

IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2020 MTWCC 5

WCC No. 2017-4127

HOLLY WARBOYS

Petitioner

vs.

LIBERTY NORTHWEST INS. CORP.

Respondent/Insurer.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND JUDGMENT

Summary: Petitioner seeks occupational disease benefits, asserting that she suffers from an asbestos-related disease and that it was proximately caused by her occupational exposure at the Stimson Lumber Company in Libby. Respondent has denied liability, asserting that Petitioner does not have an asbestos-related disease. In the alternative, Respondent asserts that if Petitioner has an asbestos-related disease, her employment at the Stimson lumbermill was not the proximate cause.

Held: Respondent is not liable for occupational disease benefits. Petitioner has not proven by a preponderance of the evidence that she currently has a diagnoseable asbestos-related disease. Although Petitioner was exposed to Libby asbestos, this Court is not convinced that her CT scan shows structural pathology that is consistent with asbestos-related pleural thickening.

¶ 1 The trial in this matter was held on August 28 and 29, 2018, in Kalispell. Petitioner Holly Warboys (Warboys) was present and represented by Ben A. Snipes. Respondent Liberty Northwest Ins. Corp. (Liberty) was represented by Leo S. Ward.

¶ 2 Exhibits: This Court admitted 7, 10, 11, 13-15, 19-20, 22-23, 26-29, and 31-47.

¶ 3 Witnesses and Depositions: This Court admitted the depositions of Warboys, Gary Schild, Stephen Becker, MD, Terry M. Spear, PhD, and Brad Black, MD, into evidence, including the videos of Dr. Black's, Dr. Spear's, and Dr. Becker's depositions. Warboys,

Alvin J. Schonfeld, DO, FACOI, FCCP, and Steven E. Haber, MD, were sworn and testified at trial.

¶ 4 Issues Presented: This Court restates the issues to be determined in the Pretrial Order as follows:

Issue One: Is Warboys suffering from an occupational disease?

Issue Two: Is Liberty liable for Warboys' occupational disease?

Issue Three: Is Warboys is entitled to her costs?

FINDINGS OF FACT

¶ 5 The following facts are established by a preponderance of the evidence.

¶ 6 Warboys is in her late 40s. She has had a body mass index (BMI) over 50, which places her in the "super morbidly obese" category.

¶ 7 Warboys has resided in Libby for most of her life. Thus, she was exposed to the background or "ambient" level of Libby asbestos that existed when she was growing up, due to the vermiculite mine northwest of town. Warboys' parents were exposed to Libby asbestos at their jobs and brought Libby asbestos home on their clothes. From this, Warboys had a "take home" or "bystander" exposure.

¶ 8 From 1998 to 2003, Warboys worked for the Stimson Lumber Company (Stimson) at its mill in Libby. The area where Warboys worked for most of her time at Stimson was contaminated with airborne Libby asbestos. Warboys was exposed to significant levels of Libby asbestos while working at the Stimson mill.

¶ 9 Liberty insured Stimson during Warboys' employment, including on her last day of employment.

¶ 10 Warboys has not had an occupational exposure to asbestos since her employment with Stimson.

¶ 11 Libby asbestos can cause cancers and nonmalignant asbestos-related disease (ARD), an umbrella term that describes several conditions in which tissue is damaged, including pleural thickening, pleural plaques, and interstitial fibrosis, each of which results in a loss of respiratory function that worsens over time. However, not every person exposed to Libby asbestos develops a cancer or an ARD.

¶ 12 The physicians who testified in this case agreed that an ARD is to be diagnosed under the criteria from the American Thoracic Society (ATS), which are colloquially called the "ATS criteria." The three criteria, as set forth by the ATS, are:

- Evidence of structural pathology consistent with asbestos-related disease as documented by imaging or histology
- Evidence of causation by asbestos as documented by the occupational and environmental history, markers of exposure (usually pleural plaques), recovery of asbestos bodies, or other means
- Exclusion of alternative plausible causes for the findings¹

ARDs have a 15- to 20-year latency period, which is the time between an exposure to asbestos and the appearance of structural pathology on an x-ray or CT scan. Because ARDs start at the subclinical level and progress slowly, the ATS explains, “nonmalignant asbestos-related disorders are difficult to detect in their earliest stages.”²

Warboys’ Evaluations at the CARD Clinic

2013

¶ 13 On January 17, 2013, Warboys went to the Center for Asbestos Related Disease (CARD Clinic) in Libby for an ARD screening. Warboys underwent a chest x-ray and a high-resolution CT scan to see if there was evidence of structural pathology consistent with an ARD. Although a chest x-ray can show structural pathology consistent with an ARD in some cases, a CT scan shows much greater detail.

¶ 14 Hugh B. Cecil, MD, read Warboys’ x-ray. He noted, “No pleural disease is evident.” Dr. Cecil concluded, “No active cardiopulmonary process is identified.”³

¶ 15 Patrick J. McDonnell, MD, read Warboys’ CT scan. He concluded:

There is slight smooth pleural thickening of the mid and lower hemithoraces bilaterally superimposed upon otherwise normal prominence of pleural fat. The findings are nonspecific though could conceivably reflect asbestos related pleural disease. There are no calcified pleural or hemidiaphragmatic plaques. No infiltrate or interstitial opacity seen within the lungs.⁴

¶ 16 The CARD Clinic sends the CT scans of its patients to other clinics to be read by B-readers, physicians who have passed a test and been certified by the National Institute for Occupational Safety and Health (NIOSH) to read chest x-rays for dust-related

¹ Scientific Assembly on Envtl. & Occupational Health, Am. Thoracic Soc’y, “Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos,” 170 Am. J. Respir. & Crit. Care Med. 691, 691 (2004).

² *Id.* at 692.

³ All caps removed.

⁴ All caps removed.

diseases of the lung, including ARDs.⁵ Jamie Szeinuk, MD, read Warboys' CT scan but did not find any evidence of an ARD. Likewise, Jeffery Kanne, MD, concluded that Warboys' CT scan showed no pleural abnormalities and no pleural calcifications.

¶ 17 However, Brad Black, MD — a physician at the CARD Clinic — read Warboys' CT scan as showing, “lamellar non-calcified pleural thickening in the bilateral lateral mid to lower chest.”

¶ 18 Based on Dr. Black's read, Warboys was diagnosed with asbestos-related pleural disease.

2015

¶ 19 Warboys returned to the CARD clinic on January 20, 2015. Stephen Becker, MD, compared her x-ray from that day to her 2013 x-ray, which Dr. Becker read as showing “some equivocal pleural based prominence,” and her CT scan, which Dr. Becker read as showing “equivocal pleural based changes.” Dr. Becker concluded that her x-ray from that day showed: “Equivocal pleural based changes [which] may or may not be due to previous asbestos exposure. Chest is stable from January 2013.” Miles Miller, PA, determined that Warboys had “stable ARD.”

2016

¶ 20 On June 8, 2016, Warboys returned to the CARD Clinic. Warboys had another x-ray, which Nicholas J. Satovick, MD, read as showing, “No visible areas of pleural thickening.” Dr. Satovick concluded, “Normal appearance of the chest. No calcified pleural plaques.” Miller determined, “Stable ARD in a low risk patient.”

2018

¶ 21 Warboys returned to the CARD Clinic on June 27, 2018. Michael T. Henson, MD, read her x-ray from that day as showing, “No evidence of asbestosis or asbestos related pleural disease. No evidence of acute cardiac or pulmonary disease.” Miller determined, “ARD with questionable stability in a low risk patient.”

⁵ The physicians who testified on the issue agreed that a physician who is a B-reader has a recognized level of expertise in reading radiographic evidence, including CT scans.

Warboys' Occupational Disease Claim

¶ 22 On November 4, 2013, Warboys filed her First Report of Injury or Occupational Disease, alleging that she had an ARD that was proximately caused by her Stimson employment.

¶ 23 On November 11, 2015, Warboys underwent an examination with David J. Hewitt, MD, MPH, DABT, at the request of the Department of Labor & Industry, under § 39-72-602(2), MCA. Dr. Hewitt sent Warboys' 2013 CT scan and her 2015 x-ray to a B-reader. The B-reader concluded neither showed "asbestosis." Thus, Dr. Hewitt concluded that Warboys' "objective tests" were "not consistent with an asbestos-related condition." Dr. Hewitt determined that Warboys' obesity may have been "a contributing factor to interpretations of pleural thickening on imaging testing."

¶ 24 Thereafter, Liberty denied liability for Warboys' claim.

Medical Testimony

Brad Black, MD

¶ 25 Dr. Black has been practicing in Libby for more than 40 years, with approximately half of that time exclusively devoted to diagnosis and treatment of those people exposed to Libby asbestos. He is the CEO of the CARD Clinic. Still, he oversees the process at the CARD Clinic by which patients are screened for an ARD and regularly sees patients.

¶ 26 Dr. Black considered the first and second ATS criteria together and diagnosed Warboys with an ARD, specifically bilateral asbestos-related pleural thickening. Dr. Black acknowledged that Warboys' CT scan by itself shows a "nonspecific thickening of the lining of the pleura" and that, "if one were to just look at that without a [Libby] exposure history, one would really not be able to diagnose." However, because he determined that Warboys had been exposed to Libby asbestos, Dr. Black read Warboys' CT scan as showing "lamellar" pleural thickening, explaining that "the presence of it is very consistent with a structural change that we see related to the fiber exposure."

¶ 27 Dr. Black explained that the CARD Clinic's working group coined the term "lamellar" pleural thickening to describe a smooth, thin pleural thickening as opposed to a "standard diffuse pleural thickening." He testified that, "lamellar pleural thickening is in itself not a disease, it is a characteristic of fibrosis, but it progresses and then becomes thick, so it does lose its thinner nature, and some people can die just basically [from] what appears to be restrictive pleural disease." Dr. Black testified that the thickening is too thin to measure its density on a CT scan; thus, he relies solely on what he sees. Dr. Black testified that a physician needs experience with Libby asbestos patients to be able to see "lamellar" pleural thickening. He explained that when looking at the "gray shadows" on a CT scan, "going from normal to abnormal is a very fine line that really comes back to individual observer experience and knowledge. And if somebody is not knowledgeable

about what they would expect to find in Libby, they probably won't see it." He further explained that, "experience develops that eye to identify things on that image" and that "it [has] taken [him] a long time to gain the understanding of really what this looks like."

¶ 28 Dr. Black acknowledged that an alternative plausible cause for the finding of "lamellar" pleural thickening is the existence of pleural fat and that it is "very difficult to see" the difference between pleural fat and pleural thickening and that "a lot of times ['lamellar' pleural thickening] could be mistaken for fat." Notwithstanding, using the lung window on Warboys' CT scan, he generally pointed out the pleural thickening and testified that the layer was "clearly different" from fat and, in some areas, that the difference was "evident." Dr. Black testified that Warboys' CT scan shows a one- to two-millimeter thick layer with "a very characteristic pattern of pleural thickening" that, "obviously is not . . . just an accumulation of fat." Thus, Dr. Black testified that Warboys has an ARD under the ATS criteria.

Stephen Becker, MD

¶ 29 Dr. Becker is a radiologist. As noted in paragraph 19 above, Dr. Becker read Warboys' 2013 CT scan and her 2015 x-ray as part of her evaluations at the CARD Clinic. Dr. Becker has significant experience reading chest x-rays and CT scans of those exposed to Libby asbestos and has seen hundreds of radiographs from the CARD Clinic showing asbestos-related pleural changes. However, Dr. Becker testified that he has "concerns" because he has seen "a number of cases" in which a patient of the CARD Clinic has been diagnosed with an ARD without sufficient radiographic findings.

¶ 30 Before his testimony, Dr. Becker read Warboys' CT scan and all of her chest x-rays. Dr. Becker agreed with Dr. McConnell that Warboys' CT scan showed a pleural prominence superimposed on an otherwise normal prominence of pleural fat. Using the soft tissue window, which Dr. Becker testified was better than the lung window to see the pleura, Dr. Becker showed an image from Warboys' CT scan which showed a grayish layer of pleural fat on the inside of her rib which became whiter toward her lung.

¶ 31 However, Dr. Becker was unwilling to opine that Warboys' CT scan showed an ARD. Dr. Becker concluded that "there were some pleural-based changes" but that they were "equivocal" and that he was "reserving judgment" on whether it was evidence of an ARD and that he "wasn't willing to call it one way or the other." When asked about Dr. McDonnell's statement that the pleural prominence was "nonspecific, though could conceivably reflect asbestos-related pleural disease," Dr. Becker agreed. When asked if the CT scan showed an ARD, Dr. Becker explained: "I don't think you could conceivably say it's not, but . . . I don't think you can say that it is at this point." Summarily, Dr. Becker stated: "I think if you had 10 people look at this, you're going to get different answers because the findings are so subtle, and I think you could argue either way with that."

¶ 32 When pressed, Dr. Becker determined Warboys' pleural prominence "was normal or probably pleural-based fat." Dr. Becker reached this determination for two reasons.

First, Dr. Becker pointed out the pleural prominence was between the ribs but not on the ribs. He explained, “it’s unlikely that you’re going to get a plaque that’s going to be just between the ribs and not really go on top where the ribs happen to hit. Very unlikely.” Second, Becker measured the density of the pleural thickening on Warboys’ CT scan by Hounsfield units, compared it to the known fat on her CT scan, and determined that the density of the thickening was closer to fat than asbestos-related pleural plaque.

¶ 33 Dr. Becker stated that the proper course of action would be to monitor Warboys’ condition and “see what develops.”

Alvin J. Schonfeld, DO, FACOI, FCCP

¶ 34 Dr. Schonfeld testified as a retained expert for Warboys. He has been involved in asbestos medicine since the 1980s. His current practice is exclusively serving as a retained expert for people who have been exposed to asbestos. Dr. Schonfeld is a B-reader. He has limited experience on cases from Libby, having reviewed less than 10.

¶ 35 Dr. Schonfeld opined that, under the ATS criteria, Warboys has bilateral asbestos-related pleural disease.

¶ 36 Applying the first ATS criterion, Dr. Schonfeld determined that there is evidence of structural pathology consistent with an ARD. Although he read Warboys’ 2016 x-ray as “normal,” showing “no interstitial or pleural abnormalities,” Dr. Schonfeld read Warboys’ CT scan as showing bilateral “pleural plaques with obvious borders,” with no calcification. Dr. Schonfeld looked at both the lung window and the soft tissue window, but showed this Court images from the soft tissue window, because “the pleural plaque would not have shown up as well on the lung images.” Dr. Schonfeld agreed that the CT scan findings are “subtle” and that it showed only a “very small amount” of pleural plaquing.

¶ 37 Dr. Schonfeld compared Warboys’ CT scan, which he pointed out shows “a bit of extra thickening or extra whiteness between the outer margin of the lung and inner margin of the rib cage,” to an example from the ATS of a CT scan showing pleural plaque in the lung of a person who was exposed to high levels of asbestos in a shipyard.⁶ Dr. Schonfeld testified that the ATS’s example CT scan looks “exactly like [Warboys’] film.” Dr. Schonfeld agreed with Dr. McDonnell’s assessment that there was “pleural thickening superimposed on an otherwise normal prominence of pleural fat” and interpreted Dr. McDonnell’s reading of Warboys’ CT scan as saying that there was “scarring on her lung, which could be from asbestos.” Dr. Schonfeld testified that his read of Warboys’ CT scan was “almost identical,” if not entirely identical, to Dr. McDonnell’s.

¶ 38 On cross examination, Dr. Schonfeld would not characterize Warboys’ pleural thickening as “lamellar” pleural thickening because he was not familiar with that term.

⁶ Scientific Assembly on Envtl. & Occupational Health, Am. Thoracic Soc’y, “Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos,” 170 Am. J. Respir. & Crit. Care Med. 691, 706 Figure 16F (2004).

And, Dr. Schonfeld testified that he did not attempt to measure the density of the thickening on Warboys' CT scan because, "Hounsfield numbers are notoriously inaccurate when you have a very thin layer of tissue that you're trying to differentiate."

¶ 39 Applying the second ATS criterion, Dr. Schonfeld determined that Warboys had been exposed to Libby asbestos. Dr. Schonfeld also testified that Warboys' development of her ARD was consistent with the 15- to 20-year latency period of ARDs.

¶ 40 Applying the third ATS criterion, Dr. Schonfeld determined that there was no alternative plausible cause for the scarring in Warboys' pleural space. Dr. Schonfeld testified that pleural fat and asbestos-related pleural thickening can coexist, and that Warboys' CT scan showed pleural fat and asbestos-related pleural plaque with borders.

¶ 41 Dr. Schonfeld had Warboys undergo pulmonary function tests, which were within the normal ranges. However, Dr. Schonfeld explained that pulmonary function tests are used to determine only the severity of an ARD, not to diagnose it. Dr. Schonfeld testified that Warboys pleural thickening has not progressed since 2013.

Steven E. Haber, MD

¶ 42 Dr. Haber testified as a retained expert for Liberty. Dr. Haber is a B-reader. Approximately 30% of his current practice is serving as a retained expert, which he equally splits between plaintiffs and defendants. He has experience with Libby asbestos cases, having served as a retained expert for W.R. Grace in the 2000s and has read many x-rays and CT scans from people exposed to Libby asbestos.

¶ 43 Dr. Haber concluded that Warboys does not suffer from an ARD under the first ATS criterion because the imaging did not show structural pathology consistent with an ARD. Based on his readings, Dr. Haber concluded that Warboys' chest x-rays and her CT scan showed only a thin, smooth layer of pleural fat and not pleural plaquing from an ARD. Dr. Haber explained that pleural fat has a "smooth" surface while a pleural plaque appears as an "irregular surface" and has "mesa tops"; i.e., a similar appearance as mountains with flat tops. Dr. Haber also explained that pleural fat appears grayish on a CT scan while pleural plaquing appears "whiter." Using an example from the soft tissue window from Warboys' CT scan, Dr. Haber showed that Warboys has a layer of grayish tissue between her rib and lung which is smooth on top and "slowly disappears" — i.e., tapers — toward its ends. Dr. Haber contrasted this example with a CT scan of a person with asbestos-related pleural plaques, which appear as a layer of whiter tissue which is jagged on top and has more abrupt ends. Dr. Haber acknowledged that measuring density of a "very, very thin structure" on a CT scan by Hounsfield units is "difficult," but testified that, like Dr. Becker, he was able to get a reading which indicated that the tissue was fat. Thus, although Dr. Haber did not address the whiter "prominence" that Dr. Black, Dr. McDonnell, Dr. Becker, and Dr. Schonfeld noted on Warboys' CT scan, he opined that the pleural thickening found on Warboys' CT scan is normal pleura and fat, and that

Warboys' health issues, including an abnormality he saw on her pulmonary function tests, stem from her obesity.

¶ 44 Because there was no evidence of structural pathology consistent with an ARD, Dr. Haber explained that there was no need to proceed to the second and third ATS criteria.

¶ 45 Dr. Haber disputed Dr. Schonfeld's determination that Warboys' CT scan looks identical to the CT scan from the ATS showing pleural plaquing. Dr. Haber pointed out that the example CT scan shows tissue that is thick and bright white because it is dense, calcified plaquing, while the tissue shown on Warboys' CT scan is a "deeper gray color because it [is] fat." Dr. Haber also testified that the example CT scan shows places where the top of the tissue has a "mesa appearance" while the tissue on Warboys' CT scan has a smooth top.

¶ 46 Dr. Haber criticized Dr. Black's approach on several grounds, three of which merit discussion. First, Dr. Haber criticized Dr. Black's determination that Warboys had "lamellar" pleural thickening, on the grounds that it is not scientific. Dr. Haber explained that under the ATS criteria, "the evidence of structural pathology . . . must be based on medically and scientifically defined entities, with specific diagnostic criteria, and must be medically sound, in other words, verifiable by others." Dr. Haber explained that despite there being decades of research into the health effects of asbestos exposure, no authoritative text recognizes or defines "lamellar" pleural thickening. Dr. Haber testified that because Dr. Black has not explained what he sees on a CT scan when he diagnoses "lamellar" pleural thickening, or how he distinguishes "lamellar" pleural thickening from pleural fat, other physicians cannot confirm nor refute his reads.

¶ 47 Second, Dr. Haber criticized Dr. Black on the grounds that Dr. Black does not apply the ATS criteria separately and in order. Dr. Haber explained that a physician should read the CT scan "blind" — i.e., without knowledge of whether the patient had been exposed to asbestos — to eliminate the possibility of confirmation bias. Dr. Haber explained that Dr. Black's determination that Warboys has asbestos-related pleural thickening as opposed to pleural fat is not necessarily valid because he works backwards; i.e., Dr. Black uses "history of exposure as a litmus [test] to decide whether or not what [he is] seeing . . . is fat or pleural thickening, so called lamellar pleural thickening." Thus, Dr. Haber explained that anyone who goes to the CARD Clinic with a pleural abnormality will be diagnosed with an ARD, even though some just have pleural fat, because they have all been exposed to Libby asbestos.

¶ 48 Third, Dr. Haber criticized Dr. Black for using the lung window of Warboys' CT scan to identify "lamellar" pleural thickening. Dr. Haber explained that physicians should use the soft tissue window when determining whether a patient has asbestos-related pleural thickening because it gives a sharper image of the pleura.

Resolution

¶ 49 The only physicians who opined that Warboys currently has an ARD under the ATS criteria were Dr. Black and Dr. Schonfeld. However, after considering the entirety of the evidence, neither Dr. Black nor Dr. Schonfeld convinced this Court that Warboys currently has a diagnosable ARD.

¶ 50 Dr. Black did not convince this Court that Warboys' CT scan, standing alone, is consistent with asbestos-related pleural thickening nor that pleural fat is not a plausible cause for the thickening. Indeed, Dr. Black acknowledged that "if one were to just look at [Warboys' CT scan] without an exposure history, one would really not be able to diagnose." Although Dr. Black thereafter testified that Warboys' CT scan showed a "very characteristic pattern of [asbestos-related] pleural thickening" that was "obviously . . . not just an accumulation of fat," Warboys did not elicit any explanation from Dr. Black from which this Court could reconcile his contradictory testimony. Moreover, Warboys did not elicit a sufficient explanation from Dr. Black as to precisely what he saw on Warboys' CT scan that led him to determine that she had "lamellar" pleural thickening and not pleural fat. This Court agrees with Dr. Haber that a physician's determination that a CT scan shows structural pathology consistent with an ARD must be verifiable. Thus, Dr. Black did not convince this Court that the first or third ATS criteria are satisfied.

¶ 51 Moreover, Dr. Black did not convince this Court that using an exposure to Libby asbestos to determine that a "nonspecific thickening" is asbestos-related pleural thickening, the so-called "lamellar" pleural thickening, and not pleural fat, is an acceptable and reliable method to satisfy the first and third ATS criteria. Although Dr. Black has greater expertise with Libby asbestos patients than the other physicians, this Court was persuaded by Dr. Haber's testimony that using an exposure to Libby asbestos as the litmus test to determine whether a CT scan shows asbestos-related pleural thickening or pleural fat will result in misdiagnoses, as every person who has had an exposure to Libby asbestos and has a nonspecific pleural thickening will be diagnosed with an ARD, even though some will only have pleural fat.

¶ 52 Likewise, Dr. Schonfeld did not convince this Court that Warboys' CT scan, standing on its own, is consistent with asbestos-related pleural thickening. This Court gives no weight to Dr. Schonfeld's testimony that Warboys' CT scan is "identical" to the example in the ATS article because Dr. Haber pointed out the considerable differences in the images, which convinced this Court that the first ATS criterion is not satisfied.

¶ 53 In addition, Dr. Schonfeld did not convince this Court that he actually thinks that Warboys has an ARD on a more-probable-than-not basis. Dr. Schonfeld urged this Court to resolve the differences in medical opinion by using Dr. McDonnell as the tiebreaker, as Dr. Schonfeld deemed Dr. McDonnell to be the only unbiased physician. Dr. Schonfeld testified his independent reading of Warboys' CT scan was "almost identical," if not entirely identical, to Dr. McDonnell's. Notwithstanding, Dr. McDonnell did not read Warboys' CT scan as showing asbestos-related pleural thickening on the more-probable-

than-not standard. Dr. McDonnell stated that the pleural abnormality on Warboys' CT scan was "nonspecific, though could conceivably reflect asbestos-related pleural disease." If Dr. Schonfeld's reading is "almost identical" to Dr. McDonnell's, then it is insufficient to prove that Warboys currently has an ARD because it does not meet the evidentiary standard.⁷

¶ 54 After considering the evidence, this Court finds that Dr. Becker's opinions are persuasive and entitled to the greatest weight. Thus, this Court finds that Warboys' CT scan does not show structural pathology consistent with an ARD; rather, it shows a nonspecific, equivocal pleural prominence. Given the latency period of ARDs and the difficulty of diagnosing an ARD at its earliest stages, Warboys may develop a diagnosable ARD in the future. Indeed, the ATS states: "It is understood that disease may be present at a subclinical level and may not be sufficiently advanced to be apparent on histology, imaging, or functional studies."⁸ But, this Court finds that Warboys did not meet her burden of proving that she currently has a diagnosable ARD.

CONCLUSIONS OF LAW

¶ 55 This case is governed by the 2001 Occupational Disease Act (ODA) since that was the law in effect during Warboys last day of work at Stimson and her last occupational exposure to Libby asbestos.⁹

Issue One: Is Warboys suffering from an occupational disease?

¶ 56 By reference to the Workers' Compensation Act, the 2001 ODA requires that an occupational disease be established by objective medical findings.¹⁰ Here, this Court has found that Warboys does not currently have objective medical findings of an ARD. Thus, she does not currently have an occupational disease under Montana law.

⁷ *Ford v. Sentry Cas. Co.*, 2012 MT 156, ¶¶ 41-43, 365 Mont. 405, 282 P.3d 687 (citations omitted) (holding that this Court is to rely upon medical testimony only if it meets the "more likely than not" standard because that standard "assures that the expert testimony or opinion 'does not represent mere conjecture, but rather is sufficiently probative to be reliable.'").

⁸ Scientific Assembly on Envtl. & Occupational Health, Am. Thoracic Soc'y, "Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos," 170 Am. J. Respir. & Crit. Care Med. 691, 691 (2004).

⁹ See *Wommack v. Nat'l Farmers Union Prop. & Cas. Co.*, 2017 MTWCC 8, ¶ 66 (citations omitted) (stating, "Generally, the law in effect when a claimant files his claim, or on his last day of work, whichever is earlier, governs an OD claim."). See also *Nelson v. Cenex, Inc.*, 2008 MT 108, ¶¶ 29-33, 342 Mont. 371, 181 P.3d 619 (holding that the law in effect on the last day of an employee's exposure to the hazards of an OD controls).

¹⁰ See § 39-72-102(10), MCA (providing that an "occupational disease" is "harm, damage, or death as set forth in 39-71-119(1) arising out of or contracted in the course and scope of employment"); § 39-71-119(1)(a), MCA ("injury" or "injured" is "internal or external physical harm to the body that is established by objective medical findings").

Issue Two: Is Liberty liable for Warboys' occupational disease?

¶ 57 Because this Court has found that Warboys does not currently have an occupational disease, this issue is moot.

Issue Three: Is Warboys entitled to her costs?

¶ 58 Because Warboys has not prevailed, she is not entitled to her costs under § 39-71-611, MCA, and ARM 24.5.342.

JUDGMENT

¶ 59 Warboys does not currently have an occupational disease; thus, Liberty is not obligated to pay her any occupational disease benefits under the ODA.

¶ 60 Pursuant to ARM 24.5.348(2), this Judgment is certified as final and, for purposes of appeal, shall be considered as a notice of entry of judgment.

DATED this 10th day of March, 2020.

/s/ DAVID M. SANDLER
JUDGE

c: Ben A. Snipes
Leo S. Ward

Submitted: September 4, 2018