U.S. Department of Labor

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

BRB No. 25-0110 BLA

DOUGLAS M. ERWIN Claimant-Petitioner v. ROCKHOUSE CREEK DEVELOPMENT CORPORATION and BRICKSTREET MUTUAL INSURANCE COMPANY Employer/Carrier-Respondents DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR Party-in-Interest	))	**NOT-PUBLISHED** DATE ISSUED: 04/21/2026 DECISION and ORDER

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

Jonathan C. Masters (Masters Law Office PLLC), South Williamson, Kentucky, for Claimant.

John R. Sigmond (Penn, Stuart & Eskridge), Bristol, Virginia, for Employer.

David Casserly (Jonathan Berry, Solicitor of Labor; Jennifer Feldman Jones, Acting Associate Solicitor; William M. Bush, Acting Counsel for

Administrative Appeals), Washington, D.C., for the Director, Office of Workers' Compensation Programs, United States Department of Labor.

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

PER CURIAM:

Claimant appeals Administrative Law Judge (ALJ) Patricia J. Daum's Decision and Order Denying Benefits (2021-BLA-05929) rendered on a claim filed on March 6, 2019,[1] pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (Act).

The ALJ found Claimant did not establish complicated pneumoconiosis and therefore did 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); 20 C.F.R. §718.304. Although the ALJ credited Claimant with thirty-five years of underground, or substantially similar, coal mine employment, she found he does not have a totally disabling pulmonary or respiratory impairment, 20 C.F.R. §718.204(b)(2), and thus cannot invoke the rebuttable presumption of total disability due to pneumoconiosis at Section 411(c)(4) of the Act, 30 U.S.C. §921(c)(4).[2] And because Claimant therefore failed to establish disability, an essential element of entitlement, she denied benefits.

On appeal, Claimant argues the ALJ erred in finding he did not establish complicated pneumoconiosis.[3] Employer responds in support of the denial of benefits. The Director, Office of Workers' Compensation Programs (the Director), responds, urging the Benefits Review Board to vacate the ALJ's finding Claimant did not establish complicated pneumoconiosis.

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[1] Claimant filed a prior claim but withdrew it. Decision and Order at 2 (unpaginated); Director's Exhibit 2. A withdrawn claim is "considered not to have been filed." 20 C.F.R. §725.306(b).

[2] Section 411(c)(4) of the Act provides a rebuttable presumption that a miner is totally disabled due to pneumoconiosis if he has 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); 20 C.F.R. §718.305.

[3] We affirm, as unchallenged on appeal, the ALJ's finding that Claimant established thirty-five years of qualifying coal mine employment. *See Skrack v. Island Creek Coal Co.*, 6 BLR 1-710, 1-711 (1983); Decision and Order at 6, 24 (unpaginated).

The 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.[4] 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, 361-62 (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 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, would be a condition that could reasonably be expected to yield a result equivalent to (a) or (b). 20 C.F.R. §718.304. In determining whether Claimant has invoked the irrebuttable presumption, the ALJ must consider all evidence relevant to the presence or absence of complicated pneumoconiosis. *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 found Claimant failed to establish complicated pneumoconiosis by any method. 20 C.F.R. §718.304(a)-(c); Decision and Order at 30 (unpaginated). Claimant asserts the ALJ failed to rationally analyze the x-ray evidence and Claimant's treatment record evidence. Claimant's Brief at 2-12. We agree.

X-Ray Evidence – 20 C.F.R. §718.304(a)

The ALJ considered six interpretations[5] of two x-rays dated April 3, 2019, and October 22, 2021. Decision and Order at 26-28 (unpaginated). The ALJ noted all the interpreting physicians are dually-qualified Board-certified radiologists and B readers and therefore found them equally qualified. *Id.* at 27.

Dr. Crum read the April 3, 2019 x-ray as positive for both simple and complicated pneumoconiosis, Category A, while both Dr. Tarver and Dr. Seaman read it as negative for

[4] The Board will apply the law of the United States Court of Appeals for the Fourth Circuit because Claimant performed his last coal mine employment in West Virginia. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc); Hearing Tr. at 19-20.

[5] Dr. Gaziano interpreted the April 3, 2019 x-ray for quality purposes only. Director's Exhibit 21.

both types of the disease. Director's Exhibits 19 at 21; 24 at 4-5; 27 at 2. Dr. Kendall read the October 22, 2021 x-ray as positive for both simple and complicated pneumoconiosis, Category A, while both Dr. Tarver and Dr. Seaman again read it as negative for both. Claimant's Exhibit 1; Employer's Exhibits 1 at 37; 8. Because there are two negative readings and one positive reading of both x-rays, the ALJ found they are negative based on a preponderance of the readings. Decision and Order at 28 (unpaginated). She then gave less weight to both x-rays because Drs. Tarver and Seaman identified abnormalities that are not "wholly inconsistent with the broader definition of pneumoconiosis," and concluded the x-ray evidence does not support a finding of complicated pneumoconiosis. *Id.*

Claimant and the Director contend the ALJ did not adequately explain her findings that the April 3, 2019 and October 22, 2021 x-rays are, and the x-ray evidence as a whole is, negative for complicated pneumoconiosis. Claimant's Brief at 7-12; Director's Brief at 1-2. We agree.

Concerning the April 3, 2019 x-ray, Dr. Crum diagnosed opacities in all lung zones, identified a Category A opacity in the right lobe, and recommended a follow-up to exclude neoplasm. Director's Exhibit 19 at 21. Dr. Tarver opined the x-ray shows "a parenchymal band of scarring" and marked the symbol for "parenchymal bands - significant parenchymal fibrotic stands in continuity with the pleura." Director's Exhibit 24 at 5-6. Dr. Seaman stated the x-ray shows "focal air space opacities at the right lung base" that may represent atelectasis, infection, or aspiration. Director's Exhibit 27 at 2. Both Drs. Tarver and Seaman concluded the x-ray does not demonstrate simple or complicated pneumoconiosis.

Concerning the October 22, 2021 x-ray, Dr. Kendall noted mild scarring at the lung bases and identified a Category A opacity in the right lung. Claimant's Exhibit 1. Dr. Tarver read the x-ray as showing a right mid and lower lung opacity or nodule and recommended a computed tomography (CT) scan to rule out lung cancer. Employer's Exhibit 1 at 37, 38. Dr. Seaman noted the right mid and basilar air space opacities had increased since the April 3, 2019 x-ray, and are associated with mediastinal and hilar lymphadenopathy. Employer's Exhibit 8 at 1. She opined the opacities could represent "indolent neoplasm, such as adenocarcinoma or lymphoma," and recommended tissue sampling. *Id.* Again, both Drs. Tarver and Seaman opined the x-ray does not demonstrate simple or complicated pneumoconiosis.

The ALJ noted the abnormalities such as scarring and air space opacities that Drs. Tarver and Seaman identified in the right lung on the April 3, 2019 and October 22, 2021 x-rays. Decision and Order at 27-28 (unpaginated). She also noted that Drs. Crum and Kendall are consistent in their diagnosis of a Category A opacity in the right lung. *Id.* The

ALJ then concluded, for both x-rays, that the negative readings are entitled to more weight than the positive reading because there is "no objective basis upon which to favor" the positive readings. *Id.* But the ALJ also found the negative readings of Drs. Tarver and Seaman are not entitled to significant weight because the abnormalities they observed "do not appear to be wholly inconsistent with the broader definition of pneumoconiosis." *Id.* at 28.

The ALJ's conclusion does not follow its premises. While the ALJ stated there is no basis upon which to favor the positive readings over the negative readings, she specifically found the x-rays, which she determined are negative for simple and complicated pneumoconiosis, are entitled to reduced weight because Drs. Tarver's and Seaman's readings may be consistent with pneumoconiosis. Decision and Order at 27-28 (unpaginated). She also noted the positive readings of Drs. Crum and Kendall are consistent with each other, and Dr. Kendall's interpretation is consistent with Dr. Tarver's observation of scarring in the lung bases. *Id.* Thus, she failed to adequately resolve the conflict in the x-ray evidence or sufficiently explain her findings, as the Administrative Procedure Act (APA) requires.[6] *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992) (it is an abdication of rational decision-making to rely on the numerical superiority of the evidence); *Allen v. Union Carbide Corp.*, 8 BLR 1-393, 1-395 (1985) (preponderance of the evidence is evidence which is of greater weight or more credible and convincing than evidence offered in opposition to it, not necessarily evidence that is numerically superior); *Sea "B" Mining Co. v. Addison*, 831 F.3d 244, 256-57 (4th Cir. 2016); *Lane Hollow Coal Co. v. Director, OWCP* [*Lockhart*], 137 F.3d 799, 803 (4th Cir. 1998); *Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162, 1-165 (1989); Decision and Order at 27-28 (unpaginated). Consequently, we vacate the ALJ's findings that the April 3, 2019 and October 22, 2021 x-rays are negative for simple and complicated pneumoconiosis and that the x-ray evidence does not establish the presence of complicated pneumoconiosis.[7] 20 C.F.R. §718.304(a); Decision and Order at 27-28 (unpaginated).

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[6] The Administrative Procedure Act requires that every adjudicatory decision include "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).

[7] Claimant argues the ALJ "conflates the medical definition and legal definition of complicated coal workers' pneumoconiosis" by analyzing Drs. Tarver's and Seaman's x-ray readings for the presence of complicated pneumoconiosis instead of for the presence of large opacities. Claimant's Brief at 12-15. However, the regulations at 20 C.F.R. §718.304(a) require the presence of one or more large opacities (greater than one centimeter in diameter) that would be classified as Category A, B, or C in accordance with

Other Medical Evidence – 20 C.F.R. §718.304(c)

Claimant argues the ALJ erred in weighing the CT scans, biopsy evidence,[8] and medical opinions in Claimant's treatment records. Claimant's Brief at 3-7.

The ALJ considered thirteen readings of eight CT scans dated October 24, 2016, June 5, 2017, January 3, 2018, September 4, 2018, February 6, 2019,[9] May 7, 2019, and May 26, 2020.[10] 20 C.F.R. §718.304(c); Decision and Order at 13-15, 29 (unpaginated). Dr. Tarver read the October 24, 2016, September 4, 2018, and May 7, 2019 CT scans, and

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the International Labour Office (ILO) x-ray form. Claimant acknowledges neither physician provided measurements for the opacities they observed and, while Claimant characterizes the opacities they noted as "large opacities," neither physician referred to them as such in their x-ray interpretations or identified them as a Category A, B, or C opacity on the ILO x-ray forms. Claimant's Brief at 14; *see* Director's Exhibits 24 at 5-6, 27 at 2; Employer's Exhibits 1 at 37-38, 8 at 1-2. Thus, we reject Claimant's argument.

[8] Claimant does not specifically challenge the ALJ's finding that the biopsy evidence is insufficient to support a finding of complicated pneumoconiosis at 20 C.F.R. §718.304(b) and, therefore, the ALJ's finding is affirmed. *See Skrack*, 6 BLR at 1-711. However, Claimant does argue that the treatment biopsy evidence, when considered along with the treatment CT scans and medical opinions, supports a finding of complicated pneumoconiosis and undermines Drs. Tarver's and Seaman's opinions that the large opacities or nodules they observed are possibly due to cancer. *See* Claimant's Brief at 3-7. As explained more fully below, we vacate the ALJ's finding that Claimant's treatment records do not support a finding of complicated pneumoconiosis at 20 C.F.R. §718.304(c).

[9] In summarizing and weighing the CT scan evidence, the ALJ indicated Dr. Seaman provided a reading of a December 6, 2019 CT scan. Decision and Order at 14, 29 (unpaginated). However, the exhibit that the ALJ cites to indicates Dr. Seaman read the February 6, 2019 CT scan, and this is consistent with Employer's Evidence Summary Form, where it designates Dr. Seaman's reading of the February 6, 2019 CT scan. Employer's Exhibit 4 at 1; Employer's Evidence Summary Form at 8.

[10] In summarizing the CT scan evidence, the ALJ noted that Drs. Tarver and Seaman are dually-qualified as Board-certified radiologists and B readers and thus stated their readings are more reliable than the readings of the treating physicians in Claimant's treatment records because their credentials are unknown, with the exception of Dr. Aker, who is a B reader. Decision and Order at 13-15 (unpaginated). However, when weighing the CT scan evidence at 20 C.F.R. §718.304(c), she does not appear to rely on these credibility determinations. *Id.* at 29.

Dr. Seaman read the February 6, 2019 and May 26, 2020 CT scans, as negative for simple and complicated pneumoconiosis. Director's Exhibit 29 at 2, 4, 6; Employer's Exhibits 2, 4, 5. The ALJ found Drs. Tarver and Seaman "may have conflated the issue of the cause of pneumoconiosis with the existence of pneumoconiosis and in so doing excluded the large nodules observed from consideration as complicated pneumoconiosis," but their CT scan readings do not support a finding of complicated pneumoconiosis. Decision and Order at 29 (unpaginated).

In the CT scans from Claimant's treatment records, Dr. Compton identified a 1.4-centimeter nonspecific right upper lobe lung nodule with other scattered nodularity and mild hilar adenopathy measuring up to 1.6 centimeters on the October 24, 2016 CT scan. Claimant's Exhibit 2 at 8. Drs. Petty, Cure, Watson, and Akers observed the same or similarly sized nodules on the June 5, 2017, January 3, 2018, September 4, 2018, and September 17, 2018 CT scans, respectively. Director's Exhibit 22 at 19; Claimant's Exhibit 2 at 8, 15, 30, 39. Dr. Akers also identified a large nodule in the right upper lung measuring 2.1 by 1.4 centimeters on the February 6, 2019 CT scan, and 2.0 by 1.2 centimeters on the May 7, 2019 CT scan along with a subpleural patchy opacity in the right lower lobe. Claimant's Exhibits 2 at 72, 3 at 12. Finally, Dr. Compton identified a 2.5 by 1.7-centimeter nodule in the right upper lobe on the May 26, 2020 CT scan along with a stable irregular parenchymal opacity in the right lower lobe. Claimant's Exhibit 2 at 88.

The ALJ summarily referred to these CT scan readings as the "treatment record CT scans" and found that, while they "consistently record the existence of subpleural nodules with some measuring over [one centimeter]," they are not positive for complicated pneumoconiosis because none diagnosed "progressive massive fibrosis or complicated pneumoconiosis."[11] Decision and Order at 29 (unpaginated).

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[11] We note the ALJ indicated Claimant's treatment records "show nodules that may meet the size dimensions for a finding of complicated pneumoconiosis." Decision and Order at 29 (unpaginated). She also noted when evaluating Dr. Tarver's CT scan readings that "there is no equivalency statement in the record." *Id.* However, the United States Court of Appeals for the Fourth Circuit, within whose jurisdiction this claim arises, requires ALJs to perform equivalency determinations based on their evaluation of all the medical evidence of record. *E. Associated Coal Corp. v. Director, OWCP* [*Scarbro*], 220 F.3d 250, 255-56 (4th Cir. 2000); *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243-44 (4th Cir. 1999). Thus, the absence of a specific statement of equivalency by a physician is not a bar to establishing complicated pneumoconiosis. *See Scarbro*, 220 F.3d at 258 (while a physician who identified a 1.7-centimeter lesion on biopsy did not provide an equivalency determination, there was "no reason to believe that nodules of 1.7 centimeters would not produce x-ray opacities greater than one centimeter"); *see also Perry v. Mynu Coals, Inc.*,

Claimant asserts the ALJ failed to adequately consider the treatment CT scan evidence. Claimant's Brief at 3-7. In addition, Claimant contends the ALJ did not consider all relevant treatment evidence in concluding Claimant did not establish complicated pneumoconiosis. *Id.* Claimant argues the treatment records, when considered as a whole, support a finding of complicated pneumoconiosis. *Id.* Claimant's arguments have merit.

In summarizing the evidence and weighing it at 20 C.F.R. §718.304(b), the ALJ noted Claimant's treatment records contain the results of a November 30, 2016 needle biopsy of Claimant's right upper lung, an October 17, 2018 endoscopic bronchial ultrasound with needle aspiration of lymph nodes, and a November 1, 2018 CT guided right lung needle biopsy.[12] Decision and Order at 16, 22 (unpaginated). Director's Exhibit 22 at 23, 34-35, 54; Claimant's Exhibit 3 at 7-10. These procedures, as outlined below, found no evidence of malignancy. In addition, in summarizing Dr. Rosenberg's medical opinion, the ALJ indicated he evaluated some treatment records, including those from Jodi Biller, a nurse practitioner. Decision and Order at 21 (unpaginated). As outlined below, Nurse Practitioner Biller treated Claimant for his pulmonary issues and ultimately concluded Claimant has complicated pneumoconiosis based on his x-rays, CT scans, and biopsy results. Claimant's Exhibit 2 at 78. However, in weighing the evidence at 20 C.F.R. §718.304(c), and in weighing the evidence as a whole at 20 C.F.R. §718.304, the ALJ did not specifically consider this evidence.

Nurse Practitioner Biller began treating Claimant on November 10, 2016, based on a newly diagnosed 1.5-centimeter nodule in his right upper lobe with multiple other smaller nodules and mild hilar adenopathy. Claimant's Exhibit 2 at 2-7. Given the size and location of the nodule, she referred him to St. Mary's Medical Center for a CT-guided fine

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469 F.3d 360, 364-65 (4th Cir. 2006) (diagnosis of a "massive" opacity "becomes a proxy for the tissue mass characteristic of complicated pneumoconiosis" and satisfies the "statutory ground for application of the presumption").

[12] At 20 C.F.R. §718.304(b), the ALJ found the hospital pathologists "did not diagnose coal workers' pneumoconiosis or report findings that clearly indicated coal dust induced fibrosis." Decision and Order at 28 (unpaginated). She determined that Dr. Vey, who reviewed the November 30, 2016 right upper lung lobe needle biopsy and November 5, 2018 right lung needle biopsy, had credentials which "render him extremely well-qualified to render an opinion on the presence o[r] absence of evidence of coal workers' pneumoconiosis." *Id.* Noting that he opined that the limited materials available for evaluation are insufficient to support a diagnosis of coal workers' pneumoconiosis, she concluded that Claimant cannot establish complicated pneumoconiosis at 20 C.F.R. §718.304(b). *Id.*

needle aspiration. *Id.* at 6-7. On November 30, 2016, Claimant underwent a right upper lobe lung needle biopsy by Dr. Dougherty, who diagnosed benign bronchial cells and pulmonary histiocytes with no evidence of malignancy.[13] Director's Exhibit 22 at 54.

Nurse Practitioner Biller continued to treat Claimant for his pulmonary issues, including reviewing periodic CT scans and other testing. Claimant's Exhibit 2 at 9-14, 16-29. After Claimant's nodule increased from 1.4 centimeters to 1.9 centimeters in size, she recommended a Positron Emission Tomography (PET)-CT scan, which showed hypermetabolic areas of subpleural nodularity in the right lung that could be infectious or inflammatory but could not exclude malignancy. *Id.* at 41-48; Director's Exhibit 22 at 41. Based on Nurse Practitioner Biller's referral, Dr. Cooper evaluated Claimant and ordered a bronchoscopy on October 17, 2018, which did not show any evidence of malignancy and the cytology was suggestive of a granulomatous process. Claimant's Exhibit 3 at 1-11; *see* Claimant's Exhibit 2 at 48-64.

Nurse Practitioner Biller continued to periodically examine Claimant and review all of his related procedures and tests. Claimant's Exhibit 2 at 65-71. In a December 16, 2019 treatment note, she indicated Claimant was being seen for "a follow-up for coal workers['] pneumoconiosis with progressive massive fibrosis," as "confirmed by [endobronchial ultrasound] EBUS in 2018 pathology consistent with anthracosis." *Id*. at 74, 78. She stated Claimant's 1.9-centimeter right upper lobe lung nodule is negative for malignancy and there is no hypermetabolic uptake. *Id.* at 74. Subsequently, she continued to treat Claimant for his pulmonary issues, noting another increase in the right upper lobe nodule on May 26, 2020. *Id.* at 80-89.

On September 28, 2020, Claimant was seen by Jacob Short, a Certified Physician Assistant, who listed the chief complaint as coal workers' pneumoconiosis and chronic obstructive pulmonary disease, noted the increase in the size of Claimant's lung nodules, and indicated the practice would continue to monitor Claimant for any changes. Claimant's

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[13] Dr. Vey, a Board-certified medical examiner and pathologist, reviewed the tissue samples obtained from the November 30, 2016 needle biopsy of the right upper lobe and the November 1, 2018 needle biopsy of the right lung. Employer's Exhibit 3. He found the November 30, 2016 specimen showed "perivascular deposits of anthracotic pigment" and "[a] few birefringent crystals associated with silica." *Id.* at 2. In addition, he observed that the November 1, 2018 specimen showed "[p]erivascular anthracotic pigment deposition" and "[a] few microscopic densely clustered interstitial aggregates of macrophages (histiocytes)." *Id.*

Exhibit 2 at 92, 95. He saw Claimant again on March 29, 2021, for another monitoring visit. *Id.* at 100-03.

Because the ALJ failed to adequately consider the treatment CT scan readings documenting opacities both larger and smaller than one centimeter in diameter, with notations in the treatment records bearing on the nature of the opacities, the ALJ's determination that Claimant's treatment records neither support nor undermine a finding of complicated pneumoconiosis is unsupported by substantial evidence and not sufficiently explained in accordance with the APA. 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 30 U.S.C. §932(a); *Addison*, 831 F.3d at 256-57; *Wojtowicz*, 12 BLR at 1-165; *McCune v. Cent. Appalachian Coal Co*., 6 BLR 1-996, 1-998 (1984) (failure to discuss relevant evidence requires remand). Further, as Drs. Tarver and Seaman read CT scans contained in Claimant's treatment records, the ALJ's findings concerning the treatment records could affect her weighing of their interpretations. We must, therefore, vacate her determinations that Claimant did not establish complicated pneumoconiosis at 20 C.F.R. §718.304(c)[14] and that the evidence as a whole does not establish complicated pneumoconiosis.[15] 20 C.F.R §718.304; Decision and Order at 29-30 (unpaginated).

Remand Instructions

On remand, the ALJ must reconsider whether the evidence supports a finding of complicated pneumoconiosis. 20 C.F.R. §718.304. She must initially reconsider whether the x-ray evidence establishes complicated pneumoconiosis. 20 C.F.R. §718.304(a). In addition, she must consider the CT scan interpretations contained in Claimant's treatment records and reconcile any conflicts between these interpretations and the interpretations of the x-rays and CT scans found elsewhere in the record. *See Scarbro*, 220 F.3d at 255-56.

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[14] At 20 C.F.R. §718.304(c), the question is whether the other medical evidence would yield a diagnosis of one or more large opacities, or massive lesions in the lung. 30 U.S.C. §921(c)(3); *see e.g. Pittsburg & Midway Coal Mining Co. v. Director, OWCP* [*Cornelius*], 508 F.3d 975, 986-87 (11th Cir. 2007) (physician need not employ "magic words" – relevant question is whether the claimant met his burden to establish "a diagnosis of complicated pneumoconiosis under accepted medical standards").

[15] The ALJ found Dr. Ammisetty's diagnosis of complicated pneumoconiosis well documented but not well-reasoned because he did not consider the negative x-ray and CT scan readings of Drs. Tarver and Seaman. Decision and Order at 29 (unpaginated). Although Claimant does not specifically challenge this finding, because we have vacated the ALJ's findings concerning the x-ray and CT scan readings, we also vacate her finding that Dr. Ammisetty's medical opinion is entitled to little weight at 20 C.F.R. §718.304(c).

In doing so, she must consider the explanations for the physicians' conclusions, the documentation underlying their medical judgment, and the sophistication of, and bases for, their diagnoses, including evaluating the diagnoses the readers provided for the scarring and opacities they identified in Claimant's lungs. *See Cox*, 602 F.3d at 283 (ALJ must consider all relevant evidence and may discount x-ray readings where there is no evidence of the alternative diagnoses for large masses present on the x-rays); *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 533 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997); *Melnick*, 16 BLR at 1-33; 20 C.F.R. §718.304(a).

In addition, the ALJ must reconsider the medical opinion evidence and consider all relevant evidence in the Claimant's treatment records in evaluating whether the evidence supports a finding of complicated pneumoconiosis. 20 C.F.R. §718.304(c); *see Cox*, 602 F.3d at 283; *Melnick*, 16 BLR at 1-33. In considering whether Claimant has complicated pneumoconiosis, the ALJ is required to consider all the relevant evidence and weigh it together in reaching a conclusion as to the credibility of the evidence. *See Cox*, 602 F.3d at 283; *Scarbro*, 220 F.3d at 255-56 (in determining the presence of complicated pneumoconiosis, an ALJ must weigh all of the relevant evidence, considering whether it supports or undercuts evidence from the same and other categories). In this regard, the ALJ should also consider Claimant's argument that the biopsy and Claimant's treatment record evidence undermine the x-ray readings of Drs. Tarver and Seaman and support the readings that are positive for complicated pneumoconiosis. Claimant's Brief at 11-12. Simply acknowledging that certain types of evidence are positive while others are negative does not satisfy the explanatory requirements of the APA. *See* 5 U.S.C. §557(c)(3)(A); *Lockhart*, 137 F.3d at 803; *Wojtowicz*, 12 BLR at 1-165.

If Claimant establishes complicated pneumoconiosis, the ALJ must determine whether the complicated pneumoconiosis arose out of Claimant's coal mine employment before awarding benefits. *Daniels Co. v. Mitchell*, 479 F.3d 321, 337 (4th Cir. 2007); 20 C.F.R. §718.203(b).

If Claimant fails to establish complicated pneumoconiosis, the ALJ must reinstate her denial of benefits, as Claimant has not challenged, and we therefore affirm, the ALJ's determination that he failed to establish a totally disabling respiratory or pulmonary impairment at 20 C.F.R. §718.204(b)(2)(i)-(iv). *See Skrack v. Island Creek Coal Co*., 6 BLR 1-710, 1-711 (1983); Decision and Order at 32 (unpaginated).

Accordingly, we affirm in part and vacate in part the ALJ's Decision and Order Denying Benefits, and we remand the case for further consideration consistent with this opinion.

SO ORDERED.

DANIEL T. GRESH, Chief
Administrative Appeals Judge

JONATHAN ROLFE
Administrative Appeals Judge

GLENN E. ULMER
Administrative Appeals Judge