

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE FOURTH CIRCUIT  
No. 12-2192**

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WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND,

Petitioner

v.

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

Respondents

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

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**BRIEF FOR THE FEDERAL RESPONDENT**

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## STATEMENT OF JURISDICTION

The Director, Office of Workers' Compensations Programs, agrees with Petitioner West Virginia Coal Workers' Pneumoconiosis Fund's (the Fund) statement of jurisdiction.

## STATEMENT OF THE ISSUE

Section 411(c)(3) of the Black Lung Benefits Act contains an irrebuttable presumption of total disability due to pneumoconiosis when a miner proves that he has complicated pneumoconiosis. Complicated pneumoconiosis can be established, *inter alia*, by chest x-ray evidence that reveals one or more large opacities in the miner's lungs that have resulted from coal dust inhalation. It is undisputed that the x-ray evidence shows large opacities in Mr. Peck's lungs, but the physicians disagree on their cause. The ALJ, after weighing all relevant evidence, accepted the x-ray interpretations of complicated pneumoconiosis because they are supported by Mr. Peck's long term and extensive treatment records. Conversely, the ALJ discredited the Fund's expert readings attributing the opacities to various other diseases because Mr. Peck had never been treated for (or diagnosed with) those other conditions. She therefore invoked the irrebuttable presumption. The question presented is:

Does substantial evidence support the ALJ's weighing of the medical evidence?

## STATEMENT OF THE CASE

This case has a long procedural history that is detailed in the summary of the decisions below. Mr. Peck applied for black lung benefits on December 16, 2005, which the district director awarded. JA 1, 5. After three separate ALJ and Benefits Review Board decisions, the award of benefits was affirmed. JA 46-129. The Fund then appealed to this Court for review. JA 130.

## STATEMENT OF THE FACTS

### A. Statutory and regulatory background.

The Black Lung Benefits Act compensates coal miners who are totally disabled due to pneumoconiosis arising out of coal mine employment. 30 U.S.C. § 901(a), 20 C.F.R. § 725.201(a). Pneumoconiosis “means 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 statutory definition includes, but is not limited to, “clinical” pneumoconiosis (*i.e.*, pneumoconiosis as defined by the medical community). 20 C.F.R. § 718.201(a)(1); *see Barber v. Director, OWCP*, 43 F.3d 899, 901 (4th Cir. 1995) (“physicians generally use ‘pneumoconiosis’ as a *medical* term that comprises merely a small subset of the afflictions compensable under the Act”).

Clinical pneumoconiosis “is generally diagnosed on the basis of x-ray opacities indicating nodular lesions on the lungs,” and it “is customarily classified as ‘simple’ or ‘complicated.’” *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7

(1976). Since the Act's inception in 1969, "a miner shown by x-ray or other clinical evidence to be afflicted with complicated pneumoconiosis is 'irrebuttably presumed' to be totally disabled due to pneumoconiosis." *Id.* at 10-11. That presumption states:

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. . . .

30 U.S.C. § 921(c)(3). The Secretary has promulgated regulations that implement the Section 921(c)(3) presumption. *See* 20 C.F.R. § 718.304.<sup>1</sup>

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<sup>1</sup> For more than fifty years, the International Labor Office ("ILO") has published guidelines for the classification of chest x-rays of pneumoconiosis. The classification system seeks to codify x-ray abnormalities of pneumoconioses in a simple, reproducible manner. *See* INTERNATIONAL LABOR OFFICE, GUIDELINES FOR THE USE OF THE ILO INTERNATIONAL CLASSIFICATION OF RADIOGRAPHS OF PNEUMOCONIOSES, at 1 (2000) [hereinafter ILO GUIDELINES]. In claims for BLBA benefits, pneumoconiosis may be established with a chest x-ray that is "classified as Category 1, 2, 3, A, B, or C, according to" the ILO classification system." 20 C.F.R. § 718.102(b). Categories 1, 2, and 3 indicate simple pneumoconiosis, categories A, B, and C complicated pneumoconiosis.

For a miner with clinical pneumoconiosis -- simple or complicated -- who worked at least ten years in the mines, the Act provides a rebuttable presumption that the pneumoconiosis arose out of coal mine employment. 30 U.S.C. § 921(c)(1).

**B. Summary of relevant evidence.**

**1. Chest x-ray evidence.**

The record includes seven ILO interpretations of two x-rays performed in 2006 -- dated March 9 and December 21 -- obtained in conjunction with Mr. Peck's claim. Dr. Rasmussen, a B-reader, read the March 9 x-ray as positive for simple and complicated pneumoconiosis, 1/1, Category A opacities. JA 49, 304. Dr. Alexander, a dually-qualified B-reader and Board-certified radiologist, read it as 1/2, Category A opacities. JA 49, 313, 314. The Fund's experts, Drs. Wheeler, Scott and Scatarige, also dually-qualified radiologists, agreed there were large opacities on the film, but nonetheless read it as negative for simple and complicated pneumoconiosis. JA 49, 315, 316, 317.

Dr. Wheeler stated that there was an "irregular 5x4 [centimeter] mass" in the lateral right upper lung "compatible with conglomerate granulomatous disease, histoplasmosis or [tuberculosis]" and a "2-3 [centimeter] mass" in the lower left apex also "compatible with conglomerate granulomatous disease." JA 315. Dr. Scott noted "infiltrates and/or fibrosis" in the upper lungs, and "calcified

granulomata. . . .probably due to TB [or] unknown activity.” JA 316. Dr.

Scatarige identified a five centimeter mass in the upper right lung and multiple calcified nodules in the left upper lung due to “healed or healing” tuberculosis. JA 317.<sup>2</sup>

The December 21 x-ray was read similarly. Dr. DePonte, a dually qualified radiologist, read the film as positive for simple and complicated pneumoconiosis, Category B. JA 49, 318. Dr. Wheeler again noted very large lesions in Mr. Peck’s lungs, including an “ill-defined 7 cm mass” and a “smaller irregular mass,” but found them “compatible with conglomerate granulomatous disease, probably histoplasmosis more likely than TB.” JA 49, 300.

Mr. Peck’s treatment records contain numerous non-ILO classified x-ray readings that consistently diagnose pneumoconiosis. JA 48-9 (first ALJ D & O summarizing x-ray evidence).<sup>3</sup> As early as May 2001, Dr. Foster read two x-rays

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<sup>2</sup> These diseases result from the inhalation of various agents unrelated to coal dust. Granuloma formation represents a chronic inflammatory response initiated by various infectious and noninfectious agents. Granulomatosis is any condition characterized by the formation of granulomas. Histoplasmosis is an infection resulting from the inhalation of fungus spores. Tuberculosis is any of the infectious diseases caused by the bacteria species mycobacterium. *See* DORLAND’S ILLUSTRATED MEDICAL DICTIONARY, (30th ed. 2003) at 795, 856, 1962.

<sup>3</sup> An April, 2001 emergency room visit for chest pain generated a chest x-ray that revealed “multi-focal areas of consolidation consistent with pneumonia in the appropriate clinical setting.” JA 204.

as revealing scars “consistent with pneumoconiosis.” JA 48, 261, 264, 283-84. Thereafter, Dr. Grover read a July 2001 x-ray as containing “significant abnormalities” consistent with “severe coal workers’ pneumoconiosis,” a November 2001 x-ray as revealing “scarring” and “changes” consistent with pneumoconiosis,” and a March 2002 x-ray as revealing “extensive scarring in the upper lung field without significant change [from prior x-rays] noted.” JA 48, 254, 260, 279, 282. X-rays from August 2002 and January 2004 likewise revealed “extensive conglomerate opacities” and “chronic apical densities suggesting pulmonary scarring.” JA 49, 271, 277. In May and September, 2005, Dr. Grover read two more x-rays that he described as showing no significant change from the March 2002 x-ray, including significant apical infiltrates and extensive parenchymal scarring in the upper lungs. His impression was coal workers’ pneumoconiosis. JA 243, 245, 269-70. Finally, in August 2006, Dr. Mullens interpreted an x-ray as revealing “silicosis with progressive massive fibrosis.” JA 48, 168.<sup>4</sup>

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<sup>4</sup> Progressive massive fibrosis is another name for complicated pneumoconiosis. See *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1359-60 (4th Cir. 1996) (*en banc*).

## **2. CT scans.<sup>5</sup>**

Mr. Mr. Peck's treatment records also include four CT scans dating back to 2001.

### **a) April 20, 2001 scan.**

Dr. John Siner, one of Mr. Peck's treating physicians, reviewed a CT scan performed April 20, 2001. He noted a small left pleural effusion, and patchy alveolar infiltrates in the upper lobes of both lungs, associated with some calcification. Dr. Siner's impression was "extensive bilateral pulmonary emboli" and "bilateral upper lobe alveolar infiltrates suggestive of pneumonia or progressive massive fibrosis." JA 51, 286.

### **b) August 15, 2002 scan.**

Dr. Thomas Lepsch, also a treating physician, interpreted an August 15, 2002 scan. He noted diffuse lung disease with central and upper lung predominance, consisting of peribronchovascular thickening and small nodules. He further observed larger nodules and mass-like areas associated with fibrosis. He believed these findings suggested sarcoidosis, although other inhalational diseases such as silicosis or coal miners' pneumoconiosis were also possible. He

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<sup>5</sup> CT (computerized axial tomography) scans record internal body images through electronic impulses on a magnetic disc that are then processed by a mini-computer for reconstruction display of the body in cross-section. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY at 1661, 1919.

described a diffuse, reticular, nodular pattern in the lungs, with more extensive conglomerate opacities in the upper lungs. JA 51, 276-77.<sup>6</sup>

**c.) February 7, 2003 scan.**

Dr. Wheeler reviewed a February 7, 2003 CT scan on behalf of the Fund. JA 51, 298. He noted irregular masses in the upper lobes and apices, and super segment of the right lower lung. He also noted a small mass in the anterior right upper lung. He described a few small nodules in the posterior lower lobes mixed with some linear scars, compatible with histoplasmosis, and minimal smooth lower right-postero-lateral pleural fibrosis from healed inflammatory disease. Dr. Wheeler opined that the scan was compatible with conglomerate granulomatous disease, with histoplasmosis more likely than tuberculosis. Dr. Wheeler noted no symmetrical, small, nodular infiltrates in the mid and upper lungs reflecting pneumoconiosis, but stated that a biopsy was needed for an exact diagnosis. JA 51, 298.

Dr. Pugh also reviewed the CT scan. JA 50, 219-20. He noted fibronodular opacities throughout the lungs, predominately in an upper-lobe distribution. He

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<sup>6</sup> Sarcoidosis is a chronic, progressive, systematic granulomatous increase in cells of unknown etiology. Silicosis, which falls within the regulatory definition of “clinical pneumoconiosis,” is a pneumoconiosis due to the inhalation of dust containing silica. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY at 1656, 1704; 20 C.F.R. § 718.201(a).

further noted confluent areas of scarring and pleural parenchymal thickening in both upper lobes. He favored silicosis as the etiology, although he noted that sarcoidosis and pneumoconiosis were also diagnostic considerations. *Id.*

**d.) March 23, 2006 scan.**

Dr. John M. McMurray, another treating physician, read this scan, noting numerous calcified lymph nodes in the mediastinum areas, many of which had a classic “eggshell” appearance. JA 50, 266-67. He further noted numerous irregular opacities, most prominent in the mid-and-upper-lobes, as well as several conglomerate opacities in both lungs, which were probably areas of progressive massive fibrosis associated with pneumoconiosis. Dr. McMurray noted an area of about 5 cm. by 3.1 cm. in the upper-right lobe, one about 5.8 cm. by 4.3 cm. with irregular margins in the right mid-lung, and a conglomerate density in the left-upper lobe about 3.9 cm. in maximum diameter. He described numerous other small reticular and nodular opacities, as well as nonspecific areas of pleural thickening. Dr. McMurray observed extensive progressive massive fibrosis in both lungs and concluded that his findings were consistent with coal workers’ pneumoconiosis and/or silicosis. *Id.*

Dr. Wheeler reviewed the same scan. He acknowledged the large masses in the lungs, but continued to assert they represented granulomatous disease. JA 50, 298.

### **3. Medical opinions.**

Dr. Rasmussen examined Mr. Peck in March 2006. Mr. Peck detailed his employment history, medical and family histories, symptoms, and smoking history. JA 51-2, 305-07. Physical examination revealed moderately reduced breathing sounds, with breathing difficulty. Based on his x-ray reading, described above, Dr. Rasmussen diagnosed complicated pneumoconiosis, category A. *Id.* He also diagnosed: chronic bronchitis with a productive cough; arteriosclerotic heart disease, with myocardial infarction in 2001 and 2003; and atrial fibrillation. JA 51-2, 305-07. Dr. Rasmussen attributed Mr. Peck's complicated pneumoconiosis and bronchitis to coal mine dust exposure, and his lung impairment to cigarette smoking and coal dust exposure. *Id.*

Dr. Spagnolo reviewed Mr. Peck's medical records at the Fund's request and prepared a report dated January 27, 2007. JA 52, 319-26. He explained that the reports of Mr. Peck's multiple x-rays (he did not actually review the x-rays himself) showed persistent abnormalities consistent with both granulomatous disease and pneumoconiosis. But he favored Dr. Wheeler's diagnosis of granulomatous disease based on Dr. Wheeler's credentials. Dr. Spagnolo further opined that heart disease was responsible for Mr. Peck's respiratory complaints. Dr. Spagnolo submitted a supplemental report after reviewing Drs. Scott and

Scatarige's interpretations of the March 2006 x-ray, opining that their reports provided additional strong evidence that the x-ray changes do not represent pneumoconiosis. JA 330. *Id.*

Dr. Repsher also reviewed Mr. Peck's medical records at the Fund's request and prepared a report. JA 53, 327-29. He concluded that Mr. Peck does not suffer from pneumoconiosis or any pulmonary or respiratory disease caused by coal dust inhalation. He admitted that Mr. Peck's x-rays and CT-scans were quite abnormal, but opined that they were consistent with tuberculosis or sarcoidosis, not pneumoconiosis. According to Dr. Repsher, Mr. Peck suffered from several serious diseases, none of which was attributable to dust exposure. Rather, they were diseases and conditions of the general population. JA 53.

Dr. Wheeler elaborated at deposition on his reasons for interpreting the x-ray and CT scans as showing granulomatous disease, *i.e.*, histoplasmosis. JA 54, 331-400. He testified that complicated pneumoconiosis is generally quite rare; a biopsy would be necessary to make an exact diagnosis in this case; and that the opacities here were asymmetrical and irregular and thus not typical of coal workers' pneumoconiosis. JA 54, 343, 347-49, 357, 364, 370.

#### **4. Treatment records.**

The record also contains treatment notes from the Richlands Community Medical Center, Johnston Memorial Hospital, Holston Valley Medical Center, and

Pulmonary Associates of Kingsport. JA 142-297. The ALJ found the notes from Richland Community Medical Center “mostly illegible,” and lacking any signature beyond initials. JA 55. To the extent that the ALJ could read the notes, however, she held that “they appear to report a mass in Mr. P’s lungs due to conglomerate pneumoconiosis and marked chronic obstructive pulmonary disease (COPD) due to complicated pneumoconiosis.” *Id.*

Working backwards in time, Mr. Peck’s hospital visits included:

An admission to Johnston Memorial Hospital on August 22, 2006, with complaints of chest tightness and shortness of breath. On the discharge summary, Dr. Wiley Kent reported diagnoses of cor pulmonale, congestive heart failure, atrial fibrillation, silicosis with massive fibrosis, diabetes, hypertension, hyperlipidemia, renal insufficiency, pulmonary hypertension, chronic obstructive pulmonary disease, coronary artery disease, and coal workers’ pneumoconiosis. JA 160-61.<sup>7</sup> Dr. Kent further noted that Mr. Peck had cor pulmonale due to right ventricular hypertrophy on EKG, increased venous pressure and edema. Dr. Kent

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<sup>7</sup> Hyperlipidemia is a general term for elevated concentrations of any or all lipids in the plasma. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY at 883.

suspected that Mr. Peck had severe pulmonary hypertension due to his progressive massive fibrosis from silicosis. JA 161.<sup>8</sup>

Dr. Larry Cox also saw Mr. Peck in consultation, noting that the admission x-ray showed progressive massive fibrosis. He opined that Mr. Peck suffered from cor pulmonale with right ventricular hypertrophy on EKG. Dr. Cox diagnosed silicosis with progressive massive fibrosis. JA 55.

Mr. Peck went to the Holston Valley Medical Center emergency room in January 2004 with complaints of chest pain. JA 56. Dr. Kathy Burniston, who completed his physical, noted a medical history including extensive bilateral pulmonary emboli and deep venous thrombosis, diabetes, chronic obstructive pulmonary disease/coal workers' pneumoconiosis with extensive massive pulmonary fibrosis, hyperlipidemia, and hypertension. JA 215-16. Mr. Peck underwent left heart catheterization and grafting. Dr. Burniston's diagnoses on discharge were, among others, chronic obstructive pulmonary disease, hypertension, dyslipidemia, and history of atrial fibrillation. JA 216.

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<sup>8</sup> Cor pulmonale is heart disease characterized by hypertrophy and sometimes dilation of the right ventricle, secondary to disease affecting the structure or function of the lungs, but excluding those pulmonary disorders resulting from congenital heart disease or from diseases affecting the left side of the heart. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY at 417. In the absence of contrary probative evidence, a miner with pneumoconiosis and cor pulmonale with right-sided congestive heart failure establishes total disability. 20 C.F.R. § 718.204 (b)(2)(iii).

Mr. Peck was also admitted to Holston in April 2001 for chest pain. JA 56. Dr. Bruce Grover noted that he had a history of silicosis and coal workers' pneumoconiosis and COPD, as well as some persistent edema. Dr. Grover's diagnoses on discharge included respiratory distress with hypoxemia, pulmonary embolus, pulmonary fibrosis secondary to progressive massive fibrosis, silicosis/pneumoconiosis, and coronary disease status post-coronary bypass surgery. JA 225-27.

Mr. Peck was also regularly treated over several years by Pulmonary Associates of Kingsport for shortness of breath, dyspnea on exertion, coal workers' pneumoconiosis with progressive massive fibrosis, and lower extremity edema. JA 56. Dr. Grover examined Mr. Peck in September 2005 finding "[n]o fevers, chills, or sweats or other infectious symptoms." JA 243. In a treatment note dated February 13, 2003, Dr. Grover noted that a CT scan showed stable fibronodular opacities in both lungs with confluent scarring. His impressions were: coal workers' pneumoconiosis with extensive scarring and mass-like opacities that were stable by CT scan; COPD based on chronic bronchitis; and restrictive lung disease. JA 249-50. In a March 2002 note, Dr. Grover reported that an x-ray showed extensive scarring in the upper lung field. Dr. Grover's impression, among other diagnoses, was coal workers' pneumoconiosis with extensive scarring. JA 253-54. Finally, Dr. Foster completed a treatment note dated May 18, 2001, reporting that

x-rays showed bilateral upper lobe chronic scarring consistent with pneumoconiosis. JA. 56.

Conspicuously absent from Mr. Peck's treatment records is any diagnosis of or treatment for granulomatous disease, such as tuberculosis or histoplasmosis, the diseases that the Fund's experts variously attributed to Mr. Peck's opacities.

**C. The decisions below.**

**1. The ALJ's 2007 award of benefits.**

Interpreting this Court's decision in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256-57 (4th Cir. 2000), the ALJ stated that Mr. Peck could invoke the § 921(c)(3) irrebuttable presumption of total disability due to pneumoconiosis "if he establishes that he has a condition that manifests itself on x-rays with opacities greater than one centimeter," unless there is "affirmative evidence" that "these opacities do not exist, or that they are the result of a disease process unrelated to coal mine dust." JA 60. Because even the Fund's experts acknowledged the presence of large masses on the x-rays, she ruled that their reports did not disprove their presence. *Id.* She further held that the non-ILO narrative x-ray and CT scan reports, while not containing an equivalency

determination that the masses would be greater than one centimeter on x-ray, added credibility to the diagnosis of complicated pneumoconiosis. JA 61-62.<sup>9</sup>

By contrast, the ALJ discredited the Fund's experts' opinions on the cause of the opacities, finding, among other things, that: they failed to explain why granulomatous disease or tuberculosis necessarily ruled out pneumoconiosis; they had divergent views on the cause of the opacities; and the treatment records going back many years belied their opinions. JA 62-5.

She thus concluded that Mr. Peck established complicated pneumoconiosis by x-ray, and because the other "evidence does not affirmatively show that the opacities are not there, or are not what they seem to be," she held that the x-ray evidence did "not lose force." *Id.* "Section 21(c)(3) and the implementing regulations at 20 C.F.R. § 718.304" thus compelled her "to invoke the irrebuttable presumption that [Mr. Peck] is totally disabled due to pneumoconiosis." JA 65. She awarded benefits on that basis.

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<sup>9</sup> The Fourth Circuit has held that the ALJ must perform an equivalency determination to make certain that, regardless of the diagnostic technique used, the same underlying condition triggers the irrebuttable presumption. Specifically, the court held that "[b]ecause prong (A) sets out an entirely objective scientific standard" -- i.e., an opacity on x-ray greater than one centimeter -- x-ray evidence provides the benchmark for determining what, under prong (B) is a "massive lesion" and what, under prong (C), is an equivalent diagnostic result reached by other means. *Double B. Mining, Inc. v. Blankenship*, 177 F.3d 240, 243 (4th Cir. 1999).

## **2. The Board's December 18, 2008 remand.**

The Board, however, vacated the decision. It held that the ALJ improperly shifted “the burden of proof to [the Fund] to affirmatively establish that the opacities seen on the x-ray by some doctors were not there” and failed to fully consider whether the opacities were the result of “a chronic dust disease of the lung.” *Id.* Moreover, the Board vacated the ALJ’s weighing of the other medical evidence under Prong C (namely, medical opinions, non-ILO x-ray readings, and CT scans) because it was predicated on her erroneous x-ray findings. JA 72. On remand, the Board instructed the ALJ to first determine whether the relevant evidence in each category tends to establish complicated pneumoconiosis, and then to weigh all the evidence together before determining whether to invoke the irrebuttable presumption. JA 74. Notably, the Board also instructed the ALJ to “interrelate the evidence, [and to] consider[] whether evidence from one category supports or undercuts evidence from other categories.” JA 75, *citing, Scarbro*, 220 F.3d at 256; *Island Creek v. Compton*, 211 F.3d 203 (4th Cir. 2000).

## **3. The ALJ's July 13, 2009 decision and order on remand awarding benefits.**

On remand, the ALJ noted that three of the ILO x-ray interpretations included findings of Category A or B opacities due to coal dust exposure, and thus satisfied the requirements of prong A. JA 81. She further noted that other record evidence, including x-rays, were relevant under prong C. *Id.* She thus weighed the

evidence together under the *Scarbro* framework to determine whether, as a whole, it indicated “a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray.” *Id.*

The ALJ observed that the ILO x-ray interpretations -- including those by the Fund’s experts -- acknowledged large opacities in Mr. Peck’s lungs exceeding one centimeter in diameter. JA 83. Additionally, she found that the narrative x-ray readings and CT scans, while lacking an ILO classification or other equivalency finding (and thus insufficient on their own under Prong C), nonetheless supported the positive ILO readings under Prong A by finding pneumoconiosis present and describing, *inter alia*, extensive scarring and large masses. JA 81-84. She concluded: “[w]eighing the evidence as a whole, I find that the x-ray and CT scan evidence vividly and overwhelmingly establishes that [Mr. Peck] has masses in both sides of his lungs greater than one centimeter in diameter.” JA 85.

Considering the etiology of the masses, the ALJ weighed the medical opinions individually and determined that the Fund’s experts’ explanations were not as credible as the explanations offered by the physicians that diagnosed pneumoconiosis. JA 85-9. The latter diagnoses, among other things, were in agreement and corroborated by years of x-rays, CT scans, and treatment records. By contrast, she found that the only thing that the Fund’s experts could agree on “is that the process is probably due to something else, and they offer divergent

views about what those possibilities could be.” JA 89. The ALJ concluded that Mr. Peck “met his burden to establish that he has a disease process in his lungs that appears as category A or B opacities on x-ray and that these opacities are due to pneumoconiosis.” JA 89. Mr. Peck was thus “entitled to the irrebuttable presumption that he is totally disabled due to pneumoconiosis.” *Id.* She once again awarded benefits.

#### **4. The Board’s August 8, 2010 second remand.**

The Board vacated, finding that the ALJ “again improperly shifted the burden of proof to the employer to establish that the x-ray and CT scan interpretations diagnosing Category A or B opacities are incorrect.” JA 96. According to the Board, rather than requiring Mr. Peck to prove complicated pneumoconiosis, the ALJ discounted the Fund’s experts’ opinions “for failing to establish a definitive alternative etiology” for the lesions. JA 96. The Board instructed “that an x-ray or CT scan that unequivocally finds no pneumoconiosis or no Category A, B, or C opacities, is not equivocal as to the existence of pneumoconiosis.” JA 97.

The Board also vacated the ALJ’s findings regarding the medical opinion evidence. According to the Board, the ALJ required the Fund’s experts to more fully explain and account for the medical evidence than other experts, and she did not otherwise provide an adequate reason for discrediting their opinions. JA 97.

**5. The ALJ's June 9, 2011 second decision and order on remand awarding benefits.**

On second remand, the ALJ detailed the *Scarbro* framework for establishing complicated pneumoconiosis as interpreted in *Westmoreland Coal Co. v. Director, OWCP [Cox]*, 602 F.3d 276 (4th Cir. 2010). JA 103. In particular, she emphasized that *Cox* affirmed the rejection of physician opinions that “consisted of speculative alternative diagnoses that were not based on evidence that the claimant suffered from any of the suggested diseases.” JA 104. The ALJ then commented that “[t]he evidence in Mr. Peck’s claim, when considered in isolation under the independent subsections of 20 C.F.R. § 718.304(a) and (c) [Prong A and C of Section 921(c)(3)], is not sufficient to establish the presence, *or absence*, of complicated pneumoconiosis.” JA 104 (emphasis in original). Nonetheless, in accordance with Board precedent, the ALJ considered the credibility of the x-ray readings in light of the medical opinion and treatment evidence. JA 104. When viewed in this light, the ALJ concluded that the non-ILO x-ray readings, CT scans, and medical records “overwhelmingly” establish that Mr. Peck has large masses in his lungs and that these would appear on x-ray as being more than one centimeter in diameter. JA 105, 107.

Finally, she re-weighed all of the evidence to determine whether the masses were due to pneumoconiosis. She concluded that the multiple diagnoses of pneumoconiosis from many sources were consistent with each other and the record

as a whole, including the treatment records and the CT scans. JA 107. By contrast, she discredited the Fund's experts' opinions for being speculative, inconsistent, and contrary to the treatment records. JA 107-112. Consequently, the ALJ again invoked the irrebuttable presumption of total disability due to pneumoconiosis.

#### **6. The Board's July 31, 2012 affirmance.**

This time the Board affirmed, finding that the ALJ permissibly credited the x-ray interpretations specifically attributing the masses to pneumoconiosis because those readings were supported by Mr. Peck's treatment records and CT scans. JA 124. The Board rejected the Fund's argument that the ALJ wrongly discredited its physicians' opinions as speculative. It found that *Cox* -- issued subsequent to the Board's last remand and "under factual circumstances similar to this case" -- permits an ALJ to reject x-ray readings as speculative and equivocal where those readings exclude pneumoconiosis and attribute lesions to conditions such "as tuberculosis, histoplasmosis or granulomatous disease, if [those physicians] fail to point to evidence in the record indicating that the miner suffers or suffered from any of the alternative diseases." JA 124, *citing* 602 F.3d 285. The record here, the Board recognized, was devoid of evidence of the diseases identified by the Fund's experts.

The Board also held that the ALJ properly rejected Dr. Wheeler's opinion that coal dust exposure was not a causative factor for the masses because: 1) Dr. Wheeler claimed that the pattern in Mr. Peck's lungs was primarily in the apices, when in reality it was not confined to that area; 2) Dr. Wheeler opined that a biopsy was necessary to diagnose complicated pneumoconiosis here when the regulations do not require it; and 3) although Dr. Wheeler claimed that complicated pneumoconiosis is a rare disease due to advances in protective equipment after World War II, he failed to explain why Mr. Peck could not be one of the miners who developed the disease after the war. JA 125.

Finally, the Board rejected the Fund's argument that the ALJ, by evaluating the different types of evidence together, violated congressional intent. The Board explained:

Contrary to employer's assertion, the administrative law judge merely noted at the outset of her analysis of the evidence that there is an equally probative number of positive and negative x-ray readings for complicated pneumoconiosis by qualified radiologists and that the non-ILO x-ray readings contained in the treatment record and the CT scans, standing alone, did not establish complicated pneumoconiosis because they did not contain an equivalency determination. The administrative law judge properly assessed the credibility of the evidence in light of *Cox* and explained why the positive x-ray readings were entitled to controlling weight, and why the evidence as a whole established the existence of the disease.

JA 126. This appeal followed.

## SUMMARY OF THE ARGUMENT

The Section 921(c)(3) irrebutable presumption of total disability due to pneumoconiosis may be established in three ways. One way is with chest x-rays showing large opacities that are classified as Category A, B, or C opacities in the ILO classification system. The chest x-ray readings here uniformly establish the presence of large opacities, but the experts disagree on their cause and thus whether they should be classified as Category A or B opacities.

In resolving this dispute over etiology, the ALJ weighed the conflicting evidence and permissibly accorded greater weight to the x-ray readings of Drs. Rasmussen, Alexander, and DePonte, who found Category A and B opacities. The ALJ reached this perfectly sensible conclusion because Mr. Peck's other medical evidence, including CT scans and treatment records, repeatedly diagnosed pneumoconiosis (and massive fibrosis) but made no mention of the conditions that the Fund's experts believed he had (granulomatous disease, histoplasmosis, tuberculosis). This Court previously accepted the same rationale given similar facts in *Westmoreland Coal Company v. Cox*, 603 F.3d 276, 283 (4th Cir. 2010). The ALJ's reasoning here is no less persuasive.

The Fund's argument that the ALJ could not consider the credibility of the x-ray readings in light of the other medical evidence of record -- in essence that she must consider the x-ray interpretations in a vacuum -- is wrong as a matter of law.

This Court has long held that all the evidence of pneumoconiosis, both simple and complicated, must be weighed together. Finally, the Fund's argument that the ALJ violated the law of the case doctrine is misguided. The doctrine does not apply where there has been an intervening interpretation of law from a higher court, such as this Court's decision in *Cox*; moreover, even when it does apply, the doctrine is only discretionary, not jurisdictional, and the Fund has not proved that the Board abused its discretion in departing from it.

The Court should therefore affirm the Board's decision and the award of benefits.

## **ARGUMENT**

### **A. Standard of review.**

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 Board is authorized to consider appeals from ALJ decisions "raising a substantial question of law or fact," and must affirm the ALJ's decision if it is "supported by substantial evidence in the record considered as a whole" and is in accordance with law. 33 U.S.C. § 921(b)(3), as incorporated by 30 U.S.C. § 932(a). Substantial evidence means evidence "of sufficient quality and quantity as a reasonable mind might accept as adequate to support the finding

under review.” *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 764 (4th Cir. 1999).

This Court, in turn, “review[s] the decision of the Benefits Review Board for errors of law and to assure that the Board adhered to its statutory authority in reviewing the ALJ’s factual determinations.” *Underwood*, 105 F.3d at 949. The Court reviews legal issues *de novo*. *Piney*, 176 F.3d at 756 (internal quotations omitted).

**B. Substantial evidence supports the ALJ’s determination that Mr. Peck suffers from complicated pneumoconiosis.**

The Act mandates the payment of benefits “in respect of total disability of any miner due to pneumoconiosis.” 30 U.S.C. § 921(a). To be eligible for those benefits, a claimant must establish (1) the existence of pneumoconiosis, (2) that the pneumoconiosis arose out of coal mine employment, and (3) that the pneumoconiosis is totally disabling. *See* 30 U.S.C. §§ 901, 921; 20 C.F.R. §§ 718.202-.204, 725.202(d). Elements 1 and 3 are satisfied when complicated pneumoconiosis is established by virtue of the irrebuttable presumption under 30 U.S.C. § 921(c)(3).<sup>10</sup>

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<sup>10</sup> There is no dispute that Mr. Peck successfully established the second element above. He worked as a coal miner for over twenty-seven years and therefore invoked the Section 921(c)(1) presumption that his pneumoconiosis arose out of his coal mine employment. The Fund made no attempt to rebut this presumption. JA 115, n.7.

Under Section 921(c)(3), complicated pneumoconiosis may be proved in three ways: (A) by a chest x-ray that yields one or more large opacities (greater than one centimeter in diameter) that are classifiable as a Category A, B, or C opacity under the ILO guidelines; (B) by biopsy or autopsy that yields massive lesions in the lung; or (C) by other means that could reasonably be expected to yield results described in clause (A) or (B). 30 U.S.C. § 921(c)(3). Although these methods are disjunctive, the evidence establishing each may interrelate. That is why the evidence must be weighed together, as the ALJ did here.<sup>11</sup>

**1. The ALJ's finding that the x-ray readings of complicated pneumoconiosis are credible while the Fund's contrary readings are not is correct under *Cox*.**

Proof of complicated pneumoconiosis by x-ray requires two elements: a large opacity (greater than one centimeter), which then must be classifiable as Category A, B, or C under the ILO guidelines. As a threshold matter, it is undisputed that the chest x-rays interpreted under the ILO classification system reveal greater-than-one centimeter opacities. Moreover, it is undisputed that the other medical evidence of record supports, rather than contradicts, the existence of large opacities. *See* JA 112. Thus, the only question is whether the large opacities

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<sup>11</sup> In argument 2a below, we refute the Fund's claim that the ALJ erred in weighing the evidence together and that the ALJ should have reviewed the x-ray readings in a vacuum.

are consistent with pneumoconiosis and hence classifiable as Category A or B or C.<sup>12</sup>

There were two camps on this question. The DOL/claimant physicians (Drs. Rasmussen, Alexander, and DePonte), by virtue of their ILO classifications, all agreed that the lesions in Mr. Peck's lungs were attributable to pneumoconiosis. The Fund's doctors, on the other hand, attributed the lesions to various, possible causes, including granulomatous disease, tuberculosis, and histoplasmosis. The ALJ assessed the credibility of these conflicting interpretations by looking to the other medical evidence of record, primarily Mr. Peck's long-term and extensive

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<sup>12</sup> Once the miner establishes with chest x-ray evidence that his opacities are properly classified as Category A, B, or C in the ILO system, he need not present additional proof that his condition is a chronic dust disease. Such classification establishes pneumoconiosis, which, by definition, is a chronic dust disease. 30 U.S.C. § 902(b). The ILO classification system "provides a means for describing and recording systematically the radiographic abnormalities in the chest *provoked by the inhalation of dusts.*" ILO GUIDELINES at 1 (emphasis added). When the ILO system is used for clinical as opposed to epidemiological purposes, physicians should "classify only those appearances which the reader believes or suspects to be pneumoconiotic in origin." *Id.* at 2.

Indeed, the ILO form on which physicians report x-ray interpretations invites the classification of opacities (in block 2B or 2C) only if the physician first reports parenchymal abnormalities consistent with pneumoconiosis (in block 2A). And the Department's regulations provide that a chest x-ray classified as Category 1, 2, 3, A, B, or C in the ILO system may establish the existence of pneumoconiosis. 20 C.F.R. §§ 718.102(b), .202(a)(1). By contrast, a claimant attempting to invoke the § 921(c)(3) presumption with evidence other than chest x-rays classified as Category A, B, or C in the ILO system must prove that the evidence reveals a chronic dust disease of the lung.

treatment records. Those records corroborated the pneumoconiosis diagnoses, but contained little or no mention of the diseases suggested by the Fund's experts. The ALJ thus accorded the Fund's expert readings little weight and found complicated pneumoconiosis established. This is precisely the method and reasoning this Court approved in *Cox*.<sup>13</sup>

In *Cox*, there was no dispute that the x-rays showed at least one mass measuring more than three centimeters in the upper part of the miner's right lung. 602 F.3d at 285. That finding was also supported by CT scans and other medical tests. Like here, the mining company's experts did not dispute the existence of the large mass, but instead attributed it "to one of a number of other possible diseases," including "tuberculosis, histoplasmosis, granulomatous disease, or sarcoidosis." *Id.* at 285-86. Upon reviewing all the relevant evidence, however, the ALJ credited the doctors who diagnosed pneumoconiosis by x-ray because that diagnosis was supported by CT scans, medical interpretations, and a biopsy. *Id.* at 285. This Court affirmed her decision, calling such corroborating evidence "certainly of 'sufficient quality and quantity as a reasonable mind might accept as adequate to support' that finding." *Id.*, citing *Piney*, 176 F.3d at 756.

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<sup>13</sup> The similarity in reasoning here is no surprise -- the ALJ here, Linda S. Chapman, was also the ALJ in *Cox*.

The Court likewise affirmed the ALJ's rejection of the company's experts as speculative and equivocal. As here, "none of the doctors discussed whether any of the diseases could occur in conjunction with pneumoconiosis" and "none of them pointed to evidence that Cox was suffering from any of the alternative diseases mentioned" or "discussed whether the tests showed any signs inconsistent with those diseases." *Id.* at 286. The Court thus deemed the opinions "speculative alternative diagnoses that were not based on evidence that Cox suffered from any of the diseases suggested." *Id.* at 287. The Court thus concluded that the ALJ "acted well within her discretion to reject opinions that she found to be unsupported by a sufficient rationale." *Id.*, citations omitted.

So too here. As the ALJ pointed out in her final decision, as far back as 2001, Mr. Peck's treatment records revealed the symptoms and diagnoses of pneumoconiosis. JA 105. She extensively detailed the narrative x-rays, CT scans, and treatment records as well as the credentials of the physicians interpreting them. JA 105-114. And she reasonably concluded:

Employer's evidence as a whole suggests the possibility that the process in Mr. Peck's lungs is probably due to something other than pneumoconiosis. But there is no consistent or corroborated medical evidence that the large opacities . . . are due to an intervening pathology. . . While Dr. Alexander, Dr. Rasmussen, and Dr. DePonte have concluded that the opacities they identified are the result of coal workers' pneumoconiosis, a conclusion that is supported by the CT scans and treatment records, the only thing that Dr. Wheeler, Dr. Scatarige, and Dr. Scott can agree on is that the process is probably

due to something else, and they offer divergent views on what those possibilities could be. . . .

JA 114-115, citation and footnote omitted.<sup>14</sup>

The ALJ followed the legal framework this Court established in *Scarbro*, and she evaluated the evidence in a manner that this Court approved in *Cox*. The Director thus respectfully submits that her decision should be affirmed. *See, e.g., Doss v. Director, OWCP*, 53 F.3d 654, 659 (4th Cir.1995) (substantial evidence means only evidence of sufficient quality and quantity as a reasonable mind might accept as adequate to support the finding under review and “a reviewing body may not set aside an inference merely because it finds the opposite conclusion more reasonable or because it questions the factual basis.”) (citation omitted).<sup>15</sup>

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<sup>14</sup> The ALJ also reasonably discredited the Fund’s remaining evidence -- evidence reviews by Drs. Spagnolo and Repsher -- because, *inter alia*, these doctors adopted, or relied on, the discredited x-ray readings of the Fund’s radiologists. JA 113-14.

<sup>15</sup> The Fund’s contention that the ALJ’s decision is not supported by substantial evidence is, in fact, simply an impermissible attempt to have this Court reweigh the evidence. *See* Pet. Br. at 45-52. The Fund does not explain why it was irrational for the ALJ to discredit its experts’ opinions when there was no corroborating record evidence to support their diagnoses. Rather, it argues that its experts’ conclusions were *more* reasonable than the contrary conclusions. But that is not the inquiry before this Court. This Court’s role is to determine whether the ALJ’s factual determinations are reasonable, not that other conclusions could have been reached. For the reasons that this Court endorsed the ALJ’s opinion in *Cox*, the ALJ’s decision here is likewise reasonable. That ends the factual inquiry.

### **C. The Fund’s legal arguments are without merit.**

In addition to arguing that the ALJ’s decision is not supported by substantial evidence, the Fund makes two legal arguments that it claims require this Court to vacate the ALJ’s decision: 1) that the ALJ was required to evaluate the evidence under the individual prongs of 30 U.S.C. § 921(c)(3) in a vacuum and determine that one of them preponderated in favor of finding complicated pneumoconiosis before interrelating the evidence from the separate prongs; and 2) that the law of the case doctrine bars the ALJ’s final decision. Both are without merit.

#### **1. An ALJ may weigh all of the evidence from the separate prongs of § 921(c)(3) concurrently.**

As noted above, the ILO x-ray readings conflicted on the cause of the large opacities in Mr. Peck’s lungs, and the ALJ resolved this discrepancy by weighing all the record evidence together. The Fund complains that the ALJ was required to review the evidence under each prong completely separately, *i.e.*, in a vacuum, and if she had done so, she would have reached the opposite conclusion.<sup>16</sup> The Fund misreads this Court’s caselaw.

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<sup>16</sup> This argument is premised in part on the Fund’s interpretation of one sentence from the ALJ’s decision, *to wit*: “[t]he evidence in Mr. Peck’s claim, when considered in isolation under independent subsections at 20 C.F.R. § 718.304(a) and (c), is not sufficient to establish the presence, *or absence*, of complicated pneumoconiosis.” JA 105 (emphasis in original). The Fund understands this to mean that “none of three categories of evidence individually tended to establish the existence of complicated pneumoconiosis.” Pet. Br. at 27. But this is an (cont’d ...)

This Court has consistently directed that all evidence of pneumoconiosis -- both simple and complicated -- should be weighed together. In *Scarbro* -- a complicated pneumoconiosis case -- this Court instructed that “the ALJ must in every case review the evidence under *each* prong of § 921(c)(3) *for which relevant evidence is presented* to determine whether complicated pneumoconiosis is present.” 220 F.3d at 256 (emphasis added). *Scarbro* further observed that because the evidence under one prong can diminish the probative force of another, “even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) or prong (C), *then all of the evidence must be considered and evaluated to determine whether the evidence as a whole* indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray.” *Id.* (emphasis added). Thus,

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(. . . cont’d)

overstatement. The ALJ provided no analysis of the evidence in support of this observation, and the ALJ’s actual analysis of the evidence and her conclusion refutes it. JA 107; 114-15. To the extent the meaning of this one sentence is unclear, this Court has held that “even when an [ALJ] explains [her] decision with less than ideal clarity, a ruling court will not upset that decision on that account, if the ALJ’s path may be reasonably discerned.” *National Elec. Mfrs. Ass’n v. U.S. Dept. of Energy*, 654 F.3d 496, 514-15 (4th Cir. 2011) (citation omitted). As discussed above, the ALJ’s path here is certainly clear, and correct.

*Scarbro* clearly endorsed weighing the evidence of complicated pneumoconiosis together. *Accord Lester v. Director, OWCP*, 993 F.3d 1143 (4th Cir. 1993).

In the simple pneumoconiosis context, this Court has reached the same result. In *Island Creek Coal Company v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Court interpreted 20 C.F.R. § 718.202(a), which, like the complicated pneumoconiosis provision, provides different methods to establish the disease. Agreeing with the coal company, the Court held that the proper method to evaluate the existence of pneumoconiosis was to weigh all the evidence in each category together. In a plainly-worded explanation, it reasoned:

The statute governing the evidence required to establish a claim for black lung benefits states that “[i]n determining the validity of claims ... all relevant evidence shall be considered. 30 U.S.C.A. § 923(b). The plain meaning of this statutory language is that all relevant evidence is to be considered together rather than merely within discrete subsections of § 718.202(a). *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997); *see also Gray v. SLC Coal Co.*, 176 F.3d 382, 388-89 (6th Cir. 1999) (relying in part on the “all relevant evidence” language of 30 U.S.C.A. § 923(b) to reject argument that existence of complicated pneumoconiosis could be determined by weighing evidence within discrete categories of 30 U.S.C.A. § 921(c)(3) rather than by weighing evidence of different categories together); *Lester v. Director, OWCP*, 993 F.2d 1142, 1145-46 (4th Cir. 1993) (rejecting argument that the categories within 30 U.S.C.A. § 921(c)(3) establish mutually exclusive means of proving complicated pneumoconiosis such that evidence relevant to the various categories should not be weighed together, on the basis that such a construction would be counter to the mandate in 30 U.S.C.A. § 923(b) to consider “all relevant evidence”).

*Compton*, 211 F.3d at 209. The Court thus concluded that while § 718.202(a) gives miners flexibility in proving their claims, it does “not establish mutually exclusive bases for determining the existence of pneumoconiosis.” *Id.* at 210.

In sum, the Court has drawn no distinction -- temporally or substantively -- in weighing together the different types of evidence. The fundamental guideline is that relevant evidence must be rationally and meaningfully considered. *Gray v. SLC Coal Co.*, 176 F.3d 382, 389 (6th Cir. 1999) (“‘all relevant evidence’ means just that--all evidence that assists the ALJ in determining whether a miner suffers from complicated pneumoconiosis”). Precisely how or when that occurs depends on the circumstances of the individual case. *See Compton*, 211 F.3d at 209 (“whether or not a particular piece of evidence or type of evidence actually *is* a sufficient basis for a finding of pneumoconiosis will depend on the evidence in each case”). Thus, while a formulaic prescription like the one the Fund calls for here may work in some cases, it will not in others, and it will thus cause more harm than good.

Indeed, this very case presents such an example. There can be little disagreement that Mr. Peck’s treatment records were relevant -- they clearly shed light on the credibility of the x-ray readings, and consequently, the ALJ reasonably considered them in evaluating the Prong A evidence. *Cox, supra*. Yet under the Fund’s statutory interpretation that evidence would have deemed insufficient under

Prong C and its probative value not fully addressed. In short, just as “[e]vidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict,” *Scarbro*, 220 F.3d at 256, evidence from a different prong may have a reinforcing, bolstering, or corroborating effect, as here.<sup>17</sup>

## **2. The ALJ’s final decision was not barred by the law of the case.**

The Fund also claims that the ALJ’s most recent decision reinstates findings that the Board previously rejected and thus offends the “law of the case” doctrine. The Board, however, did not view “law of the case” as an impediment to its affirmance of the ALJ’s decision. Neither should this Court.

The law of the case doctrine holds that an appellate decision on an issue must be followed in later proceedings unless “the presentation of new evidence or an intervening change in the controlling law dictates a different result, or the appellate decision is clearly erroneous and, if implemented, would work a manifest injustice.” *Piambino v. Bailey*, 757 F.2d 1112, 1120 (11th Cir.1985), *cert. denied*, 476 U.S. 1169 (1986) (*citing In re Sanford Fork & Tool Co.*, 160 U.S. 247, 255 (1895)). Notably, the doctrine is a rule of discretion and not a jurisdictional

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<sup>17</sup> The ALJ’s decision also could be viewed as strictly applying *Scarbro*’s rationale -- the treatment records (Prong C evidence) diminished the probative force of the Fund’s x-ray readings (Prong A evidence), thereby allowing the contrary Prong A evidence finding complicated pneumoconiosis to carry the day.

requirement. *Smith v. Bounds*, 813 F.2d 1299, 1304 (4th Cir.1987) (citing *Piambino*, 757 F.2d at 1120), *cert. denied*, 488 U.S. 869 (1988). Its purpose is designed to bring an end to litigation and to discourage “panel shopping.” *Piambino*, 757 F.2d at 1120. Accordingly, the doctrine does not prevent a higher court from examining or disagreeing with the decision of an inferior tribunal. *E.g. Payne for Hicks v. Churchich*, 161 F.3d 1030, 1038 n.9 (7th Cir. 1998).<sup>18</sup>

The Fund alleges that the ALJ violated the law of the case doctrine by discrediting its experts’ opinions for reasons that the Board previously rejected. The Board, however, did not agree that it was required to blindly sustain its prior holdings, JA 126-27, n. 11, and its affirmance of the ALJ decision clearly rested in part on this Court’s intervening decision in *Cox*. *See* JA 124 (“Subsequent to the Board’s remand decision, the Fourth Circuit held in *Cox*, under factual circumstances similar to this case,” that an administrative law judge may reject, “as speculative and equivocal, the opinions of employer’s experts, who exclude coal dust exposure as the cause for large opacities or masses identified by x-ray, and attribute the radiological findings to conditions such as tuberculosis,

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<sup>18</sup> The Fund’s focus on the ALJ’s disregard for the doctrine is entirely misplaced. Its real complaint is with the *Board’s* failure to insist on its supposedly prior, inconsistent holdings. The Fund further fails to consider that the doctrine does not bind this Court, a higher court, to the holdings of the Board, an inferior tribunal. Nor does it consider that this Court reviews the ALJ’s decision for substantial evidence, not the Board’s.

histoplasmosis, or granulomatous disease.”) (citations omitted). As such, the Board’s alleged change of mind, based on intervening case law, is entirely acceptable. *Piambino*, 757 F.2d at 1120.

In any event, the law of the case doctrine is one of discretion. Even if it did apply here, the Fund has not explained why it would be an unreasonable exercise of discretion for the Board to depart from it. *See, e.g., Bridger Coal Company v. Director, OWCP*, 669 F.3d 1183, 1192 (10th Cir. 2012) (the law of the case in black lung proceedings is a flexible one that allows the Board to depart from prior rulings because the underlying rule is one of efficiency, not restraint of judicial power). Absent such a showing, the Court should reject the Fund’s law of the case argument.

## **CONCLUSION**

For all the above reasons, the decision of the Benefits Review Board should be affirmed.

Respectfully submitted,

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## **CERTIFICATE OF COMPLIANCE**

I hereby certify that this brief complies with the type-volume limitation of FED. R. APP. P. 32(a)(7)(B). This brief contains 8,706 words, excluding the parts of the brief exempted by FED. R. APP. P. 32(a)(7)(B)(iii). I also certify that this brief 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) because it has been prepared in a proportionally-spaced typeface using Microsoft Word 2010 in fourteen-point Times New Roman font.

s/Jonathan Rolfe  
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Attorney  
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## **CERTIFICATE OF SERVICE**

I hereby certify that on February 28, 2013, an electronic copy of this brief was served through the CM/ECF system on the following:

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