

No. 12-3872

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

**WHITAKER COAL CORPORATION,
(Self-Insured through Sun Coal Corporation),**

Petitioner

v.

JAMES OSBORNE

and

**DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,**

Respondents

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

BRIEF FOR THE FEDERAL RESPONDENT

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STATEMENT REGARDING ORAL ARGUMENT

The Director agrees with Petitioner Whitaker Coal Corporation that oral argument is unnecessary in this case, which is scheduled to be submitted on the briefs on May 3, 2013.

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BRIEF FOR THE FEDERAL RESPONDENT

**STATEMENT OF APPELLATE AND SUBJECT
MATTER JURISDICTION**

This case involves a claim for benefits under the Black Lung Benefits Act (BLBA), 30 U.S.C. §§ 901-944 (2006 & Supp. IV 2010), filed by James Osborne, who worked in coal mine employment for thirty-three years. On November 29, 2010, Administrative Law Judge John P. Sellers, III (the ALJ) issued a decision

awarding the miner benefits and ordering his former employer, Whitaker Coal Corporation (Whitaker Coal), to pay them. Appendix, page (A.) 13. Whitaker Coal appealed this decision to the United States Department of Labor Benefits Review Board (BRB or Board) on December 27, 2010, within the thirty-day period prescribed by 33 U.S.C. § 921(a), as incorporated into the BLBA by 30 U.S.C. § 932(a). A.4. The Board had jurisdiction to review the ALJ's decision pursuant to 33 U.S.C. § 921(b)(3), as incorporated by 30 U.S.C. § 932(a).

On November 15, 2011, the BRB affirmed the award. A.5. Whitaker Coal sought reconsideration of this decision on December 12, 2011, within the thirty-day period prescribed by 20 C.F.R. § 802.407(a). The BRB denied the motion in a final decision on May 31, 2012. A.1. Whitaker Coal then petitioned this Court for review on July 18, 2012. A.43. The Court has jurisdiction over Whitaker Coal's petition because section 21(c) of the Longshore Act, 33 U.S.C. § 921(c), as incorporated by 30 U.S.C. § 932(a), allows an aggrieved party sixty days to seek review of a final BRB decision in the court of appeals in which the injury occurred. *See also* 20 C.F.R. § 802.406 (timely motion for reconsideration tolls the sixty-day appeal period). The injury, within the meaning of section 21(c), arose in Kentucky, within this Court's territorial jurisdiction.

STATEMENT OF THE ISSUE

Section 921(c)(3) of the Black Lung Benefits Act contains an irrebuttable presumption of total disability due to pneumoconiosis -- required elements of entitlement -- when a miner proves that he has complicated pneumoconiosis. Complicated pneumoconiosis can be established by chest X-ray, biopsy or autopsy, or by “other means,” including CT-scan and medical opinion evidence. These methods require the diagnosis of a mass of a particular size that is related to coal mine employment, and all relevant evidence must be considered, including medical opinions, in making this determination.

It is undisputed that the X-ray and CT-scan evidence here shows large masses in the miner’s lungs, but the physicians disagree as to their cause. The ALJ found the X-ray and CT-scan evidence to be inconclusive, but when weighed together with the medical opinion evidence, he concluded that the miner suffered from complicated pneumoconiosis. The ALJ discredited the contrary evidence because the authoring doctors suggested tuberculosis or histoplasmosis as causes of the mass, but none of the miner’s treating doctors diagnosed or considered those conditions, the miner had a tuberculosis test that was negative, and the authoring doctors used speculative language when

attributing the mass to tuberculosis (TB) or histoplasmosis.¹ The question presented is:

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

STATEMENT OF THE CASE

The miner filed this claim for black lung benefits in April 2008.² Director's Exhibit No. (DX.) 3.³ Following an administrative hearing, ALJ John P. Sellers, III, awarded benefits, finding that the miner was entitled to the irrebuttable presumption of entitlement at 30 U.S.C. § 921(c)(3) and 20 C.F.R. § 718.304, based upon proof that the miner suffered from complicated pneumoconiosis arising out of coal mine employment. A.13, 26-28.

¹ 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, 856, 1962 (30th ed. 2003).

² The miner filed a prior claim in 1994, DX.1 at 222, which was finally denied in October 1996 upon a finding that the miner had pneumoconiosis by X-ray but did not have a totally disabling respiratory condition. *See* DX.1 at 3.

³ The Index of Documents in the Certified Case Record, submitted October 5, 2012, by Board Clerk Thomas O. Shepherd, does not contain separate entries for the hearing exhibits, hearing transcript, or administrative proceedings occurring before the ALJ's November 2010 award of benefits. The Director is therefore unable to provide separate references to the Certified Case Record for these documents.

Whitaker Coal appealed to the BRB, arguing that the ALJ's finding of complicated pneumoconiosis was not supported by substantial evidence. The BRB rejected this argument and on November 15, 2011, affirmed the ALJ's award, A.4.; and on May 31, 2012, denied Whitaker Coal's motion for reconsideration of the BRB's affirmance. A.1. On July 18, 2012, Whitaker Coal petitioned this Court for review. A.43.

STATEMENT OF THE FACTS

A. Statutory and regulatory background.

The Black Lung Benefits Act compensates coal miners who can prove that they are totally disabled by 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 Martin v. Ligon Preparation Co.*, 400 F.3d 302, 306 (6th Cir. 2005), quoting *Richardson v. Director, OWCP*, 94 F.3d 164, 166 n.2 (4th Cir. 1996). (“[C]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis 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 may be established by three methods: (A) by a chest X-ray that yields one or more large opacities (greater than one centimeter in diameter) that are classified 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).⁴ *See also* 20 C.F.R. § 718.304 (DOL’s regulation implementing the section 921(c)(3) presumption). Proof by one method does not automatically invoke the irrebuttable presumption; instead, the ALJ must consider “all relevant evidence, which “means just that – all evidence that assists the ALJ in determining whether a miner suffers from complicated pneumoconiosis.” *Gray v. SLC Coal Company*, 176 F.3d 382, 389-90 (6th Cir. 1999). Thus, the ALJ is not limited to weighing only the conflicting

⁴ The full version of section 921(c) (3) is set forth in the Addendum of this brief.

evidence within each category but may weigh “evidence from different categories (e.g., x-ray vs. autopsy) against one another.” *Gray*, 176 F.3d at 389. *See also Dixie Fuel Co., L.L.C. v. Director, OWCP*, 700 F.3d 878, 881 (6th Cir. 2012) (vacating an ALJ’s finding of complicated pneumoconiosis because the ALJ, *inter alia*, failed to consider contrary medical opinions).⁵ “The claimant has the burden of proof in establishing the existence of complicated pneumoconiosis and thereby invoking the irrebuttable presumption of total disability.” *Sexton v. Switch Energy Coal Corp.*, 20 Fed.Appx. 325, 328 (6th Cir. 2001) (unpublished), citing *Lester v. Director, OWCP*, 993 F.2d 1143, 1146 (4th Cir. 1993).

Finally, for a medical opinion to be credited, it must be reasoned and documented. This “requires the factfinder to examine the validity of the reasoning of the medical opinion in light of the studies conducted and the objective indications upon which the medical opinion or conclusion is based.” *Director, OWCP v. Rowe*, 710 F.2d 251, 255 (6th Cir. 1983).

B. Non-medical evidence.

The miner was employed in coal mine work for thirty-three years, A.16, ending in 1994, DX.3. Whitaker Coal employed him for at least nine of those years. DX.9. He was sixty-seven years old at the time of the 2010 administrative

⁵ *Gray* observed that “x-rays are generally recognized as the least accurate method of correctly diagnosing complicated pneumoconiosis. 176 F.3d at 389-90.

hearing, and smoked about a pack of cigarettes a day for fifteen to seventeen
nineteen years until quitting in 1966. A.50, 57.

**C. Medical evidence (developed since the October 1996 denial
of the miner’s prior claim)**

Chest X-ray readings

Exhib -it No.	Physician/ Qualifications	Date	Observations	Classifi -cation⁶
DX.25 at 27	Basim W. Antoun	2/26/98	Lungs mildly emphysematous with minimal fibrotic changes	
DX.25 at 24	Basim W. Antoun	3/10/98	congestion with edema “superimposed on chronic interstitial lung disease”	
DX.24 at 18	Basim W. Antoun	4/21/98	Nodules “likely representing sequel of coal workers”” pn.;	

⁶ 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. Only the X-rays taken on June 10, 2008, and September 3, 2008, are classified under the ILO system. Consequently, only the ILO-read X-rays may establish complicated pneumoconiosis under section 921(c)(3)(A). However, as explained *infra*, the non-ILO X-ray readings may be considered as part of a medical opinion or in conjunction with the ILO X-ray readings when the ALJ considers all relevant evidence.

			fibroemphysematous pulmonary disease at the upper lobes	
DX.25 at 10	Elmer A. Anderson, Jr.	11/20/98	Chronic lung disease	
DX.21 at 22	Rodney Stinnett	6/3/03	Lobe densities “associated with anthracosis and coal worker’s lung. This also must be correlated against tuberculosis”	
DX.21 at 12	Rodney G. Stinnett	11/5/03	Consistent with pneumoconiosis; “progression of the coalescent shadows since 11-19-98”	
DX.23 at 11	John M. Harrison	5/3/04	“Diffuse reticular nodular disease most prominent in the upper 2/3 of both lung zones”; “conglomerate changes in the apices where granulomatous disease appears to have consolidated.” <u>Impression:</u> complicated pneumoconiosis	
DX.18 at 18	B.C. Trent	2/23/06	5 cm mass in right upper lobe; possible pneumoconiosis, but lobe needs to be checked for malignancy	
DX.22 at 17	Dhiren Desai	5/25/06	Lobe masses; possible “mass versus large opacities of the pneumoconiosis”	
DX.17 at 25	Ashok Patel	12/10/06	“5 cm mass in right upper lobe...may be due to pneumoconiosis”	

DX.24 at 1	Mahender Pampati	2/27/07	pneumoconiosis	
DX.16 at 1	Eric D. Johnson	1/24/08	Mass in right and left upper lobe and nodule 2-1/2 centimeters over left upper lobe; COPD	
DX.15 at 1	Peter Barrett/Board-certified radiologist, B-reader ⁷	6/10/08		Read for quality: good quality
DX.14 at 1	Abdi Vaezy/B-reader/Board-certified in internal medicine, pulmonology and critical care	6/10/08		3/2, "C" large opacities [complicated p]
DX.41 at 2	Paul S. Wheeler/B-reader/Board-certified radiologist	6/10/08 Reread 8/13/08	Masses and small nodular infiltrates probably consistent with conglomerate granulomatous disease - histoplasmosis more likely than TB	0/1 [no simple or complicated p]
EX.2	Paul S. Wheeler/B-reader, Board-certified radiologist	9/3/08 Reread 9/17/08	4 cm mass "compatible with conglomerate granulomatous disease, histoplasmosis more likely than TB"	0/1; [no simple or complicated p]

⁷ A "Board-certified radiologist" is a radiologist who is certified "in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association." 20 C.F.R. § 718.202(a)(1)(ii)(C). A "B-reader" is "a physician who has demonstrated proficiency in evaluating chest roentgenograms for roentgenographic quality and in the use of the ILO-U/C classification [required by section 20 C.F.R. § 718.102(b)] for interpreting chest roentgenograms for pneumoconiosis and other diseases." 20 C.F.R. § 718.202(a)(1)(ii)(E). See *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993) (explaining that "board certified radiologists have comparable qualifications to B-readers").

EX.8	John C. Scatarige/B-reader, Board-certified radiologist	9/3/08 Reread 9/17/08	“5 cm. mass RUL extending to pleura, laterally. 4 cm. mass in left apex with localized infiltrate [illegible] to it. Small round opacities in upper [illegible] lung zones. Based on marked asymmetry and pleural involvement, I favor histoplasmosis or TB rather than pneumoconiosis. Advice: correlate [with] ct[-scan] and get biopsy...”	1/0 [simple p]
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CT-scan readings⁸

Exhibit No.	Physician/Qualifications	Date	Observations
DX.22 at 14	Ashok Patel	11/21/ 03	Nodules in upper nodes consistent with pneumoconiosis
EX.4	Paul S. Wheeler/Board-certified radiologist; B-reader	11/21/ 03	“Masses in upper lobes are not large opacities of CWP [coal workers’ pneumoconiosis] because there are no symmetrical small nodular infiltrates in mid and upper lungs from which large opacities merge. Also it is rare to have a large opacity involv[ing] an apex.

⁸ 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.

			However, an exact diagnosis is needed for proper therapy...”
DX.22 at 3	Dhiren Desai	5/25/06	“Differential diagnostic possibilities include mass versus large opacities of the pneumoconiosis”
EX.5	Paul S. Wheeler/Board-certified radiologist; B-reader	5/25/06	“Masses in upper lobes are not large opacities of CWP because adjacent small opacities are mainly linear with only a few nodules and they contain calcified granulomata indicating healed histoplasmosis... An exact diagnosis is needed for proper therapy. . . .”
DX.17 at 23	Ashok Patel	12/9/06	“radicular nodular changes noted in both upper lobes consistent with pneumoconiosis”
EX.3	Paul S. Wheeler/Board-certified radiologist; B-reader	12/9/08	“Masses in upper lungs are not large opacities of CWP because any background nodules are low profusion and the masses contain many tiny calcified granulomata, some small nodules in upper lungs involving pleura and linear small opacities are more common. Finally he is relatively young since NIOSH and MSHA became active controlling dust levels in mines in early 1970s mandated to prevent CWP.” “Exact diagnosis is needed for proper therapy”
CX.3	Ashok Patel	12/9/08	“nodules consistent with silicosis and pneumoconiosis”

Physicians’ opinions

John M. Harrison, Board-certified internist and pulmonologist; examined the miner on May 3, 2004 (A.50); treatment report submitted by the miner.

Information relied upon: family, medical, and social (including work) histories; physical examination findings; symptoms; X-ray taken on May 3, 2004, read by the doctor as showing complicated pneumoconiosis; X-rays taken in 1998 and 2000 showing simple pneumoconiosis progressively worsening; and pulmonary function study results. A.54.

Diagnosis: Dr. Harrison examined the miner at the request of the miner's treating physician to determine whether the mass in the miner's lungs was a malignancy or complicated pneumoconiosis. The doctor concluded that a malignancy was unlikely but that the miner did have complicated pneumoconiosis. He explained that the miner "ha[d] diffuse reticular nodular disease most prominent in the upper 2/3 of both lung zones," and that "[t]here are conglomerate changes in the apices where this granulomatous disease appears to have consolidated." A.54. He concluded: "[I]t is easy to see in watching the progression of his chest x-rays from '98 until recently that this has gone from simple coal workers' pneumoconiosis to complicated coal workers' pneumoconiosis (PMF)."⁹ *Id.* Dr. Harrison also observed that the miner's cough was due to his pneumoconiosis, and that no treatment was recommended unless the miner became symptomatic.

On a prescription form dated May 3, 2004, Dr. Harrison reported that, "since 1998 [the evidence] has converted from simple coal workers' pneumoconiosis to complicated pneumoconiosis (progressive massive fibrosis)." DX.29 at 8.

Abdi Vaezy; Board-certified internist and pulmonologist with additional certification in critical care; B-reader; examined the miner on June 10, 2008, at DOL's request (A.56); report submitted by the Director.¹⁰

⁹ "PMF" is progressive massive fibrosis, another name for complicated pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 509 (6th Cir. 2003).

¹⁰ The Department provided this examination in order to fulfill its statutory duty to give each claimant-miner "an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation." 30 U.S.C. § 923(b); *see also* 20 C.F.R. § 725.406.

Information relied upon: family, medical, and social (including work) histories; physical examination findings; pulmonary function study and blood gas analysis; X-ray taken on June 10, 2008, showing pneumoconiosis 3/2 and large opacities C [complicated pneumoconiosis].

Diagnosis: Dr. Vaezy diagnosed complicated pneumoconiosis based upon his X-ray reading and the miner's thirty-five years of coal mine employment. He explained that, while the pulmonary function studies were "borderline normal," the miner was totally disabled based upon the complicated pneumoconiosis diagnosis. A.59.

A. Dahhan/Board-certified internist and pulmonologist; examined the miner on September 3, 2008 (A.60); report submitted by Whitaker Coal.

Information relied upon: family, medical, and social (including work) histories; physical examination findings; pulmonary function study and blood gas analysis; September 3, 2008 X-ray report of Dr. Scatarige (pneumoconiosis 1/0 with no large opacities; findings consistent with histoplasmosis or tuberculosis rather than pneumoconiosis"); reviewed X-ray and CT-scan reports from 1998 to 2006.

Diagnosis: Dr. Dahhan accepted Dr. Scatarige's reading of the September 8, 2008, X-ray which reported simple pneumoconiosis but not complicated pneumoconiosis. Dr. Dahhan explained that Dr. Scatarige's interpretation was confirmed by the miner's chest showing no crackles and his pulmonary function study producing normal results (A.63-64).

Christian Family Healthcare treatment records (primarily for heart disease) from 1994 to 2008; authored by numerous doctors; DX.18, 40; submitted by the miner.¹¹

¹¹ The record contains additional treatment reports. Those concerned with the miner's heart problem are not set forth here.

Information relied upon: family, medical, and social histories; physical exams and various hospital tests, including X-rays and CT-scans.

Diagnosis: pneumoconiosis or coal workers' pneumoconiosis ("cwp") frequently reported (*see, e.g.*, DX.18 at 12, 36, 49, 60, 62; DX.28 at 1, 4; DX.40 at 10, 14).

D. The decisions below.

The ALJ's award.

The ALJ first considered whether the evidence developed since the October 1996 denial of the miner's prior claim now proved that the miner had a totally disabling respiratory condition, since that was the condition of entitlement previously decided against the miner.¹² A.17-18, 29. Because the post-denial evidence did not directly prove total disability, the ALJ considered whether it established the presence of complicated pneumoconiosis arising out of coal mine employment (which would invoke the Section 921(c)(3) irrebuttable presumption of total disability due to pneumoconiosis). A.29

¹² Section 725.309, the Department's subsequent claim regulation, implements the doctrines of claim and issue preclusion. It does so by requiring a re-filing claimant to establish, based on new evidence, a change in an "applicable condition of entitlement," one that was found against the claimant in the prior claim. 20 C.F.R. § 725.309(d)(3). *See Cumberland River Coal Co. v. Banks*, 690 F.3d 477, 486 (6th Cir. 2012) (holding that, "to determine a change in condition," the ALJ need "consider only the new evidence to determine whether the element of entitlement previously found lacking is now present").

In this regard, the ALJ looked first to the two chest X-rays that had been classified under the ILO system: the June 10, 2008, and September 3, 2008, X-rays. A.31. Dr. Vaezy, a B-reader, read the June 10 X-ray as positive for complicated pneumoconiosis, whereas Dr. Wheeler, a Board-certified radiologist and B-reader, read it as negative for both simple and complicated pneumoconiosis. Dr. Scatarige, a Board-certified radiologist and B-reader, read the September 3 X-ray as positive for simple pneumoconiosis but negative for complicated pneumoconiosis; and Dr. Wheeler read the X-ray as negative for both simple and complicated pneumoconiosis.

In weighing this X-ray evidence, the ALJ observed first that all four doctors acknowledged that there was a large mass over one cm in size but differed as to its cause, with Dr. Vaezy attributing it to pneumoconiosis, Dr. Wheeler attributing it to “conglomerate granulomatous disease, with histoplasmosis being more likely than tuberculosis”; and Dr. Scatarige “favoring” histoplasmosis or tuberculosis.¹³ The ALJ then observed that, while Dr. Vaezy’s diagnosis of complicated pneumoconiosis was unequivocal, the diagnoses of the other two doctors were not:

¹³ The diseases cited by Drs. Wheeler and Scatarige 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. See DORLAND’S ILLUSTRATED MEDICAL DICTIONARY at 795. For the definitions of histoplasmosis and tuberculosis, see n.1 *supra* at 4.

Dr. Wheeler reported that “histoplasmosis [was] *more likely* than tuberculosis”; and that: “Masses in the upper lobes are not large opacities because profusion of background nodules is low and they *probably* involved pleura which has no alveoli. Also, [coal workers’ pneumoconiosis] only *rarely* involves apices.” A.31, quoting DX.41 at 2 (emphasis added). And Dr. Scatarige reported he “*avored*” the other conditions over pneumoconiosis, A.31 quoting EX.8 (emphasis added), and both doctors recommended further testing to ascertain a definitive diagnosis, A.31 quoting DX.41 at 2 and EX.8.

The ALJ also found the opinions of Drs. Wheeler and Scatarige undermined by the miner’s 2004 negative tuberculosis test, and none of the doctors in the many treatment reports diagnosed histoplasmosis. A.32-33. On this last point, however, the ALJ indicated that he could not accord less weight to their uncorroborated diagnosis of histoplasmosis due to the Board’s holding in *Deel v. Buchanan Prod. Co.*, 2006 WL 6867422 at *5 n.6 (DOL Ben. Rev. Bd. 2006), which, according to the ALJ, found it was improper for an ALJ to use the absence of supporting record evidence of histoplasmosis to discredit X-ray readings diagnosing the disease. A.32-33.¹⁴ Ultimately, the ALJ determined that the weight of the X-ray evidence was inconclusive for the existence of complicated pneumoconiosis. A.33.

¹⁴ As discussed *infra* at 34-35, the Board’s *Deel* decision is incorrect.

The ALJ next considered the CT-scan evidence. A.33. He determined that the CT-scans likewise showed large masses but were inconclusive as to their nature, with Dr. Wheeler again finding no pneumoconiosis while several other doctors found pneumoconiosis present. A.33-34.

Finally, the ALJ reviewed the medical opinions. A.36. First considered was the opinion of Dr. Harrison, the Board-certified pulmonologist whom the miner's treating doctor consulted to determine the cause of the large mass on the miner's lungs. The ALJ concluded that Dr. Harrison's opinion was entitled to substantial weight because of its thoroughness: the doctor had a detailed history of the miner's symptoms, including the fact that the miner had trouble breathing and used an oxygen machine every night; the doctor reviewed and compared a number of the X-rays; and the doctor had the miner take a tuberculosis test that proved to be negative. A.36-37. The ALJ also observed that Dr. Harrison "noted the conglomerate changes in the apices and the granulomatous disease, as well as the reticular nodular changes, and, observing an increase in severity [of the X-rays], stated that it was 'easy to see' that the Claimant's x-rays had gone 'from simple coal workers' pneumoconiosis to complicated pneumoconiosis (PMF).'" While the ALJ acknowledged that Dr. Harrison's opinion had certain limitations because the doctor was a Board-certified pulmonologist but not a B-reader, the ALJ concluded that the doctor's detailed findings and review of the X-rays "add[ed] to

his credibility.” A.37. Finally, the ALJ suggested that Dr. Harrison, as a pulmonologist, was in a better position than a radiologist to determine the miner’s condition: “Although a radiologist has expertise in reading x-rays for the presence of disease, a pulmonologist would seemingly have greater expertise in noting the progressive nature of lung disease and charting its course as it expands its presence in the lungs.” *Id.*

The ALJ turned next to the diagnosis of complicated pneumoconiosis proffered by Dr. Vaezy, a Board-certified pulmonologist and B-reader who examined the miner on DOL’s behalf. A.37. The ALJ determined that the doctor’s diagnosis of complicated pneumoconiosis rested not only on a positive X-ray reading but also upon physical examination findings, history, symptomology, and test results, including a pulmonary function study producing “borderline normal” results. The ALJ thus concluded that Dr. Vaezy’s opinion was more than a ‘restatement of an x-ray,’ and therefore entitled to substantial weight. A.37.

Finally, the ALJ considered the opinion of Whitaker Coal’s expert, Dr. Dahhan, a Board-certified pulmonologist who diagnosed simple pneumoconiosis but not complicated pneumoconiosis. *Id.* The ALJ observed that the doctor credited Dr. Scatarige’s X-ray reading (positive for simple pneumoconiosis but negative for complicated pneumoconiosis) because Dr. Scatarige was “an[] expert in the field of occupational lung disease and it’s [sic] radiological manifestations.”

Id. The ALJ also observed that Dr. Dahhan considered his diagnosis of no complicated pneumoconiosis by X-ray “confirmed” by the fact that the miner’s breathing produced no crackles and the miner’s pulmonary function study results were normal. *Id.*

The ALJ, however, was not persuaded by Dr. Dahhan’s opinion because Dr. Vaezy likewise noted the lack of crackles and only borderline pulmonary function study results, yet Dr. Vaezy “did not consider either an impediment to a diagnosis of complicated pneumoconiosis.” *Id.* In addition, the ALJ criticized Dr. Dahhan’s opinion because the doctor did not sufficiently describe the miner’s symptoms (shortness of breath and use of oxygen at night), the cause of those symptoms, or explain how he could diagnose no respiratory disability in light of those symptoms. The ALJ also criticized Dr. Dahhan’s opinion because, unlike Dr. Harrison, Dr. Dahhan was unaware of the miner’s 2004 negative tuberculosis test. Finally, the ALJ questioned Dr. Dahhan’s acceptance of Dr. Scatarige’s diagnosis of no complicated pneumoconiosis but not Dr. Scatarige’s explanation “favoring” histoplasmosis or tuberculosis. *Id.*

In weighing the medical opinion evidence, the ALJ concluded that the opinion of Dr. Harrison was entitled to the most weight because of the thoroughness of his report: “The completeness of Dr. Harrison’s report, his comparative review of several x-rays, his discussion of his x-ray findings, the fact

that he considered a negative tuberculosis test, and his in-depth discussion of the history of Claimant's symptoms, are all persuasive." A.38. And, the ALJ observed, Dr. Harrison's diagnosis of complicated pneumoconiosis was supported by that of Dr. Vaezy. Accordingly, the ALJ concluded that the weight of the medical opinion evidence proved that the miner suffered from complicated pneumoconiosis.

The ALJ then proceeded to weigh together the separate categories of evidence, namely the X-rays, CT-scans, and medical opinions. A.38. In this regard, the ALJ noted the following: the miner's symptomology included shortness of breath on exertion, nightly use of oxygen, and daily cough; the miner had worked as an underground coal miner for thirty-five years; the miner had heart disease; the miner's tuberculosis test was negative; the record lacked any explanation for the cause of the miner's alleged histoplasmosis; the record did not contain a diagnosis of tuberculosis or histoplasmosis by the miner's treating doctors; the miner's smoking history is not significant; neither Dr. Harrison nor Dr. Vaezy, both of whom diagnosed complicated pneumoconiosis, has a party affiliation (Dr. Harrison examined the miner at the request of another doctor, and Dr. Vaezy examined the miner upon DOL's request); while the X-ray evidence concerning complicated pneumoconiosis was inconclusive, it categorically supported the finding of a large mass in the miner's lungs, which was consistent

with a finding of complicated pneumoconiosis; both Drs. Wheeler and Scatarige, although reporting no complicated pneumoconiosis, raised doubts about the certainty of their diagnoses by stating that more medical testing was required; and the weight of the X-ray and CT-scan evidence was inconclusive for complicated pneumoconiosis. Based upon these factors, the ALJ determined that the section 921(c)(3) categories, when read together, established the existence of complicated pneumoconiosis. A.38-39.

Because the finding of complicated pneumoconiosis established total respiratory disability – the element of entitlement previously found against the miner – the ALJ concluded the miner had satisfied the subsequent claim prerequisite of proving an element previously decided against him. A.39. The ALJ therefore moved on to determine if the record as a whole proved the existence of complicated pneumoconiosis. *Id.*

After considering the whole record, the ALJ concluded that there was nothing in the evidence from the prior claim that undermined his finding of complicated pneumoconiosis. To the contrary, the ALJ determined that the old evidence, especially the X-ray readings, supported a finding of pneumoconiosis as far back as 1994. A.40. The ALJ found Dr. Vuskovich’s 1994 opinion particularly supportive of finding complicated pneumoconiosis: “I am concerned about the area of coalescence of small pneumoconiotic opacities in the right upper

zone. He should have a chest x-ray every year to determine whether or not this area will develop into *an area of complicated disease, progressive massive fibrosis.*” A.40 (emphasis added). Accordingly, the ALJ determined that the miner suffered from complicated pneumoconiosis and was therefore irrebuttably presumed entitled to benefits.

The Board’s affirmance and denial of reconsideration.

Whitaker Coal argued to the Board that the ALJ had erred in finding complicated pneumoconiosis based upon the medical opinion evidence. Specifically, Whitaker Coal argued that the ALJ impermissibly credited doctors’ opinions that relied on X-ray and CT-scan readings that the ALJ found inconclusive on the existence of complicated pneumoconiosis. A.9. The Board rejected this argument, explaining that the issue was whether the medical opinions relied upon by the ALJ – the opinions of Drs. Harrison and Vaezy – were reasoned and documented. The Board concluded that the ALJ properly found Dr. Harrison’s opinion to be reasoned and documented – and in fact, more reasoned and documented than Dr. Dahhan’s contrary opinion – because Dr. Harrison read X-rays taken from 1998 to 2000 and observed a pattern consistent with complicated pneumoconiosis; because Dr. Harrison had a particularly complete understanding of the miner’s medical history, including symptomology; because Drs. Harrison and Vaezy were aware that the miner’s tuberculosis test was negative; and because

Dr. Dahhan inexplicably adopted Dr. Scatarige's diagnosis of no complicated pneumoconiosis but not his diagnosis of histoplasmosis and tuberculosis.

Ultimately, the Board concluded that, "after weighing together all of the relevant evidence at section 718.304(a) and (c), the administrative law judge rationally determined that the opinions of Drs. Harrison and Vaezy were more probative and reliable than the x-ray and ct-scan evidence." A.11.

SUMMARY OF THE ARGUMENT

If a miner can prove that he suffers from complicated pneumoconiosis – the most serious form of pneumoconiosis – he is irrebuttably presumed to be totally disabled due to pneumoconiosis. Section 921(c)(3) of the BLBA provides three methods by which the miner can prove complicated pneumoconiosis: by X-ray; by biopsy or autopsy; or by "other means," such as CT-scan. This Court has made it very clear, however, that whatever method or order of review is used, the ALJ must consider all relevant evidence, including medical opinion evidence. And that is precisely what the ALJ did in this case: he considered all the relevant evidence and concluded that the miner suffered from complicated pneumoconiosis.

The ALJ first looked at the X-ray and CT-scan evidence. (There was no biopsy or autopsy evidence). He observed that, while all the doctors agreed that the miner had a large mass in his lungs, they disagreed as to whether the mass was complicated pneumoconiosis or some other condition. The ALJ weighed the

evidence and concluded that the X-ray and CT-scan readings were inconclusive. Notably, while two experts read X-rays as negative for complicated pneumoconiosis and only one expert read an X-ray as positive for that condition, the ALJ was unwilling to consider the X-ray evidence as negative. He found the negative-reading experts undermined by their use of speculative language. The ALJ also observed that the doctors offered histoplasmosis or TB as the cause of the lung mass, where the miner's extensive treatment records did not mention either condition and in fact the miner had taken a TB test that proved to be negative. It was when the ALJ considered the medical opinion evidence that he concluded the miner suffered from complicated pneumoconiosis. The ALJ found the report of Dr. Harrison, a Board-certified internist and pulmonologist who diagnosed complicated pneumoconiosis, to be both comprehensive and compelling, and to be supported by that of Dr. Vaezy, a Board-certified internist and pulmonologist and B-reader (*i.e.*, a specialist in reading X-rays for pneumoconiosis). The ALJ was particularly persuaded by the fact that Dr. Harrison had access to a series of X-rays that revealed a progressive pattern consistent with complicated pneumoconiosis.

Whitaker Coal has failed to show that the ALJ's method of weighing the evidence was improper. While the company does point to two isolated ALJ errors in weighing the evidence, the Court in its discretion may find them harmless.

Regardless, these errors do not undermine the fact that the ALJ used the correct approach in determining the existence of complicated pneumoconiosis.

ARGUMENT

A. Standard of review.

The Court reviews the ALJ's decision "to determine whether it is supported by substantial evidence and is consistent with applicable law." *Peabody Coal Co. v. Odom*, 342 F.3d 486, 489 (6th Cir. 2003). "When the question is whether the ALJ reached the correct result after weighing conflicting medical evidence, [the Court's] scope of review is exceedingly narrow. Absent an error of law, findings of fact and conclusions flowing therefrom must be affirmed if supported by substantial evidence." *Id.* Substantial evidence is that which a reasonable mind might accept as adequate to support a conclusion. *Id.* "As long as the ALJ's conclusion is supported by the evidence, [the Court] will not reverse 'even if the facts permit an alternative conclusion.'" *Id.* (quoting *Youghioghney & Ohio Coal Co. v. Webb*, 49 F.3d 244, 246 (6th Cir. 1995)). The Court exercises plenary review with respect to questions of law. *Caney Creek Coal Co. v. Satterfield*, 150 F.3d 568, 571 (6th Cir. 1998).

B. The ALJ's weighing of each category of evidence separately and then all together was proper and reasonable.

The ALJ conducted an initial evaluation of each category of evidence relevant to a finding of complicated pneumoconiosis – ILO X-ray readings, C-T

scans, and doctors' opinions – and then considered all the evidence together. This methodology comports with *Gray* and was proper and reasonable.¹⁵

As explained *supra* at 6-7, an ALJ is required under Section 921(c)(3) to consider all relevant evidence, and this in turn mandates that the ALJ consider together all the evidence relevant to the existence of complicated pneumoconiosis. *Gray*, 176 F.3d at 389-90 (holding that the ALJ must consider “all relevant evidence, which “means just that – all evidence that assists the ALJ in determining whether a miner suffers from complicated pneumoconiosis”). This is so because one type (or category) of evidence may not only diminish the probative force of another, *Eastern Assoc. Coal Corp. v. Director, OWCP*, 220 F.3d 250, 256 (4th Cir. 2000), but it may also corroborate, reinforce, or bolster another.¹⁶ Precisely when and how an ALJ weighs the evidence together -- whether the different categories of evidence are first weighed independently and then together or simply

¹⁵ Whitaker Coal for the most part challenges the ALJ's specific weighing of the evidence in this case, which we address in section C. It does, at least in the Director's reading, make a few general (and incorrect) assertions about the proper implementation and application of Section 921(c)(3), although these contentions are not well-developed. In an abundance of caution and to assist the Court, we set forth in this section the Director's understanding of how Section 921(c)(3) should operate.

¹⁶ Here, for example, it can hardly be disputed that the miner's negative TB test detracted from Dr. Wheeler's X-ray readings suggesting TB as the cause of the miner's lung opacities. Or conversely, Dr. Harrison's medical opinion, which included a review of the miner's treatment X-rays, which he believed revealed a progression from simple to complicated pneumoconiosis, bolstered Dr. Vaezy's X-ray reading of complicated pneumoconiosis.

all evidence is weighed together concurrently – may depend on the circumstances of the individual case. *Island Creek v. Compton*, 211 F.3d 203, 209 (4th Cir. 2000) (“[W]hether 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, a formulaic prescription – putting form over substance – may lead to untoward results as well as ALJ remands simply to comply with a particular procedure. Rather, the evidentiary benchmarks should be that the different types of evidence may not be considered in a vacuum and that all relevant evidence must, at some point, be rationally and meaningfully considered. *Gray*, 176 at 389.

Whitaker Coal argues that a medical opinion cannot establish the presence of complicated pneumoconiosis under section (C) where the C-T scans and evidence under sections (A) and (B) (*i.e.*, ILO X-ray readings and biopsy/autopsy evidence) fail to establish the disease. OB. 19. This claim is incorrect. A medical opinion *is itself* objective evidence that falls within category (C)’s catch-all “diagnosis made by other means.”¹⁷ And it need not depend on ILO X-ray readings or biopsy/autopsy evidence to reach its conclusion – it may do so by any acceptable “other means.” Indeed, requiring substantiation by X-ray or biopsy or autopsy

¹⁷ Whitaker Coal repeatedly confuses the term “objective evidence” with “objective testing.” Opening Brief (OB.) 17, 19. In the absence of some improper motive, a medical report is “objective evidence.” It may be not credible (or persuasive) if unsupported by objective testing, but it is still “objective.”

would largely make category (C) redundant. Instead, it is axiomatic that a physician is free to consider any available evidence in making his or her diagnosis, and there is nothing in the statute prohibiting a physician from considering information beyond ILO X-ray readings, biopsy or autopsy results. The test in assessing a medical opinion is one of credibility and persuasiveness: Whether the physician's opinion is reasoned and documented, and comports with acceptable medical procedures. *See* 20 C.F.R. § 718.304(c); *Director, OWCP v. Rowe*, 710 F.2d 251, 255 (6th Cir. 1983). Thus, depending on the particular circumstances, a medical report may prove to be more persuasive than contrary evidence, including ILO X-ray readings or the biopsy/autopsy evidence (categories (A) and (B)). Indeed, this Court in *Maynard v. Eastern Coal Co.*, 328 Fed. Appx. 980 (6th Cir. 2009), affirmed as supported by substantial evidence an ALJ's finding of *no* complicated where the X-ray readings were *positive* for complicated pneumoconiosis but the medical reports (including one from Dr. Harrison) opined the abnormalities were due to prior granulomatous disease.¹⁸

¹⁸ Given the facts of this case, Whitaker Coal's complaint that the ALJ wrongly accorded weight to the medical opinion evidence when he found the ILO X-ray readings inconclusive provides little traction. The ILO X-ray readings and CT-scan evidence uniformly established the presence of large opacities/masses in the miner's lungs. A.32, 34, 39. The issue then is the etiology of the opacities/masses, *i.e.* whether they were associated with coal mine dust exposure. A.33. The company does not explain, nor is it apparent to the Director, why that assessment cannot come in the form of a medical opinion. Indeed, this carry-over effect – where one piece of evidence may be relevant in more than one category – is one

C. Substantial evidence supports the ALJ's weighing of the evidence.

The ALJ first determined that the ILO X-ray readings and CT-scan evidence, although clearly establishing a large opacity and/or mass in the miner's lungs, were inconclusive as to its cause and therefore did not establish complicated pneumoconiosis. He then turned to the medical opinions and found Dr. Harrison's medical report diagnosing complicated pneumoconiosis credible and persuasive. According to the ALJ, Dr. Harrison, a Board-certified internist and pulmonologist (who was assisting in the miner's treatment, A.12 n.6), was able to read a series of X-rays taken from 1998 to 2004 (largely for treating the miner's heart disease) and give an opinion as to what these treatment X-rays showed and the changes they signified. To Dr. Harrison, the changes revealed a clear progression from simple to complicated pneumoconiosis. Although the ALJ acknowledged that Dr. Harrison was a pulmonologist, not a B-reader, he found this supposed shortcoming offset by Dr. Harrison's access to several X-rays, not just a single X-ray read in isolation. Having found that the medical opinions independently established complicated pneumoconiosis, the ALJ then considered all the evidence together "in

reason underlying the Director's caution against creating narrow evidentiary formulae or boxes, *supra* 27-28. Moreover, given the undisputed existence of large opacities and masses, Whitaker Coal's assertion that a doctor's opinion under category (C) could not "yield" the same results as categories (A) and (B), in addition to being wrong legally, is entirely misplaced factually.

its entirety.” After taking this second step, the ALJ concluded that complicated pneumoconiosis was established.

The ALJ’s preference for Dr. Harrison’s opinion because the doctor reviewed a series of X-rays that showed the progression of the miner’s pneumoconiosis from simple to complicated was clearly permissible.

Pneumoconiosis is a progressive disease, 20 C.F.R. § 718.201(c), and an ALJ may find more persuasive the doctor who has a clearer picture of the miner’s health.

See Youghiogheny and Ohio Co. v. Selak, 65 F.3d 169, 1995 WL 514795 at *6 and n.6 (6th Cir. 1995) (unpublished) (observing that ALJ properly gave more weight to doctor who had “a more complete picture of Claimant’s health”).

In addition, the ALJ reasonably concluded that, “[a]lthough a radiologist has expertise in reading x-rays for the presence of disease, a pulmonologist [such as Dr. Harrison] would seemingly have greater expertise in noting the progressive nature of lung disease and charting its course as it expands its presence in the lungs.” A.37. This too is reasonable inasmuch as it is a pulmonologist, not a radiologist, who specializes in the “anatomy, physiology, and pathology of the lungs.” DORLAND’S ILLUSTRATED MEDICAL DICTIONARY at 1543 (defining pulmonology). And the ALJ further recognized that Dr. Harrison’s diagnosis of complicated pneumoconiosis was confirmed by Dr. Vaezy, who as a Board-certified pulmonologist *and* a B-reader, was ideally credentialed to consider

together X-ray evidence with the miner's history, symptoms, and other medical tests.

Conversely, the ALJ gave permissible reasons for according less weight to Dr. Dahhan's contrary medical opinion and the ILO X-ray readings of Drs. Wheeler and Scatarige: their inconsistency with the treating records, which fail to note tuberculosis or histoplasmosis, their lack of knowledge of a negative tuberculosis test, and their use of diagnostic language that may be considered speculative. *See Rowe*, 710 F.2d 255 (holding that the ALJ must "examine the validity of the reasoning of the medical opinion in light of the studies conducted and the objective indications upon which the medical opinion or conclusion is based"); *see also Baker v. Arch on North Fork, Inc.*, 129 F.3d 1263 (6th Cir. 1997) (unpublished) (holding that the ALJ may discredit a medical opinion as uncertain where the doctor suggested that further medical information on the miner was required).

In its opening brief, Whitaker Coal takes exception to the ALJ rulings, contending that the ALJ erred in crediting Drs. Harrison and Vaezy's diagnoses of complicated pneumoconiosis because they relied in part upon ILO X-ray and CT-scan evidence that the ALJ found inconclusive. Opening brief at (OB.) 19-20. In essence, Whitaker Coal's argument comes down to no more than claiming Drs.

Harrison and Vaezy's opinions are unreasoned because the underlying documentation – X-ray and CT-scan readings – fails to support their conclusions.

This argument is without merit. Although the ALJ found the ILO X-ray evidence inconclusive when considered in isolation, after weighing all the relevant evidence together, as required under *Gray*, he reasonably concluded that the miner suffered from complicated pneumoconiosis. The ALJ effectively found support for this determination in Drs. Harrison and Vaezy's opinions, which in turn were supported by treatment X-rays as well as the ILO X-ray and CT-scan readings that were positive for complicated pneumoconiosis.

Whitaker Coal's assertion that the X-ray evidence "overwhelmingly [] weighs against a finding of complicated pneumoconiosis" is similarly without merit. OB. 20. The company's argument is based on the fact that Drs. Wheeler and Scatarige (both Board-certified radiologists and B-readers) read the ILO X-rays as negative for complicated pneumoconiosis, whereas only Dr. Vaezy (a B-reader) read an ILO X-ray as positive for complicated pneumoconiosis. OB. 20-21. But the company fails to acknowledge that the ALJ had strong reservations about Drs. Wheeler and Scatarige's readings because the doctors offered tuberculosis or histoplasmosis as the cause of the miner's large lung mass but his treatment records did not mention those conditions, and because the doctors were unaware of the negative tuberculosis test. A. 32, 38. The Fourth Circuit's decision

in *Westmoreland Coal Co. v. Director, OWCP [Cox]*, 602 F.3d 276 (4th Cir. 2010) makes clear that the ALJ's distrust of their readings was well-founded.¹⁹

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, 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. The court 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

¹⁹ Although the ALJ initially indicated that the Board's *Deel* decision prevented him from discrediting Drs. Wheeler and Scatarige's readings on this basis, A.32-33, his ultimate finding of complicated pneumoconiosis, after considering all the record evidence together, effectively discredited their readings. A.39.

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. The ALJ reasonably weighed the evidence of complicated pneumoconiosis, and his conclusion is supported by substantial evidence.²⁰

²⁰ A further reason for discrediting the negative X-ray readings—not discussed by the ALJ but arguably required as a matter of law – is that Dr. Wheeler premised his finding of no complicated pneumoconiosis on the fact that the X-rays did not show any pneumoconiosis, not even simple pneumoconiosis. The record, however, overwhelming proves that the miner suffered from simple pneumoconiosis; in fact, Whitaker Coal’s other expert, Dr. Scatarige, found simple pneumoconiosis. *See* DX.41 at 2, EX.8; *see also* A.39 (describing evidence of simple pneumoconiosis in the miner’s first claim, which included 9 (of 10) positive X-ray readings and all five physician opinions).

Dr. Dahhan’s medical opinion, on close examination, does not fare much better. He consistently minimizes (or ignores) findings of lung disease in the X-ray reports that he reviewed. For instance, he states a November 20, 1998 X-ray was “read as no acute disease,” A.61, when the X-ray also showed “chronic lung disease.” DX 27-8. Similar omissions appear in his descriptions of the March 20, 1998, X-ray and an April 21, 1998 X-ray. *Compare respectively* A.61 with DX 27-22 (neglecting to mention radiologist’s finding of chronic interstitial lung disease) and DX 27-16 (neglecting to mention the radiologist’s finding of “diffuse bilateral densities likely representing sequela of coal worker’s pneumoconiosis”). There may be other omissions, but these are particularly significant because, according to Dr. Harrison, who reviewed the films, not just the reports, the films clearly show a progression of the miner’s pneumoconiosis from simple to complicated. A. 54. These films were initially taken and interpreted in order to treat the miner’s heart disease.

D. Whitaker Coal correctly points out two ALJ mistakes in weighing the evidence, but they are harmless.

The ALJ accorded less weight to Dr. Dahhan's opinion because the doctor failed to note and discuss the miner's symptoms (coughing and the need for home oxygen), A.36, and because the doctor relied on the absence of crackles (abnormal breath sounds) and a normal pulmonary function study, whereas Dr. Vaezy diagnosed complicated pneumoconiosis, despite reporting these same findings (no crackles and a borderline pulmonary function study). A. 37. Whitaker Coal rightly complains about this part of the ALJ's analysis.

First, the miner's coughing and need for home oxygen do not establish disability, *see Freeman v. Director, OWCP*, 781 F.2d 79, 81 (7th Cir. 1979), and, as Whitaker Coal asserts, OB. 23, these symptoms reasonably were related to the miner's heart condition rather than to his breathing problems. Second, the ALJ gave no reason for finding fault with Dr. Dahhan's reliance on the absence of crackles and the normal pulmonary function study. He merely observed that Drs. Dahhan and Dr. Vaezy disagreed on the significance of these findings.

Whitaker Coal, therefore, has alleged two valid errors. These errors, however, do not figure largely into the ALJ's weighing of the evidence. This Court, therefore, may dismiss the errors as harmless. *See Selak*, 65 F.3d 169, 1995 WL 514795 at *6.

CONCLUSION

If the Court agrees that the errors alleged by Whitaker Coal are harmless, the Court should affirm the award. In the alternative, the Court should vacate the award and remand the case to the ALJ for further review.

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 8238 words, as counted by Microsoft Office Word 2010.

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CERTIFICATE OF SERVICE

I hereby certify that on March 20, 2013, copies of the Director's brief were served electronically using the Court's CM/ECF system on the Court and the following:

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ADDENDUM

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) (emphasis added).