U.S. Department of Labor

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

BRB No. 20-0367 BLA

DARRELL G. MEADE	)	
	)	
Claimant-Petitioner	)	
	)	
v.	)	
	)	
DOMINION COAL CORPORATION	)	DATE ISSUED: 09/23/2021
	)	
Employer-Respondent	)	
	)	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR	)	
	)	
Party-in-Interest	)	DECISION and ORDER

Appeal of the Decision and Order Denying Benefits of Timothy J. McGrath, Administrative Law Judge, United States Department of Labor.

Darrell G. Meade, Cedar Bluff, Virginia.

Charity A. Barger (Street Law Firm, LLP), Grundy, Virginia, for Employer.

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

PER CURIAM:

Claimant appeals, without the assistance of counsel,[1] Administrative Law Judge (ALJ) Timothy J. McGrath's Decision and Order Denying Benefits (2017-BLA-06279)

[1] Vickie Combs, a benefits counselor with Stone Mountain Health Services of Vansant, Virginia, requested the Benefits Review Board review the ALJ's decision, but

rendered on a claim filed pursuant to the Black Lung Benefits Act, 30 U.S.C. §§901-944 (2018) (Act). This case involves a miner's claim filed on March 20, 2017.[2]

The ALJ credited Claimant with at least 37.39 years of coal mine employment based on the parties' stipulation and found Claimant performed all of his work underground. Because the evidence did not establish complicated pneumoconiosis at 20 C.F.R. §718.304, he found Claimant could not invoke the irrebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3) (2018). In addition, as the parties stipulated that Claimant is not totally disabled by a respiratory or pulmonary impairment, the ALJ further found Claimant was unable to 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), or to establish entitlement under 20 C.F.R. Part 718. *See* Joint Stipulations at 2. Accordingly, the ALJ denied benefits.

On appeal, Claimant generally challenges the denial of benefits. Employer responds in support of the denial. The Director, Office of Workers' Compensation Programs, did not file a response brief.

In an appeal filed by a claimant without the assistance of counsel, the Board addresses whether substantial evidence supports the Decision and Order below. *Hodges v. BethEnergy Mines, Inc.*, 18 BLR 1-84 (1994). We must affirm the ALJ's Decision and Order if it is rational, supported by substantial evidence, and in accordance with applicable law.[3] 33 U.S.C. §921(b)(3), as incorporated by 30 U.S.C. §932(a); *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

Section 411(c)(3) Presumption – Complicated Pneumoconiosis

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

---

she is not representing Claimant on appeal. *See Shelton v. Claude V. Keene Trucking Co.*, 19 BLR 1-88 (1995) (Order).

[2] Claimant filed two prior claims but withdrew them. Director's Exhibit 40. A withdrawn claim is considered not to have been filed. *See* 20 C.F.R. §725.306.

[3] This case arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit because Claimant performed his coal mine employment in Virginia. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Director's Exhibit 4; Hearing Transcript at 31-32.

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 which would yield results equivalent to (a) or (b). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. The ALJ must determine whether the evidence in each category tends to establish the existence of complicated pneumoconiosis, and then must weigh the evidence at subsections (a), (b), and (c) together before determining whether Claimant has invoked the irrebuttable presumption. *See Westmoreland Coal Co. v. Cox*, 602 F.3d 276, 283 (4th Cir. 2010); *E. Assoc. Coal Corp. v. Director, OWCP* [*Scarbro*], 220 F.3d 250, 255-56 (4th Cir. 2000); *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-33 (1991) (en banc).

The ALJ correctly noted there is no biopsy evidence for consideration. Decision and Order at 10. He found the x-ray, computed tomography (CT) scans, and medical opinion evidence insufficient to establish complicated pneumoconiosis. In so doing, however, he did not resolve conflicts in the evidence and failed to fully consider the rationales of the physicians. We therefore vacate the denial of benefits and remand the case for further consideration.

The ALJ's Findings

X-Ray Evidence

The ALJ considered nine interpretations of four x-rays. Decision and Order at 7-10. All the physicians who provided an interpretation are dually-qualified B readers and Board-certified radiologists, with the exception of Dr. Forehand who is only a B reader. *Id*. In addition, all diagnosed simple pneumoconiosis but disagreed on the presence of complicated pneumoconiosis. *Id*.

Dr. DePonte read a February 24, 2017 x-ray as positive for complicated pneumoconiosis, noting a 2.5 cm pseudoplaque over the right anterior second rib. Director's Exhibit 20. Dr. Adcock read the same x-ray as negative. Employer's Exhibit 2. Dr. DePonte also read a May 22, 2017 x-ray as positive for complicated pneumoconiosis, identifying a Category A opacity in the right upper lung zone, while Drs. Adcock and Forehand read it as negative for the disease.[4] Director's Exhibits 19, 20; Employer's Exhibit 2. Dr. Crum read a June 25, 2018 x-ray as positive for complicated pneumoconiosis, identifying a Category A opacity but not indicating its location. Claimant's Exhibit 1. Dr. Adcock read the same x-ray as negative for the disease. Employer's Exhibit 5. Dr. Alexander read an October 8, 2018 x-ray as positive for

[4] Dr. Ranavaya, dually qualified as a B reader and Board-certified radiologist, read the May 22, 2017 x-ray for quality purposes only. Director's Exhibit 19.

complicated pneumoconiosis, and identified areas of coalescence in both upper zones and two large opacities in the right upper lung with "a summed diameter of 35 mm." Claimant's Exhibit 5. Dr. Adcock read the same x-ray as negative for the disease. Employer's Exhibit 7.

The ALJ determined all the physicians are qualified to interpret x-rays. Decision and Order at 8. He found the readings of the February 24, 2017, June 25, 2018, and October 8, 2018 x-rays in equipoise for complicated pneumoconiosis as two dually-qualified radiologists gave conflicting readings of each of them. Decision and Order at 8-10. He found the May 22, 2017 x-ray "positive for simple pneumoconiosis" because one dually-qualified radiologist and one B reader read the x-ray as positive for simple pneumoconiosis but negative for complicated pneumoconiosis and one dually-qualified radiologist read it as positive for simple and complicated pneumoconiosis. Decision and Order at 9. As he found the record contains one x-ray positive for simple pneumoconiosis only, and the readings of the remaining x-rays in equipoise for complicated pneumoconiosis, he concluded Claimant did not establish complicated pneumoconiosis based on the x-ray evidence. 20 C.F.R. §718.304(a). Because it is supported by substantial evidence, we affirm the ALJ's determination that the x-ray evidence alone does not support a finding of complicated pneumoconiosis. 20 C.F.R. §718.304(a); *Compton v. Island Creek Coal Co.*, 211 F.3d 203, 207-08 (4th Cir. 2000); Decision and Order at 9-10.

Other Medical Evidence and Weighing the Evidence as a Whole

The ALJ also considered whether Claimant established complicated pneumoconiosis by "other means" and after weighing the evidence as a whole. 20 C.F.R. §718.304(c); Decision and Order at 10-14. Because his findings do not satisfy the Administrative Procedure Act (APA), we must vacate his decision and remand the matter for further consideration.[5]

Treatment Records/CT Scans

Claimant's treatment records from the Salem Veterans Affairs Medical Center include two CT scans taken on September 14, 2017 and January 26, 2018. Decision and Order at 10. Dr. Madan read the September 14, 2017 CT scan as showing a 1.7 cm x 0.6 cm dominant pleural-based nodule in the azygos lobe. Claimant's Exhibit 4 at 5-6. He

[5] The APA provides that every adjudicatory decision must include a statement of "findings and conclusions, and the reasons or basis therefor, on all the material issues of fact, law, or discretion presented . . . ." 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 30 U.S.C. §932(a).

diagnosed "occupational lung disease, pneumoconiosis, silicosis or sarcoidosis" with no evidence of interstitial lung disease. *Id*. Dr. Sherigar read the January 26, 2018 CT scan as showing bilateral nodular densities measuring approximately 1 to 5 mm and predominantly involving the upper and mid lobe regions with soft pleural plaques, "consistent with patient's known history of coal workers [sic] pneumoconiosis." She also indicated there was "[o]verall no significant change" from the prior September 14, 2017 CT scan. Claimant's Exhibit 4 at 3.

Dr. Abi Hatem, a pulmonologist with the Salem Veterans Affairs Medical Center, reviewed the September 14, 2017 CT scan and stated:

> Coal worker[s'] pneumoconiosis [CWP]: CT chest reviewed and compatible with simple CWP, no evidence of [progressive massive fibrosis (PMF)]. [C]linically he is [short of breath] and has productive cough but that could be explained by his [chronic obstructive pulmonary disease (COPD)] also. [H]e does have multiple nodules, pleural based and along the fissures, the biggest one is pleural based in the azygos lobe 1.7 cm x 0.5 cm, no weight loss, no hemoptysis. [N]one of the nodules have cavitated or are calcified. [H]owever he is a smoker so there is still risk for malignancy.

Employer's Exhibit 3 at 5. In an October 30, 2017 addendum, Dr. Abi Hatem noted:

> CT chest demonstrates multiple nodules, largest is 1.7 cm x 0.05 cm, although [PMF] is defined radiologically as presence of nodules larger than 2 cm in most of the literature, 1 cm cutoff has been used often to suggest it. [H]owever such large nodules raise also the concern for lung cancer, this is why while this is suggestive of possible PMF, will obtain short term imaging to identify enlargement since that would raise concern for underlying lung cancer.

Id. at 6.

Drs. DePonte and Adcock also interpreted the September 14, 2017 and January 26, 2018 CT scans. Claimant's Exhibit 2; Employer's Exhibits 1, 9. Dr. DePonte interpreted both scans[6] as showing coalescence in the right upper lobe with a 1.7 cm x 0.85 cm large opacity adjacent to the azygos vein that parallels the azygos fissure and "is in the typical location of a large opacity of complicated [CWP] otherwise known as [PMF]." Claimant's

[6] Dr. DePonte opined that the September 14, 2017 and January 26, 2018 CT scans "reveal similar findings." Claimant's Exhibit 2 at 2.

Exhibit 2 at 1. She additionally noted sub-pleural nodules with mid to upper zone predominance, which are within the lung parenchyma and coalesced to form large opacities measuring at least 1.9 cm and 1.2 cm in the left upper lung zone and 2.4 cm in the right upper lung zone. *Id*. at 1. Lastly, she noted "several other opacities" exceeding one centimeter that would be classified as category B large opacities because the sum of their greatest dimension exceeds 5 cm. *Id*. at 1-2. She opined that they are sub-pleural and do not represent pleural plaques due to asbestos exposure. *Id*. at 2.

Dr. Adcock diagnosed simple pneumoconiosis, noting nodular pleural pseudoplaques diffusely at the mid and upper lung level and in association with an azygos fissure.[7] Employer's Exhibit 1. He found no intraparenchymal fibrotic masses or emphysema. *Id*.

Subsequently, he reviewed the CT scans again to address the issue of whether "additional upper lobe changes represent large opacities consistent with complicated CWP or comprise pleural pseudoplaque formation, a manifestation of simple CWP." Employer's Exhibit 9 at 1. He diagnosed simple pneumoconiosis and extensive pleural pseudoplaque formation, but not complicated pneumoconiosis. Employer's Exhibits 1, 9. Furthermore, he identified multiple foci of coalescent subpleural small opacities in the upper lobe, apical pleura, and azygos fissure, and explained "[n]umerous authors have documented the occurrence of these pleural-based findings in simple CWP and their distinction from the intraparenchymal fibrotic large opacities characteristic of complicated CWP." Employer's Exhibit 9 at 1. He interpreted the CT scans as showing nodular excrescences deriving from the pleura, most conspicuous in the apices and in association with the azygos fissure, which "consists of four layers of pleura as opposed to the peripheral lung where only two layers are present." *Id*. Dr. Adcock found it not surprising that one of the larger pleural pseudoplaques is associated with the azygos fissure and "appears in the central aspect of the apical right upper lobe where, in the absence of an azygos lobe, no pleura is present." *Id*. at 1-2. He determined the opacity is "nearly 2 cm in length but only [0.7 cm] thick and has a broad-based attachment to the azygos fissure, its long axis running parallel to the pleura." *Id*. at 2. Dr. Adcock noted other similarly sized and oriented nodules in the upper lobes bilaterally, each demonstrating a subpleural epicenter. *Id*.

Weighing the CT scan evidence, the ALJ noted neither Dr. Madan nor Dr. Sherigar diagnosed complicated pneumoconiosis. He found it "unclear" if Dr. Abi Hatem possesses expertise in reading CT scans since her credentials are not in the record. Decision and Order at 14. In addition, he found Drs. DePonte and Adcock both well qualified to offer opinions on the CT scans. *Id*. at 13. He therefore initially found the readings of the CT

[7] Similar to Dr. DePonte, Dr. Adcock determined "there is no significant change between the two [CT] scans." Employer's Exhibit 9 at 1.

scan evidence to be in equipoise because Dr. DePonte interpreted the CT scans as positive for complicated pneumoconiosis and Dr. Adcock interpreted them as negative for the disease. *Id*. However, the ALJ further found Dr. Adcock's subsequent report "more instructive" than Dr. DePonte's report because "it provides an in-depth explanation on why he determined the CT scans showed simple pneumoconiosis and not complicated pneumoconiosis." *Id*. Conversely, he found Dr. DePonte's report, styled as an "Outside Study Radiology Report," entitled to less weight because it notes her observations but provides "little in the way of explanatory language to her conclusions." *Id*. The ALJ also noted Dr. DePonte did not expressly state that her opinion was given with a reasonable degree of medical certainty. *Id*. Thus, the ALJ concluded the CT scan evidence did not establish complicated pneumoconiosis. *Id*.

Medical Opinions

The ALJ further considered three medical opinions. Decision and Order at 13-14. Dr. Forehand conducted Claimant's Department of Labor-sponsored examination and diagnosed simple pneumoconiosis but no respiratory impairment. Director's Exhibit 19. In a supplemental report, he agreed with Dr. DePonte's opinion that Claimant's condition had progressed to complicated pneumoconiosis. Claimant's Exhibit 3. In contrast, Dr. Fino agreed with Dr. Adcock's CT scan opinion over Dr. DePonte's and determined Claimant did not have complicated pneumoconiosis. Employer's Exhibit 4.

Dr. McSharry agreed there is clear evidence of high profusion pneumoconiosis and that coalescent lesions are seen on x-ray, but concluded the evidence does not suggest PMF lesions are present. Employer's Exhibit 6. He considered it highly likely that the lesions interpreted on x-ray as Category A are the pseudoplaques observed on the CT scans, noting Dr. DePonte seemed to assert this connection explicitly in her February 24, 2017 x-ray reading. Employer's Exhibit 6 at 2. Dr. McSharry believed Drs. DePonte and Adcock "likely disagree on the issue of whether a pseudoplaque represents PMF" and believed "most clinical opinions of this issue favor Dr. Adcock's interpretation." *Id*. at 3. "Based on the described radiographic interpretations," Dr. McSharry opined there was no PMF, "although the conglomerate lesions seen on plain chest radiographs suggest the possibility that this may develop in the future." *Id*.

After summarizing the opinions of Drs. Forehand, Fino, and McSharry, and without addressing any of the conflicts in their opinions or their evaluations of the CT scans, the ALJ simply stated, "[u]pon careful consideration of the medical opinion evidence, I find it does not support a finding of complicated pneumoconiosis." Decision and Order at 14. Weighing all the evidence together, the ALJ concluded Claimant does not have complicated pneumoconiosis and therefore did not invoke the irrebuttable presumption.

Conflicts Remaining in the Evidence

There is no dispute that Claimant has a nodule measuring approx. 1.7 cm near the azygos fissure, and several other nodules of pneumoconiosis are present that could meet the requirements for complicated pneumoconiosis. Whether any of the nodules qualify requires resolution of the conflict in the opinions of Drs. DePonte and Adcock. The ALJ summarized the physicians' findings based on the CT scan evidence, but failed to consider their rationales and give a sufficient explanation for the weight he accorded the evidence. The ALJ must resolve the physicians' conflicting opinions on whether the nodules constitute complicated pneumoconiosis, rather than simply characterizing their reports and stating a conclusion.

Dr. DePonte diagnosed a large opacity in the parenchyma of the right upper lobe, parallel to the azygos vein, "in the typical location of a large opacity of complicated coal workers' pneumoconiosis otherwise known as progressive massive fibrosis." Claimant's Exhibit 2 at 1. In addition to that nodule, Dr. DePonte identified subpleural nodularity in all lung zones, with mid to upper zone dominance, that "coalesce to form large opacities" with "several" exceeding "one centimeter in greatest dimension" that also qualify as category B complicated pneumoconiosis. *Id.*, at 2-3.

Dr. Adcock considered the upper right lobe nodule and the "other similarly sized and oriented nodules" to be "pleural pseudoplaques"[8] of simple pneumoconiosis, distinct from the "intraparenchymal fibrotic large opacities characteristic of complicated pneumoconiosis." Employer's Exhibits 1, 9. Noting its two dimensional shape, Dr. Adcock contended the pleural pseudoplaque associated with the azygos fissure in the upper right lobe would not be present, absent the azygos lobe, and he concluded that none of the

[8] Dr. McSharry also defined pseudoplaques as:

> [V]ery peripheral lung lesions formed by coalescent nodules in pneumoconiosis. They are adjacent to the pleura (at the edge of the lung alongside the chest wall) and are shaped more like a piece of paper (very thin, mostly two dimensional) than a ball or a mass (rounded with 3 dimensions). PMF lesions are generally described clinically as masses. The term pseudoplaque is not one used to my knowledge in the general medical or radiological literature to describe a subclass of PMF lesions.

Employer's Exhibit 6.

other pleural pseudoplaques of simple pneumoconiosis qualified as "large opacities consistent with the ILO criteria." *See* Employer's Exhibit 9.

The ALJ did not address whether Dr. Adcock bases his conclusion on the location of the nodule in the pleura, the shape of the nodule, or both.[9] *Id*. The ALJ should address whether Dr. Adcock's statements correspond to the same nodules Dr. DePonte referenced as being "within the lung parenchyma" that coalesced to form large opacities measuring at least 1.9 cm and 1.2 cm in the left upper lung zone and 2.4 cm in the right upper lung zone. Claimant's Exhibit 2 at 1. If the ALJ concludes the nodules are located in the pleura, he must consider whether that precludes a finding of complicated pneumoconiosis. Case law discussing complicated pneumoconiosis when the nodules arise in the pleura rather than the parenchyma includes *Pittsburg & Midway Coal Mining Co. v. Director, OWCP* [*Cornelius*], 508 F.3d 975, 978-79 (11th Cir. 2007), and *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536, 1538 (11th Cir. 1993). *See also Fennell v. R & PCC, LLC*, BRB No. 17-0413 BLA (Aug. 6, 2018) (unpub.); *Boyd v. Clinchfield Coal Corp*., BRB No. 17-0111 BLA (Dec. 26, 2017) (unpub.). The Board also has issued decisions addressing opacities that exceed one dimension in only one direction. *See Werzbicke v. Consol Energy, Inc*., BRB No. 20-0117 BLA (Feb. 24, 2021) (unpub.); *Gregory v. Barnes & Tucker, Co*., BRB No. 19-0290 BLA (May 29, 2020) (unpub.); *Barbus v. Florence Mining Co*., BRB No. 05-0213 BLA (Jul. 29, 2005) (unpub.).

Further, even assuming that pleural pseudoplaques do not constitute complicated pneumoconiosis as Dr. Adcock alleges, the ALJ did not address whether Dr. Adcock's explanation applies only to the large pleural pseudoplaque associated with the azygous fissure or also to the other "similarly sized and oriented nodules" he identified in his report. Employer's Exhibit 9. The ALJ also did not address whether Drs. Adcock and DePonte have identified the same nodules in similar locations and whether any of those additional nodules constitute complicated pneumoconiosis. *See McCune v. Cent. Appalachian Coal Co.*, 6 BLR 1-996, 1-998 (1984) (Board lacks the authority to render factual findings to fill gaps in the administrative law judge's opinion).

Whether the location and dimensions of a nodule are sufficient to support a diagnosis of complicated pneumoconiosis under the Act requires the ALJ to make specific factual findings, taking into consideration the regulations, the statutory definition of complicated pneumoconiosis, the totality of the medical evidence, and relevant case law. 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. Because the ALJ did not resolve the conflict in the evidence, properly consider the rationales underlying the physicians' opinions, and

[9] The regulatory definition of clinical pneumoconiosis does not specifically exclude consideration of nodules in the pleural area. *See* 20 C.F.R. §718.201(a)(1).

render appropriate factual findings, we vacate his finding that the CT scan evidence is insufficient to establish the disease. *See* 30 U.S.C. §923(b); *Wojtowicz*, 12 BLR at 1-165. Further, because the medical opinions are based on the CT scan interpretations and the ALJ offered only a summary conclusion that the medical opinion evidence does not establish complicated pneumoconiosis, we vacate his determination. *See Wojtowicz*, 12 BLR at 1-165; Decision and Order at 13-14. We therefore vacate the ALJ's finding that Claimant did not establish complicated pneumoconiosis and thus failed to invoke the irrebuttable presumption. Decision and Order at 14-15.

Remand Instructions

On remand, the ALJ must reconsider whether Claimant has established complicated pneumoconiosis at 20 C.F.R. §718.304(c) based on the CT scan and medical opinion evidence. The ALJ must initially reconsider Drs. DePonte's and Adcock's CT scan reports. 20 C.F.R. §718.304(c). He must address the basis for their opinions and the validity of the reasons they provided for determining why Claimant does or does not have complicated pneumoconiosis. The ALJ should resolve any conflict in the location and shape of a nodule that the physicians identify and determine if any nodule satisfies the statutory definition of complicated pneumoconiosis. 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. The ALJ must also reconsider the medical opinions of Drs. Forehand, Fino, and McSharry in light of his CT scan findings. 20 C.F.R. §718.304(c). He must address the comparative credentials of the physicians, the explanations for their conclusions, the documentation underlying their medical judgments, and the sophistication of, and bases for, their diagnoses. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997). He must also adequately explain his findings in accordance with the APA. *See Wojtowicz*, 12 BLR at 1-165. The ALJ must also weigh all relevant evidence on the issue of complicated pneumoconiosis together, interrelating the evidence from each category, before determining whether Claimant invoked the Section 411(c)(3) presumption. *See Cox*, 602 F.3d at 283; *Scarbro*, 220 F.3d at 255-56.

If Claimant establishes he has complicated pneumoconiosis, he is entitled to the irrebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(3). 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304. The ALJ must then determine whether his complicated pneumoconiosis arose out of his coal mine employment.[10] 20 C.F.R. §718.203. If Claimant establishes complicated pneumoconiosis arising out of coal mine

[10] Based on the parties' stipulation that Claimant had 37.39 years of coal mine employment, he is entitled to a presumption that his pneumoconiosis arose out of his coal mine employment, with the burden shifting to Employer to rebut it. 20 C.F.R. §718.203(b).

employment, he is entitled to benefits. If the ALJ finds Claimant has not established complicated pneumoconiosis, he may reinstate the denial of benefits.

Accordingly, the ALJ's Decision and Order Denying Benefits is affirmed in part, vacated in part, and the case is remanded to the ALJ for further consideration consistent with this opinion.

SO ORDERED.

JONATHAN ROLFE
Administrative Appeals Judge

DANIEL T. GRESH
Administrative Appeals Judge

MELISSA LIN JONES
Administrative Appeals Judge