *See Director, Office of Workers' Compensation Programs v. Congleton*, 743 F.2d 428, 430 (6th Cir.1984). Here, the ALJ adequately explained his reasons for crediting Dr. Rasmussen's opinion that Collins suffers from pneumoconiosis, which is a contributing cause of his totally disabling pulmonary impairment, over Dr. Hippensteel's and Dr. Fino's contrary views.

a. The ALJ's decision to credit Dr. Rasmussen's opinion as establishing the presence of legal pneumoconiosis and disability due to pneumoconiosis is supported by substantial evidence.

Dr. Rasmussen diagnosed Collins as being totally disabled by a respiratory obstruction that was caused, in part, by Collins's exposure to coal mine dust. App. 130, 138. The ALJ permissibly determined that Dr. Rasmussen provided a reasoned medical opinion, which was documented by Collins's physical examination as well as a pulmonary function test, arterial blood gas study and

medical treatises. App. 25-26, 48-49, 58-59.

Little David's only specific allegation of error concerning the ALJ's assessment of Dr. Rasmussen's report is that the doctor's causation opinion is too speculative. Pet. br. at 27-28. It contends that Dr. Rasmussen's etiology conclusion is essentially identical to the one this Court rejected in *Tamraz v. Lincoln Elec. Co.*, 620 F.3d 665 (6th Cir. 2010). The comparison is not well-founded. In *Tamraz*, a products liability case turned on the cause of a welder's Parkinson's disease. The Court held the district court erred in allowing a neurologist to present a purely speculative opinion that manganese exposure could have caused the welder's Parkinson: the neurologist speculated that the welder was exposed to fumes presumably containing manganese, that manganese exposure theoretically could trigger Parkinson's disease, that this welder may have had genes predisposing him to Parkinson's and, therefore, manganese exposure induced Parkinson's by triggering the welder's genetic pre-disposition. *Id*. at 670. The Court rejected the doctor's hypothesizing as based on multiple "leaps of faith" and especially on his reliance on a theoretical link between manganese and the development of Parkinson's when there was no scientific support for his premise. *Id*. In contrast, as set forth in the preamble, the scientific studies support and the medical community accepts that there is a link between coal dust exposure and the development of obstructive lung disease in coal miners independent of cigarette

smoking. 65 Fed. Reg. at 79939. Therefore, Dr. Rasmussen's opinion does not falter because it is based on scientific evidence, as opposed to a theoretical premise.

The question is whether Dr. Rasmussen adequately explained his reasons for attributing the etiology of Collins's COPD to both smoking and coal dust exposure. The ALJ permissibly found more convincing Dr. Rasmussen's explanation that Collins's smoking and coal dust exposures were both additive factors contributing to disabling emphysema because Dr. Rasmussen's opinion was based on Collins's examination and testing, on Dr. Rasmussen's medical expertise treating pulmonary disease in coal miners, and was consistent with the regulatory definition of legal pneumoconiosis. App. 24, 26. The ALJ reasonably accorded weight to Dr. Rasmussen's opinion based on his extensive experience in pulmonary medicine and in the specific area of coal workers' pneumoconiosis. *Martin v. Ligon Preparation Co.*, 400 F.3d 302, 307 (6th Cir. 2005). Accordingly, the ALJ properly concluded that Dr. Rasmussen's opinion credibly established that Collins suffers from legal pneumoconiosis. App. 26, 27-28. For the same reasons, the ALJ properly concluded that Dr. Rasmussen's opinion credibly demonstrates that Collins is totally disabled due to pneumoconiosis.

b. The ALJ rationally discounted Dr. Fino's opinion.

The ALJ permissibly discredited Dr. Fino's testimony because he only

considered the correlation between emphysema and clinical pneumoconiosis. The ALJ reasonably interpreted Dr. Fino's opinion and testimony as focusing on the largely irrelevant issue of clinical pneumoconiosis and failing to adequately address the relevant question: whether Collins's COPD/emphysema was causally related to coal dust exposure (*i.e.*, whether he suffers from legal pneumoconiosis). While Dr. Fino discussed the concept of legal pneumoconiosis in his opinion, his ultimate conclusions failed to account for whether coal mine dust exposure contributed to Collins's emphysema. App. 37 n.8, 58, 141-42. The ALJ thus provided a valid and sufficiently explained reason for according little weight to Dr. Fino's opinion. The Court should defer to it. *See Adams*, 816 F.2d at 1120.

c. The ALJ permissibly discounted Dr. Hippensteel's opinion.

The ALJ also sufficiently explained his reasons for according less weight to Dr. Hippensteel's opinion. In light of the regulatory preamble addressing the additive effect coal dust exposure could have on the development of obstructive impairment, the ALJ simply was not convinced that Dr. Hippensteel adequately considered whether coal mine dust exposure, along with smoking, could have been an aggravating factor worsening Collins's bullous emphysema. App. 25. Thus, it was reasonable for the ALJ to discount Dr. Hippensteel's opinion as failing to fully consider the possibility of coal dust as an additive or aggravating factor contributing to Collins's disabling pulmonary impairment. This is so even if it is

possible to construe Dr. Hippensteel's opinion in some other way. *See Midland Coal Co.*, 358 F.3d at 492 ("[O]n substantial evidence review we would have to find that the [employer's] interpretation [of a doctor's testimony] was the only permissible one, not that it was one of several" to reverse."); *Ramey v. Kentland Elkhorn Coal Corp.*, 755 F.2d 485, 486 (6th Cir.1985) (the Court may not set aside the ALJ's findings, "even if [the court] would have taken a different view of the evidence were we the trier of facts.").

d. Substantial evidence supports the ALJ's decision to award benefits to Collins.

Taking all of these findings together, the ALJ acted well within his discretion in crediting Dr. Rasmussen's diagnosis and in giving little weight to Dr. Fino's and Dr. Hippensteel's contrary view. Little David has failed to demonstrate that the ALJ made a mistake in his assessment of the conflicting medical opinion evidence. *See Rowe*, 710 F.2d at 255 ("The determination as to whether [a physician's] report was sufficiently documented and reasoned is essentially a credibility matter. As such, it is for the factfinder to decide."). Weighing Dr. Rasmussen's opinion against the less persuasive opinions from Drs. Hippensteel and Fino, the ALJ reasonably concluded that Collins established that his totally disabling COPD/emphysema is due, in part, to coal dust exposure. Therefore, the Court should affirm this award, as it is supported by substantial evidence.

CONCLUSION

For the foregoing reasons, the Director respectfully requests that the Court affirm the ALJ's award of benefits to Billy Collins.

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 7214 words, as counted by Microsoft Office Word 2003.

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CERTIFICATE OF SERVICE

I hereby certify that on October 31, 2011, copies of the Director's brief were served electronically using the Court's CM/ECF system on the Court and the following:

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