No. 16-1450

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

ELKAY MINING COMPANY

Petitioner

v.

HAZEL C. SMITH, widow of EDWARD W. SMITH
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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v.

HAZEL C. SMITH, widow of EDWARD W. SMITH
and
DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, UNITED STATES DEPARTMENT OF LABOR

Respondents.

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

BRIEF FOR THE FEDERAL RESPONDENT

Statement of Jurisdiction

This case involves Elkay Mining Company's (Elkay) petition for review of a final order of the Benefits Review Board, United States Department of Labor. The Board affirmed an administrative law judge's award of benefits under the Black Lung Benefits Act (the

"BLBA" or "the Act"), 30 U.S.C. §§ 901-944, to Hazel Smith, the widow of former coal miner Edward Smith.

The administrative law judge awarded benefits on November 5, 2014, and granted the claimant's motion for reconsideration on November 26, 2014. Joint Appendix, "JA," 323, 339. Elkay appealed to the Board on December 29, 2004, within the statutorily mandated thirty-day period. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 921(a)).[1] Thus, the Board had jurisdiction to review the ALJ's decision. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 921(b)(3)).

The Board issued its final order on February 23, 2016. JA 341. Elkay petitioned this Court for review on April 21, 2016, within the statutorily mandated sixty-day period. JA 354; 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 921(c)). This Court has jurisdiction over Elkay's petition under 33 U.S.C. § 921(c), as the "injury" in this case,

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[1] In 2014, December 25 and 26 were federal holidays, December 27 was a Saturday, and December 28 was a Sunday so Elkay's Board appeal, filed on Monday, December 29, 2014, was timely. 20 C.F.R. § 802.201 (in computing time, "[t]he last day of the period so computed shall be included, unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday.").

the miner's occupational exposure to coal mine dust, occurred in the State of West Virginia. JA 310, 324 n.2, 342 n.2.

Statement of the Issue

The BLBA compensates certain survivors of coal miners who died due to pneumoconiosis arising out of coal mine employment. 30 U.S.C. § 901(a). Section 411(c)(3), 30 U.S.C. § 921(c)(3), contains an irrebuttable presumption of death due to pneumoconiosis upon proof of complicated pneumoconiosis arising out coal mine employment. Complicated pneumoconiosis can be established by x-ray evidence of large opacities in the miner's lungs, autopsy or biopsy evidence of massive lesions, or by other equivalent, medically-acceptable means. *Id.*; *see also* 20 C.F.R. § 718.304(a)-(c).

Here, the ALJ credited Dr. Miller's digital x-ray reading of complicated pneumoconiosis, as supported by the miner's hospital treatment records, over Dr. Scott's negative reading.

Is the ALJ's finding of complicated pneumoconiosis, as affirmed by the Benefits Review Board, supported by substantial evidence and in accordance with law?

Statement of the Case

A. Course of the proceedings

On January 7, 2011, claimant Hazel Smith filed with the Department of Labor an application for survivor's benefits. Director's Exhibit ("DX") 4. The district director—the DOL official who processes claims and makes initial eligibility determinations—identified Elkay as the liable party (*i.e.*, the responsible operator). DX 18. The district director issued a proposed decision and order denying benefits. DX 30. Claimant contested the denial and requested a formal hearing.

Following a hearing, an ALJ awarded claimant benefits, payable by Elkay, commencing as of application date. JA 338. Claimant moved for reconsideration, correctly arguing that survivor's benefits begin with the month of the miner's death. *See* 20 C.F.R. § 725.503(c). The ALJ granted claimant's motion and changed the payment onset date to July 2009. JA 339.

Elkay appealed to the Board. A Board majority affirmed. JA 341-49. Elkay then petitioned this Court for review. JA 354-57.

B. Statutory and regulatory background

The Act compensates certain survivors of coal miners who died due to pneumoconiosis arising out of coal mine employment. 30 U.S.C.

§ 901(a). A miner with complicated pneumoconiosis, a particularly severe form of the disease, arising out of his coal mine employment is irrebuttably presumed to have died due to pneumoconiosis and the miner's survivor is entitled to benefits on that basis. *See* 30 U.S.C. § 921(c)(3), as implemented by 20 C.F.R. § 718.304;[2] *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 10-11 (1976); *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 255 (4th Cir. 2000).

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[2] 30 U.S.C. § 921(c)(3) provides in full:

> If a miner is suffering or suffered from a chronic dust disease of the lung which (A) when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization, (B) when diagnosed by biopsy or autopsy, yields massive lesions in the lung, or (C) when diagnosis is made by other means, would be a condition which could reasonably be expected to yield results described in clause (A) or (B) if diagnosis had been made in the manner prescribed in clause (A) or (B), then there shall be an irrebuttable presumption that he is totally disabled due to pneumoconiosis or that his death was due to pneumoconiosis or that at the time of his death he was totally disabled by pneumoconiosis, as the case may be.

The regulation implementing this statutory provision employs virtually identical language. *See* 20 C.F.R. § 718.304.

The presence of complicated pneumoconiosis may be established by x-ray evidence of at least one opacity greater than one centimeter in diameter and classified as Category A, B, or C under the ILO Classification system[3]; by biopsy or autopsy evidence of "massive lesions"; or by a diagnosis by other equivalent means. 30 U.S.C. § 921(c)(3)(A)-(C); *Scarbro*, 220 F.3d at 255. In considering whether a miner has complicated pneumoconiosis, an ALJ must weigh all relevant evidence together. *Scarbro*, 220 F.3d at 256 (requiring ALJ to review evidence under each prong and then weigh evidence from different prongs against each other).

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[3] The ILO Classification "provides a means for describing and recording systematically the radiographic abnormalities in the chest provoked by the inhalation of dusts. It is used to describe the radiographic abnormalities that occur in any type of pneumoconiosis." *Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses* (Rev. Ed. 2011) (hereafter "the *ILO Guidelines or ILO Classification*"), p. 1 (available at http://www.ilo.org/safework/areasofwork/occupational-health/WCMS_108548/lang--en/index.htm) (last checked August 5, 2016). Lung opacities are categorized by size, profusion, location and shape. *Id.* at 3-6. Opacities are described as either small or large in size, the latter exceeding 10 mm in longest dimension. *Id.* at 3, 6. Profusion "refers to the concentration of . . . opacities in affected zones of the lung." *Id.* at 3-4. For location, lung fields are divided into upper, middle and lower zones, each representing (from top to bottom) approximately one-third of a lung. *Id.* at 5. Opacities appear in two general shapes, rounded or irregular. *Id.*

C. Statement of the facts

1. Background

Edward Smith and Hazel Carrol McCloud married in 1973 and remained married until his death in 2009. JA 261; DX 4. She is his eligible survivor. JA 325.

Mr. Smith worked as an underground coal miner in West Virginia for at least 34 years. JA 327. He last worked in the coal mines in 1993. *Id.* Mr. Smith had a cigarette smoking history of 25 pack-years.[4] *Id.* On his death certificate, the cause of death was listed as heart failure due to hypertension and coronary artery disease. JA 261. Emphysema and COPD (chronic obstructive pulmonary disease) were listed as other significant conditions contributing to, but not directly causing, death. *Id.* During his lifetime, Mr. Smith filed claims for federal black lung disability benefits in 1973 and 1991, which the Department of Labor denied. DX 1, 2.

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[4] Pack years are calculated by multiplying the number of packs of cigarettes smoked per day by the number of years the miner smoked.

2. Medical evidence relevant to the complicated pneumoconiosis inquiry

The record contains the miner's treatment records from 2006 until his death in 2009. Most are not relevant to whether the miner had complicated pneumoconiosis, the factual question presented here. Below, we have summarized the two x-ray readings obtained for the purpose of this litigation (Drs. Miller and Scott's readings), and the x-ray readings in the miner's treatment records that the ALJ and Elkay rely on (the ALJ in awarding benefits, Elkay in asserting error).

There are nineteen additional treatment x-rays in the joint appendix. Because neither the ALJ nor Elkay references them, they are not summarized.

Readings obtained for purpose of litigation[5]

JA Page	X-Ray Date	Doctor	Narrative Findings
264	6-24-09	Thomas Miller	• Digital x-ray, suboptimal positioning • Bilateral upper lung large opacities with a combined size less than five centimeters that are compatible with complicated pneumoconiosis (A) • Diffuse small opacities compatible with pneumoconiosis • Small opacities (t/r) are predominantly irregular, with a size less than three millimeters • Secondary small opacities that are round and less than ten millimeters in size, ILO profusion 2/3 • Mild cardiomegaly
278	6-24-09	William Scott	• Improper position, scapulae over lungs • No parenchymal or pleural abnormalities consistent with pneumoconiosis • Cardiomegaly • Small bilateral pleural effusions • Pulmonary vascular congestion compatible with CHF (congestive heart failure) • Infiltrates compatible with edema • In the presence of this much CHF one could not see small opacities even if they were present

[5] These two readings are particularly significant because the doctors utilized the ILO classification system. *See* n.3 *supra*, and *infra* at 19-21.

Readings from hospital treatment records

JA Page	X-Ray Date	Doctor	Narrative Findings
28	6-29-09	Mary McJunkin	• Most likely pulmonary edema with underlying interstitial fibrosis[6] • Probably a left pleural effusion[7] and incompletely resolved consolidation in the left perihilar region
27	6-28-09	Bryson McCain	• Diffuse interstitial opacities throughout both lungs with superimposed air space disease in the left upper lung field • No effusion or pneumothorax identified
25	6-26-09	Bryson McCain	• Bilateral mixed interstitial and alveolar opacities throughout both lungs that are unchanged in configuration from the previous exam • No effusion or pneumothorax is seen[8]

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[6] Interstitial lung disease refers to a large group of diseases that inflame or scar the lungs. The scarring is called pulmonary fibrosis. Occupational exposure, such as coal mine dust exposure, is a possible cause. *MedlinePlus*, U.S. National Library of Medicine, available at https://medlineplus.gov/interstitiallungdiseases.html (last checked August 5, 2016). MedlinePlus is a website of the National Institutes of Health and produced by National Library of Medicine.

Pulmonary edema is the abnormal buildup of fluid in the lungs and can lead to shortness of breath. It is often caused by congestive heart failure. *MedlinePlus*, available at https://medlineplus.gov/ency/article/000140.htm (last checked August 5, 2016).

[7] Pleural effusion, commonly caused by heart failure, is excess fluid in the pleural space. The pleura space lies between the pleural layers, thin sheets of tissue surrounding the outside of the lung. *MedlinePlus*, available at https://medlineplus.gov/pleuraldisorders.html (last checked August 5, 2016).

JA Page	X-Ray Date	Doctor	Narrative Findings
23	6-24-09	Michael Anton	• Continued pulmonary vascular congestion with interstitial opacities which are unchanged • More focal consolidation developing at the periphery of the left upper lobe. • This has worsened since the prior study. • Aeration in the right lung base is improving.
22	6-23-09	Jennifer Smith	• Extensive bilateral airspace opacities are redemonstrated with worsening disease at right base and probable right-sided effusion.
116	3-16-09	John Mega	• No pleural effusions • Ill-defined air space disease within left perihilar region extending into the left upper lobe • Ill-defined infiltrate present throughout a majority of the right lung; new findings suggesting asymmetric pulmonary edema
3	6-5-08	John Bodkin	• Nodular densities throughout both lungs which are thought to be related to occupational pneumoconiosis • Second area in left mid-lung zone which is more prominent than on earlier examination • Two densities in the left chest that are new when compared to 9-22-06 x-ray
2	9-22-06	Carlton Herald	• No acute cardiopulmonary process • Diffuse prominence of the interstitial lung markings compatible with underlying interstitial lung disease, probably related to patient's history of coal mining • Left upper lobe nodular density measuring 1.1 centimeter in diameter

(…continued)

[8] Pneumothorax is the buildup of air or gas in the pleural space. *MedlinePlus*, available at https://medlineplus.gov/pleuraldisorders.html (last checked August 5, 2016).

Medical Opinions

Dr. James Castle provided an opinion on behalf of Elkay after reviewing the miner's treatment records. JA 265-77. (Elkay apparently did not provide Dr. Castle with Drs. Miller or Scott's interpretations. *Id.*) Dr. Castle concluded, without personally reading a single x-ray, that is "is not possible to accurately determine whether or not Mr. Smith had radiographic evidence of simple coal workers' pneumoconiosis. This process cannot be excluded as a cause of his radiographic abnormalities, nor can rheumatoid lung disease be excluded as a cause." JA 276.

Dr. Stephen Basheda also provided an opinion for Elkay based on his review of the treatment records and Dr. Castle's repot. JA 279-94. (As with Dr. Castle, Elkay did not provide Dr. Basheda with Drs. Miller and Scott's x-ray interpretations.) Dr. Basheda concluded (also without reading any x-rays himself) that there was "insufficient objective information to evaluate the diagnosis of coal worker's pneumoconiosis….The chest radiographic findings may have multiple etiologies" such as acute pulmonary edema, congestive heart failure,

severe rheumatoid arthritis, or coal workers' pneumoconiosis. JA 292-93.

3. Summary of the decisions below

a. The ALJ award

The ALJ noted that it was uncontested that claimant is an eligible survivor of the miner, that the miner worked at least 34 years in the underground coal mines, and that Elkay is the properly designated responsible operator. JA 325-26. The ALJ credited the miner with a smoking history of 25 pack-years. JA 327.

The ALJ then addressed the conflict regarding the existence of complicated pneumoconiosis in the x-ray readings submitted in connection with Mrs. Smith's claim.[9] The ALJ observed that Dr. Miller

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[9] As discussed previously, complicated pneumoconiosis can be established with x-ray evidence, pathology evidence, or by other means that "could reasonably be expected to yield [similar] results." Because the x-ray readings submitted for litigating this claim were *digital* readings that pre-dated the regulatory standards governing their use, the ALJ correctly treated them as "other medical evidence" under Section 921(c)(3)(C) and 20 C.F.R. § 718.107 (catch-all provision governing medically acceptable procedures in general). JA 328; *see* BLBA Bulletin 14-11, Digital X-ray Rule – Date Applicability (Sept. 29, 2014) (available at https://www.dol.gov/owcp/dcmwc/blba/indexes/bulletins.htm) (last checked August 5, 2016).

had classified the x-ray as positive for both simple pneumoconiosis and complicated pneumoconiosis, whereas Dr. Scott found it negative while commenting that there was too much congestive heart failure to "see small opacities even if present." JA 328. The ALJ credited Dr. Miller's reading over Dr. Scott's because he found Dr. Miller's reading "supported by medical treatment records which suggest complicated pneumoconiosis." JA 335.

Within the treatment records, the ALJ highlighted Dr. Herald's September 22, 2006 observation of a 1.1 centimeter nodule within the left upper lobe and Dr. Bodkin's June 2008 finding of "two densities in the left chest which are new compared to September 22, 2006." JA 335, 2, 152. Given the progressive and irreversible nature of pneumoconiosis, the ALJ found these records supported Dr. Miller's 2009 interpretation of large Category A opacities of a combined size less than five centimeters. JA 336.

The ALJ further determined that Dr. Castle's opinion did not undercut Dr. Miller's x-ray interpretation because Dr. Castle had not considered Dr. Miller's (or Dr. Scott's) reading and had merely opined that he could not accurately determine the existence of pneumoconiosis

based on the treatment records he reviewed. JA 336. Likewise, the ALJ observed that Dr. Basheda had not reviewed Dr. Miller's reading and had found the medical record "insufficient" to render an opinion on the existence of pneumoconiosis. The ALJ further faulted Dr. Basheda for failing to sufficiently explain why a positive interpretation for complicated pneumoconiosis in June 2009 should be scuttled merely because other disease processes—acute pulmonary edema, rheumatoid arthritis, congestive heart failure—were also present. JA 336, 330. Therefore, the ALJ found the digital x-ray and treatment records showing a nodular density of at least 1.1 centimeters, Category A, against a profusion of small opacities, 2/3, established complicated pneumoconiosis.

The ALJ then found under 20 C.F.R. § 718.203(a) that the miner's complicated pneumoconiosis arose out of his more than ten years of coal mine employment. JA 337. (Elkay has not challenged this finding on appeal.) He accordingly invoked the irrebuttable presumption of death due to pneumoconiosis and awarded benefits. JA 337.

b. The Benefits Review Board affirmance

The Board affirmed in a two-to-one decision. The majority held that the ALJ permissibly credited Dr. Miller's x-ray interpretation of complicated pneumoconiosis as supported by the treatment records. The Board explained that the ALJ reasonably had relied on the September 22, 2006 x-ray as evidence of a 1.1 centimeter nodule in the miner's left lung, which preexisted his acute pulmonary edema and congestive heart failure, conditions that Drs. Scott and Basheda opined would prevent an accurate interpretation of the 2009 x-ray. JA 346.

The majority further held that the ALJ permissibly discounted Drs. Castle and Basheda's medical opinions because neither considered the evidence that the ALJ found most probative of complicated pneumoconiosis (Drs. Miller and Scott's readings). JA 347. The majority thus concluded that substantial evidence supported the ALJ's finding of complicated pneumoconiosis and affirmed the award. JA 348.

The dissent believed that the ALJ had selectively reviewed the treatment records, and had failed to reconcile the conflicting x-ray interpretations or adequately explain his rejection of Drs. Castle and

Basheda's opinions. JA 349-52. The dissent accordingly proposed remand for further consideration. JA 352.

Summary of the Argument

The Court should affirm the award of Mrs. Smith's claim. It was well within the ALJ's discretion to credit Dr. Miller's x-ray reading of complicated pneumoconiosis over Dr. Scott's negative reading in light of the treatment records corroborating Dr. Miller's reading.

Elkay's argument that the ALJ selectively reviewed the relevant treatment records is incorrect. The allegedly "overlooked" x-rays that Elkay cites do not refute or undermine Dr. Miller's finding of complicated pneumoconiosis or the treatment records that corroborate his x-ray reading. Moreover, Elkay incorrectly asserts that the ALJ erred in discrediting its expert opinions. The ALJ permissibly rejected them because, *inter alia*, Elkay did not give them the most relevant and probative evidence to review.

Elkay's appeal essentially is a request for this Court to re-weigh the evidence. But it is the ALJ's job to weigh the medical evidence and make credibility determinations. This ALJ's assessment of the medical

record here is rational, supported by substantial evidence, and should be affirmed.

Argument

The ALJ's ruling that the evidence establishes the presence of complicated pneumoconiosis is supported by substantial evidence and in accordance with law.

A. Standard of Review

This appeal presents factual issues. In federal black lung cases, the ALJ makes credibility determinations and weighs conflicting evidence. *See Underwood v. Elkay Mining, Inc.,* 105 F.3d 946, 949 (4th Cir. 1997). The Court reviews an ALJ's findings of fact to determine whether they are supported by substantial evidence. *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 756 (4th Cir. 1999). Substantial evidence is of "sufficient quality and quantity 'as a reasonable mind might accept as adequate to support' the finding under review." *Id.* (quoting *Richardson v. Perales*, 402 U.S. 389 (1971)).

B. Substantial evidence supports the ALJ's determination that the miner suffered from complicated pneumoconiosis.

A claimant may establish the presence of complicated pneumoconiosis by x-ray evidence of large opacities; by biopsy or autopsy evidence of "massive lesions"; or by a diagnosis by other

equivalent means. 30 U.S.C. § 921(c)(3)(A)-(C); 20 C.F.R. § 718.304(a)-(c). Here, the ALJ properly considered the digital x-ray evidence under the "other equivalent means" prong. He permissibly found that Dr. Miller's x-ray reading of complicated pneumoconiosis was credible and more persuasive than Dr. Scott's negative reading because, unlike Dr. Scott's, Dr. Miller's reading was corroborated by additional x-ray readings in the miner's treatment records. The ALJ's conclusion that the weight of the evidence established complicated pneumoconiosis is rational, supported by substantial evidence and should be affirmed.

1. **The ALJ permissibly credited Dr. Miller's x-ray interpretation, as supported by the treatment records, to find complicated pneumoconiosis established.**

The June 24, 2009, x-ray was the only x-ray read specifically for pneumoconiosis under the ILO classification system. Dr. Miller interpreted it as revealing large opacities in the upper lungs that he classified as Category A, complicated pneumoconiosis. JA 264. He also reported the presence of small opacities, both irregular and round, that demonstrated simple pneumoconiosis, ILO profusion 2/3. *Id.* Dr. Scott read the same x-ray as negative for pneumoconiosis, claiming there was too much congestive heart failure to see small opacities "even if

present." JA 278. Faced with resolving the conflict in these two readings by equally qualified radiologists, the ALJ reasonably looked to the x-ray readings in the miner's treatment records to corroborate either view. JA 335.

The ALJ noted that, on a September 22, 2006 x-ray, Dr. Herald viewed a 1.1 centimeter nodular density in the miner's left upper lobe, along with interstitial lung disease, "probably related to patent's history of coal mining." JA 335, 2. The ALJ determined that this density did not disappear. JA 336. On a June 5, 2008 x-ray, Dr. Bodkin saw nodular densities throughout both lungs, thought to be related to occupational pneumoconiosis, and "two densities in the left chest which are *new when compared to* 09/22/06." JA 336, 3 (emphasis added). A year later, Dr. Miller observed large opacities, Category A, in the upper lung "with a combined size of less than five centimeters." JA 264. The ALJ reasonably determined that the 2006 and 2008 x-rays documented the existence and progression of a large opacity or nodule in the miner's upper lung that culminated in Dr. Miller categorizing the large opacities as complicated pneumoconiosis, Category A in the 2009 x-ray. JA 335-36; *see* 20 C.F.R. § 718.201(c) (pneumoconiosis "is recognized as

a latent and progressive disease"); *Eastern Associated Coal Corp. v. Director, OWCP [Toler]*, 805 F.3d 502, 512-13 (4th Cir. 2015) (confirming that the medical literature "demonstrates that both simple and complicated pneumoconiosis can be latent and progressive").

In contrast, the ALJ found little support for Dr. Scott's negative reading. JA 335. There is no indication on the 2006 and 2008 x-rays of pulmonary edema or congestive heart failure which, according to Dr. Scott obscured his view in the 2009 x-ray. JA 2, 3, 278. And the earlier x-rays document the presence of a 1.1 centimeter nodule as well as underlying interstitial lung disease related to coal mine employment, *i.e.*, pneumoconiosis. The ALJ thus permissibly concluded that these treatment records lent support to crediting Dr. Miller's interpretation over Dr. Scott's. Substantial evidence supports the ALJ's determination that Dr. Miller provided a credible and probative finding of a large opacity, Category A, sufficient to establish complicated pneumoconiosis pursuant to 20 C.F.R. § 718.304(c).

2. Elkay has not identified evidence that the ALJ failed to consider which refutes or undermines a finding of complicated pneumoconiosis.

Elkay asserts that the ALJ committed reversible error by selectively analyzing the evidence. Opening Brief 12-16. But the treatment records it cites (Op. Br. 15 citing JA 22, 23, 25, 27, 28, 116)—x-ray interpretations in March and June of 2009 by Drs. Mega, Smith, Anton, McCain and McJunkin—do not undermine, let alone refute, Dr. Miller's reading. Elkay has thus failed to meet its burden of showing that the ALJ's failure to specifically address these readings was prejudicial and would have affected the outcome below. *Sea "B" Mining Co. v. Addison*, __ F.3d __, 2016 WL 4056396 at *6 (4th Cir. 2016) (rejecting coal company argument that "ALJ's failure to evaluate the full spectrum of CT scan evidence is per se prejudicial").[10]

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[10]Unlike the ALJ in *Addison* who prejudicially excluded and thus failed to consider probative CT scans, 2016 WL 4056396 at *7, the ALJ here admitted and considered the cited treatment record x-rays. *See* JA 331 (describing "[m]edical treatment records of Charleston Area Medical Center dated … June 21, 2009 to July 3, 2009"); JA 330 (noting Dr. Basheda's review of "multiple chest radiographs [that] were taken during the miner's last hospitalization" as showing, *inter alia*, "underlying interstitial fibrosis.").

While no doctor identified large opacities, most find interstitial fibrosis or interstitial opacities present. JA 23, 25, 27, 28. These findings are consistent with a diagnosis of pneumoconiosis. *See* n.6 *supra*. Thus, these treatment records tend to corroborate, rather than refute, the occupational disease process that Drs. Herald and Bodkin respectively suggested in 2006 and 2008 and that Dr. Miller definitively diagnosed in 2009.[11] At worst, the cited treatment records are inconclusive. *Wolf Creek Collieries v. Robinson*, 872 F.2d 1264, 1264, 1270-71 (6th Cir. 1989) (substantial evidence supported ALJ determination that x-ray readings finding simple pneumoconiosis, but silent on complicated, were not contrary to readings finding complicated pneumoconiosis); *Porter v. Director, OWCP*, 883 F.2d 75 (Table), 1989 WL 96519 at *3 n.3 (6th Cir. 1989) (unpublished) (autopsy report diagnosing pneumoconiosis is evidence of the disease, but report silent

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[11] Elkay contends that these records "suggest" other possible etiologies, such as pulmonary edema, pleural effusion, or even cardiomegaly (enlarged heart), for the interstitial fibroses/opacities. Op. Br. 15. But these findings are *additional* abnormalities, and certainly not the cause of the described interstitial fibroses. Elkay's own experts underscore this fact when they speculate that the "interstitial findings including nodularity" may be due to rheumatoid arthritis and not these other conditions. JA 276, 292.

on its existence entitled to little weight unless pathologist specifically examined for pneumoconiosis); *Goff v. Eastern Coal Co.*, 2015 WL 1802692 at *2 (Ben. Rev. Bd. 2015) (treatment records silent on the existence of pneumoconiosis are inconclusive).

In any event, the March and June 2009 interpretations of interstitial fibrosis and opacities contradict Dr. Scott's opinion that there were no visible opacities in the miner's lungs in 2009. JA 2, 264, 278. Contrary to Elkay's assertion, these treatment records are more consistent with Dr. Miller's x-ray interpretation than Dr. Scott's and certainly fail to establish that the ALJ's analysis of the treatment records was flawed.[12]

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[12]The Board dissent, on which Elkay heavily relies, is likewise incorrect in asserting that the ALJ selectively assessed the evidence. For example, the dissenting judge nitpicks that Dr. Miller found "*bilateral* upper lung large opacities" compatible with complicated pneumoconiosis, whereas the 2006 and 2008 x-ray revealed large opacities on the left side only. JA 350-51. Not only does this reasoning ignore the possibility that the miner's complicated pneumoconiosis worsened (or progressed) by 2009 to both sides, it misses the ALJ's point, which is that the earlier x-rays corroborate the existence of a large opacity on the left side. That finding, standing alone, establishes complicated pneumoconiosis here. In other words, whether there were additional large opacities on the right side is irrelevant.

3. The ALJ properly rejected Drs. Castle and Basheda's opinions.

Elkay last contends that the ALJ erred in discounting the opinions of Drs. Castle and Basheda, claiming they were "[t]he only physicians to consider all of the treatment records and *the competing x-ray interpretations*." Op. Br. 15 (emphasis added). This assertion is factually incorrect, as the ALJ found. JA 336. Elkay did not provide its consulting experts with Drs. Miller and Scott's "competing" x-ray interpretations, which were the only readings that specifically addressed the presence of pneumoconiosis and utilized the ILO Classification. The ALJ thus permissibly discounted these opinions as based on an incomplete review of the available, and arguably most probative, medical evidence. *See Fox ex rel. Fox v. Elk Run Coal Co., Inc.*, 739 F.3d 131, 137 (4th Cir. 2014) (party that withholds probative evidence from its expert runs the risk that the expert's opinion will not withstand close scrutiny); *Risher v. OWCP*, 940 F.2d 327, 330 (8th Cir. 1991) ("An ALJ may discount a doctor's opinion where that opinion is based on an incorrect view of the claimant's medical history."); *cf. Sea "B" Mining Co.*, __ F.3d __, 2016 WL 4056396 at *7-*8 (remanding for

reconsideration where ALJ wrongfully excluded CT scans that supported expert's diagnosis of no pneumoconiosis).[13]

Furthermore, their opinions are equivocal. Dr. Castle stated he could not "accurately determine" the presence of pneumoconiosis, and Dr. Basheda suggested a variety of possible disease processes without settling on one. Again, the ALJ considered these opinions and permissibly determined that they were insufficient to either refute the credibility of Dr. Miller's complicated pneumoconiosis interpretation, or demonstrate that Dr. Scott's interpretation warranted greater weight.

In sum, 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. *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 342 (4th Cir. 1996). "[A]s the trier of fact,

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[13]Equally flawed is Elkay's reliance on the Board dissent, which argued that the ALJ did not fully consider Drs. Castle and Basheda's suggestion that the disease process seen on x-ray could be attributable to rheumatoid arthritis. JA 351; Op. Br. 25. The ALJ, however, fully discussed the doctors' opinions and recognized that they suggested possible alternative etiologies for the disease process seen on x-ray. JA 329-30. But acting within his discretion, the ALJ permissibly found them unpersuasive because neither doctor considered the most relevant medical evidence—the x-ray interpretations by Drs. Miller and Scott.

the ALJ is not bound to accept the opinion or theory of any medical expert." *Underwood*, 105 F.3d at 949. The ALJ need only provide a factual basis to support one reason for discrediting an opinion. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 213 n.13 (4th Cir. 2000).

Here, the ALJ reasonably found that Dr. Miller's diagnosis of complicated pneumoconiosis was supported by the earlier x-ray evidence of interstitial fibrosis and a large density in the left upper lobe. The ALJ permissibly rejected as less probative the evidence that did not recognize the presence of a large opacity or nodule in the miner's left upper lobe. The ALJ's finding of complicated pneumoconiosis is supported by substantial evidence and in accordance with law and should be affirmed.

Conclusion

The Court should affirm the decisions below.

Respectfully submitted,

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Certification of Compliance

Pursuant to Federal Rules of Appellate Procedure 32(a)(6) and 32(a)(7)(B), I hereby certify that this Brief for the Director, Office of Workers' Compensation Programs, was prepared using proportionally-spaced typeface, Century 14-point, and contains 4,994 words, as counted by the Microsoft Office Word 2010 software used to prepare this brief.

Furthermore, I certify that the text of the brief transmitted to the Court through the CM/ECF Document Filing System as a PDF file is identical to the text of the paper copies mailed to the Court and counsel of record. In addition, I certify that the PDF file was scanned for viruses using McAfee Security VirusScan Enterprise 8.8. The scan indicated there are no viruses present.

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Certificate of Service

I hereby certify that on August 5, 2016, the Director's brief was filed electronically with, and one paper copy, postage prepaid, was mailed to, the Clerk of the United States Court of Appeals for the Fourth Circuit. I further certify that the Director's brief was served on the following parties by using the appellate CM/ECF system:

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