

No. 11-1839

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT**

WESTMORELAND COAL COMPANY

Petitioners

v.

**DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
UNITED STATES DEPARTMENT OF LABOR;
JARRELL D. COCHRAN**

Respondents

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

BRIEF FOR THE FEDERAL RESPONDENT

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BRIEF FOR THE FEDERAL RESPONDENT

STATEMENT OF JURISDICTION

Westmoreland Coal Company's statement of jurisdiction, although correct, omits the jurisdictional basis for the Benefits Review Board to decide the appeal of Administrative Law Judge Richard Morgan's May 24, 2010, award of benefits, payable by Westmoreland. Westmoreland appealed the ALJ's decision to the Benefits Review Board on June 3, 2010. The Board had jurisdiction because section 21(a) of the Longshore and Harbor Workers' Compensation Act, 33 §

921(a), as incorporated by 30 U.S.C. § 932(a), allows an aggrieved party thirty days to appeal an ALJ's decision to the Board.

STATEMENT OF THE ISSUE

The preamble to the Secretary's regulations implementing the Black Lung Benefits Act, 65 Fed. Reg. 79920 (Dec. 20, 2000), sets forth the medical and scientific premises underlying the Department's revisions to the black lung regulations. The ALJ relied on the preamble in crediting Dr. Rasmussen's diagnosis of legal pneumoconiosis and rejecting Dr. Zaldivar's and Hippensteel's contrary opinions. The issue is whether substantial evidence supports his findings.

STATEMENT OF THE CASE

1. Legal framework.

Former coal miners who are totally disabled by pneumoconiosis, a respiratory or pulmonary impairment arising out of coal mine employment, are entitled to BLBA benefits. It is undisputed that claimant/respondent Jarrell Cochran suffers from chronic obstructive pulmonary disease (COPD)/emphysema that totally disables him from performing his former work as a miner.¹ The

¹ COPD is an umbrella term that "includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema, and asthma." 65 Fed. Reg. 79939. The medical experts variously described or categorized Cochran's COPD as including, *e.g.*, chronic bronchitis (Dr. Baker, JA 12), "legal pneumoconiosis" (Dr. Agarwal, JA 30; Dr. Rasmussen, JA 104), emphysema (Dr. Rasmussen, JA (continued...))

question here is whether Cochran’s disabling COPD/emphysema is “legal pneumoconiosis” as defined by 20 C.F.R. § 718.201.

“Legal pneumoconiosis” refers to “any chronic lung disease or impairment ... arising out of coal mine employment” and specifically may include “any chronic restrictive or obstructive pulmonary disease.” 20 C.F.R. § 718.201(a)(2); *see Gulf & Western Industries v. Ling*, 176 F.3d 226, 231 (4th Cir.1999) (“The regulations detail the breadth of what is frequently called “legal” pneumoconiosis. . . .”); *Richardson v. Director, OWCP*, 94 F.3d 164, 166 n. 2 (4th Cir. 1996) (“COPD, if it arises out of coal-mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis.”). A disease arises out of coal mine employment if it is “significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201(b). Moreover, pneumoconiosis is “recognized as a latent and progressive disease which may first become detectable only after cessation of coal mine dust exposure.” 20 C.F.R. § 718.201(c).²

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104; Dr. Zaldivar, JA 132), asthmatic bronchitis (Dr. Hippensteel, JA 158); and asthma (Dr. Rasmussen JA 37; Dr. Hippensteel, JA 168; Dr. Zaldivar, JA 132).

² The second form of compensable pneumoconiosis, which is not at issue here, is “clinical” pneumoconiosis. 20 C.F.R. § 718.201(a). “Clinical pneumoconiosis” refers to a cluster of diseases recognized by the medical community as fibrotic reactions of lung tissue to the “permanent deposition of substantial amounts of
(continued...)

2. Course of the proceedings below.

Jarrell Cochran filed this subsequent claim for federal black lung benefits in 2008.³ JA 144. The ALJ awarded benefits to Cochran, payable by Westmoreland, and the Benefits Review Board affirmed the decision. JA 354-390, 391-396. Westmoreland then petitioned this Court for review. JA 397. After its appeal was docketed, Westmoreland moved the Court to hold its appeal in abeyance pending a decision in *Harman Mining Co. v. Director, OWCP*, 678 F.3d 305 (4th Cir. 2012). Following the decision in *Harman Mining*, the Court reinstated the briefing schedule.⁴

(...continued)

particulate matter in the lungs.” 20 C.F.R. § 718.201(a)(1); *see also Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790 n.1 (4th Cir. 1990) (“Clinical pneumoconiosis refers to the lung disease caused by fibrotic reaction of the lung tissue to inhaled dust, which is generally visible on chest x-ray films as opacities.” (quoting *Usery v. Turner-Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976))). This cluster of diseases includes, but is not limited to, “coal workers’ pneumoconiosis” as that term is commonly used by doctors. 20 C.F.R. § 718.201(a)(1). Clinical pneumoconiosis is generally diagnosed by chest x-ray, biopsy or autopsy. 20 C.F.R. §§ 718.102, 718.106, 718.202(a)(1)-(2).

³ Cochran’s prior claim was finally denied in 2006 on the ground that he failed to prove pneumoconiosis. In order for his subsequent claim to proceed, Cochran must prove that one of the applicable conditions of entitlement, *i.e.*, the existence of pneumoconiosis, has changed since the prior denial. 20 C.F.R. § 725.309(d).

⁴ *Harman Mining* held that an ALJ may rely on the preamble to the revisions of the black lung regulations, 65 Fed. Reg. 79920 (Dec. 20, 2000), to evaluate conflicting expert medical opinions and may accord less weight to opinions that are inconsistent with the preamble’s medical and scientific findings. 678 F.3d at 314.

STATEMENT OF THE FACTS

1. Cochran's work and smoking histories.

Cochran worked as a coal miner in West Virginia for at least 16 years between 1964 and 1995. JA 356-357; Pet. Br. at 4. During this time, he worked as a roof bolter, mechanic, general laborer, and shuttle car operator. JA 357. Cochran provided a variable smoking history, but the ALJ found that he smoked one pack of cigarettes per week for "up to twenty years[.]" JA 358.

2. Relevant medical evidence⁵

This appeal centers on the ALJ's weighing of Drs. Rasmussen's, Zaldivar's, and Hippensteel's conflicting medical opinions regarding the cause(s) of Cochran's respiratory disease. Dr. Rasmussen concluded that Cochran suffered from asthma, and COPD/emphysema caused by smoking and coal mine dust exposure, whereas Dr. Zalidivar diagnosed asthma and smoking-induced emphysema and Dr. Hippensteel diagnosed asthma alone.⁶ JA 36, 101, 128, 136, 159, 162, 181.

⁵ The parties agree that Cochran has total respiratory disability, but not clinical pneumoconiosis. As a result, much of the medical evidence of record is not directly relevant on appeal. Thus, the x-ray readings, which are primarily used to diagnose clinical pneumoconiosis, and the pulmonary function tests and arterial blood gas studies, which are primarily used to determine the extent of a respiratory impairment, are not summarized here.

⁶ Additionally, Drs. Porterfield and Boustani, Cochran's treating physicians, diagnosed severe COPD and emphysema, and Drs. Baker and Agarwal diagnosed coal workers' pneumoconiosis. JA 43-64, 375; JA 9, 28. The ALJ, however, (continued...)

Dr. Rasmussen: Dr. Donald Rasmussen examined Cochran and reviewed his treatment records and the medical opinions submitted in connection with this claim for benefits.⁷ JA 36-42; 101-108. Dr. Rasmussen reported a seventeen-year coal mine employment history, a “limited” but “variable” smoking history, a positive chest x-ray reading, and pulmonary function and arterial blood gas tests demonstrating a “very severe” and “marked” impairment respectively.⁸ JA 39,

(...continued)

rejected these opinions as not credible, and no party contested these findings before the Board. Accordingly, the Director will not summarize these doctors’ opinions.

⁷ Dr. Rasmussen submitted two reports. JA 36-42, 101-108. The first, JA 101-108, describes his findings based on his examination of Cochran, which was provided by the Department to fulfill its statutory duty to provide a claimant-miner with “an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation.” 30 U.S.C. § 923(b). The second report, JA 36-42, updates his findings based on his review of Cochran’s treatment records and various medical reports submitted with this claim. We have combined the findings of the two reports as together they comprise his opinion.

⁸ A pulmonary function (or ventilatory) test is one measure of a miner’s pulmonary capacity. The test measures three values: the FEV1 (forced expiratory volume), the FVC (forced vital capacity), and the MVV (maximum voluntary ventilation). The FEV1 value measures the amount of air exhaled in one second on maximum effort. It is expressed in terms of liters per second. Obtaining a FVC value requires the miner to take a deep breath and then exhale as rapidly and forcibly as possible. The FEV1 value is taken from the first second of the FVC exercise. The MVV value measures the maximum volume of air that can be moved by the miner’s respiratory apparatus in one minute, and is expressed in liters. *See Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1138 nn. 6, 7 (7th Cir. 1988); 20 C.F.R. § 718.103; 20 C.F.R. Part 718 App. B.

Arterial blood gas tests “are performed to detect an impairment in the process of alveolar gas exchange.” 20 C.F.R. § 718.105(a). The defect primarily manifests “as a fall in arterial oxygen tension either at rest or during exercise.” *Id.*

(continued...)

101, 103. Dr. Rasmussen diagnosed clinical pneumoconiosis, asthma, and “COPD/emphysema” due to smoking and coal dust exposure. JA 38-39, 107.⁹

Explaining his dual causation diagnosis for the COPD/emphysema, Dr. Rasmussen described the effects of smoking and coal dust exposure as “independent, but additive,” though he estimated the potency of coal mine dust exposure to be 1/2 to equal of cigarette smoke. JA 38. Moreover, Dr. Rasmussen acknowledged the theoretical possibility that Cochran’s pulmonary condition could be entirely due to either cigarette smoking or to dust exposure, but, citing the medical literature, he unequivocally stated that “[w]e have no basis for excluding either [cause]. . . Not only are the signs and symptoms identical, but also the mechanisms by which smoke and coal mine dust cause lung destruction are identical.” JA 39.¹⁰ He therefore concluded that both cigarette smoking and coal

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“[A]lveolar gas” refers to “the gas in the alveoli of the lungs, where gaseous exchange with the capillary blood takes place.” Dorland’s Illustrated Medical Dictionary at 756 (30th Ed. 2003). Alveoli are the “small saclike structures” in the lungs. *Id.* at 55, 1070.

⁹ Pulmonary emphysema is defined as “a condition of the lung characterized by increase beyond normal in the size of air spaces distal to the terminal bronchioles.” Dorland’s at 606. A bronchiole is “one of the finer subdivisions of the branched bronchial tree, 1 mm or less in diameter, differing from the bronchi in having no cartilage plates and having cuboidal epithelial cells.” Dorland’s at 253.

¹⁰ Dr. Rasmussen described the pathological process as follows: “Only a minority of heavily exposed coal miners and only a minority of heavy cigarette smokers ever develop significant COPD/emphysema[.] . . . Among that minority who are
(continued...) ”

mine dust exposure were contributing causes of the COD/emphysema. JA 39.

Responding to Drs. Zaldivar's and Hippensteel's diagnoses of severe asthma (unrelated to coal mine dust exposure), Dr. Rasmussen was not convinced that Cochran has "a clear-cut case of isolated asthma."¹¹ JA 37. Rather, citing various medical studies, Dr. Rasmussen described Cochran's condition as "overlap syndrome" with "features of both asthma and COPD." *Id.*

Furthermore, Dr. Rasmussen, again relying on the medical literature, rejected the notion of a necessary correlation between loss of lung function and chest x-ray or CT scan changes. JA 38. He thus disputed Dr. Hippensteel's assertion that it would be "highly unusual for an individual to show progressive abnormalities as a consequence of coal mine dust exposure without showing progression of radiographic abnormalities of pneumoconiosis." JA 38. In addition, he disputed Dr. Hippensteel's claim that smoking and coal dust exposure

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susceptible, cigarette smoke particles and coal mine dust particles are both engulfed by scavenger cells [which] . . . release abnormal chemicals, which not only damage lung tissue directly, but also unleash a cascade of cellular and chemical changes, which dissolve lung tissue leading to identical damage." JA 104, 107-08.

¹¹ "Asthma" is defined as "recurring attacks of paroxysmal dyspnea, with airway inflammation and wheezing due to spasmodic contraction of the bronchi." Dorland's at 168. A "paroxysm" is "a sudden recurrence or intensification of symptoms" or "a spasm or seizure;" "dyspnea" means "breathlessness or shortness of breath;" and "bronchi," the plural of "bronchus," are "any of the larger air passages of the lungs[.]" Dorland's at 254, 578, and 1372.

cause different forms of emphysema, explaining that both cause panacinar emphysema, which in turn can cause bullous emphysema (which, Dr. Rasmussen explained, was not itself a separate disease but merely a descriptive term for lung damage caused by other types of emphysema). *Id.*; JA 107 (coal dust-induced emphysema may take the form of panacinar, centriacinar, bullous etc. emphysema).

Dr. Zaldivar: Dr. George Zaldivar examined Cochran (for the fourth time over a thirteen year span) and reviewed his treatment records and the medical opinions submitted in connection with this claim. JA 128, 188. He reported a seventeen-year coal mine employment history, a twenty-five year smoking history of two or three cigarettes per day, a chest x-ray reading, and pulmonary function and arterial blood gas test results. JA 112, 117, 126, 133. Dr. Zaldivar concluded that although Cochran does not have pneumoconiosis, he has emphysema with bullae and asthma – both related to smoking -- resulting in a severe and irreversible airway obstruction.¹² JA 131-132, 197, 209-210. Dr. Zaldivar also observed that

¹² Bulla, as in bullous emphysema, refers to “any space in a distended area of an emphysematous lung, ranging in size from one centimeter to most of a hemithorax.” Dorland’s at 259. Dorland’s describes bullous emphysema as a “single or multiple large cystic alveolar dilatations of the lung tissue,” and panacinar emphysema as “characterized by relatively uniform enlargement of air spaces throughout the acini.” *Id.* at 606. Acini (plural for acinus) are “a small saclike dilatation, particularly in the lung or a gland.” *Id.* at 17.

Cochran's asthma had been left untreated and had resulted in airway remodeling. JA 131.

Dr. Zaldivar distinguished Cochran's emphysema with bullae, which he believed was smoke-induced, from coal dust-induced emphysema. He explained that coal dust does not cause "bullae in connection with simple pneumoconiosis," but rather results in "centrilobular emphysema with focal emphysema." JA 196-98. Dr. Zaldivar further excluded coal dust as a cause of Cochran's pulmonary condition in part because "the chest x-ray shows [no] pneumoconiosis is just an added piece of information. It means there is not a great deal of dust in his lungs, if any." JA 209. Asked whether coal mine dust can cause emphysema without x-ray changes of coal worker's pneumoconiosis, Dr. Zaldivar replied, "If in the opinion of the physician the individual has pneumoconiosis *and* he has emphysema, emphysema can be added to the pneumoconiosis." JA 220 (emphasis added). He went on to add that "if it is end stage emphysema to a point where the lungs are severely destroyed, then you will not be able to see anything radiographically except the destroyed lung," JA 220, but prior to that point, "[y]ou would see the progression of the lung . . . you would have seen changes that were compatible with the pneumoconiosis." JA 222. As a final reason for believing Cochran's pulmonary disease was smoke-induced, Dr. Zaldivar stated that he has patients who have asthma and smoke, but no exposure to coal mine dust, whose

pulmonary symptoms are identical to Cochran's. JA 216.

Dr. Zaldivar also disagreed with Dr. Rasmussen's assertion that the effects of asthma, coal dust exposure, and smoking are indistinguishable. Adverting to an unnamed journal article from 2009, he opined that smoking "causes a chemical reaction in the lungs. . . . It is not a physical reaction. Well, it's physical in the sense that the chemical does cause damage. But coal workers' pneumoconiosis causes a particulate deposition in the lungs that causes the damage." JA 212.¹³

Dr. Hippensteel: Dr. Kirk Hippensteel reviewed Mr. Cochran's medical records, including the medical opinions submitted with this claim, but did not examine him. JA 136. He diagnosed a totally disabling respiratory impairment caused by asthmatic bronchitis. JA 158, 168. He described the asthma as having "no occupational relationship to coal mine dust exposure," explaining that "over time, however, [it] can create enough inflammation and damage or what we call remodeling to the airways of the lungs that it creates a permanent obstructive

¹³ In the course of issuing his opinion, Dr. Zaldivar relied on four post-preamble medical studies from the scientific literature. According to Dr. Zaldivar, two studies, from 2007 and 2008, indicate that untreated asthma can result in airways remodeling and a progressive decline in lung function; JA 131-32; a third study, unidentified from 2009, shows that males who begin smoking cigarettes prior to age 25 "have a more lasting obstruction than women do;" JA 209; and a fourth, also unidentified from 2009, shows that enzymes triggered by smoking cause chronic bronchitis and phlegm. *Id.*

impairment” and COPD.¹⁴ JA 168-69. He added that although asthma can result in emphysema, Cochran has “little, if any, emphysema[.] JA 172-73, 178.

Disagreeing with Dr. Rasmussen regarding the presence of legal pneumoconiosis, Dr. Hippensteel observed that asthma is not associated with coal dust exposure, that asthma “has not been associated with any other findings that would suggest that he had developed clinical pneumoconiosis,” and that Cochran’s asthma “progressed without progression of x-ray changes after he left work in the mines[.]” JA 175. Dr. Hippensteel explained that “[e]ven though coal workers’ pneumoconiosis is a latent disease, this latency begins at the time of first exposure and, like cigarette smoking, is less likely to develop or progress after cessation of such exposure, while asthma will continue to actively and sometimes rapidly progress, like occurred [*sic*] in Mr. Cochran even without a history of smoking and coal mining work.” JA 160. Finally, relying on a 1979 journal article, Dr. Hippensteel stated that although significant pneumoconiosis is possible without x-ray evidence, “it is not the usual finding regarding coal workers’ pneumoconiosis[.]” JA 161.

¹⁴ Remodeling means the “reorganization or renovation of an old structure.” Dorland’s at 1611.

3. Decisions below

ALJ award of benefits: The ALJ found that Cochran had established at least sixteen years of coal mine employment, but no more than thirteen years in an underground mine or at a surface mine in substantially similar dust conditions. JA 356-57. Consequently, the ALJ declined to invoke the 15-year presumption of entitlement at 30 U.S.C. § 921(c)(4), implemented at 20 C.F.R. § 718.305.¹⁵ JA 384.

Turning to the medical evidence, the ALJ found that the x-ray evidence did not establish clinical pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1), but found legal pneumoconiosis established by medical opinion under section 718.202(a)(4). JA 377-79. The ALJ observed that “much of the pertinent dispute between these medical experts centers on the etiology of the miner’s emphysema.” JA 379. He credited Dr. Rasmussen’s diagnosis of COPD/emphysema due to coal dust exposure and smoking over Drs. Zaldivar’s and Hippensteel’s diagnoses of smoking-induced emphysema because the preamble supported Dr. Rasmussen’s view that “dust-related emphysema and smoke-induced emphysema occur through

¹⁵ Invocation of the presumption requires a claimant to establish, *inter alia*, that the miner worked at least fifteen years at an underground mine or at a surface mine in substantially similar dust conditions.

similar mechanisms.¹⁶ JA 379. By contrast, the ALJ found that Drs. Zaldivar’s and Hippensteel’s opinions regarding the etiology of the emphysema were “inconsistent with the scientific evidence set forth” in the preamble. JA 379.

The ALJ further faulted Drs. Hippensteel and Zaldivar for “primarily concentrat[ing] on explaining why they believed the miner did not suffer from clinical pneumoconiosis and why clinical pneumoconiosis was not responsible for his symptoms or impairment.” JA 379. Moreover, the ALJ found that their rationales (for rejecting clinical pneumoconiosis) “were not in accord with the conclusions reached by the Department of Labor relying upon scientific studies in implementing the 2001 regulations when applied to ‘legal’ pneumoconiosis[.]” JA 379.¹⁷ The ALJ then found that Cochran’s pneumoconiosis arose out of coal mine employment, JA 380, and that he had total respiratory disability pursuant to 20

¹⁶ Although the ALJ grouped Drs. Hippensteel’s and Zaldivar’s opinions together, a careful reading of Dr. Hippensteel’s opinion (admittedly missed by the ALJ) reveals that the doctor did not unequivocally diagnose emphysema in the first place. JA 158 (Cochran has “severe pulmonary impairment referable to asthmatic bronchitis with *possibly* some added component of bullous emphysema); JA 178 (“It is my diagnosis that he has little, *if any*, emphysema”); JA 172 (particular test result “makes for the *possibility* that there is some emphysema present”) (emphases added). Given Dr. Hippensteel’s fundamental belief that asthma was the sole cause of Cochran’s respiratory disability, it is difficult to see the relevance of his opinion regarding the etiology of Cochran’s COPD/emphysema.

¹⁷ The ALJ accordingly ruled that the proof of legal pneumoconiosis satisfied the material change requirement in the subsequent claim regulation, 20 C.F.R. § 725.309(d). JA 370.

C.F.R. § 718.204(b) based on the pulmonary function tests and the unanimous medical opinions diagnosing total respiratory disability. JA 381-82.

Last, regarding disability causation, the ALJ rejected Drs. Zaldivar's and Hippensteel's opinions because they did not diagnose pneumoconiosis, contrary to the ALJ's finding, and credited, *inter alia*, Dr. Rasmussen's opinion that Cochran's pneumoconiosis had contributed to his total disability. JA 386-87. He thus awarded benefits against Westmoreland.

Board affirmance: The Board affirmed the award. The Board upheld the ALJ's findings regarding the length of Cochran's coal mine employment and total disability as unchallenged on appeal. JA 393.

The Board then affirmed the ALJ's finding of legal pneumoconiosis and his use of the preamble to evaluate the conflicting medical opinions: "Faced with the physicians' conflicting medical theories, the administrative law judge permissibly examined whether the physicians' opinions were consistent with the conclusions contained in the medical literature credited by the Department of Labor (DOL) in revising the definition of legal pneumoconiosis." JA 394. The Board then affirmed as supported by substantial evidence, and within his discretion, the ALJ's credibility determination that Dr. Rasmussen's opinion was "unusually thorough," consistent with conclusions contained in the preamble, and entitled to determinative weight whereas the opinions of Dr. Zaldivar and Hippensteel were

unpersuasive, inconsistent with the conclusions contained in the preamble, and entitled to less weight.” *Id.*¹⁸

Last, the Board affirmed the ALJ’s decision to credit Dr. Rasmussen’s “well-reasoned” opinion regarding disability causation and to discount Drs. Zaldivar’s and Hippensteel’s opinions regarding disability causation because they had failed to diagnose pneumoconiosis “in direct contradiction to” the ALJ’s finding. *Id.*

SUMMARY OF THE ARGUMENT

Westmoreland claims that because Dr. Rasmussen believes that the effects of cigarette smoking and coal dust inhalation are indistinguishable, his medical opinion that both exposures caused Cochran’s COPD/emphysema is legally insufficient. Dr. Rasmussen, however, based his dual-causation diagnosis on both general principles of medical science and Cochran’s specific history and testing, and he fully explained the bases for his diagnosis. Consequently, it was within the ALJ’s discretion to credit Dr. Rasmussen’s legally sufficient, well-reasoned and documented expert opinion.

¹⁸ By finding legal pneumoconiosis established, the Board affirmed the ALJ’s determination that a change in an applicable condition of entitlement had been established as well, as required by the subsequent claim regulation, 20 C.F.R. § 725.309.

Westmoreland also argues that the ALJ wrongfully rejected Drs. Zaldivar's and Hippensteel's opinions as inconsistent with the findings and medical literature credited in the preamble. But the ALJ did not mischaracterize the preamble or the conclusions of the studies cited therein, and he acted within his discretion in finding Drs. Zaldivar's and Hippensteel's opinions inconsistent with the preamble.

Finally, although not addressed by Westmoreland, the ALJ provided a valid, alternative reason for discounting Drs. Zaldivar's and Hippensteel's opinions, namely that both doctors impermissibly based their diagnoses of no legal pneumoconiosis on the absence of clinical pneumoconiosis.

ARGUMENT

THE ALJ ACTED WITHIN HIS DISCRETION IN CREDITING DR. RASMUSSEN'S OPINION OVER DRS. ZALDIVAR'S AND HIPPENSTEEL'S OPINIONS, WHICH ARE CONTRARY TO THE MEDICAL LITERATURE CITED IN THE PREAMBLE.

1. Standard of review

Westmoreland's brief is primarily dedicated to challenging the ALJ's credibility determinations and weighing of the medical opinion evidence. 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 such decisions if "supported by substantial evidence in the record considered as a whole" and in

accordance with law. 33 U.S.C. § 921(b)(3), as incorporated by 30 U.S.C. § 932(a). This Court, in turn, “review[s] the decision of the Benefits Review Board for errors of law and to assure the Board adhered to its statutory authority in reviewing the ALJ’s factual determinations.” *Underwood*, 105 F.3d at 949. To the extent that Westmoreland’s challenge to the ALJ’s reading of the preamble presents a question of law, the Court reviews that *de novo*. *Franks v. Ross*, 313 F.3d 184, 192 (4th Cir. 2002); *Underwood*, 105 F.3d at 948-49. The Director’s interpretation of the BLBA and its implementing regulations is entitled to deference. *Doss v. Director, OWCP*, 53 F.3d 654, 658 (4th Cir. 1995).

2. Dr. Rasmussen’s opinion is legally sufficient, well-reasoned and documented, and the ALJ properly credited it.

Westmoreland first argues that because Dr. Rasmussen stated that the effects of cigarette smoking and coal dust inhalation are indistinguishable, his opinion that both exposures were responsible for Cochran’s COPD/emphysema was legally insufficient and entitled to no weight. It further claims that the ALJ impermissibly created a “presumption of legal pneumoconiosis” by relying on it. Pet. Br. at 13-14, 31. But the ALJ created no such presumption. Rather, he simply employed his discretion to credit a legally sufficient, well-reasoned and documented expert opinion. *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 342 (4th Cir. 1996).

Dr. Rasmussen based his dual-causation diagnosis on both general principles of medical science and Cochran’s specific history and testing. Dr. Rasmussen

explained that as a matter of science, “[c]oal mine dust and cigarette smoke both cause COPD/emphysema. The emphysema is identical regardless of the two ideological [etiological] factors” because both cigarette smoke and coal dust “dissolve lung tissue leading to identical damage.” JA 104, 38. He added that the effects from smoking and coal dust are “independent, but additive[.]” JA 38. Dr. Rasmussen then tied his pneumoconiosis diagnosis to Cochran’s medical and employment histories, as well as his medical testing. Dr. Rasmussen stated that Cochran “has a significant history of exposure to coal mine dust,” “is a very susceptible individual” to coal dust and cigarette smoke (given the extent of his impairment), and, in light of his “variable” and “limited” smoking history, the theoretical possibility that coal dust played no role in Cochran’s disabling pulmonary impairment was simply not reasonable. JA 39, 104. Dr. Rasmussen therefore refused to exclude either cause but instead positively diagnosed both exposures as causes of his COPD/emphysema. JA 39.

Contrary to Westmoreland’s contention that the ALJ and Dr. Rasmussen employed a “presumption” of legal pneumoconiosis, Pet. Br. 13-14, Dr. Rasmussen’s medical opinion affirmatively demonstrates, based on the facts of this case, that Cochran’s COPD/emphysema is “substantially related” to his coal mine dust exposure. It is therefore legally sufficient to establish pneumoconiosis under section 718.201. Moreover, because the opinion is “consistent with, and

corroborated by” the results of the relevant objective tests, and includes the doctor’s explanation of “the basis of his conclusion,” the opinion is reasoned, documented, and credible, and the ALJ permissibly relied on it. 20 C.F.R. § 718.202(a)(4); *Mancia v. Director, OWCP*, 130 F.3d 579, 589 (3d Cir. 1997).

Indeed, the courts of appeals, including this Court, have on many occasions affirmed ALJ decisions to credit similar Dr. Rasmussen opinions, and there is no reason not to affirm the ALJ’s crediting of it here. *Southern Appalachian Coal Co. v. Adkins*, 468 Fed. Appx. 331, 334-35 (4th Cir. 2012) (affirming ALJ’s acceptance of Dr. Rasmussen’s opinion that miner’s “pulmonary disease was caused by both coal dust and cigarette smoke exposure and that it was impossible to separate the effects of the two”); *Consol. Coal Co. v. Swiger*, 98 Fed. Appx. 227, 238 (4th Cir. 2004) (affirming ALJ’s reliance on Dr. Rasmussen opinion that “it was difficult to differentiate between the effects caused by smoking and the effects caused by coal mine dust”); *A & E Coal Co. v. Adams*, 694 F.3d 798, 800 (6th Cir. 2012) (affirming ALJ’s reliance on Dr. Rasmussen’s opinion that “smoking and coal dust cause the same types of impairment, making it impossible to tell how much Adams’ COPD was caused by smoking versus coal dust”); *R.F.I. Energy, Inc. v. Dir., OWCP*, 2012 WL 2899252, *1 (3d Cir. July 17, 2012) (affirming ALJ’s reliance on Dr. Rasmussen view that “it is impossible to distinguish between the effect of smoking and the effects of coal mine dust exposure because both are toxic

exposures that result in the loss of lung function”).¹⁹

3. The ALJ permissibly relied on the preamble to the BLBA’s implementing regulations to credit Dr. Rasmussen’s pneumoconiosis diagnosis over the contrary opinions from Drs. Zaldivar and Hippensteel.

The ALJ correctly observed that the “core” of the dispute . . . is the etiology of the miner’s COPD/emphysema.” JA 377, 379.²⁰ To resolve it, the ALJ assessed the credibility of the conflicting medical opinions by relying on the medical and scientific findings in the Department’s preamble to the black lung regulations, a practice this Court approved of in *Harman Mining*, 678 F.3d at 314-15 (ALJ is not required to look at preamble in assessing the credibility of conflicting expert opinions, but is “entitled to do so”). The ALJ determined that

¹⁹ By providing these examples of judicial acceptance of Dr. Rasmussen opinions, we are not endorsing carte blanche acceptance of every one, or aspect, of his opinions. Westmoreland cites (Pet. Br. 17-18) to *United States Steel Mining Co., Inc. v. Dir.*, *OWCP*, 187 F.3d 384 (4th Cir. 1999), where the Court rejected an ALJ’s reliance on a Dr. Rasmussen opinion because Dr. Rasmussen merely speculated about possible causes of the miner’s death. 187 F.3d at 390. Here, however, Dr. Rasmussen did not speculate – he unequivocally opined that both cigarette smoking and coal mine dust exposure caused Cochran’s COPD/emphysema.

²⁰ Westmoreland argues that the ALJ failed to adequately account for Cochran’s asthma or lung remodeling from asthma, Pet. Br. 17, but this is a red herring. There is no dispute that Cochran suffered from these conditions, *e.g.* JA 379, and that no doctor related them solely to coal dust exposure. At issue is whether Cochran’s additional respiratory problem – COPD/emphysema – is significantly related to coal mine dust exposure.

Dr. Rasmussen’s opinion that cigarette smoking and coal dust exposure together caused Cochran’s COPD/emphysema was consistent with the preamble findings whereas Drs. Zaldivar’s and Hippensteel’s contrary opinions of smoking-induced emphysema were not.²¹

Westmoreland claims that the ALJ misinterpreted the preamble in finding the inconsistencies, and in any event, the inconsistencies do not undermine its doctors’ opinions because they rely on medical literature post-dating the preamble. Westmoreland is wrong on both counts.

The ALJ found that “[t]he preamble . . . appears to support Dr. Rasmussen’s view, *i.e.*, that medical literature supports the theory that dust-related emphysema and smoke-induced emphysema occur through similar mechanisms.” JA 379. This is undoubtedly correct: the preamble states “dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms.” 65 Fed. Reg. 79943 (Dec. 20, 2000). And the ALJ further correctly observed in “particular regard [to the etiology of the emphysema], the opinions of Drs. Zaldivar and Hippensteel are inconsistent with the scientific evidence set forth in the Preamble to the 2001 regulations.” JA 379. Indeed, Dr. Zaldivar, who related the

²¹ As noted above, *supra* n. 16, it is far from clear that Dr. Hippensteel actually diagnosed emphysema.

emphysema to smoking, JA 17-18, 29, explicitly testified that cigarette smoking and coal dust exposure result in different processes of cell destruction, JA 212, and Dr. Hippensteel (like Dr. Zaldivar) categorically excluded any association between coal dust exposure and panacinar emphysema. JA 160; *but see* 65 Fed. Reg. 79941-43 (describing relationship between coal dust exposure and “emphysema” without qualification); JA 38 (coal dust exposure causes panacinar emphysema); JA 107 (the emphysema caused by cigarette smoke and coal dust exposure is identical whether “panacinar, centriacinar, bullous etc.”).²² Moreover, Dr. Hippensteel disputes coal mine dust exposure as a cause of the emphysema because Cochran’s condition progressed without corresponding x-ray changes, JA 175, an assertion that is incompatible with section 718.202(a)(4) (allowing diagnosis of legal pneumoconiosis in the absence of positive x-ray ray evidence); *see also* JA 38 (coal dust exposure may cause emphysema through a different mechanism that is independent of x-ray changes). Thus, the ALJ properly found Dr. Rasmussen’s opinion consistent with the preamble and permissibly rejected

²² Not only is Dr. Zaldivar’s conclusion that coal dust exposure and cigarette smoking result in different processes of cellular destruction inconsistent with the preamble, his attempt to explain the allegedly different processes is cursory and confusing. JA 212. Nor does Dr. Zaldivar point to any specific defects in Dr. Rasmussen’s explanation of the process, which is far more detailed and consistent with the preamble’s findings. JA 107-08; 65 Fed. Reg. 79942-43.

Drs. Zaldivar's and Hippensteel's as inconsistent with it. *See Harman Mining*, 678 F.3d at 316 (affirming as “well within [ALJ's] discretion to find [doctor's] opinion less persuasive” that conflicted with preamble).

Westmoreland attempts to salvage its experts' opinions with *Island Creek Coal Co. v. Groves*, 246 Fed. Appx. 842, 2007 WL 2349337 (Aug. 17, 2007), contending that the case stands for the proposition that bullous emphysema is not related to coal dust exposure (an assertion its experts make here). Pet. Br. 14-15. But *Groves* merely held that an ALJ erred in finding unexplained a doctor's opinion eliminating coal dust as a cause of the miner's bullous emphysema when the doctor had testified that he had never seen the condition in a non-smoking miner. 246 Fed. App's at 846-47. Thus, the Court ordered a remand for the ALJ to reconsider the opinion, but it did not hold that the doctor's opinion was credible, only that the ALJ had mischaracterized it. *Id.* By contrast, the ALJ here did not find Drs. Zaldivar's and Hippensteel's diagnoses unexplained, rather he found their explanations not credible because they were inconsistent with the preamble. (As we discuss below in section 4, the ALJ also permissibly discounted their diagnoses because they rely on the absence of clinical pneumoconiosis.)

Next, Westmoreland complains that the ALJ erred in relying on the findings in the preamble to the exclusion of the more recent medical studies cited by Drs. Zaldivar and Hippensteel. This argument is without merit. Dr. Hippensteel does

not in fact refer to any medical studies post-dating the preamble, and while Dr. Zaldivar does, the studies he cites reflect unexceptional or largely irrelevant propositions. *See supra* n. 13 (describing the literature). None discuss the effects of coal dust exposure or the medical and scientific premises reached in the preamble. *Harman Mining*, 678 F.3d at 314-15. Indeed, despite Westmoreland’s repeated charge that the preamble represents “old science,” it never directly challenges the substance of the Department’s positions there. *See Harman Mining*, 678 F.3d 315 n. 3 (noting that coal company did not dispute substance of preamble findings).²³ In fact, the gist of its appeal is that its doctors’ opinions are *consistent*

²³ Notably, in reaching its preamble conclusions, the Department relied on a comprehensive study by the National Institute for Occupational Safety and Health (NIOSH). 65 Fed. Reg 79939, 79943; Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 62 Fed. Reg. 3338, 3343 (Jan. 22, 1997) (citing National Institute for Occupational Safety and Health, *Criteria for a Recommended Standard: Occupational Exposure to Respirable Coal Mine Dust* § 4.2.2. *et seq.* (1995)). In April 2011, 16 years after publication of its original *Criteria*, NIOSH released Current Intelligence Bulletin 64, *Coal Mine Dust Exposure and Associated Health Outcomes, A Review of Information Published Since 1995* (2011). As its title indicates, the purpose of the Bulletin was to “update the information on coal mine dust exposures and associated health effects from 1995 to the present.” *Id.* at iii. One of the main conclusions drawn from the review of new information was that the “new findings strengthen [the] conclusions and recommendations” [reached in the original 1995 publication]. *Id.* at 5. Among other findings, the Bulletin confirms the dust-related effects on chronic airway obstruction, including emphysema, as well as the similar effects on COPD caused by smoking and dust exposure. *Id.* at 23-24. Both Bulletin 64 and the 1995 *Criteria* are available on the NIOSH website at <http://www.cdc.gov/niosh/docs/2011-172/> and <http://www.cdc.gov/niosh/docs/95-> (continued...)

with the preamble (and the ALJ wrongly found otherwise).

In any event, Westmoreland must do more than cite a few isolated and inapposite medical studies (two of which are unidentified) in order to undermine the preamble findings. *Id.* (observing that court would credit Labor Department position in a benefits proceeding on “a question of scientific fact ‘unless mine operators produced the type and quality of medical evidence that would invalidate a regulation’” quoting *Midland Coal Co. v. Dir., OWCP*, 358 F.3d 486, 490 (7th Cir. 2004)); see also *Nat’l Mining Ass’n v. Dir., OWCP*, 292 F.3d 849, 868-69, 871 (D.C. Cir. 2002) (agency’s duty of reasoned decisionmaking includes supporting regulation with substantial evidence).

4. The ALJ’s alternative reason for discounting Drs. Zaldivar’s and Hippensteel’s opinions – that they unduly relied on the absence of x-ray evidence of pneumoconiosis – is supported by substantial evidence.

Finally, the ALJ provided a valid, alternative rationale for discounting the opinions of Drs. Zaldivar and Hippensteel, namely that although the two doctors “appear to say all the right things” regarding legal pneumoconiosis, they “primarily concentrated on explaining why they believed the miner did not suffer from clinical pneumoconiosis and why clinical pneumoconiosis was not responsible for [Cochran’s] symptoms or impairment.” JA 379. Since Westmoreland has not

(...continued)

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challenged the ALJ's finding, it has waived the issue and the Court should affirm the ALJ's decision to reject the opinions of Drs. Zaldivar and Hippensteel. *Westmoreland Coal Co., Inc. v. Sharpe*, 692 F.3d 317, 338 (4th Cir. 2012) ("even appellees waive arguments by failing to brief them"), quoting *U.S. v. Ford*, 184 F.3d 566, 578 n.3 (6th Cir. 1999).

Regardless, the fact remains that Dr. Hippensteel testified that pneumoconiosis, if latent and progressive, is "usually associated with x-ray progression," and that significant pneumoconiosis in the absence of x-ray evidence "is not the usual finding regarding coal workers' pneumoconiosis." JA 158, 161, 175. Similarly, Dr. Zaldivar relied on negative x-rays to conclude that "there is not a great deal of dust in his lungs, if any," and stated that coal dust-related emphysema is accompanied by x-ray evidence of pneumoconiosis. JA 209, 222. These opinions, if not demanding x-ray proof of pneumoconiosis and thus reflecting outright hostility to the Act,²⁴ aroused the ALJ's skepticism and

²⁴ See 30 U.S.C. § 923(b) ("[N]o claim shall be denied on the basis of the results of chest roentgenogram."); 20 C.F.R. § 718.202(a)(4) (specifically permitting a pneumoconiosis determination "notwithstanding a negative X-ray"); *Black Diamond Coal Mining Co. v. BRB*, 758 F.2d 1532, 1534 (11th Cir. 1985) (agreeing with the BRB that a doctor's opinion that pneumoconiosis may not be diagnosed absent a positive X-ray is hostile to the BLBA). See also *Barber v. Director, OWCP*, 43 F.3d 899, 901 (4th Cir. 1995) ("[E]vidence that a claimant does not have clinical pneumoconiosis is not relevant to the issue of legal pneumoconiosis.").

substantial evidence supports his according them less weight. *Midland Coal Co. v. Dir., OWCP*, 358 F.3d 486, 492 (7th Cir. 2004) (explaining that, unless a company’s interpretation of a doctor’s opinion is the only permissible one, the ALJ’s contrary interpretation must be affirmed as supported by substantial evidence).²⁵

²⁵ Westmoreland makes two additional arguments that are entirely unrelated to this case. First, it accuses the ALJ of “transforming” the rebuttable presumption of entitlement under 20 C.F.R. § 718.305 (*supra* n.16) into an “irrefutable presumption” of entitlement. Pet. Br. at 31. But the ALJ *declined to invoke* that presumption in the first instance. JA 382-84. Second, Westmoreland claims the ALJ improperly shifted the “discussion from bullous emphysema to a point about obstructive lung diseases” and as support quotes at length allegedly from the ALJ’s decision. Pet. Br. 16. But the block quote is not from the ALJ’s opinion here; it is from *Sizemore v. Westmoreland Coal Co.*, Case No. 2009-BLA-5851 (April 11, 2011) *appeal docketed* No. 12-1979 (4th Cir. July 20, 2012). Thus, these contentions are utterly baseless.

CONCLUSION

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

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I certify that this brief is proportionally spaced, using Times New Roman 14-point typeface, and contains 4719 words, as counted by Microsoft Office Word 2010.

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CERTIFICATE OF SERVICE

I hereby certify that on November 8, 2012, copies of the Director's brief were served electronically using the Court's CM/ECF system and by mail, postage prepaid, on the Court and the following:

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