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STATEMENT OF RELATED CASES

The Director, Office of Workers' Compensation Programs, is unaware of any prior or related appeals.

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

No. 18-9585

ENERGY WEST MINING COMPANY,

Petitioner,

v.

CECIL E. BRISTOW, 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, BRB No. 17-0441 and 17-0441A

BRIEF FOR THE FEDERAL RESPONDENT

This appeal concerns retired miner Cecil E. Bristow's ("Bristow's") claim for benefits under the Black Lung Benefits Act ("BLBA" or "Act"), 30 U.S.C. §§ 901-44. An administrative law judge ("ALJ") denied the claim, but the Benefits Review Board ("Board") reversed and remanded for the ALJ to enter an award of benefits. Before the ALJ could finish her fact-finding and enter an award, however, the liable coal mine operator Energy West Mining Company ("Energy

West") petitioned this Court to review the Board's non-final decision. The Director of the U.S. Department of Labor's Office of Workers' Compensation Programs ("OWCP") responds.

STATEMENT OF JURISDICTION

The ALJ denied benefits on April 26, 2017. Bristow timely appealed this decision to the Board on May 16, 2017. *See* 33 U.S.C. § 921(a).[1] The Board had jurisdiction to review the ALJ's decision under 33 U.S.C. § 921(b)(3). On October 19, 2018, the Board affirmed in part, reversed in part, and remanded the case for entry of an award of benefits. Energy West prematurely filed a petition for review with this Court on December 17, 2018.

As explained in the Director's February 7, 2019 response to the Court's January 7, 2019 order, this Court lacks jurisdiction over this appeal because the Board's October 19, 2018 decision is not a "final order" within the meaning of 33 U.S.C. § 921(c). A "final" Board order, like a final decision by a federal district court, must "end the litigation on the merits and leave nothing for the trier to do but execute the judgment." *Newpark Shipbuilding & Repair, Inc. v. Roundtree*, 723 F.2d 399, 406 (5th Cir. 1984) (en banc) (applying the definition of finality for review of district court decisions under 28 U.S.C. § 1291 to "final orders" under 33

[1] 33 U.S.C. § 921 is incorporated into the BLBA by 30 U.S.C. § 932(a).

U.S.C. § 921(c)). "[T]he touchstone of a final order is a decision by the court that a party shall recover only a sum certain. Accordingly, an order that determines liability but leaves damages to be calculated is not final." *Harbert v. Healthcare Servs. Grp., Inc.*, 391 F.3d 1140, 1145 (10th Cir. 2004) (internal quotation marks and emphasis omitted). Here, the Board reversed the ALJ's denial of benefits and remanded the case to the ALJ to enter an award, but the Board's order was not "final" for judicial review purposes because the ALJ still has more fact-finding to do before she can enter an award. Specifically, the ALJ still has to determine the date from which the miner's benefits should begin, which determines the amount of back benefits Bristow is due. 20 C.F.R. § 725.503(b); *Freeman United Coal Mining Co. v. Dir., OWCP*, 721 F.2d 629, 631 (7th Cir. 1983). Because the Board order under review is not a final order, the Court should dismiss Energy West's petition for review for lack of jurisdiction.

STATEMENT OF THE ISSUES

If the Court has jurisdiction, the Court should address the following issues:

1. Legal pneumoconiosis includes any chronic lung disease that is "significantly related to, or substantially aggravated by," coal mine dust exposure. 20 C.F.R. § 718.201(b). The ALJ found Bristow has legal pneumoconiosis because his chronic obstructive pulmonary disease (COPD)

was caused in part by coal mine dust exposure. Is this sufficient to satisfy 20 C.F.R. § 718.201(b)?

2. It is undisputed that Bristow is totally disabled by COPD. The ALJ has found that his COPD constitutes legal pneumoconiosis. Under these circumstances, has Bristow established his total disability was caused by legal pneumoconiosis?
3. Does substantial evidence support the ALJ's crediting of Dr. Sood's medical opinion?
4. Did the ALJ permissibly discredit Dr. Castle's opinion that Bristow's COPD was unrelated to coal mine dust exposure because it was based on an unsubstantiated theory that the courts have repeatedly held is inconsistent with the black lung regulations and the science behind them?
5. Does substantial evidence support the ALJ's decision to discredit Dr. Selby's opinion that Bristow's COPD was unrelated to coal mine dust exposure?
6. Does substantial evidence support the ALJ's finding that the x-ray evidence supports clinical pneumoconiosis?

STATEMENT OF THE CASE

I. Statutory and regulatory background

The BLBA provides disability compensation to coal miners who are totally disabled by pneumoconiosis, commonly referred to as black lung disease. 30 U.S.C. § 901(a); 20 C.F.R. § 718.1. A miner seeking benefits must prove four elements: (1) *disease* (he suffers from pneumoconiosis); (2) *disease causation* (his pneumoconiosis arose out of coal mine employment); (3) *total disability* (he suffers from a respiratory or pulmonary impairment that prevents him from doing his usual coal mine work); and (4) *disability causation* (his pneumoconiosis contributes to his disability). 20 C.F.R. § 725.202(d); *Spring Creek Coal Co. v. McLean*, 881 F.3d 1211, 1217 (10th Cir. 2018).

A. Disease

Pneumoconiosis is "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). The black lung regulations identify two general categories of pneumoconiosis, "clinical" and "legal." 20 C.F.R. § 718.201(a); *McLean*, 881 F.3d at 1217.

Clinical (or medical) pneumoconiosis refers to diseases that physicians would recognize as pneumoconiosis. Such conditions are characterized by 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); *McLean*, 881 F.3d at 1217. They are understood to be closely linked to occupational or environmental exposure to dust coal mine dust, silica, asbestos, cotton fibers, or other types of dust. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 6 n.1 (1976); *Andersen v. Dir., OWCP*, 455 F.3d 1102, 1107 (10th Cir. 2006); DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1470 (32nd ed. 2012).

Legal pneumoconiosis is a broader category created for purposes of the BLBA. It includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." 20 C.F.R. § 718.201(a)(2); *see Blue Mountain Energy v. Dir., OWCP*, 805 F.3d 1254, 1256 (10th Cir. 2015). A disease "aris[es] out of coal mine employment" if it is "significantly related to, or substantially aggravated by" exposure to coal mine dust. 20 C.F.R. § 718.201(b). A disease can qualify as pneumoconiosis even if coal mine dust is not its sole or even its primary cause. *Energy W. Mining Co v. Oliver*, 555 F.3d 1211, 1218 (10th Cir. 2009).

B. Disease causation

Because proving the existence of legal pneumoconiosis requires proof of both the lung disease and the causal link to coal mine employment, in a legal pneumoconiosis case, the disease causation inquiry is subsumed by the disease inquiry. *See Andersen*, 455 F.3d at 1106-07.

However, a miner with clinical pneumoconiosis still has to establish that his disease arose from coal mine employment. If the miner worked in coal mines for at least 10 years, disease causation is presumed. If he worked in coal mines for less than 10 years, he must prove his pneumoconiosis arose from coal mine employment with competent evidence. 20 C.F.R. § 718.203(b), (c); *Andersen*, 455 F.3d at 1105 (holding that the 10-year presumption applies only to clinical pneumoconiosis).

C. Total disability

20 C.F.R. § 718.204(b)(2) provides four methods by which a miner can prove a totally disabling respiratory impairment: (1) results of pulmonary function tests ("PFTs") meeting certain criteria; (2) results of arterial blood gas studies meeting certain criteria; (3) proof of pneumoconiosis and "cor pulmonale with right-sided congestive heart failure"; or (4) a physician's reasoned medical opinion "that a miner's respiratory or pulmonary condition prevents . . . the miner from engaging in" his usual coal mine work. In the absence of contrary probative evidence, "[t]he miner can establish total disability upon a mere showing of evidence that satisfies any one of the four alternative methods." *Lane v. Union Carbide Corp.*, 105 F.3d 166, 171 (4th Cir. 1997); 20 C.F.R. § 718.204(b)(2).

Relevant to this appeal are the criteria for PFTs, also called spirometry. PFTs are tests that show how well miners move air in and out of their lungs. These

tests measure data such as the volume of air that a miner can expel in one second after taking a full breath (forced expiratory volume in one second, or FEV_1), the total volume of air that a miner can expel after a full breath (forced vital capacity, or FVC), and the ratio between those two points. *See* Occupational Safety & Health Admin., U.S. Dep't of Labor, *Spirometry Testing in Occupational Health Programs: Best Practices for Healthcare Professionals* 1-2 (2013), https://www.osha.gov/Publications/OSHA3637.pdf. Under the black lung regulations, total disability can be established by showing that the miner's FEV_1 and FVC values are below certain values listed in the tables in 20 C.F.R. Part 718, Appendix B or that the miner's FEV_1/FVC ratio is below 55%. 20 C.F.R. § 718.204(b)(2)(i)(A), (C).

D. Disability causation

In addition to proving disease, disease causation, and total disability, the miner must also show that pneumoconiosis is a "substantially contributing cause" of his total respiratory disability. A miner satisfies this disability causation element if pneumoconiosis "[h]as a material adverse effect on the miner's respiratory or pulmonary condition" or if it "[m]aterially worsens a totally disabling respiratory or pulmonary impairment . . . caused by a disease or exposure unrelated to coal mine employment." *Id.* § 718.204(c)(1).

II. Relevant facts

Bristow worked in underground coal mines for a little over four years in Kentucky and a little over two years in Utah, for a total of 6.5 years. DX 3 at 1; DX 5 at 1; DX 6 at 3; Tr. 13-15.[2] In Kentucky, he worked at the face of the mine as a laborer, fire boss, and shot fireman (loading explosives and setting off shots). He was covered with coal dust at the end of each shift and he had dust in his eyes, ears, and nose even after he showered. Tr. 14-18. In Utah, he worked as a welder installing belts. His coal dust exposure was moderate to heavy. *Id.* at 21. Bristow has smoked cigarettes for at least 40 years. On average, he has smoked a pack of cigarettes each day, although there were times he smoked a little less. *Id.* at 28-29.

Bristow has chronic obstructive pulmonary disease (COPD). COPD is a lung disease characterized by airflow obstruction. *Andersen*, 455 F.3d at 1104 n.3. It includes chronic bronchitis, emphysema and certain forms of asthma. *Id.*; Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 79,920, 79,939 (Dec. 20, 2000) ("2000 Preamble"). COPD can have multiple causes, including cigarette smoking, breathing polluted air, and/or coal mine dust exposure. *See Andersen*, 455 F.3d at 1107; 2000

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[2] "DX" refers to "Director's Exhibit," "EX" refers to "Employer's Exhibit," and CX refers to "Claimant's Exhibit." "Tr." refers to the October 24, 2016 hearing transcript.

Preamble, 65 Fed. Reg. at 79,939-43 (summarizing medical and scientific evidence of link between COPD and coal mine work).

III. Relevant medical evidence

A. Medical opinions

The ALJ considered four medical opinions, summarized here.

1. Dr. Chavda

Dr. Chavda examined Bristow on behalf of the Department of Labor. He diagnosed clinical and legal pneumoconiosis based on Bristow's wheezing, dyspnea (shortness of breath), cough, positive chest x-ray, and severe obstructive and moderate restrictive airway disease (as shown through his PFT), as well as his 6.5 years of exposure to coal dust. DX 10 at 53. Dr. Chavda opined that Bristow's clinical and legal pneumoconiosis were "substantially caused and aggravated by working in coal mines and exposure to coal dust for about 6 ½ years." *Id.* "The "#1 cause for his symptoms and reduction in lung function is his smoking related COPD, and the second or minor etiology is his 6 ½ years of coal dust exposure." *Id.* at 53-54.

Dr. Chavda found Bristow totally disabled. *Id.* at 54. Regarding disability causation, Dr. Chavda opined:

> The diagnosis of legal and clinical pneumoconiosis . . . is not a substantial and significant contributing factor. He had smoked for 40 years and he worked in coal mines only 6 ½ years. So his smoking

> history is significantly more prolonged than his working history. People who smoke could definitely develop COPD. As he has worked only 6 ½ years, the smoking history is about 6 times longer than his working in coal mines. Even though he had 1/0 positive x-ray, and he has significant obstructive and restrictive airway disease, definitely pneumoconiosis is a contributing factor but it could be a secondary contributing factor in my clinical opinion.

Id. In a supplemental report, Dr. Chavda reiterated that "smoking would be the #1 etiology and coal dust related pneumoconiosis would be secondary or not a prominent etiology for his pulmonary disability." *Id.* at 55.

At his deposition, Dr. Chavda testified that he diagnosed legal pneumoconiosis

> [b]ecause he has diagnosis of clinical with the symptoms of shortness of breath, which he had described to us. He had wheezing, dyspnea and cough. He also has exposed [sic] to coal dust for six and a half years. He had significant reduction in lung function. His exercise and resting ABG's does show that he had some CO2 retention, and with all these factor[s], some of the COPD-related features could be complicated by his coal dust exposure, and COPD is one of the diagnoses that can be contributed [sic] and we call as legal pneumoconiosis.

EX 4 at 14-15. When asked why he believed Bristow's coal dust exposure was a cause of his COPD, given his smoking history, Dr. Chavda testified that, even five years of exposure could cause some COPD if the miner spent a significant amount of time at the face of the mine and he was susceptible to lung damage. *Id.* at 16. Dr. Chavda stated that, "definitely [Bristow's] smoking is substantially and [sic] much, much more than his coal dust exposure. So the risk of developing COPD

from his smoking is high and significant than [sic] risk of developing COPD from his coal dust exposure." *Id.* at 17. He agreed with Energy West's counsel that, when stating in his report that coal dust exposure was only a "second, or minor etiology," he meant coal dust exposure was not a substantial or significant cause. *Id.* He also agreed that pneumoconiosis was not a substantial or significant contributing factor to Bristow's lung impairment. *Id.*

On cross-examination, Dr. Chavda agreed that pneumoconiosis had a material adverse effect on Bristow's respiratory or pulmonary impairment and that pneumoconiosis materially worsened his totally disabling respiratory or pulmonary impairment caused by cigarette smoking. *Id.* at 28. He stated that smoking was "definitely a number one cause, I would say, a substantive cause for his COPD." *Id.* at 29. He testified that Bristow's 6.5 years of coal dust exposure may have had an additive effect on Bristow's lungs, but it was not a prolonged, substantial exposure "that could definitely make it a substantial causative factor." *Id.* Dr. Chavda could not say that the 6.5 years did not cause any damage, "but if you look at relative from his smoking and relative of his work experience [sic], then smoking would be a substantial factor for his COPD compared to his six and a half years of work exposure." *Id.* at 29-30.

On re-direct, Dr. Chavda again agreed with Energy West's counsel that, when considering Bristow's 40 years of smoking versus 6.5 years of coal dust

exposure, coal dust exposure was not a significant or substantial contributing factor in Bristow's COPD or his disability. *Id.* at 33.

2. Dr. Sood

Dr. Sood did not examine Bristow, but reviewed Bristow's medical records, including Drs. Chavda's, Selby's, and Castle's reports at Bristow's request. CX 8 at 1. Dr. Sood found Bristow did not have clinical pneumoconiosis, but he did have legal pneumoconiosis because he had COPD and his 5 to 7 years of coal mine dust exposure were a "substantial contributory cause to the causation or aggravation of his COPD." *Id.* at 9. Dr. Sood noted that Bristow's 41- pack-year smoking history was also a substantial contributory cause to his COPD, and that it was not possible to scientifically apportion between the two significant contributory exposures. *Id.* at 9-11 (discussing numerous medical studies).

Dr. Sood found Bristow was totally disabled by COPD. He also found that Bristow's COPD/legal pneumoconiosis was a "substantially contributing cause" to Bristow's respiratory or pulmonary impairment because, other than COPD, he had no other significant lung disease. Also, Bristow's COPD was associated with moderately severe to severe obstruction, hyperinflation, and air trapping, and abnormally high alveolar arterial gradient at rest and exercise. *Id.* at 13.

At his deposition, Dr. Sood testified that, by "substantial contributory factor," he meant that coal dust exposure "was an important player in the causation

of [Bristow's] lung disease, meeting a 51 percent threshold of certainty." EX 7 at 14. Dr. Sood explained that, when he offers his opinion "within a reasonable degree of medical certainty" in medical/legal cases, he means he has a "greater than 50 percent" level of certainty. He uses a 95% level of certainty when treating patients. *Id.* at 8. At 95% certainty, he "[could not] be certain about the causation conclusions" in Bristow's case. *Id.* at 9.

On cross-examination, Dr. Sood testified that he would not treat a patient differently based on whether their COPD was caused by coal dust exposure or smoking; the treatment would be the same. *Id.* at 50. He agreed that coal dust exposure was a substantial contributing factor to Bristow's total respiratory disability and that legal pneumoconiosis had a material adverse effect on Bristow's respiratory or pulmonary condition. *Id.* at 52, 55.

3. Dr. Selby

Dr. Selby examined Bristow on Energy West's behalf. EX 1 at 1. He found Bristow did not have clinical pneumoconiosis, but did have obstructive pulmonary disease and asthma, although Dr. Selby found neither was caused by coal mine dust inhalation. *Id.* at 9. Dr. Selby did not offer a definitive opinion on whether Bristow was totally disabled. He was not certain whether Bristow was permanently impaired, but he opined that, if Bristow was permanently disabled, it was due to smoking "with or without asthma." *Id.*

At his deposition, Dr. Selby testified that Bristow's bronchial asthma was the primary problem and that Bristow very likely had some permanent obstructive disease from smoking. EX 8 at 18. In Dr. Selby's opinion, Bristow did not have any significant lung disease that was substantially related to or substantially aggravated by his years working in the coal mines because:

> [h]e would have to be an extremely, extremely susceptible host to have any disease of his lungs after only five to six or seven years of exposure. My understanding on his exposure was that he worked as a welder; and, if I remember correctly, he worked on a bit of—quite a bit of his time on belt lines and things that were down. So there would be no dust while you're working on those, typically. But six, seven years of exposure, especially in Utah kind of coal mines, which is soft coal, I think, would be very unlikely to cause him any type of permanent impairment.

Id. at 18-19. When asked whether he was "ruling in or out the possibility of impairment associated with [Bristow's] work just based on his history of exposure alone," Dr. Selby answered no. *Id.* at 19. Dr. Selby also testified that asthma can be aggravated by coal mine dust exposure, but he had no reason to think Bristow's coal mine dust exposure contributed to or aggravated the asthmatic component of his disease. *Id.* at 20. He reaffirmed that, besides asthma, smoking was the only thing that contributed to Bristow's lung disease and that he did not think coal dust did any damage. *Id.* at 32. He could not say for certain if Bristow was totally or permanently disabled because he did not know how impaired Bristow might be if his asthma was recognized and treated. *Id.* at 32-33.

Dr. Selby also testified that, to him, a reasonable degree of medical certainty meant "it's a lot more likely than not" and that he used the same standard in his clinical practice as he did to evaluate coal miners. *Id.* at 34.

4. Dr. Castle

Dr. Castle did not examine Bristow, but reviewed medical records, including Drs. Selby's and Chavda's reports, at Energy West's request. EX 3 at 1-8. Dr. Castle found Bristow did not have clinical pneumoconiosis. *Id.* at 10. He also opined that Bristow did not have legal pneumoconiosis because his severe chronic airway obstruction was caused by smoking. *Id.* He reasoned that Bristow's obstructive airways disease was manifested by a reduction in both his FEV_1 and FVC with a marked reduction in his FEV_1/FVC ratio, which was "entirely in keeping with and indicative of tobacco smoke induced airway obstruction rather than a coal mine dust induced lung disease" because, "[w]hen coal workers' pneumoconiosis causes obstruction, it generally does so by causing a reduction in the [FVC] and FEV_1 with preservation of the [FEV_1/FVC ratio]." *Id.* at 9.[3]

[3] Dr. Castle refers to the FEV_1/FVC ratio as the "FEV_1 percent" or "FEV_1%." *See* EX 5 at 39. This brief will use "FEV_1/FVC ratio" to be consistent with the terminology used in case law. *E.g.*, *Cent. Ohio Coal Co. v. Dir., OWCP*, 762 F.3d 483, 491 (6th Cir. 2014).

At his deposition, Dr. Castle agreed that Bristow had COPD, but he disagreed with Dr. Sood that there was no way to use symptoms or pulmonary function tests to differentiate between smoking-related and coal dust-related COPD. Dr. Castle repeated his reasoning that "coal dust exposure does not result in a significant reduction or a marked reduction in the [FEV_1/FVC ratio]" and that "[g]enerally that number is preserved," whereas in Bristow's case, it was significantly reduced. EX 5 at 30.

Dr. Castle testified that, by "reasonable degree of medical certainty," he meant he was evaluating Bristow's case using the same standard of care he would use to diagnose or treat a patient and that his conclusions were stated with "roughly a 95 percent confidence level." *Id.* at 31-32. However, on cross-examination, Dr. Castle agreed that he would prescribe the same treatment for a patient who has irreversible COPD caused by smoking as a patient with irreversible COPD caused by coal dust exposure. *Id.* at 37.

B. X-ray evidence

The ALJ also considered nine readings of four different chest x-rays, summarized here:

X-ray date	Reading Date	Exh. #	Physician / Qualifications[4]	Physician's reading	ALJ's finding
10/28/13	10/29/13	DX 10	Myers/B, BCR	Positive	Positive
	4/1/16	CX 6	Crum/B, BCR	Positive	
	8/22/14	CX 9	Tarver/B, BCR	Positive	
	8/29/14	EX 2	Seaman/B, BCR	Negative	
8/18/15	9/22/16	CX 10	Alexander/B, BCR	Positive	Equivocal
	2/26/16	EX 6	Adcock/B, BCR	Negative	
8/20/15	8/20/15	EX 1	Selby/B	Negative	Negative
11/24/15	4/3/16	CX 7	Crum/B, BCR	Positive	Equivocal
	8/22/16	EX 9	Adcock/B, BCR	Negative	

IV. Decisions below

Bristow filed his claim with an OWCP district director on September 3, 2013. DX 2. The district director awarded benefits. DX 22. Energy West then requested a hearing before an ALJ, which took place on October 24, 2016. DX 23; ALJ Decision & Order ("ALJ D&O") at 1.

The ALJ denied benefits on April 26, 2017. She found that Bristow had clinical pneumoconiosis based on x-ray evidence and Dr. Chavda's opinion. ALJ D&O at 5, 23-24. She also found Bristow had legal pneumoconiosis based on Dr.

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[4] "B" is for "B-reader," which means "the physician has demonstrated ongoing proficiency . . . in the use of the [International Labour Organization] classification for interpreting chest [x-rays] for pneumoconiosis and other diseases by taking and passing a specially designed proficiency examination" and maintaining his or her certification. 20 C.F.R. § 718.102(e)(2)(iii). "BCR" is for "Board-certified radiologist," i.e., a physician who is certified in radiology by either the American Board of Radiology or the American Osteopathic Association. *Id.* § 718.102(e)(2)(i).

Sood's and Dr. Chavda's opinions. Although she understood Dr. Chavda's opinion to be that coal dust exposure was not a substantial factor in Bristow's COPD, the ALJ found Dr. Chavda's opinion that coal dust exposure was a second or minor etiology to be sufficient to show that coal dust exposure contributed "at least in part" to his COPD, as she believed Sixth Circuit case law required. *Id.* at 25 (citing *Arch on the Green, Inc. v. Groves*, 761 F.3d 594 (6th Cir. 2014); *Southard v. Dir., OWCP*, 732 F.2d 66 (6th Cir. 1984)).[5] She discredited Dr. Selby's opinion that Bristow's obstructive lung disease and asthma were unrelated to coal mine dust exposure because Dr. Selby did not explain why Bristow in particular was not a susceptible host to coal dust-induced lung disease. Nor did he explain why coal dust exposure did not have any additive effects on Bristow's COPD, nor why Bristow's alleged asthma was not aggravated by coal dust exposure. *Id.* at 26. She discredited Dr. Castle's opinion that Bristow's COPD was caused by smoking and not coal dust exposure because Dr. Castle's reasoning concerning Bristow's markedly reduced FEV_1/FVC ratio was contrary to the black lung regulations and the science behind them. *Id.* at 26-27.

[5] It is not clear why the ALJ thought Sixth Circuit law was controlling. Under the Board's precedent, the ALJ should have applied the law of the Tenth Circuit, where Bristow was last employed as a coal miner. *Shupe v. Dir., OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc).

The ALJ also found Bristow had a totally disabling respiratory impairment based on his PFT results and the opinions of Drs. Chavda, Sood, and Castle (even though Dr. Castle believed Bristow's total disability was caused by smoking). *Id.* at 29-30. She discredited Dr. Selby's opinion on Bristow's degree of impairment as "entirely speculative." *Id.* at 30.

The ALJ nonetheless denied benefits because she found Bristow failed to establish that pneumoconiosis was a substantially contributing cause of his total disability. *Id.* at 31-32. She noted that Dr. Chavda had "on more than one occasion" opined that coal dust exposure was not a substantial or significant contributing factor to his COPD or his disability and that legal and clinical pneumoconiosis were not substantial or significant contributing factors in his respiratory impairment. *Id.* at 31. She found Dr. Sood's opinion that coal dust exposure materially worsened Bristow's totally disabling respiratory impairment to be unpersuasive because he also testified that smoking was the dominant cause of Bristow's COPD and that Bristow would still have a disabling impairment from smoking alone, even if he never worked as a miner. *Id.* She discredited Drs. Castle's and Selby's opinions on whether pneumoconiosis caused Bristow's disability because neither had found clinical or legal pneumoconiosis to begin with. *Id.*

Bristow appealed to the Board, challenging the ALJ's finding of no disability causation. Energy West cross-appealed the ALJ's findings of clinical and legal pneumoconiosis (but not the ALJ's finding of total disability.)

Also applying Sixth Circuit law, the Board affirmed the ALJ's finding of legal pneumoconiosis, including her decisions to credit Drs. Chavda and Sood and to discredit Drs. Selby and Castle. Ben. Rev. Bd. Decision & Order ("BRB D&O") at 3-7. However, the Board reversed the ALJ's finding of no disability causation. The Board held that, having found Bristow's COPD constituted legal pneumoconiosis (i.e., that his COPD was significantly related to, or substantially aggravated by, coal mine dust exposure), the only issue before the ALJ regarding disability causation was whether the COPD/legal pneumoconiosis was a substantially contributing cause of Bristow's total disability. The ALJ should not have considered whether coal dust exposure itself, as opposed to the disease COPD (which the ALJ had already found was legal pneumoconiosis), was a contributing factor to total disability in evaluating Drs. Chavda's and Sood's opinions on disability causation. *Id.* at 9 (citing 20 C.F.R. § 718.204(c)(1)).

The Board decided to reverse rather than remand on the issue of disability causation because the ALJ had already made the factual findings necessary to resolve the case. The Board explained that she had resolved conflicting medical evidence and found Bristow's COPD constituted legal pneumoconiosis, had found

Bristow totally disabled by COPD, and that there was no evidence in the record that any other condition could have caused Bristow's total disability. Thus, the Board held that Drs. Chavda's and Sood's opinions established disability causation. Accordingly, the Board remanded the case for entry of an award of benefits. *Id.* at 9-10.[6]

Energy West then (prematurely) petitioned this Court for review.

STANDARD OF REVIEW

Whether the ALJ and the Board applied the correct legal standards for disease causation and disability causation are questions of law that the Court reviews de novo, with "substantial deference to the [Director's] reasonable interpretation of [her] own regulations." *Andersen*, 455 F.3d at 1103; *Lukman v. Dir., OWCP*, 896 F.2d 1248, 1251 (10th Cir. 1990) (deferring to Director's interpretation of black lung regulations); *cf. Kisor v. Wilkie*, 139 S. Ct. 2400 (2019) (upholding *Auer* deference doctrine).

Challenges to the ALJ's credibility determinations and her weighing of the x-ray evidence are questions of fact. With questions of fact, the Court's "task is to determine whether the Board properly concluded that the ALJ's decision was

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[6] In light of its holding that Bristow established disability due to legal pneumoconiosis, the Board did not address clinical pneumoconiosis. BRB D&O at 10 n.11.

supported by substantial evidence." *Hansen v. Dir., OWCP*, 984 F.2d 364, 368 (10th Cir. 1993). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971). In determining whether substantial evidence exists, the Court does not reweigh the evidence, but recognizes that the "task of weighing conflicting medical evidence is within the sole province of the ALJ." *Hansen*, 984 F.2d at 368, 370.

Courts reviewing agency decisions must take "due account . . . of the rule of prejudicial error." 5 U.S.C. § 706. An error is prejudicial only if there is a reasonable chance the outcome of the case would have been different if the error had not occurred. *See Gunderson v. U.S. Dep't of Labor*, 601 F.3d 1013, 1021 (10th Cir. 2010).

SUMMARY OF ARGUMENT

The Court should dismiss this case for lack of jurisdiction because the Board's decision is not a "final order" under 33 U.S.C. § 921(c). However, if the Court decides it has jurisdiction, the Court should affirm the Board's award of benefits. A miner's lung disease or impairment qualifies as legal pneumoconiosis under the BLBA if it is "significantly related to, or substantially aggravated by," coal mine dust exposure. Substantial evidence supports the ALJ's finding that Bristow's COPD is legal pneumoconiosis under this standard. Because Bristow's

COPD is legal pneumoconiosis and he is totally disabled by COPD, logically, Bristow's total disability was due to legal pneumoconiosis.

The Court should reject Energy West's host of challenges to the ALJ's credibility determinations, as well as the ALJ's weighing of the x-ray evidence. Contrary to Employer's contentions, the BLBA does not require physicians to offer opinions with "medical certainty." Instead, it requires that medical opinions be documented and reasoned, which Dr. Sood's opinion was. The ALJ was correct to discredit Dr. Castle's opinion because it was based on a theory regarding miners' FEV_1/FVC ratios that the courts have held is incompatible with the black lung regulations and the science behind them. Substantial evidence also supports the ALJ's decision to discredit Dr. Selby's opinion for not being adequately explained. Finally, the ALJ properly weighed the x-ray evidence based on the physicians' qualifications, and not the chronological relationship between the x-rays. Accordingly, the Court should affirm the ALJ's credibility determinations and x-ray findings.

ARGUMENT

I. A miner's COPD constitutes legal pneumoconiosis if it is "significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

The ALJ found, based on the medical opinions of Drs. Chavda and Sood, that Bristow's coal mine dust exposure contributed to "the development of his

obstructive respiratory impairment," *i.e.*, COPD. ALJ D&O at 27. She therefore ruled that Bristow had established the existence of legal pneumoconiosis. *Id*. at 28. The Court should affirm this finding as supported by substantial evidence.

Under the BLBA, pneumoconiosis is defined 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). This includes not only diseases recognized by the medical community as pneumoconiosis ("clinical pneumoconiosis"), but also a broader range of diseases that are legally recognized as pneumoconiosis for purposes of the BLBA ("legal pneumoconiosis"). 20 C.F.R. § 718.201(a). Any type of chronic lung disease or impairment that "aris[es] out of coal mine employment" can qualify as "legal" pneumoconiosis. *See id.* § 718.201(a)(2). A disease "aris[es] out of coal mine employment" if it is "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* § 718.201(b).

This Court and others agree that the miner's lung disease need not be solely caused by coal mine dust exposure in order to be a disease "arising out of coal mine employment." *See, e.g.*, *Oliver*, 555 F.3d at 1218; *Stomps v. Dir., OWCP*, 816 F.2d 1533, 1535 (11th Cir. 1987); *Southard*, 732 F.2d at 71.

However, the case law is sparse regarding exactly how big a part coal mine dust exposure needs to play in order for the miner's disease to qualify as

pneumoconiosis. The Sixth Circuit, whose law the ALJ and the Board applied, has read the § 718.201(b) "significantly related to, or substantially aggravated by" language as allowing a miner to establish disease causation by showing that his disease was caused "at least in part" by coal mine employment. *Arch on the Green*, 761 F.3d at 598-99. The Sixth Circuit took the "at least in part" formulation from 20 C.F.R. § 718.203(a), which states: "In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose *at least in part* out of coal mine employment." *See id.* at 598. The Sixth Circuit believed the "at least in part" formulation was appropriate because "neither the Act nor § 718.201 requires a claimant to establish what portion of his disease is due to non-mine exposure, and what portion is due to mine exposure." *Id.* (quoting *Southard*, 732 F.2d at 72). The court also reasoned that reading the "significantly related to, or substantially aggravated by" language in § 718.201(b) as imposing the only causal standard would effectively negate the § 718.203(a) "at least in part" language because "a disease would always arise 'at least in part' out of coal mine employment, if it is 'significantly related to or substantially aggravated by,' § 718.201, exposures in coal mine employment." *Id.* (quoting *Southard*, 732 F.2d at 72).

Other circuits have used the "at least in part" language in the disease causation context, but exactly how big a part coal mine dust exposure needs to play

was not at issue in those cases. *See Harman Mining Co. v. Dir., OWCP*, 678 F.3d 305, 309-10 (4th Cir. 2012) (describing the issue on review as whether the miner's COPD "arose at least in part" out of his coal mine employment and affirming the ALJ's legal pneumoconiosis finding); *Stomps*, 816 F.2d at 1535 (emphasizing that, although the black lung regulations require the claimant to establish a causal relationship between his condition and his employment, he does not need to prove employment was the sole cause of his condition).[7]

This Circuit regularly quotes the "significantly related to, or substantially aggravated by" language in § 718.201(b), but has not addressed the interaction between that language and the "at least in part" language in § 718.203(a). *E.g.*, *Energy W. Mining Co. v. Lyle*, __F.3d __, 2019 WL 2934065, at *6 (10th Cir. 2019); *Oliver*, 555 F.3d at 1218; *Andersen*, 455 F.3d at 1105.

The Director's position is that there is only one disease causation standard: to arise out of coal mine employment, a disease must be "significantly related to, or substantially aggravated by," coal mine dust exposure. 20 C.F.R. § 718.201(b).

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[7] *See Lollar v. Alabama By-Prod. Corp.*, 893 F.2d 1258, 1263-64 (11th Cir. 1990) (clarifying that *Stomps* addressed the standard for disease causation under §§ 718.201 and 718.203(a), not disability causation under § 718.204). *Stomps* and *Lollar* applied the pre-2000 version of § 718.201(b), but the relevant disease causation language was the same. *Compare* 20 C.F.R. § 718.201(b) (1999) *with* 20 C.F.R. § 718.201(b) (2019).

The "at least in part" language in § 718.203(a) does not set a different standard, and it is not in tension with § 718.201(b). "At least in part" merely emphasizes that a lung disease can "arise out of coal mine employment" so long as the disease is sufficiently related to coal mine dust exposure, even if the disease has other substantial causes. *See Stomps*, 816 F.2d at 1536-37; *cf.* Standards for Determining Coal Miners' Total Disability or Death Due to Pneumoconiosis, 45 Fed. Reg. 13,677, 13,687 (Feb. 29, 1980) (§ 718.203 "is not intended to suggest that where there is another substantial source of the pneumoconiosis, because of

dust exposure outside of the miner's coal mine employment, coal mine employment cannot also be a substantial source of the pneumoconiosis.").[8]

That said, the "significantly" or "substantially" standard is not a stringent one. What matters under the "significantly related to, or substantially aggravated by" standard is that coal mine dust exposure was a material cause of the miner's lung disease or that it materially worsened his disease. That is, coal mine dust exposure must have a tangible and actual effect on the development of the disease. A negligible, inconsequential, or insignificant effect is insufficient. The standard for *disease* causation parallels the *disability* causation standard at § 718.204(c)(1),

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[8] In the alternative, even if "at least in part" in § 718.203(a) is a different, more lenient standard, it arguably applies only to clinical pneumoconiosis. This Court held in *Andersen* that the word "pneumoconiosis" in the neighboring provision, § 718.203(b), refers to clinical pneumoconiosis only, not legal pneumoconiosis. 455 F.3d at 1105. Section 718.203(b) is a rebuttable presumption that, if a miner has clinical pneumoconiosis and he worked at least 10 years in coal mines, his clinical pneumoconiosis arose from his coal mine employment. The Court reasoned that "lung diseases the medical community refers to as pneumoconiosis are closely linked to dust exposure." *Id.* at 1107. In contrast, diseases like COPD are "disease[s] of the general population with an overwhelming majority of cases being caused by cigarette smoking." *Id.* at 1106-07. Thus, it made sense to require the claimant to prove that his COPD was "significantly related to, or substantially aggravated by," coal mine employment without the benefit of the 10-year presumption. *Id.* at 1107. If this Court finds the "significantly related to, or substantially aggravated by" language in § 718.201(b) to be irreconcilable with the "at least in part" language in § 718.203(a) (although the Director submits that they are reconcilable), the Court should hold that the "at least in part" language applies only to clinical pneumoconiosis, consistent with the reasoning in *Andersen*.

which uses similar wording. *See* 20 C.F.R. § 718.204(c)(1) (pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a "material adverse effect" on the miner's condition or "materially worsens" the miner's impairment); *see also* 2000 Preamble, 65 Fed. Reg. at 79,946 (under the "material" standard, "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability"); Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 62 Fed. Reg. 3,338, 3,345 (Jan. 22, 1997) ("substantially contributing cause" standard "ensures a tangible and actual contribution; a more demanding standard would be too harsh, especially when many miners suffer from a multiplicity of respiratory problems"). This construction requires a tangible causal nexus between the miner's coal mine employment and his lung disease while still being faithful to the remedial nature of the BLBA. *Mangus v. Dir., OWCP*, 882 F.2d 1527, 1531 (10th Cir. 1989) (recognizing that Congress enacted the BLBA in response to problems such as "inflexible, often impenetrable, proof of causation requirement[s]" in state workers' compensation programs and that the BLBA's "broad remedial

purposes . . . cannot be achieved if claimants are held to a standard of proof approaching medical certitude") (citations omitted).[9]

Energy West argues that the Sixth Circuit was wrong to use the "in part" standard in *Arch on the Green*. Opening Brief ("OB") at 32. If *Arch on the Green* and *Southard* would allow a claimant to establish legal pneumoconiosis by showing only a negligible relationship between his disease and his coal mine employment, the Director would agree. However, it is not clear that Sixth Circuit case law actually imposes the lower standard Energy West suggests. Rather, *Southard* and *Arch on the Green* could be read as merely emphasizing that a high degree of specificity is not required to establish disease causation. For instance, in *Southard*, Mr. Southard worked in a coal mine for three years but the bulk of his coal dust exposure came from his sixteen years of working as a deliveryman for a coal retailer, which the court held did not qualify as coal mine employment under the Act. 732 F.2d at 68-70. When asked whether Mr. Southard's "diagnosed

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[9] *Mangus* concerned a pre-2000 version of the disability causation standard. *Compare* 20 C.F.R. § 718.204(a) (1999) (requiring miners to prove their total disability was "due to" pneumoconiosis) *with* 20 C.F.R. § 718.204(c)(1) (2019) (clarifying that total disability is "due to" pneumoconiosis if it has a "material adverse effect" on the miner's respiratory condition or "[m]aterially worsens" a totally disabling respiratory impairment). However, the Court's observations regarding Congress's intent to provide liberal assistance to totally disabled coal miners and Congress's concern about overly stringent causation standards, *Mangus*, 882 F.2d at 1530, 1532, apply to disease causation as well.

condition [was] related to coal mine employment," Dr. Wong checked the "yes" box, but also added the word "possible." *Id.* at 72. The ALJ held this was insufficient to establish disease causation because Dr. Wong's report did not reference Mr. Southard's exposure to coal dust in his non-mining job. *Id.* The court rejected this holding on the ground that neither the Act nor § 718.201 required Mr. Southard to establish what portion of his disease was due to his coal mine employment versus his other exposures; he was only required to establish that his coal mine employment contributed at least in part to his disease. *Id.* The facts of *Southard* suggest that the court was more concerned about the ALJ requiring too much specificity from a form report than with the exact degree of relatedness between Mr. Southard's coal mine employment and his disease.

Similarly, in *Arch on the Green*, the court affirmed the ALJ's finding of legal pneumoconiosis because Dr. Rasmussen "clearly stated that Groves' coal mine employment contributed to Groves' disease," even though Dr. Rasmussen acknowledged smoking was the more important cause. 761 F.3d at 599. Again, the court appeared more concerned with not requiring physicians to utter magic words in order to establish disease causation. It is thus not clear that there is really a meaningful difference between the "significantly related, or substantially aggravated by" and "at least in part" phrases as applied in the Sixth Circuit case law.

The Court, however, need not closely parse the Sixth Circuit decisions. Even if the Sixth Circuit has a lower causation standard and the ALJ erred in using it, that error is harmless because substantial evidence supports that Bristow's COPD is significantly related to his coal mine dust exposure. The ALJ credited Dr. Sood and Dr. Chavda on the issue of legal pneumoconiosis. Dr. Sood found coal mine dust exposure was a "substantial contributory cause to the causation or aggravation of [Bristow's] COPD." CX 8 at 9. His opinion alone can support the finding of legal pneumoconiosis.[10] *Freeman United Coal Mining Co. v. Cooper*, 965 F.2d 443, 449 (7th Cir. 1992) (ALJ's error in relying on Dr. Martin's opinion was harmless where ALJ also permissibly relied on two other doctors' medical opinions to find legal pneumoconiosis).

As for Dr. Chavda, he said in his initial report that Bristow's "pneumoconiosis which is legal and clinical is substantially caused and aggravated by" his coal mine dust exposure. DX 10 at 53. At times during his deposition, he seemed to backtrack. But a close reading of the transcript shows that, every time he said coal dust exposure was not a significant or substantial cause, he was

[10] Although Energy West attacks the credibility of Dr. Sood's opinion, *see* OB at 25-29, Energy West does not dispute that Dr. Sood's opinion, if credited, would otherwise satisfy the "significantly related" standard for legal pneumoconiosis.

comparing Bristow's relative exposures to smoking and coal dust. EX 4 at 16-17, 29-30, 33. As discussed above, the fact that smoking is a significant, substantial, or even primary cause of Bristow's COPD does not preclude coal mine dust exposure from also being a significant or substantial cause. Dr. Chavda's initial report establishes that coal mine dust exposure was a significant and substantial cause.[11]

For these reasons, the Court should hold that the "significantly related to, or substantially aggravated by" and "at least in part" formulations are not appreciably different and that the causation standard for legal pneumoconiosis is satisfied so long as coal mine dust exposure has a material effect on the disease. In the alternative, the Court should hold that any error in the ALJ's legal pneumoconiosis analysis was harmless and affirm that Bristow has legal pneumoconiosis. *See Energy W. Mining Co. v. Estate of Blackburn*, 857 F.3d 817, 832 (10th Cir. 2017) (declining to decide whether the ALJ erred in using the wrong standard where the alleged error was harmless); *Antelope Coal Co./Rio Tinto Energy Am. v. Goodin*,

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[11] Energy West's experts Dr. Selby and Dr. Castle opined that Bristow did not have legal pneumoconiosis because his COPD was unrelated to coal mine dust exposure, but the ALJ permissibly discredited their opinions for reasons unrelated to her consideration of Dr. Chavda's and Dr. Sood's opinions. *See* ALJ D&O at 25-27; *infra* at 46-52. Thus, even if the ALJ applied an erroneous disease causation standard, Dr. Chavda's and Dr. Sood's legal pneumoconiosis opinions do not need to be re-weighed against Dr. Selby's and Dr. Castle's.

743 F.3d 1331, 1347 (10th Cir. 2014) (declining to decide whether the BLBA's limitations on methods of rebutting certain presumptions applied to employer because "any error in the ALJ's invocation of the rebuttal limitations was harmless").

II. If Bristow's COPD constitutes legal pneumoconiosis and his COPD is a substantially contributing cause of his respiratory disability, then his total disability is caused by legal pneumoconiosis.

Once legal pneumoconiosis is established, a miner must still prove that pneumoconiosis is a "substantially contributing cause" of his disability. Energy West agrees that disability causation is a required element, but contends that, to establish disability causation, Bristow's COPD "must be shown to have substantially arisen from exposure to coal mine work." OB at 23. Energy West's argument conflates disease causation and disability causation and should be rejected.

Whether a miner has legal pneumoconiosis (disease and disease causation) and whether his legal pneumoconiosis caused his total disability (disability causation) are separate inquiries. *Lollar*, 893 F.2d at 1263-64 (the causal relationship between a miner's pneumoconiosis and coal mine employment is "an issue separate from and precedent to the causal link between pneumoconiosis and total pulmonary disability under section 718.204"). It is only after legal pneumoconiosis is established, and total disability is proven, that the disability

causation inquiry begins. Not only is this a matter of plain logic, that is the regulations are structured: § 718.201(a)(2) sets out the definition of legal pneumoconiosis, § 718.204(b) the definition and medical criteria for total disability, and then § 718.204(c) defines disability causation.

At the disability causation stage, the issue is whether the miner's *pneumoconiosis*, *as defined in § 718.201*, is a "substantially contributing cause" of the miner's respiratory or pulmonary disability. 20 C.F.R. § 718.204(c) (emphasis added). The focus of the disability causation inquiry is not whether coal mine dust exposure directly caused the miner's disability. The causal role of coal mine dust exposure was already determined under § 718.201(a) and (b), in the disease and disease causation elements. Rather, as § 718.204(c)'s plain text demonstrates, the point of disability causation is to consider the role of pneumoconiosis, not whether it exists. In that regard, the regulation makes plain that disability causation can be satisfied even if the miner's disability is primarily caused by something other than pneumoconiosis, so long as the miner's pneumoconiosis "[h]as a material adverse effect on the miner's respiratory or pulmonary condition" or if it "[m]aterially worsens a totally disabling respiratory or pulmonary impairment . . . caused by a disease or exposure unrelated to coal mine employment." *Id.* § 718.204(c)(1); *see Dixie Fuel Co., LLC v. Dir., OWCP*, 820 F.3d 833, 848 (6th Cir. 2016) (affirming disability causation finding based in part on a medical opinion that

pneumoconiosis, in tandem with other illnesses, had an adverse effect on the miner's condition and contributed to his impairment).

In this case, the disability causation analysis is straightforward. All the medical experts agreed Bristow has COPD. DX 10 at 53-54; CX 8 at 9; EX 3 at 9-10; EX 5 at 29-30; EX 8 at 8-9, 18. They disagreed whether the COPD was sufficiently linked to coal mine dust exposure to constitute legal pneumoconiosis, but the ALJ resolved the conflicts in the evidence and found that the COPD was legal pneumoconiosis. ALJ D&O at 24-28. It is also undisputed that Bristow is totally disabled, and all the medical experts who found Bristow totally disabled agreed that his COPD contributed to his total disability.[12] EX 4 at 19; CX 5 at 17 (attributing total disability to COPD); CX 8 at 11, 13-15 (finding Bristow was totally disabled by COPD, explaining why Bristow's respiratory abnormalities cannot be explained away by obesity, and explaining why Bristow is unlikely to have sleep apnea, hypertension, or asthma); EX 3 at 10 (opining Bristow "is disabled as a result of . . . chronic airway obstruction").

The only rational inference that can be drawn from this record is that Bristow's COPD had (at a minimum) "a material effect on [his] respiratory or

[12] Energy West has not challenged the ALJ's total disability finding or contended that anything other than COPD caused Bristow's disability. *See* OB.

pulmonary condition," 20 C.F.R. § 718.204(c)(1)(i), and disability causation was therefore established. *Accord Island Creek Kentucky Mining v. Ramage*, 737 F.3d 1050, 1062 (6th Cir. 2013) (where all the medical experts agreed COPD caused the miner's total disability, the legal pneumoconiosis inquiry "completed the causation chain from coal mine employment to legal pneumoconiosis which caused Ramage's pulmonary impairment that led to his disability"); *cf. Collins v. Pond Creek Mining Co.*, 751 F.3d 180, 186-87 (4th Cir. 2014) (holding death causation satisfied where the court found the miner's COPD was legal pneumoconiosis and all medical experts agreed that COPD contributed to the miner's death); *Conley v. Nat'l Mines Corp.*, 595 F.3d 297, 304 (6th Cir. 2010) (death causation not established where the miner suffered from cancer and legal pneumoconiosis, but the claimant failed to prove that legal pneumoconiosis hastened the miner's death).

This is the reasoning adopted by the Board, BRB D&O at 10, which Energy West claims was a reweighing of the evidence (and thus beyond the Board's standard of review). OB at 18. But the Board understood its standard of review. BRB D&O at 3, 9 (observing that its review is defined by statute and factual determinations are province of the ALJ). And it properly reversed where, as here, the evidence can support only one outcome. *E.g.*, *Kowalchick v. Dir., OWCP*, 893 F.2d 615, 624 (3d Cir. 1990) (no need to remand where outcome is foreordained); *see also Westmoreland Coal Co., Inc. v. Sharpe*, 692 F.3d 317, 328 (4th Cir. 2012)

(upholding Board reversal of ALJ ruling where ALJ "reinvent[ed] the applicable law").

Energy West also asserts that Dr. Chavda's opinion is insufficient to establish disability causation because Dr. Chavda believed that coal dust exposure was not a substantial or significant contributing factor in his COPD or disability. *See* OB at 20, 23; DX 10 at 54-55; EX 4 at 33. This again conflates disease causation with disability causation. *See* BRB D&O at 9. As discussed above, the role of coal dust exposure is considered in the disease causation analysis, not at the disability causation stage. On the latter question, Dr. Chavda attributed Bristow's total disability to COPD. EX 4 at 19; CX 5 at 17. Since the ALJ found Bristow's COPD is legal pneumoconiosis, Dr. Chavda's opinion supports the conclusion that Bristow's total disability was attributable to pneumoconiosis.

Similarly off-point, Energy West contends that Dr. Sood's opinion is insufficient to establish disability causation because, if Bristow had not been a coal miner, Dr. Sood would have found that he was totally disabled due to smoking alone. *See* OB at 20, 23. It is unclear how Energy West can prevail based on this speculative snippet of testimony: Bristow *was* a coal miner, and Dr. Sood painstakingly explained his opinion that coal dust exposure was a substantial contributor to Bristow's COPD (establishing legal pneumoconiosis) and that his

COPD was a substantial contributor to Bristow's pulmonary or respiratory impairment (establishing disability causation). CX 8 at 9-13; EX 7 at 16, 55-56.

Energy West also confusingly asserts that, even if Bristow's COPD is legal pneumoconiosis and his COPD is causing his total disability, Bristow still has to show that "all of the disabling COPD was caused by legal pneumoconiosis." OB at 21-22. This misapprehends the regulations. COPD is not "caused by" legal pneumoconiosis. COPD *is* legal pneumoconiosis if it is significantly related to or substantially aggravated by coal mine dust exposure. 20 C.F.R. § 718.201(b). Once that is established, the question becomes whether the COPD/legal pneumoconiosis substantially contributed to the miner's disability. *Id.* § 718.204(c).

Energy West seems to suggest that Bristow has two separate COPDs, a smoking-related COPD and a coal mine dust-related COPD. This ignores the central premise of the definition of legal pneumoconiosis: that a lung disease counts fully as pneumoconiosis for BLBA purposes so long as it is "significantly related to, or substantially aggravated by," coal mine dust exposure, even if the disease has other causes, like smoking. *See id.* § 718.201(b). In any event, the medical opinions do not support Energy West's two-COPD conjecture, nor does the scientific understanding of COPD underlying the regulations. Smoking and coal mine dust exposure have additive effects on the lungs. *Estate of Blackburn*,

857 F.3d at 828 (quoting 2000 Preamble, 65 Fed. Reg. at 79,939-41). Furthermore, dust-induced and smoking-induced emphysema (a type of COPD) occur through similar mechanisms. *See McLean*, 881 F.3d at 1225 (citing 2000 Preamble, 65 Fed. Reg. at 79,943). Indeed, the medical experts in this case testified that treatment of patients with irreversible COPD is the same regardless of what caused the COPD. EX 7 at 50; *see also* EX 5 at 37-38. This all indicates that Bristow's COPD is one disease with multiple causes; accordingly, it is not feasible to treat it (medically or legally) as if it were two separate diseases, one caused by smoking and another by coal mine dust exposure.

In sum, determining whether a lung disease qualifies as legal pneumoconiosis requires evaluating the link between the lung disease and coal mine dust exposure, whereas disability causation concerns the link between the disease (pneumoconiosis) and the miner's disability. Bristow's COPD was found to be legal pneumoconiosis and medical evidence further establishes that COPD caused Bristow's disability. Accordingly, Bristow has established disability causation.

III. To be credited, Dr. Sood's opinion need only be a "reasoned medical opinion"; medical certainty is not required.

After careful review of Bristow's medical records and the relevant medical literature, Dr. Sood found Bristow had legal pneumoconiosis and found legal

pneumoconiosis was a substantial cause of Bristow's total disability. CX 8 at 9, 13. Energy West contends that Dr. Sood's medical opinion is speculative and is inadmissible as expert opinion under Federal Rule of Evidence 702[13] because it was not based on the same degree of "reasonable medical certainty" or "reasonable medical probability" Dr. Sood uses to treat patients. OB at 26-28. Despite Energy West's attempt to dress up this issue as one of scientific knowledge and evidentiary admissibility, Energy West's arguments boil down to an attack on Dr. Sood's credibility. The Court should reject these arguments, as Dr. Sood's opinion was reasoned and documented and the ALJ permissibly credited it.

As Energy West itself recognizes, the Federal Rules of Evidence do not apply in black lung proceedings. OB at 28 n.11; 33 U.S.C. § 923(a) (incorporated by 30 U.S.C. § 932(a)) ("In making an investigation or inquiry or conducting a hearing the [ALJ] or Board shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure . . . ."); 20 C.F.R. § 725.455(b) (same). Thus, expert reports and testimony offered in black lung

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[13] Rule 702 provides that an expert witness may testify if, *inter alia*, (1) "the testimony is based upon sufficient facts or data," (2) "the testimony is the product of reliable principles and methods," and (3) the witness "has reliably applied the principles and methods reliably to the facts of the case." Fed. R. Evid. 702.

cases are not subject to the same technical standards for admissibility as in federal district court. Consequently, Energy West's assertion that Dr. Sood's opinion should be excluded under Rule 702 is unpersuasive.[14]

Moreover, courts have expressly held that a medical opinion does not need to be stated with "reasonable medical certainty" to be credited in black lung proceedings. *See Underhill v. Peabody Coal Co.*, 687 F.2d 217, 223 (7th Cir. 1982) (rejecting "reasonable medical certainty" standard where regulations required only a physician's "reasoned medical judgment"); *see also Drummond Coal Co. v. Freeman*, 733 F.2d 1523, 1527 (11th Cir. 1984). Thus, Energy West's

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[14] Even if Rule 702 did apply, the case cited by Energy West, *Tamraz v. Lincoln Elec. Co*., 620 F.3d 665, 669-70 (6th Cir. 2010), is distinguishable. *Tamraz* was a products liability case that turned on the cause of a welder's Parkinson's disease. A neurologist speculated that the welder was exposed to fumes presumably containing manganese, that manganese theoretically could trigger Parkinson's disease, that this welder may have had genes predisposing him to Parkinson's and, therefore, that manganese 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 was especially critical of his reliance on a theoretical link between manganese exposure and the development of Parkinson's when there was no scientific support for this premise in the first place. *Id.* In contrast, Dr. Sood in the instant case identified coal mine employment as one of the causes of Bristow's COPD, and his opinion was based on the non-speculative (and undisputed) understanding that coal mine employment can in fact cause COPD.

suggestion that Dr. Sood had to couch his opinion in terms of reasonable medical certainty or probability is simply wrong and the Kentucky state court medical malpractice cases cited by Energy West for this proposition are irrelevant.[15]

None of this is to say that there are no rules to ensure the reliability of medical opinion evidence in black lung cases. Rule 702's principles—that opinions should be based on facts and data and should be formed using reliable methods and principles—are consistent with the standards for medical opinions in the black lung regulations. A medical opinion used to establish the existence of

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[15] Furthermore, "there is no consensus among judges, attorneys, or commentators as to the [] precise meaning [of 'reasonable medical certainty']—whether it be more probable than not, beyond a reasonable doubt, or somewhere in between." *Johnson v. Memphis Light Gas & Water Div.*, 695 F. App'x 131, 136 (6th Cir. 2017). Nor is there a common understanding among physicians because "[t]he standards 'reasonable medical certainty' and 'reasonable medical probability' are [] terms of art in the law and have no analog for a practicing physician." Fed. Judicial Ctr., *Reference Manual on Scientific Evidence* 691 (3d ed. 2011). Indeed, the medical experts in this case gave different definitions for "reasonable medical certainty." EX 3 at 31-32; EX 7 at 8-9; EX 8 at 34. Thus, Energy West's assertion that Dr. Sood is deviating from some accepted medical practice by giving his opinion with a greater-than-50% level of "reasonable medical certainty" is also incorrect. Given that a claimant for black lung benefits only has to prove causation by a preponderance of the evidence, it is reasonable to allow Dr. Sood to use the same more-likely-than-not standard in giving his opinion in this case. *See Dir., OWCP v. Greenwich Collieries*, 512 U.S. 267, 277-78 (1994) ("[T]he party with the burden of proof must prove its case by a preponderance [of the evidence] . . . ."); *Johnson*, 695 F. App'x at 137 (where "plaintiff need only prove causation by a preponderance . . . a doctor need only testify that his conclusion is more likely than not true.").

pneumoconiosis must be a "reasoned medical opinion" from a physician "exercising sound medical judgment." 20 C.F.R. § 718.202(a)(4). Total respiratory disability may be found by "a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory techniques." 20 C.F.R. § 718.204(b)(2)(iv). And the cause(s) of a miner's total disability must be established "by means of a physician's documented and reasoned medical report." *Id.* § 718.204(c)(2).

Here, the ALJ was well-aware of these principles in crediting Dr. Sood's opinion. *See* ALJ D&O at 24-25, 27. Dr. Sood reviewed Bristow's symptoms, occupational history, smoking history, objective test results, and medical records, as well as the relevant medical literature on the relationship between smoking, coal dust exposure, and COPD. CX 8. In addition, the ALJ was aware of Dr. Sood's testimony that his opinion was offered at a greater-than-50% level of certainty and his testimony that, in treating patients, he used a 95% level of certainty. ALJ D&O at 13. It was reasonable for her to credit him anyway. For one thing, Dr. Sood further testified that causation does not make a difference in his treatment of COPD. EX 7 at 49-50. For another, Dr. Sood's testimony can be considered an expression of candor that "enhance[d] rather than undermine[d]" his credibility. *Perry v. Mynu Coals, Inc.*, 469 F.3d 360, 366 (4th Cir. 2006) (ALJ erred in rejecting Dr. Mellen's opinion because he said he was not "one-hundred percent

sure" because "[a] refusal to express a diagnosis in categorical terms is candor, not equivocation, and we are of opinion that it enhances rather than undermines Dr. Mellen's credibility"); *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 763 (4th Cir. 1999) ("Many wise speakers choose their words carefully and conservatively, never overstating as certain an opinion that admits of any doubt, and some timid ones unnecessarily couch a sound message in noncommittal language. Still others believe passionately in the palpably not true, and forgo no opportunity to share these beliefs.") (internal quotation omitted).

Because there was a rational basis for the ALJ to credit Dr. Sood's opinion, the Court should affirm that the ALJ's credibility determination. *See Oliver*, 555 F.3d at 1217 (factfinder afforded wide discretion to determine whether a medical opinion is documented or reasoned and ultimately whether a medical opinion is credible); *Greene v. King James Coal Mining, Inc.*, 575 F.3d 628, 635 (6th Cir. 2009) ("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.") (internal quotation marks and citation omitted).

IV. The ALJ correctly discredited Dr. Castle's opinion regarding legal pneumoconiosis because it relied on a theory about the FEV_1/FVC ratio that is incompatible with the black lung regulations.

The Court should also affirm the ALJ's discrediting of Dr. Castle's opinion regarding legal pneumoconiosis because his underlying theory regarding the

effects of coal dust exposure on a miner's FEV_1/FVC ratio is at odds with the black lung regulations and the science behind them.

Dr. Castle opined that Bristow's chronic airway obstruction was caused by smoking and not coal mine dust exposure because Bristow's pulmonary function tests showed a disproportionate reduction in both his FEV_1 and FVC, with a marked reduction in the FEV_1/FVC ratio. EX 8 at 9-10. Dr. Castle reasoned that, "[w]hen coal workers' pneumoconiosis causes obstruction, it generally does so by causing a reduction in the [FVC] and FEV_1 with preservation of the [FEV_1/FVC ratio]." *Id.* at 9. That is, he would expect Bristow's FVC and FEV_1 to fall proportionately and his FEV_1/FVC ratio to stay over 70%. EX 5 at 39-40. Bristow's pulmonary function tests showed his FEV_1/FVC ratio was between 55%-63%. *See* DX 10 at 29; CX 5 at 25, 32; EX 1. Since Bristow's FEV_1/FVC ratio was significantly reduced, Dr. Castle concluded that Bristow's COPD was caused by smoking and not coal mine dust exposure. EX 5 at 30.

As the ALJ found, Dr. Castle's theory conflicts with the black lung regulations. To prevail, a miner must prove that he is totally disabled from a respiratory standpoint. He must also prove that his respiratory disability is caused by a lung disease that is, in turn, related to coal mine dust exposure. 20 C.F.R. § 725.202(d)(2); *McLean*, 881 F.3d at 1217. One way a miner can prove total respiratory disability is by showing his FEV_1/FVC ratio is 55% or less. 20 C.F.R.

§ 718.204(b)(2)(i)(C). If, as Dr. Castle believes, a 55% or lower ratio establishes that a lung disease was necessarily caused by smoking and not coal mine dust exposure, there would be no point in including the 55% FEV_1/FVC ratio as a method of establishing total disability under the BLBA, which also requires the disabling lung disease to be linked to coal mine dust exposure. In other words, if Dr. Castle's theory was correct, a miner who proves total disability by showing that his FEV_1/FVC ratio is 55% or less would then also be proving that his lung disease is solely caused by smoking, which would then preclude an award of BLBA benefits. Thus, § 718.204(b)(2)(i)(C) demonstrates the incompatibility between the Department's and Dr. Castle's views. *Westmoreland Coal Co. v. Stallard*, 876 F.3d 663, 671 (4th Cir. 2017).

As the ALJ also found, Dr. Castle's theory is also inconsistent with the science underlying the regulations, as described in the preamble to the 2000 BLBA regulations. The preamble "sets forth the medical and scientific premises relied on by the Department in coming to . . . conclusions in its regulations." *Harman Mining Co.*, 678 F.3d at 314. An ALJ may rely on the preamble in gauging an expert's credibility. *Estate of Blackburn*, 857 F.3d at 830; *Blue Mountain Energy*, 805 F.3d at 1261. Relevant to Dr. Castle's opinion, the preamble states that "epidemiological studies have shown that coal miners have an increased risk of developing COPD. COPD may be detected from decrements in certain measures

of lung function, especially FEV_1 *and the ratio of* FEV_1/FVC." 2000 Preamble, 65 Fed. Reg. at 79,943 (quoting Nat'l Inst. for Occupational Safety & Health, *Criteria for a Recommended Standard, Occupational Exposure to Respirable Coal Mine Dust* § 4.2.3.2 (1995), http://www.cdc.gov/niosh/docs/95-106/) (emphasis added). The clear import of the preamble finding is that coal dust exposure can cause COPD in miners and this COPD can be reflected by a reduced FEV_1/FVC ratio. Dr. Castle's refusal to accept a reduced ratio as indicative of impairment from coal dust exposure is directly contrary to this finding.

This Court and others have repeatedly affirmed ALJ decisions to discredit medical opinions that rely on this flawed FEV_1/FVC ratio theory. *See McLean*, 881 F.3d at 1225; *Stallard*, 876 F.3d at 671; *Cent. Ohio Coal Co.*, 762 F.3d at 491; *Island Creek Coal Co. v. Dir., OWCP*, 711 F. App'x 153, 154 (4th Cir. 2018) (discrediting Dr. Castle).[16] The Court should do so again here.

[16] In addition to these court cases, the Benefits Review Board, as of this filing, has affirmed dozens of ALJ decisions to discredit medical opinions on this basis. Nearly a dozen of these decisions have involved Dr. Castle. (This computation was derived from using the search terms "Castle /s (ratio /s (preserved reduced)" in the Benefits Review Board database in Westlaw.)

V. The ALJ permissibly discredited Dr. Selby's opinion on legal pneumoconiosis.

The Court should also affirm the ALJ's decision to discredit Dr. Selby's opinion on legal pneumoconiosis. Energy West argues that, in discrediting Dr. Selby, the ALJ erroneously required the employer to "rule in or out" causation instead of leaving the burden of proof on the claimant. OB at 36. That is not what the ALJ did. Energy West's counsel asked Dr. Selby during his deposition whether he was "ruling in or out the possibility of impairment associated with [Bristow's] work just based on his history of exposure." Dr. Selby answered no. EX 8 at 19. The ALJ merely paraphrased this line of questioning in her summary of Dr. Selby's testimony. *See* ALJ D&O at 26. She did not require Energy West to prove or disprove anything about the cause of Bristow's disease. She held Bristow to his burden to prove that he has legal pneumoconiosis. *See id.* at 24-28.

In doing so, the ALJ permissibly found Dr. Selby's opinion unpersuasive because the doctor conceded that an "extremely susceptible host" could develop a lung disease after 5-6 years of coal mine dust exposure, but failed to explain why Bristow was not one of those hosts. *Id*. at 26; *see Lyle*, 2019 WL 2934065 at *8 ("[The doctor] has again relied on statistical probabilities. Under *Goodin*, the administrative law judge could reasonably fault [the doctor] for failing to explain why Mr. Lyle wasn't among the miners in the western United States suffering legal

pneumoconiosis from exposure to coal dust."); *Goodin*, 743 F.3d at 1345-46 (affirming ALJ's decision to discredit medical opinions claiming there was a low statistical probability of developing COPD from surface mine work, but failing to show why the miner was not within the subgroup who could develop COPD from surface mine work); *Consolidation Coal Co. v. Dir., OWCP*, 521 F.3d 723, 726 (7th Cir. 2008) (faulting expert opinion for failing to explain why miner was not the "rare" where coal dust exposure causes COPD).

In addition, the ALJ properly faulted Dr. Selby for acknowledging that smoking and coal dust exposure could have additive effects on Bristow's lung disease, but not explaining why Bristow's years of coal mine employment did not have additive effects on his smoking-induced COPD. ALJ D&O at 26; *see Estate of Blackburn*, 857 F.3d at 828-29 (affirming ALJ's decision to discredit medical opinion from a physician who failed to consider the possibility that coal mine dust and smoking have additive effects). Similarly, the ALJ reasonably criticized Dr. Selby, the only medical expert who diagnosed asthma, for not explaining why Bristow's asthma was not caused or aggravated by coal mine dust exposure. *Id.* at

26.[17] Thus, the Court should affirm the ALJ's decision to discredit Dr. Selby's opinion.

VI. The ALJ properly weighed the x-ray evidence based on physicians' qualifications and not the chronological relationship of the x-rays.

Finally, Energy West takes issue with the ALJ's weighing of the x-ray evidence, which the ALJ found supported clinical pneumoconiosis. OB at 34-35. If the Court affirms Bristow's award of benefits based on legal pneumoconiosis, the Court need not address clinical pneumoconiosis. However, if the Court does address clinical pneumoconiosis, the Court should reject Energy West's arguments.

The ALJ considered nine readings of four x-rays done between 2013 and 2015. *See supra* at 18 (table of x-ray readings). The first x-ray, dated October 28, 2013, was read as positive for pneumoconiosis by Drs. Myers, Crum, and Tarver and as negative for pneumoconiosis by Dr. Seaman. All four of these physicians were dually-qualified as B-readers and Board-certified radiologists. The ALJ found this x-ray to be positive for pneumoconiosis based on the preponderance of positive interpretations. The ALJ found the second x-ray, dated August 18, 2015,

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[17] In addition, Dr. Selby mistakenly believed that Bristow worked for 6-7 years in Utah mines with "soft coal" and that he was not actually exposed to much dust in the coal mines as a welder working on belt lines. EX 8 at 18-19. Actually, Bristow worked in Utah for only a little over two years and his coal dust exposure there was moderate to heavy. DX 3 at 1; Tr. 21.

to be equivocal (i.e., did not establish the presence or absence of pneumoconiosis) because it was read as positive by Dr. Alexander but negative by Dr. Adcock, both of whom were also dually-qualified. The third x-ray, dated August 20, 2015, was only read once by Dr. Selby, who found it negative for pneumoconiosis. Dr. Selby is a B reader, but not a Board-certified radiologist. The fourth x-ray, dated November 24, 2015, was read as positive by Dr. Crum but negative by Dr. Adcock, both of whom were dually-qualified. The ALJ found this x-ray to be equivocal. Weighing the x-ray evidence altogether, the ALJ gave the positive 2013 x-ray greater weight than the negative August 20, 2015 x-ray because of the superior qualifications of the physicians who read the 2013 x-ray. She found the x-ray evidence overall to support a finding of clinical pneumoconiosis. ALJ D&O at 23-24.

The Court should affirm the ALJ's weighing of the evidence. In evaluating x-ray evidence, an ALJ is required to consider the radiological qualifications of the x-ray readers. 20 C.F.R. § 718.202(a)(1). It is well-established that the ALJ may give greater weight to readings by dually-qualified physicians than to readings by physicians who are only B-readers. *Oak Grove Res., LLC v. Dir., OWCP*, 920 F.3d 1283, 1287-88 (11th Cir. 2019); *Zeigler Coal Co. v. Kelley*, 112 F.3d 839, 842-43 (7th Cir. 1997); *Woodward v. Dir., OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993). Energy West suggests the ALJ can only consider radiological qualifications

when resolving conflicts between different readings of the same x-ray film or image, but not when resolving conflicts between different x-rays. OB at 35. But, Energy West cites no authority for this proposition, and it is simply inconsistent with "[g]ood old common sense . . . [R]eading x-rays, after all, is *what radiologists do*." *Oak Grove Res.*, 920 F.3d at 1288. Indeed, the case law goes the other way. *See Amax Coal Co. v. Dir., OWCP*, 312 F.3d 882, 889 (7th Cir. 2002) (considering all x-rays together and according greater weight to readings by dually-qualified physicians); *Consolidation Coal Co. v. Held*, 314 F.3d 184, 185-87 (4th Cir. 2002) (considering 59 readings of 29 x-rays as a whole and suggesting that "those physicians who gave negative readings had, as a group, far more impressive credentials than those who rendered positive readings").

Energy West also argues, essentially, that the ALJ should have given greater weight to the negative and equivocal x-rays from 2015 than to the positive x-ray from 2013 because they are more recent. OB at 34-35. Although Energy West, again, cites no authority to support its proposition, its argument appears to be based on a misunderstanding of the "later evidence rule." The theory behind the later evidence rule is that "(1) pneumoconiosis is a progressive disease; (2) therefore, claimants cannot get better; (3) therefore, a later test or exam is a more reliable indicator of the miner's condition than an earlier one." *Adkins v. Dir., OWCP*, 958 F.2d 49, 51 (4th Cir. 1992). This theory only works, though, if the evidence

suggests that the miner's condition deteriorated over time, e.g., if the miner's older x-rays are negative and his more recent ones are positive for pneumoconiosis, consistent with the progressive and irreversible nature of pneumoconiosis. *Id.* at 52.

However, if the evidence is the other way around, like in this case, the later evidence rule does not apply. If the chronological progression of the x-ray evidence suggests that the miner is improving, then "[e]ither the earlier or the later result *must* be wrong, and it is just as likely that the later evidence is faulty as the earlier. The reliability of irreconcilable items of evidence must therefore be evaluated without reference to their chronological relationship." *Id.* Here, Bristow's older 2013 x-ray was positive for pneumoconiosis and his more recent 2015 x-rays were negative or equivocal. The ALJ appropriately evaluated the x-ray evidence based on the readers' radiological qualifications and not the x-rays' chronological relationship. To do otherwise would have been legal error. *Woodward*, 991 F.2d at 320. Accordingly, the Court should reject Energy West's later evidence argument.

CONCLUSION

For the reasons above, the Director asks the Court to dismiss this appeal for lack of jurisdiction because the Board has not yet issued a final order. If the Court finds it has jurisdiction, the Director asks the Court to affirm the Board's decision.

Respectfully submitted,

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STATEMENT REGARDING ORAL ARGUMENT

The Director, Office of Workers' Compensation Programs, believes oral argument on the standards for disease causation and disability causation and the relationship between the two may be helpful to the Court.

CERTIFICATE OF COMPLIANCE

1. All required privacy redactions have been made;
2. Any hard copies to be submitted to the Court and parties to the case are exact copies of the version submitted electronically today;
3. This electronic submission was scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses; and
4. This brief was produced using Microsoft Word, in Times New Roman font, 14-point typeface, and complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6). The brief also complies with Fed. R. App. P. 32(a)(7)(B) because it contains 12,745 words, excluding the material referenced in Fed. R. App. P. 32(f) and 10th Cir. R. 32(B).

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CERTIFICATE OF SERVICE

I hereby certify that on July 23, 2019, an electronic copy of this brief was served through the CM/ECF system on the following:

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