No. 14-1401

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

SEWELL COAL COMPANY,

Petitioner

v.

BARBARA M. DEMPSEY

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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BRIEF FOR THE FEDERAL RESPONDENT

This case involves the February 2001 application of William O. Dempsey—a non-smoker who labored in the coal mines for 23 years—for benefits under the Black Lung Benefits Act (BLBA), 30 U.S.C. §§ 901-44.[1] His claim for lifetime benefits is before the

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[1] Mr. Dempsey died in 2013, and his claim is being pursued by his widow, Barbara M. Dempsey. Because Mr. Dempsey filed his claim in 2001, the amendments to the BLBA contained in Section 1556 of the Affordable Care Act (ACA) do not apply to his lifetime claim, and are not directly implicated in this appeal. *See* Pub. L. No. 111-148, (cont'd . . .)

Court for the third time. In its most recent decision, the Court vacated an award of benefits to Mr. Dempsey, and remanded the case for further consideration. *Sewell Coal v. Dempsey*, 429 Fed. Appx. 311 (4th Cir., May 19, 2011). On remand, a Department of Labor (DOL) administrative law judge (ALJ) again awarded benefits, and the Benefits Review Board affirmed that decision. Sewell Coal Company, Mr. Dempsey's former employer, has petitioned for review of the Board's decision. The Director, Office of Workers' Compensation Programs, responds in support of the award, and to specifically address two of Sewell's arguments, which raise issues of programmatic importance to the Director.[2]

(. . . cont'd)
§ 1556(c) (2010). Mrs. Dempsey, however, also has filed a claim for survivor's benefits under the BLBA, which the district director awarded, but is pending before an administrative law judge on Sewell's appeal. If the award on Mr. Dempsey's lifetime claim is upheld, Mrs. Dempsey will be automatically entitled to survivor's benefits based on the ACA amendments. *See* Pub. L. No. 111-148, § 1556(b); *West Virginia CWP Fund v. Stacy*, 671 F.3d 378, 388-91 (4th Cir. 2011) (ACA Section 1556 restored automatic entitlement for eligible survivors of miners who received lifetime awards).

[2] The Black Lung Disability Trust Fund paid benefits to Mr. Dempsey on an interim basis. *See* 20 C.F.R. § 725.522(a). If the Court affirms his award, Sewell will have to reimburse the Trust Fund for the payments made. *See* 20 C.F.R. § 725.602. Likewise, (cont'd . . .)

STATEMENT OF JURISDICTION

This Court has both appellate and subject matter jurisdiction over Sewell's petition for review under Section 21(c) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 921(c), as incorporated into the BLBA by 30 U.S.C. § 932(a). Sewell petitioned for review of the Board's February 28, 2014, decision on April 28, 2014, within the 60-day limit prescribed by Section 21(c). Moreover, the "injury" as contemplated by Section 21(c)—Mr. Dempsey's exposure to coal-mine dust—occurred in West Virginia.

The Board had jurisdiction to review the ALJ's decision on remand under Section 21(b)(3) of the Longshore Act, 33 U.S.C. § 921(b)(3), as incorporated by 30 U.S.C. § 932(a). The ALJ issued his decision on November 28, 2012. Sewell filed a notice of appeal with the Board on December 12, 2012, within the 30-day period prescribed by Section 21(a) of the Longshore Act, 33 U.S.C.

(. . . cont'd)
the Trust Fund is currently paying survivor's benefits to Mrs. Dempsey on an interim basis. If the Court affirms Mr. Dempsey's award, Sewell will also have to reimburse the Trust Fund with respect to Mrs. Dempsey's claim, and pay her ongoing survivor's benefits.

§ 921(a), as incorporated by 30 U.S.C. § 932(a).

STATEMENT OF THE ISSUES[3]

1. DOL's regulations call for the classification of chest x-rays according to International Labour Organization (ILO) standards. ILO standards permit a diagnosis of clinical pneumoconiosis when an x-ray shows irregularly-shaped opacities (spots) situated in the lower part of the lung. Dr. Wiot (in his x-ray readings) and Dr. Renn (in his medical opinion) found that although Mr. Dempsey's x-rays showed opacities, they did not represent clinical pneumoconiosis because 1) there were no opacities in the upper lung zones and 2) the opacities present in the lower lung zone were irregular and not rounded.

Did the ALJ properly discount these views because they are contrary to DOL's regulations?

2. An August 2001 x-ray was read as positive for clinical pneumoconiosis by Drs. Patel and Alexander, and as negative by

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[3] In addition to the issues we identify, Sewell raises various contentions regarding the ALJ's evaluation of the medical opinions of Drs. Renn and Cohen. We will not address those arguments, other than to note that the Court can affirm the decisions below without reaching them.

Dr. Wheeler. Patel and Alexander were B-readers (physicians with expertise in reading x-rays for the presence of pneumoconiosis), but the record evidence indicated Wheeler was not when he read the August 2001 x-ray.

Did the ALJ properly give the Patel and Alexander readings greater weight based on their superior radiological qualifications?

3. Did Mr. Dempsey establish all elements of entitlement on his claim?

STATEMENT OF THE CASE

A. Statutory and Regulatory Background

The BLBA provides benefits to coal miners who are totally disabled due to pneumoconiosis. 30 U.S.C. § 901(a). To obtain benefits on a miner's lifetime claim, the claimant must prove that he had pneumoconiosis, that it arose out of his coal-mine employment (disease causation), and that he had a totally disabling respiratory impairment, which was due, at least in part, to pneumoconiosis (disability causation). 20 C.F.R. §§ 718.202-.204; *Daniels Co., Inc., v. Mitchell*, 479 F.3d 321, 336 (4th Cir. 2007). The primary element of entitlement at issue here is whether Mr. Dempsey had pneumoconiosis.

"Pneumoconiosis" includes both "clinical pneumoconiosis" (diseases commonly recognized as pneumoconiosis by the medical community) and the broader category of "legal pneumoconiosis" (any chronic lung disease caused by coal-mine-dust inhalation, including "any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment"). 20 C.F.R. § 718.201(a)(1), (2); *Westmoreland Coal Co. v. Cochran*, 718 F.3d 319, 320-21 (4th Cir. 2013). This case turns on whether Mr. Dempsey had clinical pneumoconiosis, as shown by x-ray and medical-opinion evidence.[4] *See* 20 C.F.R. § 718.202(a)(1), (4).

With respect to the x-ray evidence of pneumoconiosis, DOL regulations provide that an x-ray is sufficient to establish the presence of pneumoconiosis

> [if] classified as Category 1, 2, 3 . . . according to the International Labour Organization Union Internationale Contra Cancer/ Cincinnati (1971) International Classification of Radiographs of the Pneumoconioses (ILO-U/C 1971) [hereafter the "ILO Classification"], or

[4] Mrs. Dempsey cannot establish that her husband had clinical pneumoconiosis under 20 C.F.R. § 718.202(a)(2) or (3), as there is no biopsy or autopsy evidence, and no presumptions are available to aid her.

subsequent revisions thereof.[5]

20 C.F.R. § 718.102(b). Thus, an x-ray showing an opacity profusion of 1/0 or greater is sufficient to prove that a miner had pneumoconiosis.[6] *See* 20 C.F.R. § 718.102(b); *U.S. Steel Min. Co. v. Director, OWCP*, 386 F.3d 977, 982 n. 6 (11th Cir. 2004); *Wolf Creek Collieries v. Director, OWCP*, 298 F.3d 511, 514 n. 4 (6th Cir. 2002). Neither the BLBA nor DOL's implementing regulations require the opacities to be of any particular shape, or that they appear in any particular zone (upper, middle or lower) of a miner's lung.

When the x-ray evidence is in conflict, the ALJ must consider

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[5] The ILO has published guidelines for physicians, which are an integral part of the ILO Classification. *Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses* (Rev. Ed. 2011) (hereafter "the *ILO Guidelines*"), p. 1 (available at http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@safework/documents/publication/wcms_168260.pdf). Lung opacities are categorized by profusion, location and shape. *Id.* at p. 3. Profusion "refers to the concentration of . . . opacities in affected zones of the lung," and is categorized by comparison to a set of standard radiographs. *Id.* For location, lung fields are divided into upper, middle and lower zones, each representing (from top to bottom) approximately one-third of a lung. *Id.* at 5. Finally, opacities appear in two general shapes, rounded or irregular. *Id.*

[6] Conversely, an x-ray read as showing a profusion of 0/-, 0/0 or 0/1 "does not constitute evidence of pneumoconiosis." 20 C.F.R. § 718.102(b).

"the radiological qualifications of the physicians interpreting such X-rays." 20 C.F.R. § 718.202(a)(1)(i). In particular, the ALJ must consider whether the physician is a board-certified radiologist or a B-reader.[7] 20 C.F.R. § 718.202(a)(1)(ii)(C), (E).

B. Statement of the Facts

We summarize only the evidence relevant to the issues addressed in this brief—whether, in finding clinical pneumoconiosis, the ALJ properly discounted the x-ray readings of Drs. Wiot and Wheeler, and the medical report of Renn. The joint appendix contains voluminous additional medical evidence, some of which is relevant to issues addressed by the private parties, but much of it was excluded by the ALJ pursuant to the evidence-limiting rules contained in 20 C.F.R. § 725.414, and is not relevant to the present appeal.

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[7] "Board certified" refers to certification in the practice of radiology by either the American Board of Radiology 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 the use of the [ILO Classification] for interpreting chest [x-rays] for pneumoconiosis . . . by . . . passing a specially designed proficiency examination." 20 C.F.R. § 718.202(a)(1)(ii)(E) (cross-referencing 42 C.F.R. § 37.51(b)(2)).

1. X-ray Evidence

There are readings of four x-rays from Mr. Dempsey's 2001 claim.[8] Dr. Wiot, a board-certified radiologist and B-reader, read a July 2001 x-ray. Joint Appendix (JA) at 155-56. He indicated that the x-ray showed "perfectly clear" "upper lung fields" and a "basilar interstitial change of an irregular type."[9] *Id.* He opined that the abnormality could not be coal worker's pneumoconiosis, which "invariably" begins in the upper zones and usually involves rounded, not irregular, opacities. JA at 155.

An August 2001 x-ray was read as positive for pneumoconiosis (with a profusion of 2/2) by Drs. Patel and Alexander (both of whom are board-certified radiologists and B-readers). JA at 189, 194.

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[8] There are also several x-rays from Mr. Dempsey's original 1989 claim. X-rays from 1976 and 1983, as well as two x-rays from 1989 were read as positive for clinical pneumoconiosis. JA at 26, 32, 36, 52, 53. A 1978 x-ray was read as negative. Joint Appendix at 29. The ALJ gave "some weight" to the 1989 positive x-ray readings, but gave little or no weight to the earlier ones because the readers' qualifications were not in the record. JA at 797.

[9] A "basilar interstitial change" refers to a change seen in the small spaces between tissues (interstices) at the base or bottom of a lung. *See Dorland's Illustrated Medical Dictionary* (32d ed. 2012) 203, 951.

The same film was read as negative for pneumoconiosis by Dr. Wheeler. JA 192. Dr. Wheeler's *curriculum vitae* indicated that he was a board-certified radiologist and that he was a B-reader from May 1997 through April 2001. Employer's Exhibit 6.[10] Dr. Wheeler, however, read the August 2001 x-ray in March 2002. JA at 192.

Dr. Wiot read an October 1, 2002, x-ray as negative for pneumoconiosis, again noting the presence of bibasilar fibrosis. JA at 274. He indicated that the fibrosis was "more likely IPF [idiopathic pulmonary fibrosis],"[11] "not CWP [coal workers' pneumoconiosis]." *Id.*

Finally, Dr. Alexander and Dr. Cohen read an October 25, 2002, x-ray as positive for clinical pneumoconiosis with a profusion

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[10] Exhibit numbers refer to the record created before the ALJ, and are cited where a document is not included in the appendix.

[11] Generally speaking, an "idiopathic" disease is one with no known cause. *See Dorland's Illustrated Medical Dictionary* (32d ed. 2012) 912. Idiopathic pulmonary fibrosis (IPF) is the most common form of a category of diseases identified as idiopathic interstitial pneumonias, which (in turn) are a group of interstitial lung diseases of unknown origin. *The Merck Manual* (19th ed. 2011), 1945, 1947. IPF is characterized by progressive pulmonary fibrosis, and occurs predominantly in male smokers. *Id.* at 1947.

of 2/1 (Alexander) or 2/2 (Cohen). JA at 278; Claimant's Exhibit 6. Dr. Wiot read the same x-ray as negative for pneumoconiosis, but again noted "bibasilar fibrosis" that was "more [or most] likely IPF [and] not CWP." JA at 275; *see also* JA at 279.

In addition to the x-ray readings, the record contains Dr. Wiot's deposition.[12] JA at 338. When asked what he "need[ed] to see on a chest x-ray" to diagnose pneumoconiosis," he stated that "coal workers pneumoconiosis, *invariably*, begins in the upper lung fields," and consists of "primarily small, rounded opacities." JA at 352 (emphasis added); *see also* JA at 373. He acknowledged that secondarily "there will be some irregular opacities in almost all cases, . . . [b]ut it always begins in the upper lung zones." JA at 352. He also reiterated his interpretation of the July 2001 x-ray and of both of October 2002 x-rays as showing "basilar fibrosis" attributable to IPF, not pneumoconiosis. JA at 361-64. On cross-

[12] Dr. Wiot's deposition should have been considered a medical opinion. *See* 20 C.F.R. § 725.414(c). As such, it would have been in excess of the two opinions that Sewell was permitted, and had already submitted (from Drs. Bellotte and Renn). *See* 20 C.F.R. § 725.414(a)(3)(i). No party challenged the ALJ's admission of the Wiot deposition, however, thus waiving any error in its admission.

examination, Dr. Wiot acknowledged that the basilar fibrosis he diagnosed presented as irregular opacities on x-ray, but averred that "you can't make a diagnosis of pneumoconiosis unless you consider the type and the distribution." JA at 371.

2. Medical-Opinion Evidence

The record contains the following medical opinions relevant to the issues discussed in this brief:

Dr. Renn examined Mr. Dempsey on Sewell's behalf.[13] JA at 234. He found that Mr. Dempsey's x-rays showed irregular opacities (with a profusion of 2/1), but concluded that the x-rays indicated IPF rather than coal workers' pneumoconiosis because the opacities were irregular and only in the mid and lower lung zones. *Id.*

Dr. Renn subsequently affirmed his diagnosis on deposition. JA at 377. Like Dr. Wiot, he testified that coal workers'

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[13] As part of his examination, Dr. Renn reviewed a substantial body of medical evidence, much of which was ultimately excluded from the record. After this case was remanded by the Court in 2011, the ALJ permitted Sewell to submit an additional letter from Dr. Renn in which he stated that his opinion would not change, even if he excluded the inadmissible evidence from his consideration. JA at 743.

pneumoconiosis "invariably" causes opacities beginning in the upper lung zones. JA at 437. In addition, he admitted that the medical literature showed that coal workers' pneumoconiosis could cause irregular opacities, but refused to endorse it, stating that "I'm not sure that I believe that very strongly . . . . I keep looking for it, but I don't—I have not really found it myself yet." JA at 438. Since Mr. Dempsey's x-rays showed only irregular opacities and only in the mid and lower lung zones, Dr. Renn concluded that they were not consistent with pneumoconiosis. JA at 402-05.

The record also contains opinions from Dr. Rasmussen (who examined Mr. Dempsey on behalf of DOL), and from Drs. Gaziano and Cohen (submitted by Mr. Dempsey). JA at 157, 336, 455, 458. All three doctors found that Mr. Dempsey had clinical pneumoconiosis, and Drs. Rasmussen and Cohen attributed his total respiratory disability to pneumoconiosis.[14] JA 160, 468. Dr. Rasmussen also stated that the only risk factor that Mr. Dempsey had for the development of his lung disease was coal-mine-dust exposure. JA at 169. He further testified on deposition that while

[14] Dr. Gaziano did not address disability causation.

rounded opacities are more characteristic of coal workers' pneumoconiosis, the disease can also produce irregular opacities (even in the absence of rounded opacities). JA at 306, 323-24. He further stated that pneumoconiotic opacities may be found in any lung zone, and may begin in the lower zones, JA at 307, 324.

Likewise, Dr. Gaziano indicated that pneumoconiosis may cause irregular opacities. JA at 336. Finally, Dr. Cohen (who attached several medical journal articles to support his opinion) stated that the presence of irregular opacities did not rule out a diagnosis of coal workers' pneumoconiosis.[15] JA at 464. Indeed, according to Dr. Cohen, a NIOSH study found that 17% of miner's with x-ray evidence of coal workers' pneumoconiosis had only irregular opacities, and another 13% had mixed rounded and irregular opacities. *Id.*

[15] As with Dr. Renn, Dr. Cohen's opinion was based, in part, on evidence that was ultimately excluded from the record. After this case was remanded by the Court in 2011, the ALJ permitted Mr. Dempsey to submit an additional letter from Dr. Cohen in which he stated that his opinion would not change, even if he excluded the inadmissible evidence from his consideration. JA at 745.

C. Procedural History and Prior Decisions

Mr. Dempsey originally applied for benefits in April 1989, Director's Exhibit (DX) 1, and a DOL district director denied this claim in August of that year. *Id.* Mr. Dempsey took no further action on the 1989 claim. He filed the instant, subsequent claim on February 8, 2001. JA at 1; *see* 20 C.F.R. § 725.309. The district director awarded this claim, DX 33, and Sewell requested a hearing before an ALJ. DX 41.

1. The First ALJ Decision Awarding Benefits

The ALJ awarded benefits. JA at 541. He found Mr. Dempsey's 2001 claim was not time-barred, as he believed that the BLBA's three year statute of limitations, 30 U.S.C. § 932(f), did not apply to subsequent claims. JA at 553. On the merits, the ALJ determined that Mr. Dempsey had established all elements of entitlement. JA at 553-61.

In finding pneumoconiosis established, the ALJ gave less weight to Dr. Wiot's negative readings because other highly qualified radiologists (board-certified radiologists, B-readers, or both) refuted his finding that the upper-lung zones were entirely clear (and thus pneumoconiosis not possible). JA at 556. He also gave greater

weight to the readings of Drs. Patel and Alexander, as they were both B-readers and board-certified radiologists. *Id.* In contrast, the ALJ found that Dr. Wheeler was not a B-reader when he read the August 2001 x-ray, and declined to give his reading equal weight to those of Patel and Alexander. JA at 545, n. 5. Thus, he concluded that the x-ray evidence supported a finding of clinical pneumoconiosis. *Id.*

Likewise, the ALJ found that the medical-opinion evidence demonstrated the presence of clinical pneumoconiosis. JA at 557-59. He credited the positive diagnoses of Drs. Rasmussen, Gaziano and Cohen, and discounted the negative opinion of Dr. Renn because he impermissibly relied on evidence that had been excluded from the record pursuant to 20 C.F.R. § 725.414.[16] *Id.* He further found that Mr. Dempsey's pneumoconiosis arose out his coal-mine work and he had a totally disabling pulmonary impairment under 20 C.F.R. §§ 718.203 and .204(b). JA at 553-56, 559-60. Finally, based on Rasmussen's and Cohen's opinions, he

[16] There is an additional negative report from Dr. Bellotte, but the Court affirmed the ALJ's rejection of that report in its prior decision in this case. 429 Fed. Appx. at 315, n. 4.

concluded that Mr. Dempsey's disability was due to his clinical pneumoconiosis, rejecting Dr. Renn's contrary view because the doctor wrongly failed to diagnose pneumoconiosis or total disability in the first place. JA at 560-61 & n. 16.

2. The First Board Decision -- Remand

Sewell appealed, principally arguing that the evidence-limiting rules of 20 C.F.R. § 725.414 (which the ALJ had applied) were invalid, but also challenging a number of the ALJ's evidentiary and procedural rulings, as well as his findings on the merits. The Board affirmed the ALJ's decision on most points, but ultimately vacated his award of benefits, and remanded the case for further consideration. JA at 637.

The Board affirmed the ALJ's finding that the 2001 claim was timely on the ground that the statute of limitations does not apply to subsequent claims. JA at 639-40. The Board then upheld Section 725.414's evidentiary limitations. JA at 642-44; *see Elm Grove Coal Co. v. Director, OWCP*, 480 F.3d 278, 287-97 (4th Cir. 2007) (affirming validity of Section 725.414). It also affirmed most of the ALJ's evidentiary and procedural rulings, JA at 645-48, but ruled that the ALJ had erred in excluding certain CT-scan readings

and medical records. JA at 644-45.

The Board also affirmed the ALJ's finding that Mr. Dempsey had established clinical pneumoconiosis by x-ray and total respiratory disability under 20 C.F.R. §§ 718.202(a)(1), .204(b), respectively.[17] JA at 649-52.

The Board, however, vacated the ALJ's finding that the medical-opinion evidence supported a finding of clinical pneumoconiosis under Section 718.202(a)(4), as well as disability causation under Section 718.204(c). JA at 651-52. It held that the ALJ's rejection of Drs. Renn's opinion (based on the doctor's review of excluded evidence) could not be sustained because the ALJ had improperly excluded some of the evidence Renn reviewed. *Id.* JA at 651. Thus, the Board remanded the case for the ALJ to reconsider Dr. Renn's opinion and to reweigh it against the other credible and conflicting medical opinions of record.[18] JA at 652.

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[17] Notably, Sewell did not challenge the ALJ's findings that Dr. Wheeler lacked B-reader status when he read the August 2001 x-ray, and that Wheeler's reading of that x-ray deserved less weight than the positive readings of Drs. Patel and Alexander, based on their respective radiologic qualifications.

[18] The Board affirmed the ALJ's finding that the opinions of Drs. (cont'd . . .)

3. The Second ALJ Decision Awarding Benefits

On remand, the ALJ again awarded benefits. JA at 656. After admitting additional CT-scan evidence and medical records, the ALJ found again that Mr. Dempsey had clinical pneumoconiosis, and was disabled due to the disease. JA at 659-663.

In making these findings, the ALJ considered the extent to which the competing medical reports were based on inadmissible evidence. He again gave little weight to Dr. Renn's opinion, concluding that the physician's finding of no pneumoconiosis was unreliable because thirteen of the sixteen x-ray readings he considered had been excluded.[19] JA at 660-61. He then credited the opinions of Drs. Rasmussen, Gaziano, and Cohen, and found both clinical pneumoconiosis and disability causation based on those opinions, along with the x-ray evidence. JA at 661-63

(. . . cont'd)
Rasmussen, Gaziano and Cohen were credible on the issue of clinical pneumoconiosis. JA at 652.

[19] On disability causation, the ALJ rejected Dr. Renn's opinion because he incorrectly assumed that Mr. Dempsey did not have pneumoconiosis. JA at 663.

4. The Second Board Decision -- Affirmance

Sewell appealed, but the Board affirmed the ALJ's award of benefits in a split decision. JA at 667. The majority affirmed the ALJ's evidentiary rulings, and his finding that the medical opinions established clinical pneumoconiosis. JA at 673-75. On this second point, the majority held that the ALJ acted within his discretion in giving little weight to Dr. Renn's negative opinion because it was primarily based on inadmissible evidence. JA at 673-74. The majority also again affirmed the ALJ's crediting of the opinions of Drs. Cohen and Rasmussen and their diagnoses that Mr. Dempsey's disability was due to pneumoconiosis. JA at 674-76. The dissenting judge believed the ALJ had inadequately considered the impact of the excluded evidence on Renn's and Cohen's opinions and would have remanded for their reconsideration and reweighing. JA at 676-78.

5. The Court's First Decision -- Remand

Sewell petitioned the Court to review the Board's decision, and the Court vacated the award of benefits. JA at 696-700; *Sewell Coal Co. v. Director, OWCP*, 523 F.3d 257 (4th Cir. 2008). The Court held that the BLBA's statute of limitations for miners' lifetime

claims, 30 U.S.C. § 932(f), applies to all miner claims, including subsequent claims. 523 F.3d at 259. Since the ALJ and the Board had ruled, as a matter of law, that the limitations provision did not apply to subsequent claims (like Mr. Dempsey's), the Court vacated the award of benefits and remanded the case for reconsideration of whether Mr. Dempsey's 2001 claim was timely. *Id.* It accordingly declined to address the remainder of Sewell's contentions.

6-7. The Third ALJ Decision Awarding Benefits and Board Affirmance

On remand, the ALJ found Mr. Dempsey's 2001 claim timely filed, JA at 701, 703, and the Board affirmed that finding. JA at 705, 707-09.

8. The Court's Second Decision -- Remand

Sewell petitioned the Court to review the Board's decision. It reiterated most of the evidentiary, procedural and merits arguments from its first appeal, which the Court had declined to address. This time, the Court affirmed and vacated in part the ALJ and Board decisions, and remanded for further consideration. JA at 725-739; *Sewell Coal Co. v. Dempsey*, 429 Fed. Appx. 311 (4th Cir. May 19, 2011).

The Court summarily rejected Sewell's evidentiary and procedural arguments, and affirmed the timeliness of Mr. Dempsey's 2001 claim. JA at 729-33 & n. 1. Turning to the merits of the claim, the Court affirmed the ALJ's crediting of the medical opinions of Drs. Gaziano and Rasmussen, and his rejection of Dr. Bellotte's. JA at 733-34. The Court, however, vacated the ALJ's evaluation of the opinions of Drs. Renn and Cohen, holding that the ALJ erroneously focused on the amount of inadmissible evidence that each physician reviewed, rather than on the extent to which the physician based his opinion on the excluded evidence. JA at 734-38. Accordingly, the Court vacated the ALJ's award of benefits, and remanded the case for the ALJ to reconsider the Renn and Cohen opinions, as well as to reconsider the x-ray readings of Drs. Wiot, Patel and Alexander.[20] JA 738-39 & n. 6.

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[20] The Court's opinion directed the ALJ to reconsider both the existence of pneumoconiosis and "total disability." Sewell, however, had not challenged the ALJ's finding that Mr. Dempsey had a totally disabling pulmonary impairment under 20 C.F.R. § 718.204(b), but had challenged his finding that the disability was due to pneumoconiosis under 20 C.F.R. § 718.204(c). Moreover, Drs. Renn, Rasmussen, Gaziano and Cohen all agreed that Mr. Dempsey's pulmonary condition prevented him from performing his last coal-mine job. In any event, Sewell does not now argue that (cont'd . . .)

9. The Fourth ALJ Decision Awarding Benefits

The original ALJ had retired by the time the case was remanded, and it was reassigned to a new ALJ. *See* JA at 792. The new ALJ permitted the parties to submit supplemental statements from Drs. Renn and Cohen. *See id*. He then issued a decision awarding benefits. JA at 791.

The ALJ interpreted the Court's decision as requiring him to re-examine whether the x-ray evidence supported a finding of pneumoconiosis. JA at 796. He found that two 1989 x-rays from Mr. Dempsey's prior claim were positive for the presence of pneumoconiosis, as all readings of those x-rays were positive.[21] JA at 791.

The ALJ likewise found that the x-rays submitted in connection with the current claim were positive for pneumoconiosis. He fully credited the positive readings by Drs. Patel, Alexander (both

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(. . . cont'd)
Mr. Dempsey was not totally disabled prior to his death.

[21] The ALJ gave little weight to three other x-rays from the prior claim (from 1976, 1978 and 1983) based on the absence of evidence regarding the readers' qualifications. JA at 797.

board-certified radiologists and B-readers) and Dr. Cohen (a B-reader), while giving little or less weight to Drs. Wiot and Wheeler's negative readings. JA 797-78. The ALJ discredited Dr. Wiot's readings because the doctor's view—that coal workers' pneumoconiosis could be diagnosed only where there are rounded opacities in the upper lung zones—was contrary to the black lung regulations, namely, 20 C.F.R. § 718.102(b), which permits a finding of pneumoconiosis where there is a profusion of 1/0 or greater of either rounded or irregular opacities in any lung zone. *Id.* And Dr. Wheeler's negative reading was less credible because (as the original ALJ found) he was not a B-reader at the time he provided his reading. *Id.* Thus, the ALJ concluded that the x-ray evidence was positive for the presence of clinical pneumoconiosis. *Id.*

The ALJ also found that the medical-opinion evidence supported a finding of clinical pneumoconiosis.[22] JA at 799-802. As an initial matter, he accepted the statements of both Drs. Renn

[22] The ALJ specifically declined to address whether Mr. Dempsey had legal pneumoconiosis. JA at 802, n. 18. The prior ALJ had not addressed this issue either.

and Cohen that neither of their opinions would change if they had not considered inadmissible excess evidence. JA at 799. The ALJ discounted Dr. Renn's negative opinion, however, because (similar to Dr. Wiot) the physician believed that pneumoconiosis could only be diagnosed when rounded opacities appear in the upper lung zones. JA at 800. He also found that Dr. Renn failed to adequately explain his diagnosis of idiopathic pulmonary fibrosis, given that those stricken with the disease typically have a short life-span, whereas Mr. Dempsey's lung condition had been evident for over 30 years prior to his death. JA at 800-01.

The ALJ then went on to credit the positive opinions of Drs. Rasmussen, Gaziano and Cohen, and concluded that their opinions (in conjunction with the x-ray evidence) established the presence of clinical pneumoconiosis. JA at 801-02. Finally, the ALJ concluded that all other elements of entitlement—disease causation, total disability and disability causation—were established.[23] JA at 802-

[23] The ALJ specifically discredited Dr. Renn on disability causation because the physician assumed (contrary to the ALJ's finding) that Mr. Dempsey did not have pneumoconiosis. JA at 803; *see Scott v. Mason Coal Co.*, 289 F.3d 263, 269-70 (4th Cir. 2002) (ALJ may discount opinion of no disability causation where physician (cont'd . . .)

03.

10. The Fourth Board Decision -- Affirmance

Sewell appealed, but the Board affirmed the ALJ's decision in a split decision. JA at 806. With respect to the x-ray evidence, the Board held that the ALJ was not required to give Dr. Wheeler and Dr. Wiot greater weight based on their academic qualifications, and was not required to go outside the record to determine whether Dr. Wheeler was a B-reader when he read the August 2001 x-ray. JA at 810-11. It also held that the ALJ properly discounted Dr. Wiot's x-ray readings because his views conflicted with the DOL's regulations. JA at 811-12. Finally, the Board held that Drs. Patel and Alexander were not required to explain their x-ray reading beyond identifying opacity profusions that were indicative of the presence of pneumoconiosis. JA at 812.

Turning to the medical-opinion evidence on clinical pneumoconiosis, the Board affirmed the ALJ's reliance on the opinions of Drs. Rasmussen, Cohen and Gaziano. JA at 813, 815-

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(. . . cont'd)
erroneously assumes that miner did not have pneumoconiosis).

16. It also affirmed his discounting of Dr. Renn's opinion because the doctor erroneously relied on the shape and lung-zone location of opacities in determining whether Mr. Dempsey had clinical pneumoconiosis, and because he failed to adequately explain his diagnosis of IPF. JA at 813-15.

The dissenting judge saw no inconsistency between the regulations and Drs. Wiot and Renn's opinions and would have remanded for reconsideration of the x-ray evidence and Dr. Renn's opinion. JA at 817-25. Sewell then petitioned the Court to review the Board's decision. JA at 827.

SUMMARY OF THE ARGUMENT

The Court should affirm the award of benefits on Mr. Dempsey's lifetime claim. The ALJ properly found that Mr. Dempsey had clinical pneumoconiosis based on the x-ray and medical-opinion evidence. In so doing, he correctly rejected the x-ray readings of Dr. Wiot and the medical opinion of Dr. Renn. Although both physicians found opacities on Mr. Dempsey's x-rays, they refused to diagnose clinical pneumoconiosis simply because the opacities were irregular and not present in the upper lung zones. Their categorical insistence on rounded and upper zone

opacities is contrary to ILO standards, which have no such requirement, and DOL regulations (specifically 20 C.F.R. § 718.102(b)), which utilize ILO standards to identify pneumoconiosis. Moreover, neither doctor provided any medical or scientific support for their constricted understanding, and Drs. Rasmussen, Gaziano and Cohen specifically rejected it. Last, current medical literature demonstrates that neither the presence of irregular opacities nor the absence of upper-lung-zone opacities is a basis for ruling out clinical pneumoconiosis.

The ALJ also properly gave less weight to Dr. Wheeler's negative reading of the August 2001 x-ray. Unlike the other readers of that film, the record does not disclose that Dr. Wheeler was a B-reader when he read the x-ray. Moreover, Sewell has waived any challenge regarding Wheeler's B-reader status, and regardless, Wheeler's negative reading would be outweighed by the overwhelmingly positive x-ray evidence. Last, recent events have called into serious question Dr. Wheeler's credibility as an impartial interpreter of x-rays.

Finally, Mr. Dempsey established all other elements of entitlement. Sewell does not contest disease causation or total

respiratory disability. The ALJ properly discounted Dr. Renn on disability causation because he incorrectly assumed clinical pneumoconiosis was not present. The remaining evidence supports a finding that Mr. Dempsey's disability was due to pneumoconiosis.

After ten administrative and judicial decisions and thirteen years of litigation, hopefully, the long road of Mr. Dempsey's black lung claim has reached its end. The Court should affirm the award of benefits.

ARGUMENT

The ALJ properly found that Mr. Dempsey had clinical pneumoconiosis. In so doing, he properly discounted the negative x-ray readings of Dr. Wiot and the negative medical opinion of Dr. Renn. He also correctly gave less weight to the negative x-ray reading of Dr. Wheeler. As a result, Mr. Dempsey established all elements of his claim.

A. Standard of Review

In reviewing the Board's decision, this Court "engage[s] in an independent review of the record to determine whether substantial evidence exists to support the ALJ's findings of fact." *Consolidation Coal Co. v. Williams*, 453 F.3d 609, 614 (4th Cir. 2006). The Court reviews legal issues *de novo*. *Elm Grove*, 480 F.3d at 288.

B. The ALJ properly discounted Dr. Wiot's x-ray readings and Dr. Renn's medical opinion because both doctors erroneously believed that clinical pneumoconiosis can only be diagnosed when rounded opacities are present in a miner's upper lung zones.

Sewell contends that in finding clinical pneumoconiosis, the ALJ erred by discounting Dr. Wiot's x-ray readings and Dr. Renn's medical opinion diagnosing IFP (idiopathic pulmonary fibrosis), not pneumoconiosis. The ALJ, however, properly rejected their opinions because they are contrary to the black lung regulations and lack credibility.

Drs. Wiot and Renn both acknowledged the presence of irregularly-shaped opacities in Mr. Dempsey's lower lung zones. But both assumed that clinical pneumoconiosis "invariably" presents on x-ray as mostly or entirely rounded opacities, beginning in the upper lung zones. If an x-ray does not show opacities in the upper zones, or if the opacities are mostly or entirely irregular, then these physicians will refuse to read the x-ray as showing clinical pneumoconiosis. Consequently, because they interpreted Mr. Dempsey's x-rays as showing only irregular opacities in the lower

lung zones,[24] they concluded that he had a lung disease of an unknown etiology, IPF—and not pneumoconiosis, notwithstanding his 23 years of coal mine employment (and no smoking history).

The ALJ found their categorically-held beliefs – that x-ray opacities of clinical pneumoconiosis must appear in the upper zones lung as rounded opacities - to be contrary to DOL regulations. The ALJ was right.

A claimant can establish the presence of clinical pneumoconiosis by means of a positive x-ray. 20 C.F.R. § 718.202(a)(1). An x-ray will be considered positive for clinical pneumoconiosis if it is "classified as Category 1, 2, 3 . . . according to the [ILO Classification], or subsequent revisions thereof." 20 C.F.R. § 718.102(b). This means that an x-ray showing an opacity profusion of 1/0 or greater may be considered positive for the presence of clinical pneumoconiosis. *U.S. Steel Min. Co.*, 386 F.3d

[24] Other physicians found that Mr. Dempsey's x-rays showed both rounded or irregular opacities in all lung zones. Because the ALJ did not resolve this disagreement, we take no position on whether those physicians were correct. For purposes of this brief, we will assume that Mr. Dempsey's x-rays revealed only irregular opacities, with none in the upper lung zones.

at 982 n. 6; *Wolf Creek Collieries*, 298 F.3d at 514 n. 4. Conversely, an x-ray is considered negative for pneumoconiosis when it is classified as Category 0, meaning a profusion of 0/-, 0/0, or 0/1. 20 C.F.R. § 718.102(b).

Section 718.102 makes no distinction between rounded and irregular opacities, nor between opacities appearing in the upper, middle or lower lung zones. Indeed, when DOL first promulgated the original version of Section 718.102(b), it explained that irregular opacities must be included when assessing the degree (or profusion) of pneumoconiotic opacities on x-ray (despite neither type of opacity being explicitly mentioned in the regulation).[25] 45 Fed. Reg. 13680-81 (Feb. 29, 1980). Likewise, the Seventh Circuit, in interpreting a predecessor regulation, 20 C.F.R. § 410.428, held that "an x-ray showing a profusion of at least 1/0 small irregular opacities is a positive reading and established the existence of pneumoconiosis." *Consolidation Coal Co. v. Chubb*, 741 F.2d 968, 973 (7th Cir. 1984).

Thus, under the plain language of current Section 718.102

[25] The original version of the regulation, 20 C.F.R. § 718.102(b) (1980), is substantively identical to the current regulation with respect to adoption of the ILO Classification.

(and its predecessors), an x-ray showing either rounded or irregular opacities with a profusion of 1/0 or greater in any lung zone may be positive for the presence of clinical pneumoconiosis. Drs. Wiot and Renn, however, require more—rounded opacities in the upper zones. This express limitation, not found in the regulation, is contrary to its plain text. *See Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 413-14 (1945) (no further inquiry where regulatory language is plain and unambiguous).[26]

The ILO Classification, which Section 718.102 utilizes to evaluate x-rays for the presence of pneumoconiosis, is likewise not limited as Drs. Wiot and Renn would require. Nothing in the *ILO Guidelines*—an integral part of the Classification, *see* note 5, *supra*—states or suggests that either the presence or predominance of irregular opacities, or the absence of opacities in the upper lung zones, rules out clinical pneumoconiosis. In fact, *two* ILO "standard radiographs" depicting pneumoconiosis show only

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[26] Even if there were any ambiguity in the language of the regulation, the Director's interpretation thereof is entitled to "substantial deference." *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 500 (4th Cir. 1999).

irregular opacities *and* show no opacities in the upper lung zones. *ILO Guidelines*, Appx. D at 31, 32.[27] In short, Drs. Wiot and Renn's views run counter to the very classification system they purportedly utilized.

Furthermore, recently-published medical literature is directly on point, and confirms that irregular opacities, standing alone, in the lower zone of the lung are evidence of pneumoconiosis. *See* Petsonk, Rose and Cohen, *Coal Mine Dust Lung Disease: New Lessons From an Old Exposure*, Am. J. Respir. Crit. Care Med., Vol. 178(11) (2013), pp.1178-84 ("Radiographic opacities in CWP [coal workers' pneumoconiosis] occur frequently in the lower zones and often appear predominantly irregular in shape, not just rounded;" "surprisingly little" evidence that "upper lung zone–predominant small rounded opacities is the *sine qua non* of CWP"); Laney and Petsonk, *Small Pneumoconiotic Opacities on U.S. Coal Worker*

[27] The ILO standard radiographs are examples of pneumoconiosis. A doctor views the standard radiograph and a subject x-ray together and compares the two to classify the subject x-ray. *ILO Guidelines* at 12. Unfortunately, the *ILO Guidelines* do not number the standard radiographs found in Appendix D. The first x-ray we reference is the third of four on page 31; the second is the first of four (including the composite radiograph) on page 32.

Surveillance Chest Radiographs Are Not Predominantly in the Upper Lung Zones, Am. J. Indus. Med., Vol. 55 (2012), pp. 793-98 (x-ray evidence of coal workers' pneumoconiosis may present radiographically as either rounded or irregular opacities and there is lower-zone predominance if opacities primarily irregular; scientific foundation for upper-zone-predominance view is "unclear"). Thus, Drs. Wiot and Renn's views also run contrary to current medical science.

In light of these unexplained inconsistencies, the ALJ properly discounted Drs. Wiot and Renn's restrictive views and resulting diagnoses. As stated by the Third Circuit,

> [i]t is perfectly reasonable to discredit an expert's conclusion with regard to whether a condition defined by statute and regulation does or does not exist when that expert bases his conclusion on a premise fundamentally at odds with the statutory and regulatory scheme.

Penn Allegheny Coal Co. v. Mercatell, 787 F.2d 106, 109-10 (3d Cir. 1989). Similarly, this Court has explained that a physician's opinion based on an assumption that contravenes the BLBA or its regulations is "undermined." *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173, 174-75 (4th Cir. 1995). Because such conflicting assumptions are at work here, the Court should affirm the ALJ's

rejection of Dr. Wiot's x-ray readings and Dr. Renn's medical opinion.[28]

Sewell nonetheless argues that the ALJ erred in evaluating the Wiot x-ray readings and Renn's opinion. The operator notes that clinical pneumoconiosis "consists of those diseases recognized by the *medical community* as pneumoconioses," 20 C.F.R. § 718.201(a)(1) (emphasis added) and asserts that the ALJ could not discount Wiot's and Renn's views where they relied on the "medically-accepted radiographic representation of coal workers' pneumoconiosis." Pet. Br. at 22. In essence, Sewell contends that Wiot's and Renn's views represent those of the "medical community." This argument is without merit and should be rejected.

As an initial matter, it strains credulity to suggest that these two doctors' views (that the absence of upper-zone opacities,

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[28] Conversely, the positive x-ray readings by Drs. Patel and Alexander (who both found x-rays with opacity profusions greater than 1/0 positive for clinical pneumoconiosis) fully conform to the regulations and the ILO Classification. Thus, as the Board held (and contrary to Sewell's argument), the ALJ was not required to more stringently review their readings, as they did not express views that contravene the regulations.

particularly rounded opacities, rules out the presence of clinical pneumoconiosis) represent those of "the medical community" when three other physicians (Rasmussen, Gaziano and Cohen) disputed those views in this very case. Moreover, neither doctor cited any medical or scientific authority for their positions, or offered any explanation beyond their conclusory assumptions.[29] And as discussed above, their views conflict with accepted medical science.[30] Thus, Sewell's contention that Wiot and Renn's views represent the medical community is entirely without foundation. Certainly, it presented no such evidence to the ALJ.

In sum, the weighing of medical opinions falls well within the

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[29] Dr. Renn went so far as to state that he did not truly believe what the medical literature said about pneumoconiotic opacities. JA at 738.

[30] Their diagnosis of idiopathic pulmonary fibrosis ignores the plain and undisputed facts here. An "idiopathic" disease is one with no known cause. *See Dorland's Illustrated Medical Dictionary* (32d ed. 2012) 912. As Dr. Rasmussen pointed out, however, Mr. Dempsey did have a known risk factor (but only one) for the development of his lung disease—coal-mine dust exposure. JA at 160. Likewise, Dr. Cohen did not think it possible to attribute Mr. Dempsey's opacities to "'unknown' causes when [he had] 25 years of exposure to a substance which is well known to cause such scarring." JA at 467.

ALJ's fact-finding authority. *See Mingo Logan Coal Co. v. Owens*, 724 F.3d 550, 557 (4th Cir. 2013); *Harman Mining Co. v. Dir., Office of Workers' Comp. Programs*, 678 F.3d 305, 310 (4th Cir.2012). An ALJ may "reject opinions that she found to be 'unsupported by a sufficient rationale.'" *Westmoreland Coal Co. v. Cox*, 602 F.3d 276, 287 (4th Cir. 2010) (quoting *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 533 (4th Cir. 1998); *see also Risher v. OWCP*, 940 F.2d 327, 331 (8th Cir. 1991) (ALJ can reject opinion that "does not adequately explain the basis for its conclusion"). This is certainly true with respect to "speculative" and unsupported x-ray evaluations. *See Westmoreland Coal*, 602 F.3d at 286-87. Wiot and Renn provided no bases for their diagnoses of IPF other than their non-credible x-ray evaluations. Thus, the Court should affirm the ALJ's rejection of their diagnoses. *See id.* at 287; *Milburn Colliery*, 138 F.3d at 533.

C. The ALJ properly gave Dr. Wheeler's negative reading of the August 2001 x-ray less weight than the positive readings of more qualified physicians.

Sewell also contends that the ALJ erred in crediting Drs. Patel and Alexander's positive readings of the August 2001 over Dr. Wheeler's negative reading based on Alexander's and Patel's

superior radiological qualifications. The Court should reject this contention. First, Sewell waived any error in the identification of Wheeler's B-reader status by failing to raise it in prior appeals. Second, the record does not show that Dr. Wheeler was a B-reader at the relevant time (whereas Patel and Alexander were); thus, the ALJ properly gave greater weight to the latter's positive readings. Third, even if Wheeler was considered as a B-reader, his negative reading is outweighed by the positive x-ray evidence of record. And fourth, recent disclosures regarding Dr. Wheeler undercut any argument that his negative reading is credible.

The August 2001 x-ray was read as positive for clinical pneumoconiosis by Dr. Patel and Dr. Alexander, both of whom are board-certified radiologists and B-readers. The same x-ray was read as negative by Dr. Wheeler. Dr. Wheeler is a board-certified radiologist. Employer's Exhibit 6. The B-reader certification provided by Sewell for Dr. Wheeler, however, expired on April 30, 2001. *Id.* Because Dr. Wheeler did not read the August 2001 x-ray until March 20, 2002, the first ALJ found that Wheeler was not a B-reader at that point. Based on this finding, the second ALJ gave greater weight to the Patel and Alexander readings based on their

superior qualifications.

The ALJ's evaluation of the conflicting readings was correct. As an initial matter, Sewell waived its contention that Wheeler should have been considered as a B-reader.[31] The first ALJ found that Wheeler was not a B-reader when he read the August 2001 x-ray in the very first decision in this case (issued May, 2003), JA at 545, n. 5, and he consequently gave the readings of Drs. Patel and Alexander greater weight based on their superior radiological qualifications. JA at 556. Sewell did not challenge this finding in

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[31] While not contesting that the B-reader certificate of record for Dr. Wheeler had expired before he read the 2001 x-ray, Sewell argues (Pet. 29-30) that the second ALJ should have gone outside the record to consult DOL's list of physicians with B-reader status to determine Dr. Wheeler's status and given greater credence to Dr. Wheeler's academic appointment and membership in professional associations. This argument is off the mark. An ALJ is required to take official notice of an adjudicative fact only when a party requests that he do so, and provides him with the necessary information. 29 C.F.R. § 18.201(d). Sewell did neither. Thus, while the ALJ had the discretion to take notice of the list of his own accord, he clearly was not required to do so. See 29 C.F.R. § 18.201(c). Likewise, while the ALJ arguably could have considered Wheeler's academic position and membership in professional associations (although the extent to which these factors bear on his expertise in reading x-rays for the presence of pneumoconiosis is not wholly apparent), he was not required to do so. *See Harris v. Old Ben Coal Co.*, 23 BLR 1-98, 1-114 (BRB 2006), *aff'd on recon.*, 24 BLR 1-13 (BRB 2007).

its appeal of the first ALJ decision to the Board (which affirmed the ALJ's evaluation of the x-ray evidence, JA at 650) or in either of its prior two appeals to this Court. It was only when the second ALJ adopted the first ALJ's finding on Wheeler's B-reader status (JA at 798)—nearly ten years after the original finding—that Sewell objected.

Sewell's objection comes too late. By failing to present this argument in its first appeal to the Board, Sewell "waived [the] issue for consideration on appeal" by the Court. *Armco, Inc., v. Martin*, 277 F.3d 468, 476 (4th Cir. 2002). Perhaps more importantly, Sewell's failure to raise the issue in either of its prior appeals to this Court—when it had the opportunity to do so—bars it from now raising the issue. *See Rowland v. Am. Gen'l Finance, Inc.*, 340 F.3d 187, 191, n. 1 (4th Cir. 2003) (issue waived in subsequent appeal where party had opportunity to raise it in prior appeal, but failed to do so) (citations omitted); *Omni Outdoor Advertising, Inc., v. Columbia Outdoor Advertising, Inc.*, 974 F.2d 502, 505 (4th Cir. 1992) ("It is elementary that where an argument could have been raised on an initial appeal, it is inappropriate to consider that argument on a second appeal following remand.") (quoting

Northwestern Ind. Tel. Co. v. FCC, 862 F.2d 475, 470 (D.C. Cir. 1989)). As a result of Sewell's prior inaction, the first ALJ's finding on Wheeler's B-reader status was effectively affirmed and cannot now be challenged by Sewell. *See Doe v. Chao*, 511 F.3d 461, 465 (4th Cir. 2007) ("any issue that could have been but was not raised on appeal is waived and thus not remanded") (internal quotation and citation omitted).

Based on the ALJ's determination of Wheeler's B-reader status, he properly gave Wheeler's reading less weight.[32] Where x-ray evidence is in conflict, an ALJ should consider readers' radiological qualifications, particularly whether they are board-certified radiologist and/or B-readers. 20 C.F.R. § 718.202(a)(1)(i), (ii)(C), (E). And he can give greater weight to the reading of a B-

[32] There may be an additional defect in Dr. Wheeler's reading. While he indicated that the August 2001 x-ray had no abnormalities consistent with pneumoconiosis, he did find that it showed "minimal increased lower lung markings consistent with pulmonary vascular prominence . . . or possible early linear interstitial infiltrate or fibrosis." JA at 192. If Dr. Wheeler believed (like the other doctors retained by the coal company) that opacities appearing only in the lower lung zones cannot be diagnostic of clinical pneumoconiosis, his reading would not be credible for the same reason as the readings of Dr. Wiot and the medical opinion of Dr. Renn.

reader than to the reading of a non-B-reader. *Adkins v. U.S. Dep't of Labor*, 824 F.2d 287, 289 n. 3 (4th Cir. 1987); *see also Mingo Logan Coal Co.*, 724 F.3d at 557-58 (affirming ALJ's reliance on readings by two dually qualified physicians over readings of one dually qualified physician and one physician who subsequently lost B-reader certification). Moreover, even if the ALJ had considered Dr. Wheeler as qualified as Patel and Alexander, Wheeler's negative reading would still have been outweighed by Patel's and Alexander's corroborating positive readings. *See id.* at 557 (affirming ALJ's crediting of two corroborating positive readings over single negative reading).

Finally, Sewell's continued reliance on Dr. Wheeler's x-ray reading is misplaced in light of recent disclosures which cast doubt on the credibility of Dr. Wheeler. *See Eastern Assoc. Coal Corp. v. Director, OWCP*, --- Fed. Appx. ---, 2014 WL 2978540, *3, n. 7 (4th Cir. Jul. 3, 2014) (acknowledging issues regarding Dr. Wheeler's credibility). On October 30, 2013, the Center for Public Integrity (CPI) and ABC News released investigative reports indicating that since 2000, in 1,500 black lung claims, Dr. Wheeler never once interpreted an x-ray as positive for complicated pneumoconiosis in

more than 3,400 readings, and almost never interpreted any as positive for simple pneumoconiosis.[33] *See* News Article, Breathless and Burdened, Part 2, CPI, dated October 30, 2013 (available at http://www. publicintegrity.org/2013/10/30/3637/johns-hopkins-medical-unit-rarely-finds-black- lung-helping-coal-industry-defeat); ABC News Report, For Top-Ranked Hospital, Tough Questions About Black Lung and Money, dated October 30, 2013 (available at http://abcnews.go.com/Blotter/investigation-johns-hopkins-tough-questions-black-lung-money/story?id=20721430#).

As a result of these reports, the Johns Hopkins Medical Institutions, Dr. Wheeler's employer, immediately suspended its black-lung-x-ray reading program and launched an internal investigation. As of this date, the program remains suspended and, to our knowledge, the investigation is on-going. *See* "Statement from Johns Hopkins Medicine Regarding ABC News Report About Our B-reads for Pneumoconiosis (Black Lung)," dated November 1, 2013 (available at http://www.hopkinsmedicine.org/news/abc_

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[33] The CPI report won the prestigious 2014 Pulitzer Prize for Investigative Reporting. *See* http://www.pulitzer.org/citation/2014-Investigative-Reporting.

report_b-reads_pneumoconiosis_statement.html). In light of this information, DOL's Division of Coal Mine Workers' Compensation Programs instructed its district directors to take notice of the reports on Dr. Wheeler and not to credit his readings in the absence of evidence challenging the reports or otherwise rehabilitating Dr. Wheeler's credibility. *See* Bulletin 14-09 (Jun. 20, 2014) (available at http://www.dol.gov/owcp/dcmwc/blba/indexes/BL14.09OCR.pdf). In our view, even if the ALJ had not properly evaluated Dr. Wheeler's x-ray reading, that reading would still not have been credible.[34] Thus, for all of the foregoing reasons, the Court should affirm the ALJ's crediting of Patel's and Alexander's positive readings over Dr. Wheeler's negative reading.

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[34] If the Court were to remand the case for the ALJ to reconsider Dr. Wheeler's x-ray reading, the Director would request that he take official notice of the reports on Dr. Wheeler, as well as of the responses of Johns Hopkins and DOL. *See* 5 U.S.C. § 556(e); 29 C.F.R. §§ 18.45, .201 (providing that ALJs may take official notice of certain material facts not in the record). In this regard we note that proceedings under the BLBA generally are not bound by formal rules of evidence or procedure, 33 U.S.C. § 923(a), as incorporated by 30 U.S.C. § 932(a), and hearsay evidence is admissible in such proceedings if deemed reliable by the ALJ. *Pothering v. Parkson Coal Co.*, 861 F.2d 1321, 1330, n. 15 (3d Cir. 1988); *see Richardson v. Perales*, 402 U.S. 389, 400 (1971).

D. Mr. Dempsey established all the elements of his claim.

As discussed herein, the ALJ properly rejected the negative x-ray readings of Drs. Wiot and Wheeler. All the other x-ray readings from Mr. Dempsey's 2001 claim were positive for clinical pneumoconiosis. Thus, the x-ray evidence clearly supports the ALJ's finding of clinical pneumoconiosis.

Likewise, the medical-opinion evidence supports his finding. As discussed above, he properly rejected Dr. Renn's negative medical opinion. In its prior decision, the Court affirmed the ALJ's crediting of the positive opinions of Drs. Rasmussen and Gaziano.[35] JA 733-34 & n. 4. Thus, the only credible medical opinions of record support the ALJ's finding of clinical pneumoconiosis.[36] Based on the combination of the x-ray and medical-opinion evidence, the Court should affirm the ALJ's finding that Mr. Dempsey had clinical pneumoconiosis under 20 C.F.R. § 718.202.

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[35] Sewell again attacks Dr. Rasmussen's opinion, but the Court's prior holding on his report is the law of the case. *See U.S. v. Aramony*, 166 F.3d 655, 661 (4th Cir. 1999).

[36] Dr. Cohen's opinion also supports that finding. While we take no position on Sewell's challenges to Dr. Cohen's opinion, we note that even if his opinion were not credible, the credible reports of Drs. Rasmussen and Gaziano are sufficient to support the ALJ's finding.

See Island Creek Coal Co. v. Compton, 211 F.3d 203, 208-11 (4th Cir. 2000).

Sewell does not argue that it rebutted the presumption that Mr. Dempsey's pneumoconiosis arose out of his coal-mine employment, *see* 20 C.F.R. § 718.203, and there is no evidence establishing rebuttal. Likewise, Sewell no longer contests that Mr. Dempsey had a totally disabling pulmonary impairment under 20 C.F.R. § 718.204(b).

Finally, there is no question now that Mr. Dempsey's disability was due to pneumoconiosis under 20 C.F.R. § 718.204(c). The negative opinion of Dr. Renn is not credible because he failed to diagnose clinical pneumoconiosis in the first place. *See Scott*, 289 F.3d at 269-70. That leaves the positive opinion of Dr. Rasmussen (which the Court already held to be credible) essentially uncontradicted.[37] Thus, Mr. Dempsey met all the requirements for entitlement in his lifetime claim, *see Daniels Co.*, 479 F.3d at 336, and the Court should affirm the decisions below.

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[37] Dr. Gaziano did not directly address disability causation. Dr. Cohen's report also supports a finding of disability causation, but we take no position on Sewell's current challenge to his opinion.

CONCLUSION

The Director requests that the Court affirm the decisions of the ALJ and Board awarding Mr. Dempsey's lifetime claim.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with 1) the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 9,419 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and 2) the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally-spaced typeface using Microsoft Word 2010 in fourteen-point Bookman Old Style font.

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CERTIFICATE OF SERVICE

I hereby certify that on September 9, 2014, an electronic copy of the Director's brief was served through the CM/ECF system, and paper copies were served by mail, postage prepaid, on the following:

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