U.S. Department of Labor

Benefits Review Board
200 Constitution Ave. NW
Washington, DC 20210-0001

BRB Nos. 18-0066 BLA
and 18-0066 BLA-A

RHODES OOTEN, III	)	
	)	
Claimant-Petitioner	)	
Cross-Respondent	)	
	)	
v.	)	
	)	
PITTSTON COAL MANAGEMENT COMPANY	)	DATE ISSUED: 9/30/2022
	)	
and	)	
	)	
WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND	)	
	)	
Employer/Carrier-Respondents	)	
Employer/Carrier-Cross-Petitioners	)	
	)	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR	)	
	)	
Party-in-Interest	)	DECISION and ORDER

Appeal and Cross-Appeal of the Decision and Order Denying Benefits of Richard A. Morgan, Administrative Law Judge, United States Department of Labor.

Leonard Stayton, Inez, Kentucky, for Claimant.

William S. Mattingly (Jackson Kelly, PLLC), Morgantown, West Virginia, for Employer and its Carrier.

Ann Marie Scarpino (Seema Nanda, Solicitor of Labor; Barry H. Joyner, Associate Solicitor), Washington, D.C., for the Director, Office of Workers' Compensation Programs, United States Department of Labor.

Before: BOGGS, Chief Administrative Appeals Judge, BUZZARD and ROLFE, Administrative Appeals Judges.

BUZZARD and ROLFE, Administrative Appeals Judges:

Claimant appeals,[1,] and Employer and its Carrier (Employer) cross-appeal, the Decision and Order Denying Benefits (2013-BLA-06011) of Administrative Law Judge (ALJ) Richard A. Morgan rendered on a claim filed pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2018) (Act).[2]

[1] At the outset, we must acknowledge the significant delay the parties have faced in litigating this case. Claimant filed his subsequent miner's claim on October 22, 2012. After receiving a favorable determination from the district director on June 5, 2013, his claim sat at the Office of Administrative Law Judges (OALJ) for more than three years before it was assigned to the ALJ on October 24, 2016. The ALJ took timely action on the case after that point, but the OALJ's initial delay in assigning the case to him resulted in his October 18, 2017 Decision and Order Denying Benefits being issued five years after Claimant first filed his claim. Following Claimant's timely appeal to this Board on November 14, 2017, the case has languished for nearly another five years. Despite repeated inquiries from the parties and a formal motion for a decision from the Department of Labor, our concurring colleague did not take a position in this case until late September 2022. In total, it has taken nearly ten years for this claim to reach a conclusion through the administrative adjudicatory process which, of course, does not account for additional time the parties may expend on appeal in federal court. Far too often, Black Lung claims take years and years to litigate, with costly effects for claimants. The Board's delay in this case is inexcusable and, for that, we owe the litigants our sincerest apology.

[2] Claimant filed two prior claims for benefits. His first claim, filed on January 1, 1970, was lost or destroyed. Decision and Order at 3; Hearing Transcript at 5-6; Director's Exhibit 1. On June 10, 2011, the district director denied Claimant's second claim, filed on November 7, 2008, for failure to establish total respiratory disability. Director's Exhibit 2. Claimant took no further action until he filed the current claim. Director's Exhibit 4.

Summary

The ALJ found Claimant has twenty-nine years of coal mine employment, at least fifteen years of which were underground. He also found Claimant established he suffered from clinical pneumoconiosis and legal pneumoconiosis in the form of severely disabling pulmonary fibrosis due in part to coal mine dust exposure. The ALJ nevertheless found Claimant not entitled to benefits under 20 C.F.R. Part 718 or the Section 411(c)(4) presumption because he determined Claimant's subsequent left lung transplant, necessitated by the pneumoconiosis/pulmonary fibrosis, rendered him no longer disabled from a respiratory standpoint and capable of performing his previous coal mine work.[3]

On appeal, Claimant raises several arguments, the most pertinent of which is that the ALJ irrationally concluded he is no longer totally disabled from a respiratory standpoint from performing his previous coal mine work following his lung transplant. The Director, Office of Workers' Compensation Programs (the Director), filed a response, urging the Benefits Review Board to vacate the ALJ's denial of benefits and remand the case for further consideration of whether Claimant is totally disabled. In its cross-appeal, Employer argues the ALJ erred in finding Claimant established the existence of clinical and legal pneumoconiosis.

Claimant filed a reply brief, reiterating his previous arguments, and a response brief, asserting the ALJ's findings on clinical and legal pneumoconiosis should be affirmed. In a consolidated reply brief, Employer contends the Director waived his arguments

[3] Section 411(c)(4) of the Act provides a rebuttable presumption that a miner is totally disabled due to pneumoconiosis if he has at least fifteen years of underground or substantially similar surface coal mine employment and a totally disabling respiratory impairment. 30 U.S.C. §921(c)(4) (2018); *see* 20 C.F.R. §718.305.

concerning the ALJ's analysis of total disability by failing to raise them below[4] and reiterates its previous contentions of error.[5]

We agree with Claimant that the ALJ erred as a matter of law and his decision must be reversed. Counter to the ALJ's findings, Claimant was not required to redemonstrate disability after he received his life-saving lung transplant. Regardless, the medical opinions establish he remains incapable of performing his last coal mine job from a respiratory perspective. Finally, substantial evidence supports the ALJ's finding that coal mine dust substantially contributed to Claimant's disabling pulmonary fibrosis, preventing Employer from rebutting the Section 411(c)(4) presumption under the facts of this case. [6]

Procedural History and Facts

As noted, Claimant filed his claim for benefits on October 22, 2012. Dr. Rasmussen performed the Department of Labor (DOL)-sponsored complete pulmonary evaluation on November 30, 2012. Director's Exhibit 13. He diagnosed Claimant with "totally disabling chronic respiratory disease" based on Claimant's "markedly reduced" diffusion capacity on pulmonary function testing and "marked hypoxia" and "very marked impairment in

[4] We reject Employer's contention that the Director waived the right to challenge the ALJ's findings on total disability because he did not attend the hearing. The Director is a party-in-interest at all stages of the adjudication in a claim for benefits under the Act, regardless as to whether he participates at the hearing. *See Hodges v. BethEnergy Mines, Inc.*, 18 BLR 1-84, 1-89 (1994).

[5] We affirm, as unchallenged on appeal, the ALJ's finding that Claimant is unable to invoke the irrebuttable presumption at that he suffers from complicated pneumoconiosis. *See Skrack v. Island Creek Coal Co.*, 6 BLR 1-710, 1-711 (1983); Decision and Order at 4-5.

[6] Claimant also alleges the ALJ erred in not admitting Dr. Abraham's deposition and the OALJ violated his due process by failing to timely refer the claim to the ALJ for a hearing, which skewed his weighing of the evidence. Specifically, Claimant argues (and the ALJ found) he was totally disabled due to pneumoconiosis at the time the case was transferred to the ALJ; had the OALJ timely referred the claim to the ALJ for a hearing prior to his left lung transplant, which the ALJ found rendered him no longer disabled, there would be no factual basis for the ALJ's denial of benefits. Alternatively, Claimant contends that even if the ALJ permissibly found him no longer disabled, he is entitled to benefits for the period in which he was indisputably disabled due to pneumoconiosis, prior to his left lung transplant. Due to our disposition of this case –that Claimant's left lung transplant did not cure him of his total disability due to pneumoconiosis for purposes of benefits under the Act – we need not address these arguments.

oxygen transfer" on blood gas testing. *Id*. at 2-3. According to Dr. Rasmussen, Claimant "does not retain the pulmonary capacity to perform any gainful employment . . . ." *Id*. at 3. He also diagnosed both clinical and legal pneumoconiosis, identifying opacities in all zones of Claimant's right and left lung; attributing his totally disabling pulmonary fibrosis to coal mine dust exposure; and concluding his "clinical coal workers' pneumoconiosis and its associated interstitial pulmonary fibrosis . . . are material contributing causes of his disabling chronic lung disease." *Id*. at 4.

Employer submitted the report of Dr. Zaldivar who examined Claimant on April 3, 2013. Director's Exhibit 28. Although he disputed Dr. Rasmussen's diagnoses of clinical and legal pneumoconiosis, he agreed that Claimant "definitely has pulmonary fibrosis;" he is "severely *and permanently impaired*" by it because "the oxygen [during exercise blood gas testing] is rapidly consumed and his lungs cannot replace it as typically happens in pulmonary fibrosis;" and he "is not able to perform *any work*." *Id*. at 5 (emphasis added). As for the etiology of the fibrosis, he determined it was "idiopathic," meaning its cause is unknown. *Id*.

In his Proposed Decision and Order issued on June 5, 2013, the district director awarded benefits under 20 C.F.R. Part 718, finding Claimant established he has pneumoconiosis, the pneumoconiosis arose from his coal mine employment, he is totally disabled, and his total disability is due to pneumoconiosis. He also found Claimant entitled to benefits by operation of the Section 411(c)(4) presumption (which Employer did not rebut) based on Claimant's greater than fifteen years of coal mine employment and agreement by Drs. Rasmussen and Zaldivar that Claimant "is totally disabled from a respiratory standpoint." At Employer's request, the claim was transferred to the OALJ for a hearing on August 7, 2013. While Employer formally disputed the district director's finding of total disability (along with all other elements of entitlement), from an evidentiary standpoint, the only two physicians to offer an opinion on the issue at that time were in agreement that Claimant suffered from a permanently and totally disabling respiratory impairment.

The day after the district director issued his Proposed Decision and Order, one of Claimant's physicians at Cleveland Clinic, Dr. Olbrych, recommended Claimant "initiate pre-transplant evaluation now" because his "quality of life is poor." Claimant's Exhibit 7 at 2.

Not long after, Employer deposed Dr. Highland, one of the pulmonologists at Cleveland Clinic who examined Claimant for inclusion on the lung transplant list. Claimant's Exhibit 10. She confirmed that Claimant suffers from severely disabling interstitial fibrosis; the fibrosis is due to his coal mine dust exposure; and his treatment and placement on the lung transplant list is necessitated by his severely disabling coal dust-

induced fibrosis. She determined he "absolutely cannot" "go back and do his past coal mine employment." *Id*. at 12-18, 22, 26. She also stated that after Claimant was referred to her for examination, she "immediately recognized that his [coal dust-induced] lung disease was severe enough that we didn't have anything that was going to be able to treat it, reverse it, and that he needed to begin the transplant evaluation." *Id*. at 18. Pointedly, she concluded, "He either needs a lung transplant or he will die." *Id*. at 27.

On November 13, 2013, Claimant again presented to Cleveland Clinic for "cardiac evaluation prior to listing for lung transplantation." Claimant's Exhibit 14 at 2. Dr. Lai noted Claimant was undergoing evaluation for a lung transplant to treat his "established pneumoconiosis/pulmonary fibrosis now with end-stage disease [i.e., the final terminal stages of the disease]." *Id*. He further noted Claimant's "significant restrictive pulmonary physiology and marked gas exchange defects by his [pulmonary function tests]" which required "continuous supplemental [oxygen]." *Id*.

On January 13, 2014, Employer secured the opinion of Dr. Castle who reviewed Claimant's medical records. Employer's Exhibit 9. Like Dr. Zaldivar, he disputed that coal mine dust exposure caused Claimant's lung disease but agreed that Claimant suffered from interstitial pneumonitis and is "clearly and unequivocally permanently and totally disabled" by it. *Id*. at 22-23.

On May 16, 2014, while the claim was still awaiting referral to an ALJ, Claimant underwent a left lung transplant at Cleveland Clinic to treat his "progressive respiratory insufficiency due to interstitial lung disease," which, as noted, Dr. Highland concluded was necessary to prevent his death. Claimant's Exhibit 12 at 1. According to the surgeon, Dr. McCurry, Claimant was admitted to the hospital due to "progressive decompensation," i.e., organ failure, and was deemed an acceptable transplant recipient. *Id*. After his doctors identified a donor lung and discussed with him and his family the "risks, benefits, and alternatives" of the transplant, Claimant "desired to proceed." *Id*. Consistent with Drs. Rasmussen's and Highland's earlier diagnoses of totally disabling coal dust-induced interstitial fibrosis, post-operative pathology of Claimant's dissected left lung and lymph nodes by Dr. Farver confirmed interstitial pneumonia with "hyalinizing fibrosis and anthracotic and birefringent material suggestive of environmental exposure." Claimant's Exhibit 13.

After the claim was finally assigned to the ALJ on October 24, 2016, the parties developed additional medical evidence. Claimant submitted the March 8, 2017 report of Dr. Go who conducted a detailed review of Claimant's medical records, including those postdating his lung transplant. Claimant's Exhibit 15. He agreed with the diagnoses of clinical pneumoconiosis and coal dust-induced interstitial pulmonary fibrosis based on radiographic evidence of the diseases, as well as the pathological examination of the left

lung tissue taken at the time of Claimant's transplant. *Id*. at 19-22. He further disputed Dr. Zaldivar's assessment that the fibrosis was idiopathic because the progression of Claimant's disease over the course of more than ten years suggested occupational exposures, not an unknown cause; diagnostically, occupational exposures must be excluded before considering fibrosis to be idiopathic; and Claimant was in fact exposed to fibrosis-causing agents, including silica dust, during his coal mine employment. *Id.* at 21-22.

As for the degree of impairment caused by Claimant's coal dust-induced lung disease, Dr. Go acknowledged his pulmonary function tests improved post-transplant to the point where he "no longer needed supplemental oxygen," but nevertheless concluded Claimant "remains totally disabled for his last coal mine work or other similar employment." Claimant's Exhibit 15 at 22. He also described the improvement on Claimant's pulmonary function tests as not an actual "'improvement' in his lung disease, but rather the replacement of one of his severely diseased lungs with a donated lung." *Id*. "Additionally," he concluded, Claimant is disabled from performing any coal mine work by virtue of the fact that his donor lung is vulnerable "to any form of injury through the inhalation of potentially damaging substances." *Id*.

At his May 17, 2017 deposition, Dr. Go maintained his opinion that Claimant is totally disabled by coal dust- and smoke-induced pulmonary fibrosis/legal pneumoconiosis, with a less significant contribution from clinical pneumoconiosis. Claimant's Exhibit 16. He reiterated that the pneumoconiosis was confirmed by radiography and pathology, with silica exposure during coal mine employment being a significant contributor to the disabling fibrosis/legal pneumoconiosis. *Id*. at 23-31.

With respect to total disability, Dr. Go again acknowledged that the values reflected on Claimant's post-transplant pulmonary function studies eventually "normalized" because "by necessity . . . more air will enter the donated lung." Claimant's Exhibit 16 at 15-16. However, he stated Claimant's "ventilation function" is not actually "normal" and he continues to have "some impairment with regard to physiological function" because "he has one remaining heavily scarred and abnormal [right] lung." *Id*. Although he "d[id] not have any test that would quantify [it]," Dr. Go elaborated Claimant does not have "normal physiologic function between the two lungs . . . equivalent to someone with two healthy native lungs . . . [because] there is still blood flow through [his] scarred native lung." *Id*. at 16. He also noted that while Claimant's post-transplant pulmonary function tests normalized, the primary source of his total disability leading up to the transplant was a diffusion capacity impairment, along with disabling blood gas studies, of which there is no post-transplant testing available to indicate those disabling values also normalized. *Id*. at 14-15, 36-37, 40-41. Finally, he agreed with Employer's counsel that "with respect to

medical hygiene it would be totally unacceptable for a gentleman with a transplanted lung to go back to be exposed to any occupational dust or irritants." *Id.* at 16.

Claimant also submitted Dr. Cohen's April 26, 2017 deposition. Claimant's Exhibit 9. Based on his review of Claimant's medical records and other physicians' opinions submitted in this claim, Dr. Cohen diagnosed both clinical and legal pneumoconiosis in the form of disabling "aggressively progressive interstitial lung disease," which he stated is "[coal mine] dust-related diffuse fibrosis." *Id.* at 7, 21. He, like Dr. Go, also disagreed with Dr. Zalidvar's diagnosis of idiopathic fibrosis because Claimant "was exposed to fibrosing dust," including "silicate and silica particles" identified on pathological examination of Claimant's dissected lung. *Id.* at 13, 22. He deemed this evidence the "smoking gun" as to the fibrosis' etiology because silicate and silica "are very highly toxic particulates and they are associated with causing pulmonary fibrosis." *Id* at 13.

Dr. Cohen further opined that Claimant has a totally disabling pulmonary impairment based on his pre-transplant pulmonary function studies that showed a "severe or moderately severe restrictive impairment with severe diffusion impairment as well as his disabling gas exchange abnormalities with exercise." Claimant's Exhibit 9 at 26. While he acknowledged that Claimant's pulmonary function studies improved after his transplant, he stated he could not conclude that Claimant's overall lung function improved to the point he is no longer disabled because the record lacks any post-transplant testing on the "really critical" diffusion capacity, or any new blood gas testing showing an improvement in his disabling gas exchange impairment with exercise. *Id.* at 25-26.

Dr. Cohen also explained that from a respiratory standpoint, there is "no way" Claimant could return to coal mine work because he "require[s] frequent bronchoscopies to rule out rejection [of the transplanted lung];" he "cannot be exposed to any respiratory hazards, which includes vapors, gases, dust or fumes, [or] extremes of temperature;" and his "lungs are very sensitive because [he is] on high-dose immunosuppressive medications" to keep his body from rejecting . . . the new lung." Claimant's Exhibit 9 at 27. He further concluded that while Claimant could do sedentary work, he does not "retain the residual functional capacity to do [coal mine work]." *Id.* On cross-examination by Employer's counsel, Dr. Cohen again acknowledged that the record lacks new data measuring changes in Claimant's pre- and post-transplant diffusion capacity impairment and gas exchange impairment on exercise. He nevertheless stated he would be "amazed" if Claimant had the respiratory capacity to perform his previous coal mine work. *Id.* at 59.

In support of its defense, Employer submitted Dr. Zaldivar's July 10, 2017 deposition. Employer's Exhibits 19, 20. Dr. Zaldivar reiterated his earlier opinion that prior to his lung transplant Claimant was totally disabled by severe pulmonary fibrosis, but the fibrosis was unrelated to coal mine dust exposure. Employer's Exhibit 19 at 20-21.

According to Dr. Zaldivar, Claimant needed a transplant because he was "in trouble" and "at death's doorstep." *Id*. at 22. Although Claimant's pulmonary function test values normalized after his lung transplant, Dr. Zaldivar acknowledge the record contains no new diffusion capacity measurements or blood gas studies; nevertheless, he speculated that the values would be "very close to normal" because the native right lung is "so badly damaged" and incapable of accepting enough air, "so the bulk of his pulmonary artery blood flow is going through the left lung, which is the transplanted lung." *Id*. at 22-23. Therefore, according to Dr. Zaldivar, Claimant "[with his] transplant . . . can do whatever he wants to according to those [post-transplant pulmonary function studies]." *Id*. at 42.

When asked whether he agrees with Dr. Cohen that Claimant's lung transplant prevents him from returning to work in the coal mines, Dr. Zaldivar replied that if he, himself, had received a lung transplant, he "would be afraid to do anything" and "would be afraid of getting anything in [his] lungs" or even catching a cold from a neighbor. Employer's Exhibit 19 at 43. Despite Dr. Zaldivar's own fears about the risk of infection following a lung transplant, and his acknowledgment that Claimant "is in fact more likely to develop an infection," Dr. Zaldivar concluded there is no "physiological" reason to keep him from coal mining because "he didn't have the [coal mine dust] particles [in his lungs] to begin with after thirty years of work in the coal mines, so why would he get it now if he takes the proper precautions, as he should." *Id*. at 44-45.

Employer also submitted Dr. Castle's July 13, 2017 deposition. Employer's Exhibit 20. He reiterated that while Claimant did not have a coal dust-induced lung disease, he was totally disabled from a respiratory standpoint by severe idiopathic pulmonary fibrosis prior to his lung transplant. *Id*. at 24-25, 37, 41. He stated Claimant had "moderately severe restriction," "significant oxygen desaturation," and "hypoxemia with exercise." *Id*. at 25. He described Claimant's disease as "end stage," noting he was "very symptomatic" and "seemed to be deteriorating." *Id*. at 25-26. Dr. Castle stated Claimant's Cleveland Clinic records leading up to the lung transplant showed he had "clearly and unequivocally severe restrictive lung disease." *Id*. at 28. He stated that transplant doctors must be very cautious to perform the transplant at the right time because "lungs are in short supply" and more people "die on the transplant list" with Claimant's condition than any other. *Id*. at 29. He stated the process Claimant and his physicians underwent "is like walking a tight rope as far as how long to wait and when to do it," but eventually, Claimant got "bad enough where they needed to do it." *Id*.

As for whether Claimant remains totally disabled following his lung transplant, Dr. Castle stated he has "normal pulmonary capacity" on pulmonary function testing, and one post-transplant oxygen saturation walk test allowed him to calculate an approximate PO2 value to conclude Claimant is no longer hypoxic. Employer's Exhibit 20 at 48. However, he conceded that blood gas tests, of which there are none following Claimant's transplant,

are the "best way" to determine "an accurate" PO2 measurement. *Id.* at 49. Although he concluded Claimant could go back to work in the mines "from a purely functional point of view," Dr. Castle stated he would "never" release Claimant back to coal mine work because "he has a transplanted lung that has to be treated with great respect." *Id.* at 44, 54-55. He described Claimant's new lung as "a blessing to him [that] needs to be treated very gently" and concluded Claimant "cannot be exposed to any type of potential harm" – even exposures as common as fumes from pumping gasoline into his car. *Id.*

Finally, the parties submitted pathology reports from Drs. Oesterling and Abraham who reviewed the slides Dr. Farver prepared from Claimant's dissected lung. Dr. Oesterling who identified "the presence of silica and silicates" and "deposits of [black pigment of coal dust origin]." Employer's Exhibit 11. He concluded, however, the coal dust was "very modest" and insufficient to have contributed to Claimant's "marked fibrotic change" or "any alterations in pulmonary function." *Id.* He stated Claimant instead has usual interstitial pneumonia which is "usually an idiopathic process." *Id.*

Dr. Abraham concluded the pathology slides show "numerous lymph nodes containing a mixture of coal dust macrophages and classic silicotic nodules." Claimant's Exhibit 8. He also stated the lung "shows variable fibrosis ranging from moderate interstitial fibrosis to end stage honeycombing" and there are "several deposits of typical coal mine dust characterized by coal particles, with abundant silica and silicate particles also visible." *Id.* Although Dr. Abraham found the amount of dust "disproportionate" with the degree of fibrosis, he nevertheless "confirmed" Claimant "had evidence of exposure to silica and other fibrogenic dusts in his lung as well as coal dust particles" and "a mild degree of [clinical] coal workers' pneumoconiosis." Claimant's Exhibit 8. He elaborated that under the American Thoracic Society (ATS) diagnosing criteria, "it is important to not use the diagnosis of 'idiopathic' pulmonary fibrosis when there is a history and evidence of exposure to dusts capable of causing pulmonary fibrosis, such as the silica and other dusts demonstrated" in Claimant's lung. *Id.* Thus, although he could not ascertain the "extent" of its contribution, he opined coal dust "certainly made some contribution by causing lung injury" as evidenced by the presence of silicotic nodules. *Id.*

Neither pathologist specifically offered an opinion on whether Claimant is totally disabled, but Dr. Farver stated he "has very severe pulmonary interstitial fibrosis necessitating his lung transplantation," while Dr. Oesterling concluded his fibrosis is "end stage." Claimant's Exhibit 8; Employer's Exhibit 11 at 5.

The ALJ's Decision

After acknowledging that all parties agree and that the evidence conclusively establishes Claimant's total disability prior to his lung transplant, the ALJ nevertheless

observed that Claimant's entitlement to benefits must be determined *as of the time of the hearing* -- which occurred approximately five years after his claim was filed and three years after his lung transplant. Decision and Order at 51, emphasis added. He found the pulmonary function study evidence insufficient to establish total disability because all of the studies are non-qualifying, including the two studies conducted prior to Claimant's transplant and fifteen treatment studies obtained after his transplant. *Id*. at 52; *see* 20 C.F.R. §718.204(b)(2)(i). The ALJ noted *there are no post-transplant blood gas studies* for consideration but found the qualifying exercise values Dr. Rasmussen obtained on November 30, 2012 support a finding of total disability.[7] 20 C.F.R. §718.204(b)(2)(ii); Decision and Order at 52.

In considering the medical opinion evidence at 20 C.F.R. §718.204(b)(2)(iv), the ALJ initially determined Claimant's last coal mine work as a mine inspector required light to moderate labor.[8] Decision and Order at 7-8. He found the opinions of Drs. Cohen, Go, and Castle that Claimant could not return to work because of the risks associated with exposing his transplanted lung to coal mine dust were insufficient as a matter of law to support a finding of total disability. *Id*. at 53-54. He explained:

> A long list of precedent firmly establishes that medical opinions that exposure to dusty conditions is medically contraindicated are not tantamount to a finding of total disability exists. The general rationale is that the question is whether the claimant can engage in the rigors of the work and the nature of the environment is irrelevant. Thus, despite the fact the miner has pneumoconiosis and had a lung transplant, I have no choice but to adhere to the precedent which in some ways lags far behind medical science.

Id. at 54.

[7] Dr. Rasmussen's November 30, 2012 blood gas study was non-qualifying at rest but qualifying with exercise. Director's Exhibit 13. Dr. Zaldivar's April 3, 2013 study was non-qualifying at rest and no exercise testing was conducted. Director's Exhibit 28.

[8] The ALJ noted Claimant's duties as a mine inspector required him to crawl, "duck-walk," stand for seven to eight hours, lift and carry fifteen to thirty pounds twenty to thirty feet three to four hours a day, and walk ten miles per day. Decision and Order at 7-8, *quoting* Director's Exhibit 21. He also noted a statement describing Claimant's last coal mine job as "inspecting some and operating equipment." *Id*. at 8. He further noted Claimant did not merely sit in an office, but mostly walked two to three miles a day "without carrying or lifting anything big." *Id*.

The ALJ also gave less weight to the opinions of Drs. Go and Cohen because they did not "explicitly" address the rigors of Claimant's prior coal mine work. Decision and Order at 53. Although the ALJ noted Drs. Castle and Zaldivar also did not explicitly address Claimant's previous job requirements, he found their opinions better documented and reasoned, and consistent with the objective studies. *Id*. at 53-54. Finding that Claimant's lung condition did not render him physically unable to perform his usual coal mine work,[9] the ALJ found that Claimant did not establish total disability. *Id*. at 54; *see* 20 C.F.R. §718.204(b)(2)(iv). The ALJ concluded Claimant could not invoke the Section 411(c)(4) presumption, though he failed to make an overall determination, based on the record as a whole, as to whether Claimant is totally disabled.

Claimant's Entitlement to Benefits

The ALJ erred as a matter of law in denying benefits. *First*, all parties agree, and the evidence conclusively establishes, that Claimant was totally disabled prior to his life-saving lung transplant, entitling him to invoke the 15-year presumption. Nothing required him to reestablish disability after receiving a new lung, as the ALJ mistakenly held. *Second*, in any event, it is patently irrational to interpret the medical opinions after Claimant's transplant as establishing he currently retains the respiratory capacity to go back to perform his previous work in the mines. *Finally*, substantial evidence supports the ALJ's finding that coal dust caused the scarring in Claimant's lungs that led to the transplant. Employer therefore has not met its burden to rebut the presumption that Claimant's disabling lung scarring is legal pneumoconiosis, entitling him to benefits.

Claimant was not required to reprove disability after his transplant.

A miner is totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work or comparable gainful work. *See* 20 C.F.R. §718.204(b)(1). A claimant may establish total disability based on pulmonary function studies, arterial blood gas studies, evidence of pneumoconiosis and cor pulmonale with right-sided congestive heart failure, or medical opinions. 20 C.F.R. §718.204(b)(2)(i)-(iv).

As the uncontested evidence shows, the medical opinions unequivocally establish total disability: all physicians agree that Claimant's severe pulmonary fibrosis was totally disabling and would have killed him prior to his lung transplant. 20 C.F.R. §718.204(b)(2);

[9] The ALJ considered Claimant's testimony that he is unable to do yard work or "anything." Decision and Order at 52, *quoting* Hearing Transcript at 51. He also noted Claimant is not allowed to lift more than twenty pounds and could not perform his prior mine work. *Id*., *quoting* Hearing Transcript at 43.

Decision and Order at 53. The ALJ found, and Employer maintains on appeal, however, that the transplant that removed Claimant's lung also removed his disability as a matter of law, thereby rendering him ineligible for benefits. But that position has no legal basis.

> Relying solely on a single, dated Board case interpreting a specific way to rebut an interim presumption that is not at issue in this case (and subsequent circuit cases adopting it for the same limited purpose), the ALJ mistakenly held that "a claimant's entitlement to benefits is measured by his physical condition at the time of the hearing." Decision and Order at 51, *citing Coffey v. Director, OWCP*, 5 BLR 1-404 (1982) (citations omitted). The ALJ applied *Coffey*, however, out of context and for a sweeping purpose for which it was never intended.
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> The interim presumption at issue in *Coffey* was repealed in 1980 and only applied to claims filed prior to that date. Under it, eligible miners who had 10 or more years of coal mine employment and who met certain medical requirements were presumed to be entitled to benefits. 20 C.F.R. §727.203. The presumption, however, could be rebutted through any of four methods, including establishing the miner "[was] doing his usual coal mine work," or "[was] able" to do such work. 20 C.F.R. §727.203(b)(1), (2).
>
> *Coffey* solely involved rebuttal under those two distinct methods in that specific context. The Board first held that the question of whether a miner *was* doing his usual coal mine work under (b)(1) was a strictly factual matter determined by whether he was employed at the time of the hearing: "At the outset, we note that, since claimant was not employed at the time of the hearing, the administrative law judge erred in finding the presumption rebutted under 727.203(b)(1), and his finding is therefore reversed." *Coffey*, 5 BLA at 1-405. As a corollary, the Board then held the question of whether he *was able* to perform his usual coal mine work under (b)(2), since he was not employed, similarly had to be assessed at the same time. *Id.* at 1-407.
>
> *Coffey's* holding thus does not extend past explaining two practical methods of rebuttal under a regulation that has long-since been repealed, and it has never been appropriately cited as establishing that evidence relating to disability should be evaluated solely according to its temporal proximity to the hearing. Instead, a long line of circuit court cases provides that ALJs must evaluate disability evidence both qualitatively and quantitively, without resorting to mechanically crediting later evidence and, when a miner's condition improves, without reference to its chronological order. *See Adkins v. Director, OWCP*, 958 F.2d 49, 51-52 (4th Cir. 1992) (given the progressive nature of pneumoconiosis an ALJ must resolve conflicting evidence when the miner's condition improves "without reference to their chronological relationship."); *see also*, *Thorn v. Itmann Coal Co.*, 3 F.3d 713, 719 (4th Cir. 1993) ("A bare appeal to recency" in evaluating medical opinions "is an abdication of rational decisionmaking.");

Woodward v. Director, OWCP, 991 F.2d 314, 319-20 (6th Cir. 1993) (same); *Sunny Ridge Mining Co. v. Keathley*, 773 F.3d 734, 740 (6th Cir. 2014) (ALJs must do a qualitative analysis of conflicting disability evidence).

Allowing ALJs to credit physician opinions over others solely given their closeness to the hearing -- without otherwise evaluating their probative force -- violates these bedrock principles. The ALJ did so here by completely disregarding the medical opinions prior to Claimant's transplant for no reason other than the date they were obtained. But his central legal proposition for doing so, that evidence can be favored given its proximity to the hearing, is simply wrong. *Adkins*, 958 F.2d 51-52 ("Later is better is not a reasoned explanation.").

Stripped of its faulty premise, the ALJ's reasoning finds no other support in the Act, the regulations, or the case law. Employer cites no other authority for the proposition that a claimant must prove that he continues to suffer from totally disabling pneumoconiosis following a lung transplant that was itself necessitated by the claimant's pneumoconiosis.

Indeed, we have consistently reached the opposite result under analogous circumstances. In *Maggard v. Kat Ran Enterprises, Inc.*, BRB No. 18-0451 BLA, slip op. at 3-5 (Sept. 11, 2019) (unpub.), we considered whether a claimant could prove the existence of complicated pneumoconiosis when a biopsy removed the only massive lesion evidencing the disease. We held that "[n]either the Act nor the regulations require a claimant to also prove that residual complicated pneumoconiosis remains after the biopsy." *Id.* at 5; *see also Simpson v. U.S. Steel Mining Co. Ala.*, BRB Nos. 11-0684 BLA and 11-0834 BLA, slip op. at 5 (Sept. 24, 2012) (unpub.) (a claimant "is not required to provide evidence that residual pneumoconiosis remains after [a] massive lesion had been surgically excised during[a] lobectomy").

We reached the same conclusion that a claimant need not reestablish disability in *McCauley v. DLR Mining, Inc.*, 25 BLR 1-259, 1-262-63 (2019). There, the employer "argue[d] that because claimant's lesion of complicated pneumoconiosis was surgically removed before he filed his current claim, he [was] precluded from invoking the irrebuttable presumption of total disability due to pneumoconiosis." *Id.* at 1-262. We rejected that argument, noting that the Act and its implementing regulations mandate that a claimant may use biopsy evidence to prove complicated pneumoconiosis (which, by its very presence, establishes total disability). *Id.* (citing 30 U.S.C. § 921(c)(3)(B); 20 C.F.R. § 718.304(b)). These provisions, we explained, "would be rendered useless if there had to be other qualifying evidence that complicated pneumoconiosis existed after the biopsy excised the lesion of complicated pneumoconiosis." *Id*.

So too here. The Board's reasoning in *Maggard*, *Simpson*, and *McCauley* apply with equal force: the Act and its regulations require a responsible operator to pay for a miner's lung transplant when the procedure is necessary to treat the miner's pneumoconiosis. *See Kenner v. Tenn. Consol. Coal Co*., 22 BLR 1-287, 1-289, 1-291-92 (2003) (employer required to pay "reasonable medical expenses associated with the miner's lung transplant" when the transplant "was necessary and related to the treatment of the miner's pneumoconiosis"); *see also* 33 U.S.C. § 907(a); 20 C.F.R. § 725.701(b). As we reasoned in *McCauley*, these provisions similarly would be rendered useless if a claimant was required to show that pneumoconiosis continued to exist after receiving a new lung. Indeed, if a lung transplant removes the claimant's pneumoconiosis and thus his eligibility for benefits, responsible operators could never be held liable for a claimant's medical expenses associated with the procedure. Such an absurd result cannot be tolerated.[10]

The medical opinion evidence conclusively establishes Claimant was disabled prior to his lung transplant. Nothing more is required for Claimant to invoke the 15-year presumption. 20 C.F.R. §718.305(b)(1). But, even if Claimant had to prove he remains disabled after his transplant, he has easily done so here.

Regardless, no reasonable person could maintain Claimant currently retains the respiratory capacity to return to the mines.

In concluding Claimant currently is not totally disabled, the ALJ similarly erred in relying on inapposite Board and federal caselaw holding that a physician's advisement against further dust exposure is insufficient, by itself, to establish total disability. Decision and Order at 54; *see e.g. Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir.

[10] Our concurring colleague mischaracterizes our opinion in stating we have taken the position that "disability should not be assessed at the time of the hearing," "that newer evidence has no relevancy to a total disability determination," and "that it was error for the ALJ to evaluate Claimant's entitlement to benefits based on his current physical condition." *See infra* at 24. We have held no such thing. We have instead held that it was plain error for the ALJ to credit evidence solely based on its temporal proximity to the hearing, without otherwise doing the qualitative and quantitative analysis the law requires. *See Adkins*, 958 F.2d at 51-52; *Thorn*, 3 F.3d at 719; *Woodward*, 991 F.2d at 319; *Keathley*, 773 F.3d at 740. And that when all of the relevant evidence is properly considered, 30 U.S.C. §923(b), no reasonable person would come to the conclusion Claimant retains the respiratory capacity to perform his usual coal mine work after receiving a life-saving lung transplant necessitated by the coal dust that scarred and destroyed his lung. 20 C.F.R. §718.204(b).

1989);[11] *Taylor v. Evans and Gambrel Co., Inc.*, 12 BLR 1-83, 1-87-88 (1988). Those cases do not apply in situations like this in which the claimant has already demonstrated disability through medical opinions.

Instead, they stem from the concept that miners who have pneumoconiosis, but have not become totally disabled by it, have not established all elements of entitlement necessary for benefits under the Act but nevertheless should not be forced to work in medically contraindicated dusty conditions. Congress provided those miners an option to transfer to a less dusty position. *See* 30 U.S.C. §843, *cited in Justice v. Island Creek Coal Co.*, 11 BLR 1-91, 1-93 (1988); *Coleman v. Kentland Elkhorn Coal Co.*, 5 BLR 1-268 n.8 (1982); *Hatcher v. Consolidation Coal Co.*, 5 BLR 1-132, 1-143 n.6 (1982). Those cases also encompassed situations where the miner relied on his pneumoconiosis diagnosis – and the concomitant recommendation against further dust exposure – to prove total disability, without other credible evidence that he lacked the respiratory or pulmonary capacity to perform the work.

That is not the case here. Claimant relies on uncontradicted objective evidence and medical opinions that he developed a totally disabling and deadly pulmonary impairment necessitating a life-saving lung transplant, and unanimous expert opinions that his survival – quite literally his life – post-surgery depends on him refraining from *any* activity that could harm his lungs.

Three of the four medical experts to squarely address the issue, including Employer's expert witness, Dr. Castle, described returning to coal mine employment as a clear and present danger to his life. Dr. Cohen testified that lung transplant recipients, like Claimant, require frequent monitoring to ensure their bodies do not reject the donor lung and cannot be exposed to "any respiratory hazards," thus precluding a return to coal mine employment. Claimant's Exhibit 9 at 27-28. Dr. Go stated that because donor lungs are vulnerable "to any form of injury through the inhalation of potentially damaging substances," Claimant cannot return to coal mine employment. Claimant's Exhibit 15 at 22. Dr. Castle agreed he would "never" release Claimant back to coal mine work because "he has a transplanted lung that has to be treated with great respect." Employer's Exhibit 20 at 44. He likened the process of undergoing a lung transplant to "walking a tight rope" and stated Claimant's new lung is "a blessing to him [that] needs to be treated very gently."

[11] Using a preprinted form, the physician in *Zimmerman* recommended that "[t]his patient should not return to underground coal mining because of his Silicosis." 871 F.2d at 567. The Sixth Circuit held that this statement recommending against further dust exposure at the coal mine based on a silicosis diagnosis is not the equivalent of a finding that the miner lacked the pulmonary capacity to do the work. *Id.* As explained herein, the facts of this case are clearly distinguishable.

Id. at 29, 44. He concluded Claimant "cannot be exposed to any type of potential harm" – even exposures as common as fumes from pumping gasoline into his car. *Id*. at 44.

To analogize the recommendations against further dust exposure in this case to the above cases involving non-disabled miners is to draw a connection that does not exist. Quite simply, a miner who undergoes a lung transplant necessitated by his disabling and deadly black lung disease is entitled to benefits under the Act. Further coal dust exposure risks not distant, tenuous, and unknown consequence, but immediate, direct, and deadly ones.

Indeed, relevant case law directly contradicts the ALJ's finding. In *Davis v. Director, OWCP*, 936 F.2d 1111, 1114-16 (10th Cir. 1991), the United States Court of Appeals for the Tenth Circuit specifically held a miner established total disability based on a physician's opinion that the miner's pneumoconiosis and industrial bronchitis, *when coupled with exposure to coal dust*, rendered him unable to perform the duties of last coal mine job. The court acknowledged that such an opinion goes beyond a "mere" statement that further coal dust was inadvisable but "must be characterized as expressing the opinion that coal dust exposure is disabling." *Id*. Given the ALJ's finding that Claimant's legal pneumoconiosis rendered him totally disabled and necessitated his lung transplant, Drs. Cohen's, Go's, and Castle's statements that Claimant will suffer further disability or death if exposed to coal mine dust constitute diagnoses of continued disability. *Id.*

The only physician to conclude otherwise, Dr. Zaldivar, stated that if Claimant were his patient, "I would say, sure, you can [resume your coal mine employment]." Employer's Exhibit 19 at 45. On its face, this advice is difficult to reconcile with the physician's statement that if he personally had a lung transplant, he would be "afraid . . . of getting anything in [his] lungs," would be "afraid to catch a cold from [his] neighbor," and would be "afraid to do anything." *Id*. at 43. His advice was also premised on the "dust . . . levels [being] maintained" in the mine (an unknown variable), Claimant having "no other source of income" than coal mining (a factor irrelevant to a total disability finding), and Claimant's agreement that he "feels fine [and] can go back to the mines" (a factor not present here). *Id*. at 43, 44-45.

Any remaining credibility on this issue totally evaporates when Dr. Zaldivar's opinion is considered alongside the ALJ's findings that coal mine dust caused Claimant's severe, disabling, and deadly pulmonary fibrosis. Dr. Zaldivar reasoned that returning to coal mine employment despite having undergone a lung transplant posed no risk of further disability or death to Claimant because "he didn't have the [coal mine dust] particles to

begin with after thirty years of work in the coal mines, so why would he get it now . . . ."[12] *Id*. at 45. But, as discussed below, the ALJ flatly rejected his opinion that coal mine dust had no impact on Claimant's pulmonary condition and unequivocally found, based on unanimous agreement among the pathologists, that Claimant did in fact have coal dust and silica dust in his dissected lung.

Finally, the Board has routinely held a miner's medical treatment does not adversely impact entitlement to benefits. The relevant question in assessing total disability "is whether a miner is able to perform his job from a respiratory standpoint, not whether he is able to perform his job after he takes medication."[13] *Baird v. Westmoreland Coal Co.*, BRB No. 10-0254 BLA, slip op. at 9 (Dec. 23, 2010) (unpub.); *see* 45 Fed. Reg. 13,678, 13,682 (Feb. 29, 1980); *see also Lamb v. Brody Mining, LLC*, BRB No.20-0155 BLA, slip op. at 8 (June 29, 2021) (unpub.); *Robinson v. Rum Creek Coal Sales, Inc.*, BRB No. 20-0208, slip op. at 5 (Apr. 28, 2021) (unpub.); *Miles v. 17 West Mining, Inc.*, BRB No. 20-0007 BLA, slip op. at 10 (Jan. 5, 2021) (unpub.). The record is clear that Claimant remains totally disabled by virtue of the fact that his lung transplant prevents him, from a pulmonary capacity standpoint, from performing his previous coal mine work. The legal inquiry at total disability in such a case need go no further.

Having proven at least 15 years of qualifying coal mine employment and a totally disabling pulmonary impairment, Claimant is entitled to benefits unless Employer can rebut the presumption. 20 C.F.R. §718.305. It cannot.

Employer has failed to demonstrate that the pulmonary scarring that led to Claimant's transplant is not legal pneumoconiosis.

To disprove legal pneumoconiosis, Employer must establish the Miner did not have a chronic lung disease or impairment "significantly related to, or substantially aggravated

[12] Here again, Dr. Zaldivar premised his opinion on Claimant being able to take the "proper," yet unidentified precautions. Employer's Exhibit 19 at 45.

[13] The Director correctly notes that Claimant "requires constant medications to ensure that the transplanted lung is not rejected." Director's Brief at 7. The regulations do not require a Miner to use medications in order to perform his usual coal mine work.

by, dust exposure in coal mine employment."[14] 20 C.F.R. §§718.201(a)(2), (b), 718.305(d)(1)(i)(A); *see Minich v. Keystone Coal Mining Co.*, 25 BLR 1-149, 159 (2015).

As noted, Claimant's medical experts, Drs. Rasmussen, Cohen, Go, and Highland diagnosed legal pneumoconiosis because his disabling fibrosis is significantly related to his coal mine dust exposure. Drs. Zaldivar and Castle stated it was idiopathic, meaning of unknown origin, but was not related to coal mine dust exposure. The ALJ gave greatest weight to Claimant's experts and found their opinions, as supported by the pathology evidence of Claimant's dissected lung, establish Claimant has legal pneumoconiosis. Decision and Order at 45-46. We see no error in that finding.

Dr. Castle excluded coal mine dust as a cause of Claimant's fibrosis because he has a purely restrictive impairment. Employer's Exhibit 9. He explained that when coal mine dust exposure causes an impairment, it "generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect. In fact, the most likely isolated abnormality found in coal workers' pneumoconiosis is that of an obstructive process. That was never the finding in this case." *Id*. The ALJ permissibly found Dr. Castle's rationale contrary to the regulations, which recognize that legal pneumoconiosis may include a restrictive *or* obstructive impairment, or a combination of both. 20 C.F.R. §718.201; Decision and Order at 44. We therefore affirm the ALJ's finding that Dr. Castle's opinion is not adequately reasoned. *See Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 533 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997).

Dr. Zaldivar excluded coal mine dust as a cause of Claimant's fibrosis because he does not have evidence of complicated pneumoconiosis. Employer's Exhibit 19. He testified that coal dust can "cause[] pulmonary fibrosis by causing complicated coal workers' pneumoconiosis and the pulmonary fibrosis that goes with it." *Id*. at 47. Thus, he agreed with Employer's counsel that "you only have pulmonary fibrosis caused by coal mine dust exposure if you have complicated pneumoconiosis." *Id*. The ALJ permissibly rejected this rationale as unsupported; the regulatory standard for diagnosing legal pneumoconiosis does not depend on or require the presence of clinical pneumoconiosis. *See* 65 Fed. Reg. 79,920, 79,941 (Dec. 20, 2000); *Harman Mining Co. v. Director, OWCP* [*Looney*], 678 F.3d 305, 314-16 (4th Cir. 2012); *J.O.* [*Obush*] *v. Helen Mining Co.*, 24

[14] The ALJ evaluated the evidence with the burden on Claimant based on his finding that Claimant did not establish total disability. Decision and Order at 31. Because we reversed this finding, the burden is on Employer to rebut the presumption. 20 C.F.R. §718.305(d)(1). However, the burden applied does not make a difference as Claimant is entitled to benefits under either standard.

BLR 1-117, 1-125-26 (2009), *aff'd Helen Mining Co. v. Director, OWCP* [*Obush*], 650 F.3d 248 (3d Cir. 2011); Decision and Order at 44.

Dr. Zaldivar also relied on various scientific studies, including a 2011 ATS study, to exclude coal mine dust as a cause of Claimant's pulmonary fibrosis. Director's Exhibit 28. He identified the study as supporting a connection between smoking and pulmonary fibrosis and, although the study concludes occupational exposures can also be a cause, "coal mining was not mentioned." *Id*. at 3-4. Employer's Exhibit 19 at 21, 34. Despite the possible connection to smoking and environmental exposures, he reiterated that Claimant's pulmonary fibrosis is of unknown origin; otherwise, "we wouldn't call it idiopathic." *Id*. at 48. When asked how he was able to exclude Claimant's twenty-nine years of coal mine dust exposure as a cause given the 2011 ATS study's conclusion that occupational exposures can cause pulmonary fibrosis and should be excluded before deeming it idiopathic, Dr. Zaldivar responded that the "proof" is the analysis of Claimant's biopsied lung which revealed "absolutely nothing related to pneumoconiosis." *Id*. at 24-25.

As is within his discretion, the ALJ permissibly found Dr. Zaldivar's explanation and reliance on the 2011 ATS study to exclude coal mine dust as among the environmental factors that can cause or contribute to interstitial pulmonary fibrosis "unconvincing" and unsupported, particularly given that the pathologists agree Claimant's dissected lung contained silicates and silica, itself a component of coal mine dust, and Dr. Zaldivar acknowledged silica exposure can cause pulmonary fibrosis. Employer's Exhibit 28 at 4; Employer's Exhibit 19 at 35, 47; Decision and Order at 44-45.

For related reasons, i.e., the 2011 ATS study's conclusion that environmental exposures should be excluded before concluding that fibrosis is idiopathic and the undisputed pathology evidence of coal dust and silica dust in Claimant's dissected lung, the ALJ permissibly found Dr. Castle's diagnosis of idiopathic pulmonary fibrosis unsupported and "questionable." Decision and Order at 46; *Looney*, 678 F.3d at 316-17; *Hicks*, 138 F.3d at 533.

In contrast, the ALJ permissibly found the opinions of Drs. Cohen, Go, and Highland credibly establish Claimant's totally disabling pulmonary fibrosis is legal pneumoconiosis. Decision and Order at 46; *Looney*, 678 F.3d at 316-17; *Hicks*, 138 F.3d at 533. As noted, Dr. Cohen attributed Claimant's totally disabling fibrosis to coal mine dust exposure; he rejected the view that its cause was unknown because Claimant "was exposed to fibrosing dust," including "silicate and silica particles" during his coal mine employment which "are very highly toxic" and "are associated with causing pulmonary fibrosis." Claimant's Exhibit 9 at 7, 13, 21-22.

Dr. Go, quoting the ATS criteria, concluded Claimant's fibrosis is not idiopathic: "The diagnosis of [idiopathic pulmonary fibrosis] requires: a. Exclusion of other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity)." Claimant's Exhibit 15 at 20. Rather, he concluded Claimant's fibrosis is due to his coal mine dust exposure because silica, a known cause of pulmonary fibrosis, "is a significant potential component of coal mine dust, particularly in those who cut or otherwise disrupt rock layers outside of the coal seam as [Claimant] did in his role as a roof bolter." *Id*. at 21.

Finally, Dr. Highland opined Claimant's pulmonary fibrosis is not idiopathic, but due to coal mine dust exposure because idiopathic pulmonary fibrosis "is a diagnosis of exclusion" and Claimant "has a significant occupational history," "a diffuse dust related interstitial lung disease [which] is has been reported with coal workers," and a CT scan pattern that, although atypical, "has been reported in case series of patients that have been coal miners." Claimant's Exhibit 10 at 13.

With respect to whether coal mine dust can cause interstitial pulmonary fibrosis, the ALJ permissibly gave greatest weight to Claimant's medical experts' explanations that the 2011 ATS study requires a physician to exclude environmental causes before diagnosing pulmonary fibrosis as idiopathic, as it is supported by the study itself. *Looney,* 678 F.3d at 316-17; *Hicks*, 138 F.3d at 533; Decision and Order at 45; Claimant's Exhibit 15 at 20. He also permissibly found that Drs. Cohen, Go, and Highland credibly explained why coal mine dust is an environmental exposure that contributed to Claimant's pulmonary fibrosis in this case, particularly given the undisputed evidence (and concurrence by Dr. Zaldivar) that silica dust, a component of coal mine dust, can cause pulmonary fibrosis and agreement among the pathologists that Claimant's dissected lung contains both coal mine dust and silica dust. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); Decision and Order at 45-46; Director's Exhibits 26, 28; Claimant's Exhibits 8, 9, 10, 13, 15, 16; Employer's Exhibits 11, 19.

While Employer argues the ALJ erred in finding Dr. Abraham's pathology report, and the pathology evidence as a whole, "tends to" prove legal pneumoconiosis, Employer ignores the salient aspects of the ALJ's analysis. Decision and Order at 39; *see* Employer's Response Brief at 31. He did not credit the medical opinions of Drs. Cohen, Go, and Highland simply because Dr. Abraham also diagnosed legal pneumoconiosis on pathology. Rather, he credited their medical opinions because they were supported by the medical literature, undisputed evidence that silica dust can cause pulmonary fibrosis, and agreement among the pathologists, including employer's expert, Dr. Oesterling, that Claimant's dissected lung contains deposits of coal dust and silica dust. Decision and Order at 38, 45-46. Even had the ALJ discredited Dr. Abraham's diagnosis of legal pneumoconiosis, such a finding would not have undermined the reasons the ALJ gave for finding Claimant's

medical experts credible.[15] *Shinseki v. Sanders*, 556 U.S. 396, 413 (2009) (appellant must explain how the "error to which [it] points could have made any difference"). Nor does Employer contest the ALJ's rational inference that "the findings regarding the removed left lung would be the same or near so for the remaining right lung" which, the ALJ also noted, is afflicted with "interstitial lung disease with (advanced) fibrosis (UIP) volume loss." Decision and Order at 37, 39; *Skrack*, 6 BLR at 1-711.

As it is rational and supported by substantial evidence, we affirm the ALJ's finding that "[C]laimant's experts' documentation and reasoning, particularly when viewed with the pathology evidence, support their conclusions far better than those physicians finding otherwise." Decision and Order at 46; *see Compton*, 211 F.3d at 207-208; *Hicks*, 138 F.3d at 528. We thus affirm his finding that Claimant established his deadly, totally disabling, lung-transplant-necessitating pulmonary fibrosis is legal pneumoconiosis. And given that finding, Employer cannot demonstrate that no part of Claimant's disability is caused by pneumoconiosis, 20 C.F.R. §718.305(d)(1)(ii), preventing it from rebutting the Section 411(c)(4) presumption.

Conclusion

Claimant developed severely disabling and deadly pulmonary fibrosis due to his coal mine dust exposure. This coal mine dust-induced disease required a life-saving left lung transplant that demands constant treatment and monitoring to ensure Claimant's body does not reject the donor lung. Any injurious exposure to the donor lung, including coal mine dust, puts Claimant at direct risk of further disability and death. The only physician to conclude otherwise based his opinion on his discredited view that Claimant's prior coal mine dust exposure had no impact on his severely disabling, deadly fibrosis that led to the lung transplant in the first place.

The ALJ's decision that Claimant is not disabled is founded on clear errors of law. But more than that, to affirm the ALJ's decision would contravene logic, the facts, and the

[15] Moreover, Employer is incorrect that Dr. Abraham's opinion is facially insufficient to establish legal pneumoconiosis. Employer's Response Brief at 32-33. Although he could not determine the "extent" of coal mine dust's contribution to Claimant's fibrosis, he nevertheless concluded the fibrosis is not idiopathic because coal mine dust "certainly made some contribution by causing lung injury" as evidenced by the presence of silicotic nodules. Claimant's Exhibit 8. To the extent Dr. Abraham attributed Claimant's disabling fibrosis in part to coal mine dust exposure, the ALJ permissibly credited his opinion as a diagnosis of legal pneumoconiosis. *Island Creek Coal Co. v. Young*, 947 F.3d 399, 405 (6th Cir. 2020); *Crockett Colleries, Inc. v. Director, OWCP* [*Barrett*], 478 F.3d 350, 356 (6th Cir. 2007); Decision and Order at 39.

remedial purpose of the Act. *Shepherd v. Incoal, Inc.*, 915 F.3d 392, 402 (6th Cir. 2019) (the Act "is remedial legislation that should be liberally construed so as to include the largest number of miners within its entitlement provisions."); *Southard v. Director, OWCP*, 732 F.2d 66, 71 (6th Cir. 1984). The ALJ's decision gives miners a false choice between foregoing life-saving medical treatment necessitated by their totally disabling black lung disease, so as to remain totally disabled and eligible for compensation benefits; or, availing themselves of medical treatment to which they are entitled under the Act, here a lung transplant, but rendering themselves – and their survivors – ineligible for compensation benefits and, under this ALJ's analysis, further medical treatment for their black lung disease. Such a result is a miscarriage of justice.

Accordingly, the ALJ's Decision and Order Denying Benefits is reversed.

SO ORDERED.

GREG J. BUZZARD
Administrative Appeals Judge

JONATHAN ROLFE
Administrative Appeals Judge

BOGGS, Chief Administrative Appeals Judge, concurring:

I concur in the majority's finding that Claimant is totally disabled. As the majority notes, all of the physicians agree that Claimant was totally disabled prior to his May 2014 left lung transplant, which was conducted as part of ongoing treatment for his advanced interstitial lung disease. *See supra* at 12; Director's Exhibit 26; Claimant's Exhibit 14. Further, Claimant's right lung remains totally disabled post-transplant, and, as the majority observes, the physicians who specifically addressed the requirements of Claimant's ongoing treatment for his disabling impairment agree that returning to coal mine employment is proscribed as a matter of that treatment. Claimant's Exhibits 9 at 27, 15, 16 at 13-14, 15; Employer's Exhibit 20 at 44, 55; *see supra* at 15-16. Thus, Claimant remains disabled on an ongoing basis.

However, I respectfully disagree with the majority's position that total disability should not be assessed at the time of the hearing – which is notably not an argument raised

by the Director. They note the Board has held that treatment of a miner's complicated pneumoconiosis, through excision of the lesion, does not defeat the miner's entitlement. *See Simpson v. U.S. Steel Min. Co., Alabama*, 2012 BRB Nos. 11-684 BLA and 11-834 BLA, slip op. at 5 (Sept. 24, 2012) (claimant "not required to provide evidence that residual pneumoconiosis remains after the massive lesion has been surgically excised during the lobectomy"). However, because this case does not involve complicated pneumoconiosis and the irrebuttable presumption that condition invokes, it, is not analogous to the cases they cite. *See supra* at 14-15.[16]

In *Maggard v. Kat Ran Enterprises, Inc.*, BRB No. 18-0451 BLA (Sept. 11, 2019) (unpub.), the Board did not hold that, *in all cases*, a diseased lung is evidence of a miner's condition regardless of subsequent changes. Rather, the Board held that due to the unique nature of the irrebuttable presumption applicable in *complicated pneumoconiosis* cases, once an individual establishes entitlement to that presumption (of total disability due to pneumoconiosis), the subsequent condition of the lung is irrelevant. Once the presumption is invoked, it cannot be revoked. *Maggard*, slip op. at 4-5; *see* 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304; *see also Simpson v. U.S. Steel Mining Co. Ala.*, BRB Nos. 11-0684 BLA and 11-0834 BLA (Sept. 24, 2012); *McCauley v. DLR Mining, Inc.*, 25 BLR 1-259 (2019). However, in cases like this one, which do not involve complicated pneumoconiosis, the fact that Claimant had diseased tissue removed or replaced is evaluated differently because there is *no presumption* that precludes a showing Claimant is no longer totally disabled. For this reason, I disagree with the underlying premise of the majority's holding that newer evidence has no relevancy to a total disability determination simply because Claimant was totally disabled prior to his transplant and that no further inquiry is required. Indeed, because this is an original entitlement case, the burden is on Claimant to establish entitlement, not on Employer to establish a change in condition post-transplant.

Therefore, it was not error, as the majority contends, for the ALJ to evaluate Claimant's entitlement to benefits based on his current physical condition. *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 624 (6th Cir. 1988); *Gray v. Director, OWCP*, 943 F.2d 513, 521 (4th Cir. 1991); *Parsons v. Wolf Creek Collieries*, 23 BLR 1-29, 1-34-35 (2004) (en banc); *Workman v. Eastern Associated Coal Corp.*, 23 BLR 1-22, 1-27 (2004) (en banc); Decision and Order at 51. However, given the facts of this case, the ALJ erred in not considering Claimant's current condition in the context of all relevant evidence, including the requirements of the treatment for his disabling impairment. *See Compton v. Island Creek Coal Co.*, 211 F.3d 203, 207-208 (4th Cir. 2000); *see Sunny Ridge Mining Co. v. Keathley*, 773 F.3d 734, 740 (6th Cir. 2014); *Woodward v. Director, OWCP*, 991 F.2d 314, 319-20 (6th Cir. 1993). Consequently, I concur with the majority that the ALJ's

[16] Unpublished cases may be relevant for the persuasive power of their reasoning. However, in this case the reasoning is inapplicable.

finding concerning total disability must be reversed and he is entitled to invoke the Section 411(c)(4) rebuttable presumption that he is totally disabled by pneumoconiosis. 30 U.S.C. §921(c)(4) (2018); *see* 20 C.F.R. §718.305; *supra* at 18.

I also concur with the majority that the ALJ provided permissible reasons for discrediting Drs. Zaldivar's, Castle's, and Oesterling's opinions concerning legal pneumoconiosis in the context of rebutting the presumption.[17] Notably, he determined that their diagnosis of idiopathic fibrosis did not preclude a contribution by Claimant's coal dust exposure; thus the physicians' opinions excluding coal dust on the basis of their diagnosis of idiopathic fibrosis were inadequate for purposes of rebuttal [of the view that it did]. *See* 65 Fed. Reg. 79,920, 79,941 (Dec. 20, 2000); *Harman Mining Co. v. Director, OWCP* [*Looney*], 678 F.3d 305, 314-16 (4th Cir. 2012); Decision and Order at 44-46; Director's Exhibit 28; Employer's Exhibits 9, 19, 20. Similarly, he permissibly determined that Dr. Oesterling failed to adequately explain his exclusion of coal dust exposure as a factor in Claimant's condition. *Looney*, 678 F.3d at 316-17; *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); Decision and Order at 44, 46; Employer's Exhibit 11. Therefore, their opinions are inadequate to rebut the presumption, i.e. to show it is more likely than not that Claimant did not have a chronic lung disease or impairment "significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[18] 20 C.F.R. §§718.201(a)(2), (b), 718.305(d)(1)(i)(A); *see Minich v. Keystone Coal Mining Corp.*, 25 BLR 1-149, 1-155 n.8 (2015). Further, I concur that the ALJ permissibly found that their opinions as to disability causation were not credible for the reason cited by the majority. *See* 20 C.F.R. §718.305(d)(1)(ii); *supra* at 22; *see also*

[17] The ALJ placed the burden of persuasion on Employer's physicians in this regard. Decision and Order at 45-46. However, any error is harmless as Employer has the burden of persuasion in the context of rebuttal of the presumption. *See Johnson v. Jeddo-Highland Coal Co.*, 12 BLR 1-53, 1-55 (1988); *Larioni v. Director, OWCP*, 6 BLR 1-1276, 1-1278 (1984).

[18] As the only evidence in the record supporting Employer's burden on rebuttal is insufficient to rebut the existence of legal pneumoconiosis, Employer is precluded from rebutting the Section 411(c)(4) presumption by establishing that Claimant does not have pneumoconiosis. 20 C.F.R. §718.305(d)(1)(i). Further, because Employer bears the burden of proof on rebuttal and the ALJ's rejection of its experts is affirmable, it is not necessary to address Employer's arguments concerning the ALJ's weighing of Claimant's medical experts, Drs. Rasmussen, Cohen, Go, and Highland, who diagnosed legal pneumoconiosis. *See* Employer's Reply Brief at 20-24; Employer's Response Brief at 34-43.

Hobet Mining, LLC v. Epling, 783 F.3d 498, 504-05 (4th Cir. 2015); *Scott v. Mason Coal Co.*, 289 F.3d 263, 269-70 (4th Cir. 2002).

Consequently, I also would determine that Claimant is entitled to benefits based on the unique facts of this case.

JUDITH S. BOGGS, Chief
Administrative Appeals Judge