U.S. Department of Labor

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

BRB No. 22-0155 BLA

MICHAEL B. IRELAND, SR.	)	
	)	
Claimant-Petitioner	)	
	)	
v.	)	
	)	
MANOR MINING & CONTRACTING, INCORPORATED	)	
	)	
and	)	
	)	
ROCKWOOD CASUALTY INSURANCE COMPANY	)	DATE ISSUED: 7/26/2023
	)	
Employer/Carrier-Respondents	)	
	)	
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 Natalie A. Appetta, Administrative Law Judge, United States Department of Labor.

Heath M. Long and Matthew A. Gribler (Pawlowski, Bilonick, & Long), Ebensburg, Pennsylvania, for Claimant.

Christopher Pierson (Burns White LLC), Pittsburgh, Pennsylvania, for Employer.

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

GRESH, Chief Administrative Appeals Judge, and ROLFE, Administrative Appeals Judge:

Claimant appeals the Decision and Order Awarding Benefits (2021-BLA-05147) of Administrative Law Judge (ALJ) Natalie A. Appetta rendered on a claim filed on September 11, 2017, pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2018) (Act). The sole issue before the ALJ was the commencement date of benefits as Employer conceded Claimant invoked the irrebuttable presumption of total disability due to pneumoconiosis under Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3).[1] The relevant procedural history follows.

The district director issued a Proposed Decision and Order denying benefits on June 5, 2018, because Claimant did not establish a totally disabling respiratory or pulmonary impairment. Director's Exhibit 28. Claimant timely requested modification on September 20, 2018. Director's Exhibit 13. In support, he submitted Dr. Costa's August 5, 2008 biopsy report, and Dr. DePonte's interpretation of an August 7, 2018 computed tomography (CT) scan. Director's Exhibits 13, 35.

On May 22, 2019, the district director issued a Proposed Decision and Order granting modification, finding Claimant established complicated pneumoconiosis. Director's Exhibit 37. Employer timely requested a hearing; however, while the case was pending before the Office of Administrative Law Judges, Employer withdrew its controversion of Claimant's entitlement and requested the case be remanded to the district director to institute payment of benefits. Employer's April 15, 2020 Motion to Remand. The ALJ granted Employer's motion and remanded the claim to the district director for payment of benefits. Order Cancelling Hearing and Remanding Claim to District Director for Payment of Benefits (Apr. 30, 2020). Finding Dr. Costa's biopsy report diagnosed

[1] Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he suffers from a chronic dust disease of the lung which: (a) when diagnosed by x-ray, yields one or more large opacities greater than one centimeter in diameter that would be classified as Category A, B, or C; (b) when diagnosed by biopsy or autopsy, yields massive lesions in the lung; or (c) when diagnosed by other means is a condition that would yield results equivalent to (a) or (b). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304.

complicated pneumoconiosis, the district director awarded benefits commencing August 2008. Director's Exhibit 37.

Employer requested a hearing on the commencement date for benefits, and the case was returned to the ALJ. Director's Exhibit 44. The ALJ determined the first "definitive diagnosis" of complicated pneumoconiosis is Dr. DePonte's reading of the August 7, 2018 CT scan and awarded benefits commencing August 2018. Decision and Order at 6-7.

On appeal, Claimant alleges he is entitled to benefits commencing August 2008, as the district director found, and not August 2018. Employer responds in support of the ALJ's finding. The Director, Office of Workers' Compensation Programs, has declined to file a response.

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.[2] 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).

Commencement Date for Benefits

The commencement date for benefits is the month in which the miner became totally disabled due to pneumoconiosis. 20 C.F.R. §725.503(b); *see Lykins v. Director, OWCP*, 12 BLR 1-181, 1-182 (1989). When a miner suffers from complicated pneumoconiosis, the factfinder must consider whether the evidence establishes the date of onset of the disease. *See Williams v. Director, OWCP*, 13 BLR 1-28, 1-30 (1989). If it does not, the commencement date is the month in which the claim was filed, unless the evidence establishes the miner had only simple pneumoconiosis for any period subsequent to the date of filing. In that case, the date for the commencement of benefits follows the period when the miner had only simple pneumoconiosis. *Williams*, 13 BLR at 1-30.

The ALJ considered four pieces of evidence in determining the onset date of Claimant's complicated pneumoconiosis: Dr. Costa's August 5, 2008 biopsy report, two readings of an October 30, 2017 x-ray, and Dr. DePonte's interpretation of the August 7, 2018 CT scan. Director's Exhibits 11, 13, 14, 35.

[2] This case arises within the jurisdiction of the United States Court of Appeals for the Third Circuit because Claimant performed his coal mine employment in Pennsylvania. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Director's Exhibit 3.

As part of his treatment at Dubois Regional Medical Center, Claimant underwent a biopsy of his right upper lobe and right lower lobe lung on August 1, 2008. Director's Exhibit 35. Dr. Costa examined the lung tissue slides and issued a report on August 5, 2008. *Id.* He noted a "somewhat firm and well circumscribed" pneumoconiotic nodule measuring 1.7 centimeters (cm) in greatest dimension within the right upper lobe specimen and diagnosed both lung resections as "consistent with coal workers' pneumoconiosis with formation of coal nodules." Director's Exhibit 35 at 2-3.

Although the ALJ observed that the biopsy report suggests statutory complicated pneumoconiosis may have existed as early as 2008, she noted Dr. Costa did not specifically diagnose *massive lesions* or explain whether the nodule he saw would appear as a greater than one centimeter opacity on x-ray. Decision and Order at 6. She stated "a finding [that the nodule is] complicated CWP based on this measurement would be a medical diagnosis, *and as a judge rather than a physician*, I am disinclined to make a medical diagnosis of complicated pneumoconiosis based on the biopsy." *Id.* (emphasis added). Thus, the ALJ found Dr. Costa's biopsy report insufficient to establish Claimant had complicated pneumoconiosis as early as August 2008. *Id.* at 6-7.

Dr. Afzal read the October 30, 2017 x-ray as positive for simple pneumoconiosis and emphysema with "focal scarring" in the right upper lung but negative for large opacities. Director's Exhibit 11. Dr. Simone read the same x-ray as negative for simple and complicated pneumoconiosis, but noted *a right upper-lobe density* that represents "either fibrosis or a speculated lesion."[3] Director's Exhibit 14 (emphasis added). As neither physician diagnosed complicated pneumoconiosis, the ALJ found Claimant did not establish the onset date of his complicated pneumoconiosis as October 2017. Decision and Order at 6-7.

Finally, Dr. DePonte interpreted Claimant's August 7, 2018 CT scan as showing a 2 cm mass in the right upper lobe, a 1 cm nodule in the right lower lobe, and similar smaller nodular lesions. Director's Exhibit 13 at 2. She offered the following "differential diagnosis" for the observed opacities: complicated coal workers' pneumoconiosis, scarring from the earlier surgery, and histoplasmosis with histoplasmoma. *Id.* at 2. In addition, she stated the 2 cm opacity "would measure similar in size and greater than one centimeter on a standard chest radiograph (x-ray)." *Id.* at 3.

[3] Dr. Afzal observed irregular and rounded parenchymal densities, while Dr. Simone observed "no rounded opacities that would suggest coal workers pneumoconiosis." Director's Exhibits 11, 14.

The ALJ found Dr. DePonte's interpretation of the 2018 CT scan is the "earliest definitive diagnosis of complicated pneumoconiosis" because Dr. DePonte both diagnosed the disease and provided an equivalency determination. Decision and Order at 5-7. Thus, the ALJ found Dr. Costa's biopsy report insufficient to establish Claimant had complicated pneumoconiosis as early as August 2008. *Id.* at 6-7.

Claimant contends the ALJ failed to adequately consider whether Dr. Costa's description of a 1.7 cm pneumoconiotic constitutes a "massive lesion" or whether the evidence as a whole is sufficient to establish he had complicated pneumoconiosis in 2008. *See* 20 C.F.R. §718.304(b); Claimant's Brief at 6-7 (citing *Gruller v. Bethenergy Mines, Inc.*, 16 BLR 1-3, 1-5 (1991)). We agree with Claimant that the ALJ's finding as to the onset date of his complicated pneumoconiosis cannot be affirmed.

Section 411(c)(3) of the Act provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he suffers from a chronic dust disease of the lung which: (a) when diagnosed by x-ray, yields one or more large opacities greater than one centimeter in diameter that would be classified as Category A, B, or C; (b) when diagnosed by biopsy or autopsy, yields massive lesions in the lung; or (c) when diagnosed by other means, is a condition that would yield results equivalent to (a) or (b). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. The ALJ must weigh together all of the evidence relevant to the presence or absence of complicated pneumoconiosis. 30 U.S.C. §923(b); *see Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33 (1991) (en banc).

Biopsy evidence can support a finding of complicated pneumoconiosis where a physician diagnoses massive lesions or where an evidentiary basis exists for the ALJ to make an equivalency determination between the biopsy findings and x-ray findings. *See* 20 C.F.R. §718.304(b); *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14, 16 (3d Cir. 1981). The United States Court of Appeals for the Third Circuit, within whose jurisdiction this case arises, has held that a designated adjudicator is competent to make an equivalency determination between the pathology evidence and x-ray findings where there is "some evidentiary basis" for doing so. *Clites*, 663 F.2d at 16. The Board has also construed *Clites* to mean the ALJ must make an equivalency determination if the record permits. *Britten v. Florence Mining Co.*, BRB No. 04-0947 BLA, slip op. at 4 n.4 (Sept. 23, 2005) (unpub.).

Here, the ALJ erred in failing to address whether the evidence as a whole permitted him to render an equivalency determination taking into consideration both the biopsy and CT scan evidence. The ALJ specifically credited Dr. DePonte's CT scan findings in 2018 of a 2 cm mass and her explicit equivalency determination as establishing complicated pneumoconiosis in Claimant's right upper lobe, the same location of the 1.7 cm pneumoconiotic nodule that Dr. Costa had identified on biopsy ten years earlier. Decision and Order at 7; Director's Exhibits 13 at 2-3, 35 at 2-3. Given the progressive nature of

pneumoconiosis, the ALJ did not address whether the biopsy and CT scan identified lesions are the same, or otherwise consider whether Dr. DePonte's opinion provides a sufficient basis for the ALJ to infer Claimant had complicated pneumoconiosis when the biopsy was conducted. *See* 20 C.F.R. §718.201(c); *Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162, 1-165 (1989).

Further, the ALJ's conclusion that the readings of the intervening 2017 x-ray do not indicate Claimant had complicated pneumoconiosis fails to address the fact that those same x-ray readings nevertheless identified abnormalities in the same location. Director's Exhibits 11, 14. The ALJ's analysis therefore fails to adequately consider whether the evidence, as a whole, establishes that Claimant had a nodule of complicated pneumoconiosis that simply grew in size over the ten-year period between the biopsy and Dr. DePonte's CT scan reading. Consequently, as the ALJ did not conduct the analysis contemplated by *Clites,* we vacate her finding that Dr. Costa's biopsy report is insufficient to establish Claimant had complicated pneumoconiosis in 2008. *See Clites*, 663 F.2d at 16. We therefore vacate the ALJ's findings that Dr. DePonte's 2018 CT scan report is the first definitive diagnosis of complicated pneumoconiosis and her determination that the proper commencement date for benefits is August 2018. Decision and Order at 7.[4]

[4] Our dissenting colleague asserts the ALJ's decision should be affirmed because "the ALJ fully considered the evidence" and reasonably concluded "Dr. DePonte's reading of the August 2018 CT scan is the 'earliest definitive evidence' of complicated pneumoconiosis." *Infra* at 11. But the ALJ's sole reason for failing to find an earlier onset date is based on a misapplication of the governing law: the ALJ stated she was disinclined as a judge rather than as a physician to make what she considered a medical judgment when the Third Circuit has held she can, and the Board has held she must, make one when "some evidentiary basis" exists for it. *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14, 16 (3d Cir. 1981) ("the ALJ was no less competent to evaluate expert testimony in this instance than on any other subject"); *Britten v. Florence Mining Co.*, BRB No. 04-0947 BLA, slip op. at 4 n.4 (Sept. 23, 2005) (unpub.) (interpreting *Clites*). But for the ALJ's legal error, a review of the record indicates a readily apparent evidentiary basis for an earlier onset date here. "Magic words" like massive lesions are not necessary to diagnose complicated pneumoconiosis by biopsy if the results are consistent with a diagnosis of complicated pneumoconiosis under accepted medical standards -- and the physician who conducted a biopsy of Claimant's lung in 2008 reported that the portion contained a nodule of clinical pneumoconiosis almost twice the size necessary to satisfy the statutory criteria. *Pittsburgh & Midway Coal Mining Co. v. Director,* OWCP, 508 F.3d 975, 986 (11th Cir. 2007); *Grueller v. Beth Energy Mines, Inc.*, 16 BLR 1-3 (1991) (evidence is sufficient under the second prong if it "adequately describe[s] the condition comprehended by the regulatory term 'massive lesions'"). There are no contrary interpretations. A subsequent x-ray

Remand Instructions

On remand, the ALJ must reconsider the evidence as to the onset date of Claimant's complicated pneumoconiosis. Specifically, the ALJ must weigh the biopsy evidence at 20 C.F.R. §718.304(b) and determine, pursuant to *Clites*, 663 F.2d at 16, whether it is sufficient to establish statutory complicated pneumoconiosis under 20 C.F.R. §718.304(b). In addressing whether Dr. Costa's biopsy finding of a 1.7 cm pneumoconiotic nodule would show as a one centimeter or greater opacity on x-ray, the ALJ must consider the totality of the evidence in conjunction with Dr. DePonte's equivalency determination. *See Barren Creek Coal Co. v. Witmer*, 111 F.3d 352, 354 (3d Cir. 1997). If the ALJ finds Dr. Costa's biopsy report establishes the onset of Claimant's complicated pneumoconiosis, Claimant will have established modification based on a mistake in fact and the ALJ must set the commencement date for benefits as August 2008. *See* 20 C.F.R. §725.503(b), (d)(1); *Williams*, 13 BLR at 1-30. Alternatively, if she again finds Dr. Costa's biopsy report insufficient to establish complicated pneumoconiosis, she may reinstate her findings that Dr. DePonte's CT scan report establishes complicated pneumoconiosis as of August 7,

revealed both simple pneumoconiosis and a right upper lobe density in the same location, before the ALJ finally decided Dr. DePonte's CT scan reading -- which makes the determination the ALJ erroneously declined to -- definitively established the existence of the disease in 2018. Without the ALJ's threshold legal error, it is difficult to see how a reasonable person could review this record and decide the 2 cm lesion the ALJ determined to be complicated pneumoconiosis in 2018 either was not there or was something else ten years earlier when a biopsy showed a 1.7cm lesion of clinical pneumoconiosis in the same location. But that is a determination for the ALJ in the first instance. *See Clites*, 663 F.2d at 16; *Melnick*, 16 BLR at 1-31, 1-33 (1991) (en banc); *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113 (1989). It is also difficult to see how Claimant did not adequately raise this issue, as our colleague contends. Claimant succinctly argues: "As a general rule, the biopsy evidence is sufficient to establish complicated CWP if the [ALJ] finds that it 'adequately describes the condition comprehended by the regulatory terms 'massive lesions.'" Claimant Brief at 6 (citing *Gruller*, 16 BLR at 1-5).

2018, based on a change in condition and that benefits therefore commence August 2018. *See* 20 C.F.R. §725.503(b), (d)(2); *Williams*, 13 BLR at 1-30.

Accordingly, the Decision and Order Awarding Benefits is vacated and the case is remanded for further consideration consistent with this opinion.

SO ORDERED.

DANIEL T. GRESH, Chief
Administrative Appeals Judge

JONATHAN ROLFE
Administrative Appeals Judge

BUZZARD, Administrative Appeals Judge, dissenting:

I respectfully disagree with my colleagues' decision to vacate the ALJ's findings as to the onset of Claimant's complicated pneumoconiosis and the date benefits commence.

Under the Act, benefits generally commence the month the miner became totally disabled due to pneumoconiosis. 20 C.F.R. §725.503(b). Because Claimant established entitlement based on the irrebuttable presumption of total disability due to complicated pneumoconiosis at Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), the date his disease became onset controls the benefits commencement date. *See Williams v. Director, OWCP*, 13 BLR 1-28, 1-30 (1989). However, because Claimant's award was issued pursuant to his request to modify an earlier order denying benefits, additional rules apply. If Claimant's award is based on a change in conditions, e.g., he establishes he developed the disease at some point after the earlier denial, benefits are not awardable for any month prior to the earlier denial of benefits. 20 C.F.R. §725.503(d)(2). But if the award is based on a mistake in fact, i.e., he establishes the earlier order denying benefits incorrectly found he did not have the disease, benefits can be awarded either when he initially filed the claim or when his disease became onset. 20 C.F.R. §725.503(d)(1).

On appeal, Claimant alleges the ALJ erred in finding his disease became onset, and thus benefits are awardable, in August 2018, the date of a CT scan read by Dr. DePonte as

positive for complicated pneumoconiosis. Instead, Claimant alleges the ALJ should have found benefits are awardable in August 2008, the date Dr. Costa identified pneumoconiotic lesions on biopsy. For the following reasons, I disagree.

A claimant can invoke the Act's irrebuttable presumption of total disability due to complicated pneumoconiosis based on: (A) x-ray findings of one or more large opacities greater than one centimeter in diameter that would be classified as Category A, B, or C under the International Labour Organization criteria; (B) biopsy or autopsy findings of massive lesions in the lung; or (C) a diagnosis by other means that yields results equivalent to large opacities on x-ray or massive lesions on biopsy or autopsy. 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304.

As it relates to prong (B), some circuits have held that autopsy and biopsy reports can establish complicated pneumoconiosis only if they identify "massive lesions" or the record contains evidence that would allow the ALJ to perform an "equivalency determination" to ensure that the lesions identified on autopsy or biopsy would appear "on an x-ray [as] greater than one centimeter." *Eastern Associated Coal Corp. v. Director* [*Scarbro*], 220 F.3d 250, 256 (4th Cir. 2000);[5] *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 241 (4th Cir. 1999); *Perry v. Mynu Coals, Inc.*, 469 F.3d 360, 365 (4th Cir. 2006) (diagnosis of "massive lesions" on autopsy is "another statutory ground" to invoke the presumption, independent of an equivalency determination); *Gray v. SLC Coal Co.*, 176 F.3d 382, 390 (6th Cir.1999) (lesion identified on autopsy can invoke the irrebuttable presumption only if it is described as "massive" or would appear on x-ray as greater than one centimeter). Other circuits have squarely rejected that approach, instead holding that a claimant can invoke the irrebuttable presumption under prong (B) so long as the "autopsy or biopsy results are consistent with a diagnosis of complicated pneumoconiosis under accepted medical standards." *The Pittsburg & Midway Coal Mining Co. v. Director* [*Cornelius*], 508 F.3d 975, 986 (11th Cir. 2007); *Bridger Coal Co. v. Director* [*Ashmore*], 669 F.3d 1183, 1194 (10th Cir. 2012).

Meanwhile, the Third Circuit, within whose jurisdiction this claim arises, has not squarely addressed whether autopsy or biopsy evidence under prong (B) *must* be accompanied by evidence that the lesions identified on pathology are equivalent to one-centimeter opacities if viewed on x-ray. Instead, in *Clites v. Jones and Laughlin Steel*

[5] The Fourth Circuit reasoned that because x-rays under prong (A) provide "an entirely objective" standard for diagnosing complicated pneumoconiosis, an ALJ must perform an "equivalency determination" to ensure that the lesions identified on autopsy or biopsy would appear "on an x-ray [as] greater than one centimeter." *Scarbro*, 220 F.3d at 256.

Corp., 663 F.2d 14 (3d Cir. 1981), the court interpreted prong (C) as "plainly" requiring equivalency determinations to assess whether a "diagnosis made by other means" is equivalent to a one-centimeter opacity on x-ray under prong (A) or a massive lesion on autopsy or biopsy under prong (B), so long as there is "some evidentiary basis" for doing so. Thus, in *Clites*, despite the autopsy report's silence as to whether the miner had "massive lesions," the ALJ's finding of complicated pneumoconiosis was supported by the prosector's subsequent testimony that the nodules he saw on pathology would appear on x-ray as greater than one centimeter. 663 F.2d at 16; *see Ashmore*, 669 F.3d at 1192 n.9 ("[*Clites*] held equivalency determinations were necessary to apply [prong (C)], but did not decide whether such a requirement is implicit in [prong (B)]."); *Cornelius*, 508 F.3d at 987 n.7 (citing *Clites* for the proposition that equivalency determinations between autopsies/biopsies and x-rays are not required under prong (B), but "may already [be] allow[ed]" under prong (C)).

But regardless of whether equivalency determinations are required under prong (B), or are simply one method to invoke the irrebuttable presumption, these circuit cases share a common thread. None have found the irrebuttable presumption invoked by autopsy or biopsy evidence absent a clear diagnosis of massive lesions, complicated pneumoconiosis, or progressive massive fibrosis,[6] or at least "some evidentiary basis" for the ALJ to conclude that the lesion identified on pathology is equivalent to one of those diagnoses. *Clites*, 663 F.2d 14 (ALJ's finding of massive lesions supported by the prosector's subsequent testimony that the nodules identified on autopsy would appear as greater than one centimeter if x-rayed).[7] And importantly, all circuits have held that an ALJ's

[6] Progressive massive fibrosis is another term used for diagnosing complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976) (complicated pneumoconiosis "involves progressive massive fibrosis as a complex reaction to dust and other factors").

[7] *See also Scarbro*, 220 F.3d at 256-257 (ALJ was "incorrect" to find "massive lesions" established under prong (B) based on autopsy prosector's identification of "pneumoconiotic nodules" in more than fifty to seventy percent of the miner's lungs); *Blankenship*, 177 F.3d at 244 (physician's identification of 1.3 centimeter lesion on biopsy and diagnosis of "massive fibrosis," but not "massive lesions," is "insufficient [alone] to determine whether [the miner] had complicated pneumoconiosis"); *Cornelius*, 508 F.3d at 987-89 (physician's identification of 1.2 centimeter nodule on autopsy and testimony explaining "how her findings satisfied each of the criteria for diagnosing complicated pneumoconiosis" is substantial evidence of "massive lesions"); *Ashmore*, 669 F.3d at 1194 (medical examiner's autopsy report identifying 6.35 centimeter lesion and diagnosing "progressive massive fibrosis" is substantial evidence of complicated pneumoconiosis); *Perry*, 469 F.3d at 365 (autopsy's identification of "mass lesions" sufficient to invoke the

determination as to the presence or absence of complicated pneumoconiosis must be affirmed if supported by substantial evidence. *Id*. at 16; *Cornelius*, 508 F.3d at 980; *Ashmore*, 669 F.3d at 1190; *Perry*, 469 F.3d at 363; *Gray*, 176 F.3d at 387.

In the present claim, the ALJ fully considered the evidence and concluded that because Dr. DePonte's reading of the August 2018 CT scan is the "earliest definitive evidence" of complicated pneumoconiosis, Claimant's benefits should commence in August 2018. Decision and Order at 6. Claimant's sole argument on appeal as to why his benefits should commence ten years earlier, in August 2008, is that the "ALJ erroneously states that the biopsy did not definitively diagnose complicated [pneumoconiosis]." Claimant's Brief at 6-7. But his argument is based on the mistaken belief that identification of a 1.7-centimeter pneumoconiotic nodule on biopsy, by itself, is sufficient to establish complicated, rather than simple, pneumoconiosis. *See Clites*, 663 F.2d at 16 (physician's testimony that autopsy nodules would appear as greater than one centimeter on x-ray necessary to the ALJ's finding of massive lesions).

The ALJ accurately observed – consistent with Claimant's own recitation of the evidence – that while Dr. Costa's August 2008 biopsy report identifies a 1.7 centimeter pneumoconiotic lesion, neither he nor any other physician of record described it as a massive lesion, complicated pneumoconiosis, or progressive massive fibrosis, or opined that the lesion on biopsy would appear as greater than one centimeter on x-ray. Decision and Order at 6; Director's Exhibit 35 at 2-3. Thus, while Claimant alleges "this portion of the biopsy" by itself contains "the requisite findings for complicated [pneumoconiosis]," substantial evidence supports the ALJ's determination that the record lacks sufficient medical evidence for her to find that the 1.7-centimeter lesion identified on biopsy in August 2008 is the equivalent of a diagnosis of complicated pneumoconiosis. *Clites*, 663 F.2d at 16; Decision and Order at 6.

Although not argued by Claimant, the majority holds that Dr. DePonte's reading of an August 2018 CT scan, and Drs. Afzal's and Simone's readings of an October 2017 x-ray, may support an inference that the August 2008 biopsy revealed complicated pneumoconiosis. *See* 20 C.F.R. §802.211(b) (A petition for review "shall be accompanied by a supporting brief, memorandum of law or other statement which . . . [s]pecifically states the issues to be considered by the Board."); *Sarf v. Director, OWCP*, 10 BLR 1-119, 1-

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presumption, as was his testimony that the lesions identified on autopsy would appear as greater than one centimeter if x-rayed); *Gray*, 176 F.3d at 390 (ALJ's finding of no complicated pneumoconiosis supported by physician's opinion that lesions identified on autopsy were not massive lesions and would not appear on x-ray as greater than one centimeter).

120-21 (1987) (Board must limit its review to contentions of error that are specifically raised by the parties). But given the progressive nature of pneumoconiosis,[8] and the deference afforded ALJs in making factual determinations, the ALJ was not required to infer that, because Claimant's disease process met the criteria for complicated pneumoconiosis by August 2018, or possibly October 2017, it also met the definition nine or ten years earlier when the biopsy was performed. *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113 (1989) (The Board is not empowered to reweigh the evidence or substitute its own inferences for those of the ALJ, even if it believes other conclusions could have been reached from the evidence.).

Moreover, the ALJ did not ignore the evidence relied upon by the majority. She accurately observed that Dr. DePonte diagnosed complicated pneumoconiosis based on a two-centimeter mass on the August 2018 CT scan, which the physician stated would appear "similar in size and greater than one centimeter" on x-ray. Decision and Order at 6-7; Director's Exhibit 13. Dr. DePonte did not, however, discuss the August 2008 biopsy or offer any indication as to whether Claimant had complicated pneumoconiosis ten years before her diagnosis. The ALJ also accurately observed that while Drs. Afzal and Simone identified abnormalities on the October 2017 x-ray, only Dr. Afzal diagnosed simple pneumoconiosis, neither physician diagnosed complicated pneumoconiosis, and Dr. Simone did not discuss the size of the non-pneumoconiotic abnormalities she identified. Decision and Order at 7; Director's Exhibits 11, 14. And, like Dr. DePonte, neither discussed the August 2008 biopsy nor offered an opinion on whether it revealed complicated pneumoconiosis.

Thus, substantial evidence supports the ALJ's determination that the record lacks sufficient medical evidence for her to find that the 1.7-centimeter lesion identified on biopsy in August 2008 is the equivalent of a diagnosis of complicated pneumoconiosis. *Clites*, 663 F.2d at 16; *Anderson*, 12 BLR at 1-113; Decision and Order at 6. I therefore would affirm her finding that, for purposes of determining the onset date for benefits, Claimant established complicated pneumoconiosis as of the August 2018 CT scan.

[8] *See* 20 C.F.R. §718.201(c) (pneumoconiosis "is recognized as a latent and progressive disease"); *Usery*, 428 U.S. at 7 (pneumoconiosis "is progressive . . . in its complicated stage).

Decision and Order at 6. Because Claimant raises no other allegations of error, I would affirm the ALJ's finding that benefits commence in August 2018.[9]

GREG J. BUZZARD
Administrative Appeals Judge

[9] Although Claimant alternatively suggests benefits are awardable in September 2017, the month he initially filed this claim, he offers only one conclusory sentence "that the most recent award is based on a modification resulting from mistake of fact." Claimant's Brief at 7. Because this argument is not adequately briefed, and no specific error is identified in the ALJ's conclusion that Claimant's entitlement is based on a change in conditions, I decline to consider it. 20 C.F.R. §802.211(b); *Cox v. Benefits Review Board*, 791 F.2d 445, 446-47 (6th Cir. 1986); *Sarf v. Director, OWCP*, 10 BLR 1-119, 1-120-21 (1987).