**U.S. Department of Labor**

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

BRB No. 21-0341 BLA

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| TOMMIE G. DEARIEN (deceased) | ) | |
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| Claimant-Respondent | ) | |
| | ) | |
| v. | ) | |
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| SOUTHERN APPALACHIAN COAL COMPANY | ) | |
| | ) | |
| and | ) | |
| | ) | DATE ISSUED: 6/23/2022 |
| AMERICAN ELECTRIC POWER CORPORATION | ) | |
| | ) | |
| Employer/Carrier-Petitioners | ) | |
| | ) | |
| DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR | ) | |
| | ) | |
| Party-in-Interest | ) | DECISION and ORDER |

Appeal of the Decision and Order Awarding Benefits of Patricia J. Daum, Administrative Law Judge, United States Department of Labor.

Lynda D. Glagola (Lungs at Work), McMurray, Pennsylvania, lay representative, for Claimant.

Mark J. Grigoraci (Robinson & McElwee PLLC), Charleston, West Virginia, for Employer.

Before: BUZZARD, GRESH, and JONES, Administrative Appeals Judges.

PER CURIAM:

Employer appeals Administrative Law Judge (ALJ) Patricia J. Daum's Decision and Order Awarding Benefits (2018-BLA-05490) rendered on a claim filed on March 22,

2016,[1] pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2018) (Act).

The ALJ credited the Miner with thirteen years of coal mine employment. Because he had less than fifteen years of coal mine employment, the ALJ found Claimant could not invoke the presumption of total disability due to pneumoconiosis at Section 411(c)(4) of the Act, 30 U.S.C. §921(c)(4) (2018).[2]

The ALJ next considered whether Claimant established entitlement to benefits pursuant to 20 C.F.R. Part 718 without the presumption. She found Claimant established the Miner had clinical pneumoconiosis arising out of coal mine employment and legal pneumoconiosis. 20 C.F.R. §§718.202(a), 718.203. She further found Claimant established the Miner had a totally disabling respiratory or pulmonary impairment due to pneumoconiosis. 20 C.F.R. §718.204(b)(2), (c). Thus she awarded benefits.

On appeal, Employer argues the ALJ erred in finding Claimant established the Miner had clinical and legal pneumoconiosis, his pneumoconiosis arose out of coal mine employment, and he was totally disabled due to pneumoconiosis. Claimant responds[3] in support of the award of benefits.[4] The Director, Office of Workers' Compensation Programs, has not filed a response brief.

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[1] The Miner filed this claim on March 22, 2016. Director's Exhibit 3. He died on September 16, 2019. ALJ Exhibit 52. Claimant, his daughter, is pursuing the claim on behalf of his estate. *Id.*

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

[3] On June 28, 2021, Claimant filed her first motion for an enlargement of time to file a brief in response to Employer's Petition for Review and Brief. On July 28, 2021, the Benefits Review Board issued an Order granting Claimant's motion, and stated Claimant may file her response brief within thirty days from receipt of the Order. Order Granting Claimant's First Mot. for Extension of Time. On November 10, 2021, Claimant filed her second motion for an extension of time. Thereafter Claimant filed her response brief on November 29, 2021. On January 21, 2022, the Board granted Claimant's second motion for an extension of time and accepted the response brief as part of the record. Order Granting Claimant's Second Mot. for Extension of Time.

[4] We affirm, as unchallenged on appeal, the ALJ's findings that Claimant established thirteen years of coal mine employment and total disability. *See Skrack v.*

The Benefits Review Board's scope of review is defined by statute. We must affirm the ALJ's Decision and Order if it is rational, supported by substantial evidence, and in accordance with applicable law.[5] 33 U.S.C. §921(b)(3), as incorporated by 30 U.S.C. §932(a); *O'Keeffe v. Smith, Hinchman, & Grylls Assocs., Inc.*, 380 U.S. 359 (1965).

**Entitlement to Benefits**

To be entitled to benefits under the Act, Claimant must establish disease (pneumoconiosis); disease causation (it arose out of coal mine employment); disability (a totally disabling respiratory or pulmonary impairment); and disability causation (pneumoconiosis substantially contributed to the disability). 30 U.S.C. §901; 20 C.F.R. §§718.3, 718.202, 718.203, 718.204. Failure to establish any one of these elements precludes an award of benefits. *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 BLR 1-26, 1-27 (1987); *Perry v. Director, OWCP*, 9 BLR 1-1 (1986) (en banc).

**Clinical Pneumoconiosis**

Clinical pneumoconiosis consists of "those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by coal dust exposure in coal mine employment." 20 C.F.R. §718.201(a)(1).

The ALJ found the preponderance of the x-ray and medical opinion evidence establishes clinical pneumoconiosis. 20 C.F.R. §718.202(a)(1), (4); Decision and Order at 32, 38. She further found the Miner's treatment records do not undermine a finding of pneumoconiosis, and the computed tomography (CT) scan readings and the Miner's death certificate are inconclusive. Decision and Order at 39-40; s*ee* 20 C.F.R. §718.202(a)(4). Considering the evidence as a whole, she found Claimant established clinical pneumoconiosis. 20 C.F.R. §718.202(a); Decision and Order at 40.

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*Island Creek Coal Co.*, 6 BLR 1-710, 1-711 (1983); 20 C.F.R. §718.204(b)(2); Decision and Order at 42-43.

[5] The Miner performed his last coal mine employment in West Virginia. Director's Exhibits 4, 9. Accordingly, the Board will apply the law of the United States Court of Appeals for the Fourth Circuit. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc).

Employer first contends the ALJ improperly engaged in a "numerical headcount" of the x-ray readings. Employer's Brief at 11. We disagree.

The ALJ considered six readings of two x-rays dated June 2, 2016, and November 7, 2018, by Drs. Smith, DePonte, Adcock, and Zaldivar. Decision and Order at 29-32. She noted Drs. Smith, DePonte, and Adcock are all dually-qualified as Board-certified radiologists and B readers, and she found their readings entitled to equal weight. *Id*. at 29. As Dr. Zaldivar is only a B reader, she found his reading entitled to less weight. *Id*.

Dr. Smith read the June 2, 2016 x-ray as positive for clinical pneumoconiosis, 1/1 with p/s opacities;[6] Dr. DePonte also read it as positive for clinical pneumoconiosis, 1/2 with t/q opacities; and Dr. Adcock read it as negative for the disease. Director's Exhibit 12; Claimant's Exhibit 1; Employer's Exhibit 1. The ALJ found this x-ray positive for clinical pneumoconiosis because a greater number of dually-qualified radiologists read it as positive for pneumoconiosis. Decision and Order at 30-31. However, because Drs. Smith and DePonte disagreed as to the profusion and types of opacities on this x-ray and the x-ray's quality, the ALJ assigned the x-ray some, but not significant, weight. *Id*.

Dr. Smith read the November 7, 2018 x-ray as positive for clinical pneumoconiosis, 2/1 with q/t opacities; Dr. DePonte also read it as positive, 2/2 with q/t opacities; and Dr. Adcock read it as negative for pneumoconiosis. Claimant's Exhibits 7, 9; Employer's Exhibit 3. Further, Dr. Zaldivar initially read this x-ray as "possible" for clinical pneumoconiosis, 1/1 with q/t opacites, but subsequently changed his opinion and adopted

[6] The International Labour Organization (ILO) x-ray form allows a radiologist to identify if there are any parenchymal abnormalities consistent with pneumoconiosis. 20 C.F.R. §718.102 (standards for x-rays), *incorporating by reference Guidelines for the Use of the ILO International Classification of Radiographs Of Pneumoconioses*, Revised edition 2011 (ILO Guidelines). If the radiologist indicates there are such abnormalities, he or she should identify the profusion, affected zones of the lung, shape (rounded or irregular), and size of any opacities. ILO Guidelines at 3-6. The profusion of opacities refers to the concentration of small opacities in affected zones of the lung and includes four categories ranging from 0 to 3 representing increasing profusion. *Id*. A radiologist may identify that an alternative category was seriously considered through use of an "an oblique stroke, i.e. 0/ , 1/ , 2/ , 3/" as the form so allows. *Id*. Thus a radiologist who indicates a profusion of 1/2 is stating that the profusion is 1, but he or she seriously considered a profusion of 2. *Id*. With respect to size and shape, a radiologist may mark small, rounded opacities via the three size ranges denoted by the letters p, q, and r representing increasing size, or small, irregular opacities denoted by the letters s, t, and u representing increasing size. *Id*. Through use of an "oblique stroke," a radiologist may indicate he or she saw a "significant number" of another shape or size. *Id*.

Dr. Adcock's negative reading. Employer's Exhibit 2. Because Dr. Zaldivar did not explain the basis for changing his opinion, the ALJ found his initial reading supports a finding of clinical pneumoconiosis. Decision and Order at 31. She found this x-ray positive for clinical pneumoconiosis because a greater number of the dually-qualified radiologists read it as positive for pneumoconiosis, and because Dr. Zaldivar's initial reading supports the readings of Drs. Smith and DePonte. *Id*. at 31-32. However, she again assigned this x-ray only "some weight" based on Dr. Zaldivar's decision to abandon his initial positive reading. *Id*. Because she found both x-rays positive for pneumoconiosis, the ALJ found the preponderance of the x-ray evidence establishes clinical pneumoconiosis.[7] *Id*.

Contrary to Employer's argument, the ALJ did not merely engage in a headcount when resolving the conflicting x-ray readings; instead, she properly performed both a qualitative and quantitative analysis of the x-ray evidence, taking into consideration the physicians' qualifications, their specific interpretations, and the number of readings of each film. *See Sea "B" Mining Co. v. Addison*, 831 F.3d 244, 256 (4th Cir. 2016); *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992). She permissibly found both the June 2, 2016 and November 8, 2018 x-rays positive for clinical pneumoconiosis based on the preponderance of the positive readings by dually-qualified radiologists.[8] *Adkins*, 958 F.2d at 52; Decision and Order at 30-32. Because it is supported by substantial evidence, we

[7] Although the ALJ found both x-rays to be positive for pneumoconiosis and entitled to "some weight," Employer argues she erred in finding the x-ray evidence establishes clinical pneumoconiosis because she found neither x-ray entitled to "significant weight." Employer's Brief at 12. This argument has no merit. Claimant need only establish the preponderance of the x-ray readings are positive for clinical pneumoconiosis. *See Director, OWCP v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 281 (1994), *aff'g sub nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993); *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992). Thus, regardless of whether they are entitled to either some or significant weight, both x-rays meet Claimant's burden of establishing pneumoconiosis, particularly given that no x-rays were found negative for pneumoconiosis.

[8] Employer also argues the ALJ erred in finding Dr. Zaldivar's initial reading of the November 7, 2018 x-ray supports a diagnosis of clinical pneumoconiosis as the doctor noted only "possible" clinical pneumoconiosis. Employer's Brief at 12; Employer's Exhibit 2. Because the positive readings by Drs. Smith and DePonte, dually-qualified radiologists, establish this x-ray is positive for clinical pneumoconiosis, we need not address Employer's argument. *See Larioni v. Director, OWCP*, 6 BLR 1-1276, 1-1278 (1984).

affirm the ALJ's finding that the x-ray evidence establishes the existence of clinical pneumoconiosis. 20 C.F.R. §718.202(a)(1).

Because Employer does not separately challenge the ALJ's finding that the medical opinion evidence establishes clinical pneumoconiosis, 20 C.F.R. §718.202(a)(4), or her finding that the totality of the evidence establishes clinical pneumoconiosis, we affirm these findings. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-09 (4th Cir. 2000); *Skrack v. Island Creek Coal Co.*, 6 BLR 1-710, 1-711 (1983); Decision and Order at 38, 40.

**Legal Pneumoconiosis**

To establish legal pneumoconiosis, Claimant must establish the Miner had a chronic lung disease or impairment "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(a)(2), (b). Claimant can establish legal pneumoconiosis by showing coal dust exposure contributed "in part" to the Miner's respiratory or pulmonary impairment. *See Westmoreland Coal Co., Inc. v. Cochran*, 718 F.3d 319, 322-23 (4th Cir. 2013); *Harman Mining Co. v. Director, OWCP* [*Looney*], 678 F.3d 305, 311 (4th Cir. 2012); *see also Arch on the Green v. Groves*, 761 F.3d 594, 598-99 (6th Cir. 2014) (A miner can establish a lung impairment is significantly related to coal mine dust exposure "by showing that his disease was caused 'in part' by coal mine employment.").

The ALJ considered the medical opinions of Drs. Celko, Sood, and Krefft that the Miner had legal pneumoconiosis, and of Drs. Zaldivar and Rosenberg that he did not.[9] Decision and Order at 32-38.

[9] Employer asserts the ALJ shifted the burden of proof in this case when addressing the issue of legal pneumoconiosis. Employer's Brief at 12-18. We disagree. The ALJ specifically recognized "Claimant bears the burden of proving each element of the claim by a preponderance of the evidence except insofar as a presumption may apply." Decision and Order at 26. She noted that the Section 411(c)(4) presumption is not available to Claimant and thus Claimant must establish the Miner had legal pneumoconiosis. *Id*. at 26 n.27. The ALJ found Claimant established legal pneumoconiosis by a preponderance of the evidence because the opinions of Drs. Celko, Krefft, and Sood that the Miner had legal pneumoconiosis outweigh the contrary opinions of Drs. Zaldivar and Rosenberg. *Id*. at 33-38. We address Employer's additional arguments with respect to the weighing of these opinions below.

**Drs. Celko, Krefft, and Sood**

Dr. Celko diagnosed the Miner with a disabling pulmonary impairment evidenced by multiple lung conditions: hypoxemia, a mixed severe restrictive and obstructive ventilatory pattern, and a reduced diffusion capacity. Director's Exhibit 12. He opined coal mine dust exposure and cigarette smoking were "causative factors" in the Miner's disabling pulmonary impairment. *Id*. at 1-2. He explained "both exposures are consistent with the abnormalities in gas exchange, obstructive ventilatory pattern, and the diffusing capacity identified during [the Miner's] examination."[10] *Id*. With respect to other possible causes, he acknowledged the Miner was obese, his x-rays are consistent with granulomatous disease, and the record includes a history of congestive heart failure. *Id*. He opined obesity contributed to the Miner's restrictive impairment and hypoxemia. *Id*. In addition, Dr. Celko was unable to exclude granulomatous disease as a contributing factor to the "restrictive portion of [the Miner's] lung disease alongside his coal mine dust exposure." *Id*. He concluded the Miner's "chronic" congestive heart failure, however, was "likely not a significant contributor to his pulmonary dysfunction" because the Miner was not suffering from this condition "at the time of his pulmonary evaluation" and thus congestive heart failure's "impact on lung function would be insignificant." *Id*.

Dr. Sood diagnosed the Miner with "mixed chronic bronchitis and emphysema" consistent with chronic obstructive pulmonary disease (COPD). Claimant's Exhibit 3 at 7-8. He concluded coal mine dust exposure and cigarette smoking substantially contributed to the COPD. *Id*. He explained it "is not possible to scientifically apportion between these two significant contributory exposures." *Id*. at 8. Based on the results of pulmonary function and arterial blood gas testing, he opined the Miner "was totally disabled by COPD/legal pneumoconiosis and simple medical or clinical coal workers pneumoconiosis." *Id*. at 10-11. Addressing other potential causes, he opined the Miner's "coronary artery disease . . . would not result in severely reduced lung functions or gas exchange impairments, particularly in the absence of clinical evidence of congestive heart failure." *Id*. at 11. He determined the Miner's "non-morbid obesity" also "would not explain away his respiratory or pulmonary impairment" as this condition "may be associated with [a] reduced FVC but would not result in a moderately severely reduced total lung capacity." *Id*.

Dr. Krefft opined the Miner had COPD and chronic bronchitis, and concluded these impairments are "likely related to both coal mine dust exposure and tobacco smoke exposure." Claimant's Exhibit 5 at 4. She disagreed with Dr. Celko that obesity

[10] Dr. Celko also opined pulmonary function testing is consistent with emphysema and chronic bronchitis, and concluded "both phenotypes of COPD are significantly related to both coal mine dust and tobacco smoke exposure." Director's Exhibit 12.

contributed to the Miner's "chronic hypoxemic respiratory failure." *Id*. at 4. In addition, she opined "the likelihood of asbestos-related lung disease is decreased given the short duration of employment in asbestos abatement." *Id*. With respect to total disability, Dr. Krefft opined the Miner had "clear evidence of severe lung disease based on multiple pulmonary diagnostic tests . . . with evidence of worsening lung function." *Id*. at 8-9. She concluded his total disability was due to clinical and legal pneumoconiosis. *Id*. Furthermore, she noted "other comorbid conditions such as coronary artery disease, history of [congestive heart failure], leg claudication, and obesity are present," but concluded "they do not explain his resting lung function" and gas exchange abnormalities. *Id*.

The ALJ found the opinions of Drs. Celko and Sood well-reasoned, documented, and entitled to great weight. Decision and Order at 33-35. She specifically found "Dr. Celko fully considered the other possible contributing factors or etiologies" when diagnosing legal pneumoconiosis. *Id*. at 34. Similarly, she found Dr. Sood provided a "comprehensive consideration of all possible other causes for the [Miner's] lung function impairment" when diagnosing legal pneumoconiosis. *Id*. at 35. She found Dr. Krefft's opinion to be generally well-reasoned and documented except in regard to the doctor's consideration of other possible etiologies of the Miner's impairments, and thus found it entitled to "some weight," but not "significant weight." *Id*. at 36.

Employer contends the ALJ erred in crediting the opinions of Drs. Celko, Sood, and Krefft because they did not rely on an accurate cigarette smoking history. Employer's Brief at 17. We disagree. The ALJ found the Miner had a cigarette smoking history of seventy-five pack-years. Decision and Order at 6-7. She acknowledged Employer's argument that the opinions Drs. Celko, Sood, and Krefft are not reliable "because they failed to properly account for the [Miner's] smoking history."[11] *Id*. at 45 n.50, *citing* Employer's Post-Hearing Brief at 16. But she found that, regardless of whether the doctors were able to identify the Miner's smoking history with "pinpoint accuracy," they adequately assumed his "smoking history was extensive and played a role in [his] disease process and impairment."[12] *Id*. She permissibly found any failure to precisely calculate

[11] Dr. Celko assumed a smoking history of one-half to two packs per day between ages eighteen and sixty-eight. Director's Exhibit 12 at 2. Dr. Krefft noted the Miner had a "substantial smoking history" of at least forty pack-years. Claimant's Exhibit 5 at 2, 4. Dr. Sood stated that regardless of whether the Miner had a forty-five or one-hundred pack-year smoking history, he would have considered the Miner's smoking history "substantial and heavy" and a "substantial contributory factor to his lung disease." Employer's Exhibit 11 at 5, 30.

[12] Employer argues the ALJ erred in finding the Miner had a seventy-five pack-year smoking history when the record establishes a one-hundred pack-year smoking history. Employer's Brief at 10. Employer has failed to explain how the error it alleges makes a

the length of a smoking history does not render "their opinions 'unreliable'" as all three doctors opined it "was not possible to differentiate between the contributions from smoking and coal dust" in the Miner's case. *Id.*; *see Consolidation Coal Co. v. Williams*, 453 F.3d 609, 622 (4th Cir. 2006) (doctor need not apportion a specific percentage of a miner's lung disease to cigarette smoke versus coal mine dust exposure to establish the existence of legal pneumoconiosis); *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 530 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 439-40 (4th Cir. 1997).

Employer also contends the ALJ erred in crediting Dr. Sood's opinion because it asserts the doctor conceded the Miner's dust exposure from road construction work with the West Virginia Division of Highways could have caused his lung impairments. Employer's Brief at 16-17. It maintains the ALJ failed to consider this aspect of the doctor's opinion. *Id*. Contrary to Employer's assertion, the ALJ acknowledged Employer's argument and found the record does not support Employer's characterization of Dr. Sood's opinion. Decision and Order at 45-46 n.50. Specifically, Dr. Sood acknowledged dust exposure from the Miner's road construction work "could be a possible contributing factor to his lung diseases," but further stated "it is unlikely to be the only contributory factor" to those diseases. Employer's Exhibit 11 at 17. Dr. Sood reiterated that the Miner had legal pneumoconiosis because his emphysema and chronic bronchitis are "consistent with coal mine dust exposure." *Id*. at 30-31. Thus the ALJ rationally found the Miner's exposure to road dust while working with the West Virginia Division of Highways does not undermine the credibility of Dr. Sood's opinion. *Hicks*, 138 F.3d at 530; *Akers*, 131 F.3d at 439-40; Decision and Order at 45-46 n.50.

Employer also generally asserts the doctors failed to adequately account for other possible causes of the Miner's lung impairments and thus the ALJ should have rejected their opinions. Employer's Brief at 13-19. We consider Employer's argument with respect to Drs. Celko, Sood, and Krefft to be a request to reweigh the evidence, which we are not empowered to do. *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113 (1989). The ALJ specifically addressed the physicians' opinions as to other possible causes of the Miner's impairments and Employer does not identify any error in her credibility determinations. Thus, as it is supported by substantial evidence, we affirm the ALJ's finding that the opinions of Drs. Celko, Sood, and Krefft are reasoned, documented, and

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difference as the ALJ found Drs. Sood, Celko, and Krefft adequately considered the Miner's "smoking history was extensive," and their failure to identify a smoking history with "pinpoint accuracy" does not undermine their opinions. Decision and Order at 45 n.50; *see Shinseki v. Sanders*, 556 U.S. 396, 413 (2009) (appellant must explain how the "error to which [it] points could have made any difference"). Further, the record reflects Dr. Sood opined he would have still diagnosed legal pneumoconiosis even if the Miner had a one-hundred pack-year smoking history. Employer's Exhibit 11 at 5, 30.

sufficient to establish legal pneumoconiosis. *Hicks*, 138 F.3d at 530; *Akers*, 131 F.3d at 439-40; Decision and Order at 33-35.

**Drs. Zaldivar and Rosenberg**

Dr. Zaldivar opined the Miner did not have legal pneumoconiosis, but had emphysema due to smoking and restrictive pleural thickening caused by surgical trauma exacerbated by cardiomyopathy. Employer's Exhibits 2, 9. Dr. Rosenberg also opined the Miner did not have legal pneumoconiosis but had emphysema caused by smoking and pleural thickening with calcifications resulting from asbestosis. Employer's Exhibit 10.

Employer argues that, in discrediting their opinions, the ALJ misapplied the definition of legal pneumoconiosis. Employer's Brief at 12-18. It asserts she required the doctors to "rule out" coal mine dust exposure as a cause of the Miner's pulmonary condition to constitute contrary probative evidence rather than evaluating whether their opinions are reasoned and documented. *Id.* We disagree.

The ALJ did not disregard the opinions of Drs. Zaldivar and Rosenberg because they failed to "rule out" coal mine dust exposure. Rather, she found them not credible because they did not adequately explain their assessments that the Miner's lung diseases or impairments are not significantly related to, or substantially aggravated by, coal mine dust exposure. 20 C.F.R. §718.201(a)(2), (b); Decision and Order at 33-38. Moreover, she found they are not credible on the issue of legal pneumoconiosis because they considered evidence outside of the record. Decision and Order at 33-38.

Initially, we note Employer does not challenge the ALJ's finding that the legal pneumoconiosis opinions of Drs. Zaldivar and Rosenberg are not credible because the physicians considered evidence outside of the record. Decision and Order at 36-37. Thus we affirm this finding. *Harris v. Old Ben Coal Co.*, 23 BLR 1-98, 1-108 (2006) (en banc); *Dempsey v. Sewell Coal Co.*, 23 BLR 1-47, 1-67 (2004); *Skrack*, 6 BLR at 1-711.

Further, in weighing Dr. Zaldivar's opinion, the ALJ noted the doctor diagnosed emphysema and initially "excluded smoking as contributing to [this] lung disease/impairment, but in his supplemental report opined [the] emphysema was caused by smoking and 'acquired' asthmatic bronchitis from smoking." Decision and Order at 37. The ALJ found Dr. Zaldivar "did not explain the basis for now including smoking as a cause of the [Miner's] COPD/emphysema or how he was able to exclude coal dust exposure as a causative factor." *Id.*; *Westmoreland Coal Co. v. Stallard*, 876 F.3d 663, 673-74 n.4 (4th Cir. 2017); *Hicks*, 138 F.3d at 530; *Akers*, 131 F.3d at 439-40.

Employer argues Dr. Zaldivar "explained in detail" why the Miner's emphysema was due to smoking alone. Employer's Brief at 18-19. We consider this argument also to be a request to reweigh the evidence, which we are not empowered to do. *Anderson*, 12

BLR at 1-113. As it is supported by substantial evidence, we affirm the ALJ's decision to discredit Dr. Zaldivar's opinion.

With respect to Dr. Rosenberg, the ALJ acknowledged his opinion that the Miner had widespread diffuse emphysema, a form of emphysema caused by cigarette smoking and not caused by coal mine dust exposure. Decision and Order at 38. As the preamble to the 2001 revised regulations cites studies concluding the risks of smoking and coal mine dust exposure may be additive, the ALJ permissibly found Dr. Rosenberg's opinion unpersuasive because he failed to "adequately explain why he excluded [thirteen] years of heavy coal dust exposure" as an "additive factor" in the Miner's emphysema. Decision and Order at 38-39; *see Stallard*, 876 F.3d at 673-74 n.4; *Hicks*, 138 F.3d at 530; *Akers*, 131 F.3d at 439-40; 65 Fed. Reg. 79,920, 79,941 (Dec. 20, 2000).

Because it is supported by substantial evidence, we affirm the ALJ's finding that the preponderance of the medical opinion evidence establishes the Miner had legal pneumoconiosis.[13] Decision and Order at 38.

**Disease Causation**

Employer argues the ALJ erred in finding the Miner's pneumoconiosis arose out of his coal mine employment. 20 C.F.R. §718.203(b); Employer's Brief at 18.

As she found the Miner had at least thirteen years of coal mine employment, the ALJ properly found Claimant entitled to the presumption that the Miner's clinical pneumoconiosis arose out of his coal mine employment. 20 C.F.R. §718.203(b); Decision and Order at 41; Hearing Transcript at 7. In addressing whether Employer rebutted the presumption, the ALJ rationally discredited the opinions of Drs. Zaldivar and Rosenberg that the Miner's clinical pneumoconiosis did not arise out of coal mine employment because they failed to diagnose clinical pneumoconiosis, contrary to her finding he had the disease. S*ee Hobet Mining, LLC v. Epling*, 783 F.3d 498, 504-05 (4th Cir. 2015); Decision and Order at 41. Thus we affirm the ALJ's finding that clinical pneumoconiosis arose out of coal mine employment. 20 C.F.R. §718.203.

Further, the ALJ correctly noted that having found Claimant also established legal pneumoconiosis, *i.e.*, the Miner had a lung disease or impairment that arose out of coal mine dust exposure, she was not required to separately determine the cause of the legal pneumoconiosis at 20 C.F.R. §718.203, as her finding at Section 718.202(a)(4) necessarily

[13] Because the ALJ provided a valid reason for discrediting the opinions of Drs. Zaldivar and Rosenberg on the issue of legal pneumoconiosis, we need not address Employer's remaining arguments regarding the weight accorded their opinions. *See Kozele v. Rochester & Pittsburgh Coal Co.*, 6 BLR 1-378, 1-382 n.4 (1983).

subsumed that inquiry. *Henley v. Cowan & Co.*, 21 BLR 1-147, 1-151 (1999); Decision and Order at 40-41.

**Disability Causation**

To prove total disability due to pneumoconiosis, Claimant must establish pneumoconiosis was a "substantially contributing cause" of the Miner's totally disabling respiratory or pulmonary impairment. 20 C.F.R. §718.204(c)(1); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990). Pneumoconiosis is a substantially contributing cause of a miner's totally disabling impairment if it has a "material adverse effect on the miner's respiratory or pulmonary condition" or it "[m]aterially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." 20 C.F.R. §718.204(c)(1)(i), (ii); *Gross v. Dominion Coal Co.*, 23 BLR 1-8, 1-17 (2003).

The ALJ found Dr. Sood's opinion persuasive and establishes the Miner was totally disabled due to clinical and legal pneumoconiosis. Decision and Order at 46. She specifically found Dr. Sood examined "each of the other possible factors and explain[ed] why those factors did not rule out a contribution from pneumoconiosis . . . ." Decision and Order at 45.

Employer argues Dr. Sood was equivocal as to whether pneumoconiosis contributed to the Miner's disability. Employer's Brief at 19-20. We disagree. Dr. Sood specifically opined as follows:

> Other than COPD/legal pneumoconiosis and simple medical or clinical coal workers pneumoconiosis, [the Miner] had no other significant lung disease. Further, the COPD/legal pneumoconiosis and simple medical or clinical coal workers pneumoconiosis was associated with severe exercise intolerance, severe spirometric impairment, severe reduction in diffusing capacity, and abnormally elevated alveolar arterial gradient. Therefore his legal pneumoconiosis and simple medical or clinical coal workers' pneumoconiosis [were] substantially contributing causes to his respiratory or pulmonary impairment.

Claimant's Exhibit 3 at 11. In a later report, he reiterated the Miner's "pneumoconiosis [] rendered him disabled from returning to his last coal mining job or job requiring a similar effort." Claimant's Exhibit 3a at 4. Thus, contrary to Employer's argument, Dr. Sood was not equivocal on the issue of disability causation. *U.S. Steel Mining Co. v. Director, OWCP* [*Jarrell*], 187 F.3d 384, 389 (4th Cir. 1999). The ALJ permissibly found Dr. Sood's

opinion reasoned and documented on disability causation. *Hicks*, 138 F.3d at 530; *Akers*, 131 F.3d at 439-40.

Further, Dr. Celko opined the Miner was totally disabled by a pulmonary impairment evidenced by hypoxemia, a mixed obstructive and restrictive impairment, and a reduced diffusion capacity. Director's Exhibit 12. As discussed above, the ALJ permissibly relied on Dr. Celko's opinion to find this disabling impairment constitutes legal pneumoconiosis. Decision and Order at 33-35. Thus Dr. Celko's opinion also establishes legal pneumoconiosis was a substantially contributing cause of the Miner's total disability. *See Brandywine Explosives & Supply v. Director, OWCP* [*Kennard*], 790 F.3d 657, 668-69 (6th Cir. 2015); *Hawkinberry v. Monongalia County Coal Co.*, 25 BLR 1-249, 1-255-57 (2019); Decision and Order at 23.

Employer does not challenge the ALJ's finding that the opinions of Drs. Zaldivar and Rosenberg are not credible on disability causation because they failed to diagnose pneumoconiosis, contrary to her finding the Miner had the disease. Decision and Order at 45-46. Thus we affirm this finding. *Epling*, 783 F.3d at 504-05; *Skrack*, 6 BLR at 1-711. Because it is supported by substantial evidence, we affirm the ALJ's finding that Claimant established total disability due to pneumoconiosis through Drs. Sood's and Celko's opinions. 20 C.F.R. §718.204(c). We therefore affirm the award of benefits.

Accordingly, the ALJ's Decision and Order Awarding Benefits is affirmed.

SO ORDERED.

GREG J. BUZZARD
Administrative Appeals Judge

DANIEL T. GRESH
Administrative Appeals Judge

MELISSA LIN JONES
Administrative Appeals Judge