2016 IL App (4th) 160431WC-U

Order filed November 6, 2017

IN THE

APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

FILED
November 6, 2017
Carla Bender
4th District Appellate
Court, IL

WORKERS' COMPENSATION COMMISSION DIVISION

MYRON SIMS,	)	Appeal from the Circuit Court
	)	of the Seventh Judicial Circuit
	)	Sangamon County, Illinois
Appellant,	)	
	)	
v.	)	Appeal No. 4-16-0431WC
	)	Circuit No. 15-MR-78
	)	
ILLINOIS WORKERS' COMPENSATION COMMISSION, *et al.*, (Mike Frerichs, State Treasurer and Ex-Officio Custodian of The Rate Adjustment Fund and Freeman United Coal Mining Company, Appellees).	)	Honorable John P. Schmidt, Judge, Presiding.

PRESIDING JUSTICE HOLDRIDGE delivered the judgment of the court.
Justices Hoffman, Hudson, Harris, and Moore concurred in the judgment.

ORDER

¶ 1 *Held*: (1) The Commission's finding that the claimant did not suffer from an occupational disease in the form of CWP arising out of and in the course of his employment was not against the manifest weight of the evidence; (2) the Commission's finding that the claimant was not "disabled" under section 1(e) of the Illinois Workers' Occupational Disease Act was not against the manifest weight of the evidence; and (3) the Commission's finding that the claimant was not entitled to wage differential benefits was not against the manifest weight of the evidence.

¶ 2 The claimant, Myron Sims, appeals from a decision of the Illinois Workers' Compensation Commission (Commission) denying his claim for benefits under the Illinois Workers' Occupational Disease Act (Act) (820 ILCS 310/1 et seq. (West 2008)). The Commission found that the claimant failed to prove he suffered from an occupational disease, specifically coal workers' pneumoconiosis (CWP), and that he failed to prove that his current condition of ill-being was causally related to his employment with Freeman United Coal Mining Co. (employer). The Commission's decision reversed the award of the arbitrator, which found that the claimant suffered from an occupational disease (CWP) causally related to his employment and awarded permanent partial disability (PPD) to the extent of 10 percent of the person-as-a-whole. The claimant sought judicial review of the Commission's decision in the circuit court of Sangamon County. The circuit court confirmed the Commission's ruling. This appeal followed.

¶ 3 FACTS

¶ 4 The following factual recitation is taken from the evidence presented at the March 20, 2014, arbitration hearing. The claimant was 58 years old at the time of arbitration. He worked in coal mining for 38 years, the last 20 of which were spent underground. During the course of his coal mining career, the claimant was exposed to coal and silica dust, diesel fumes, and roof bolting glue fumes.

¶ 5 The claimant’s last coal mining exposure occurred on August 29, 2007, at the employer’s Crown II Mine in Virden, Illinois. The employer’s Crown II mine closed on that date. The claimant went on the panel for recall so that he could be called back to work by the employer. During the arbitration hearing, the claimant testified that, as far as he knew, he was still on the employer’s recall panel.

¶ 6 The claimant testified that he suffered from breathing problems, congestive heart failure, and deep vein thrombosis of the right leg. He also suffered from circulatory problems for the past 30 years. The claimant stated that, after he decided that he was not going back to work in the mine in September 2007, he applied for Social Security Disability benefits. The Social Security Disability application asked the claimant to identify any activities he had once been able to do but could no longer do, and to explain why he could no longer do them. The claimant answered that he could no longer walk, stand, sit, drive, lift, bend, twist, squat, or climb due to pain in his heart, back, feet, and legs. In the "Work History Report" section of the application, the claimant noted that he started having more pain and trouble with his present job in 2005. He indicated that the pain was in his lower back, right foot, and ankle. He also had excessive swelling of the right leg and thigh. The claimant did not indicate that he was experiencing any breathing problems.

¶ 7 The claimant testified that he began experiencing breathing problems in the mid-1990s while he worked as a rock duster. A rock duster spreads rock dust over the mine surfaces to prevent combustion of the coal. The rock dust that the claimant used was a fine powder that would float in the air and could become respirable. On one occasion in 1995, the claimant was working in the mines when rock dust was accidentally dumped on him through a chute, burying him. The claimant finished his shift that day, but required medical attention thereafter and missed several work days because of the incident. He had trouble breathing and was prescribed an inhaler, which he used occasionally while mining. The claimant stated that he has experienced breathing problems ever since the 1995 incident. He claimed that his breathing problems affected his ability to walk and prevented him from doing the work that he formally did

as a miner.[1]

¶ 8 The claimant testified that, due to his breathing and vascular problems, he bid for an "Outby" position (a semi-surface position which covered various jobs performed away from the coal face) in 2005. The claimant presented medical restrictions to the employer relating to vascular problems in his legs. The employer moved the claimant to an Outby position in 2005. The claimant remained in that position until the mine closed in August 2007.

¶ 9 On March 29, 2009, the claimant was examined by Dr. Robert Cohen, a Board Certified pulmonologist and B-Reader. Dr. Cohen has been the Senior Attending Physician of the Division of Occupational Medicine and the Director of the Black Lung Clinic program at Stroger Hospital of Cook County since 1993. He has been a B-reader since 1998. The claimant told Dr. Cohen that he had been experiencing shortness of breath for 20 years. He first noted it with strenuous exercise, and it had progressed gradually over the years. By the time of Dr. Cohen's examination, the claimant reported experiencing shortness of breath when he walked two blocks or climbed one flight of stairs. The claimant also reported experiencing a nonproductive cough for the past 20 years which had become more frequent over the years.

¶ 10 Dr. Cohen's examination of the claimant's chest revealed normal auscultation and percussion. The claimant's pulmonary function tests were mostly normal. The claimant's spirometry (*i.e.*, the volume and flow of air through his lungs) and blood gases at rest were within normal ranges. However, Dr. Cohen opined that the claimant had a diffusion impairment.[2] Dr. Cohen noted that a diffusion impairment is something that can been seen in people with CWP. However, Dr. Cohen also explained that diffusion impairment could also be

[1] The claimant testified that, at the time of arbitration, he was only able to walk 50 yards at a regular pace on level ground before becoming short of breath.

[2] The diffusion capacity measures the ability of the lungs to transfer gas from the alveolar space into the bloodstream.

caused by smoking in a patient who has emphysema. Dr. Cohen also noted that the claimant had smoked one and one-half packs of cigarettes per day since he was 20 years old (*i.e.*, for 36 years). He advised the claimant to stop smoking. Dr. Cohen further noted that the claimant had a significant medical history of congestive heart failure, pulmonary embolism, deep venous thrombosis, and herniated lumbar disc.

¶ 11 Dr. Cohen interpreted a February 11, 2009, x-ray of the claimant's chest as positive for CWP, category 1/0. According to Dr. Cohen, a category 1/0 is the lowest profusion rating the x-ray films could have been given and still be considered positive for CWP. Dr. Cohen opined that the February 11, 2009, x-ray showed a calcified granuloma as well as P/Q shaped opacities in all lung zones. Dr. Cohen made an identical interpretation of an earlier chest x-ray taken on October 9, 2007. Based on the claimant's history of exposure (*i.e.*, his 31-year history of working as a coal miner) and his positive chest x-rays for CWP, Dr. Cohen opined that the claimant had CWP. Dr. Cohen testified that, more likely than not, CWP will not progress once the exposure ceases. He could not form an opinion to a reasonable degree of medical certainty as to whether the claimant's CWP was progressing. Dr. Cohen opined that the best way for the claimant to avoid any progression of the disease would be for him to avoid exposure to any pulmonary toxins, including coal dust.

¶ 12 Dr. Cohen further opined that the claimant's diffusion impairment was causally related to his CWP. However, he conceded that the claimant's diffusion impairment could also be partially related to a prior pulmonary embolism. Dr. Cohen also opined that the claimant's chronic cough was causally related to his smoking history and to his history of exposure to coal mine dust. However, Dr. Cohen noted that coughing was also associated with sinusitis and with the use of ACE inhibitors such as Lisinopril, which the claimant was taking. He also stated that shortness

of breath has many causes, including deconditioning. He opined that the claimant's history of congestive heart failure was a confounding factor as to his shortness of breath. In sum, Dr. Cohen opined that the claimant had physiologically significant pulmonary impairment that could be causally related, at least in part, to his CWP. However, Dr. Cohen concluded that the claimant did not meet the criteria for diagnosis of chronic bronchitis.

¶ 13 Dr. Cohen does not get paid personally for his B-reader examinations, his review of a claimant's medical records, his preparation of expert reports, or his deposition testimony. The money charged for these services is donated to the Hospital's Occupational Medicine Research Fund. Although Dr. Cohen acknowledged that a patient's treatment records can be valuable in evaluating a patient for the presence and significance of an occupational disease, he did not review any of the claimant's treatment records in this case.

¶ 14 Dr. Henry Smith, a Board Certified radiologist and B-reader, interpreted a July 27, 2004, x-ray as positive for CWP, category 1/0 with P/S opacities in all lunch zones. Dr. Smith interpreted x-rays of July 28, 2004, October 9, 2007, and February 11, 2009, as positive for CWP, category 1/0, with P/S opacities in bilateral middle and lower lung zones. He noted small, calcified granuloma in the right lung on all the chest films. Dr. Smith also reviewed a CT scan dated July 27, 2004. He noted mild, diffuse interstitial fibrosis throughout the upper, mid, and lower lung zones consistent with radiographic type-P CWP. Dr. Smith also noted the presence of so-called "dust emphysema," a type of focal emphysema which is found most commonly in CWP with P-type changes.

¶ 15 Dr. Michael Alexander, a Board Certified radiologist and B-reader, interpreted the claimant's July 27, 2004, chest x-ray as positive for CWP, category 1/0 with P/P opacities in all lung zones. Dr. Alexander interpreted the claimant's July 28, 2004, x-ray as positive for CWP,

category 1/0 with P/P opacities in all lung zones except for the right lower zone. Dr. Alexander noted a calcified lung granuloma in the right mid lung zone and scarring or plate atelectasis in the left lower lung zone.

¶ 16 The employer introduced into evidence records from the National Institute of Occupational Safety and Health (NIOSH) of B-readings of the claimant's chest x-rays taken as part of the Coal Workers' Surveillance Program. A chest x-ray dated May 29, 1998, was interpreted by one B-reader as being negative for CWP. A second B-reader interpreted the film as 0/1 profusion with S/S opacities in the bilateral middle and lower lung zones. The claimant received a letter from NIOSH dated November 10, 1998, advising him that one of the physicians who reviewed his May 29, 1998, chest x-ray noted possible evidence of atelectasis (unspecified type), calcifications, and fibrosis. A chest x-ray taken on May 8, 2007, was interpreted by two B-readers as having no abnormalities consistent with CWP.

¶ 17 At the employer's request, Dr. Jerome Wiot reviewed several of the claimant's chest x-rays. Dr. Wiot is a Board Certified radiologist and B-reader. He was previously the president of both the American Board of Radiology and the American College of Radiology. As a member of the Task Force on Pneumoconiosis, Dr. Wiot helped to develop a weekend symposium which eventually became the B-reader program, and he has been a B-reader and a teacher in the B-reading program since the program started in 1970. Dr. Wiot reviewed x-rays of the claimant dated July 27, 2004, July 28, 2004, October 9, 2007, and February 11, 2009. According to Dr. Wiot, the 2004 films and the 2007 film showed a calcified granuloma in the right lung but no evidence of CWP and no other abnormalities. Dr. Wiot further opined that the 2009 film showed no evidence of CWP, but he found that film to be grossly overexposed.

¶ 18 Dr. Wiot also reviewed the claimant's July 27, 2004, CT scan. He interpreted the CT

scan as showing no evidence of CWP. The scan revealed a calcified granuloma in the right upper lung field laterally and a few linear strands, particularly in the right lung base. Dr. Wiot opined that the stranding could be attributable to any number of things, including a prior lung infection (such as pneumonia), prior pulmonary emboli, or hemorrhaging caused by prolonged anticoagulation therapy.[3] Dr. Wiot did not believe that the stranding in the claimant's lungs was evidence of CWP.

¶ 19 At the employer's request, the claimant's medical and radiological records (including the claimant's chest x-rays, CT scan, and the B-readings of Drs. Cohen, Smith, and Wiot) were reviewed by Dr. David Rosenberg. Dr. Rosenberg is a B-reader who is Board Certified in internal medicine, pulmonary disease, and occupational medicine. Dr. Rosenberg is the Medical Director of Corporate Health, the center for occupational medicine at the University Hospitals of Cleveland, where he treats patients for black lung disease. Dr. Rosenberg charged $3,320 for his medical records review and $1,500 for his deposition.

¶ 20 Dr. Rosenberg interpreted the claimant's x-rays and CT scan to be negative for CWP. He read the July 2004 x-rays and the October 2007 x-ray as 0/0 granulomatous changes in the right mid lung zone with atelectasis in the left costophrenic angle. Dr. Rosenberg also interpreted the February 2011 x-ray as 0/0 for the presence of micronodularity, although he opined that it was a markedly underexposed and marginal film. According to Dr. Rosenberg, the July 2004 CT scan revealed bibasilar atelectasis as well as a granuloma in the right upper lung lobe, but no micronodularity.

¶ 21 Dr. Rosenberg opined that, because the claimant's radiology showed no CWP micronodularity, his decreased diffusion capacity was caused by his thromboembolic disease, not

[3] Dr. Wiot explained that patients on anticoagulant therapy occasionally experience a small hemorrhage into their lungs. This causes stranding with fibrosis because the blood is an irritant to the lungs.

by CWP. He noted that the claimant had a genetic predisposition for developing blood clots and had been taking Coumadin for many years to treat this condition. Dr. Rosenberg explained that the diffusion capacity measures the function of the capillary bed in a patient's lungs, which can be partially destroyed if the patient develops blood clots in the lungs. He further noted that Coumadin can cause bleeding in the lungs which can also have an effect on the capillary bed. Dr. Rosenberg opined that category 1/0 changes shown on a patient's chest x-ray would not contribute to a low diffusion capacity.

¶ 22 Dr. Rosenberg further opined that the claimant's cough was causally related to the high dose of Lisinopril that the claimant was taking to treat his high blood pressure. He concluded that there was no evidence that the claimant had reactive airways disease based upon the most recent testing that he had, and that any conclusion to the contrary would be speculative. Dr. Rosenberg agreed that the claimant's 31-year history of coal mining could be sufficient to cause a cough. However, after reviewing the claimant's history of tobacco use and other potentially causative factors, Dr. Rosenberg opined that the most likely cause of the claimant's continued cough was medication or smoking, not his exposure to coal dust while coal mining.

¶ 23 Dr. Rosenberg noted that the claimant's medical records revealed that the claimant was covered by coal dust in a mine on one occasion in 1995. After reviewing the medical records relating to this incident (including the serial spirometry performed on the claimant), Dr. Rosenberg opined that, although the incident had initially affected the claimant's breathing, his pulmonary function improved into the normal range within a month of the incident and he suffered no permanent injury to his lungs as a result.

¶ 24 Some of the claimant's medical records were introduced into evidence. Following the 1995 incident, the claimant was treated by Dr. Stephen Jennison, a cardiologist at Prairie

Cardiovascular. Dr. Jennison noted in his medical records that the claimant had reported experiencing shortness of breath following an accidental dust exposure at work. The doctor administered a cardiopulmonary exercise study which revealed no pulmonary limitation on exercise but demonstrated a steep heart rate responsive curve compatible with deconditioning. According to Dr. Jennison's records, the claimant reported a history of developing shortness of breath "20 years ago" when he was diagnosed with pulmonary embolism. Two years later he was diagnosed with a deep vein thrombosis (DVT) that resulted in a chronically swollen right leg. The doctor noted that the 1995 accident caused an acute exacerbation of the claimant's shortness of breath which took the claimant some months to recover from. On examination, the claimant's respiratory system was clear. Dr. Jennison concluded that the claimant had a remote history of significant pulmonary embolus that may have caused a degree of permanent pulmonary vascular damage, presenting with shortness of breath syndrome that appeared temporarily related to the acute dust exposure that occurred during the 1995 accident. Dr. Jennison wrote a note suggesting that the claimant's placement at the mine should be changed because he was currently experiencing respiratory symptoms associated with the exhaust fumes from the mines.

¶ 25 In April and November of 1995, the claimant underwent pulmonary function studies at St. Vincent Hospital (St. Vincent). The studies revealed normal lung function except for a slightly reduced diffusing capacity, which the examining doctor thought was most likely caused by cigarette smoking. The doctor noted that the claimant's diffusion capacity had improved from the previous test in April 1995.

¶ 26 The claimant was seen at the Springfield Clinic (Springfield) on May 7, 1993. His right leg was swelling at that time. His lungs were clear. The assessment was postphlebitic

syndrome, history of pulmonary emboli, lifelong Coumadin use, hyperlipidemia and hypertriglyceridemia. On February 8, 1995, the claimant returned to Springfield complaining that his right leg was bothering him more and more all of the time. His lungs were still clear at that time. He was advised to quit smoking.

¶ 27 The claimant returned to Springfield on March 15, 1995. He reported that he had a cough and was having difficulty breathing even since a load of coal dust was dumped on him while he was working in a coal mine. The treating doctor noted diminished breath sounds and an occasional, scant wheeze. Pulmonary function tests showed a mixed restrictive/obstructive pattern with a low diffusing capacity suggesting an interstitial component. The assessment was acute bronchitis and pneumonitis secondary to dust exposure. Nine days later, the claimant continued to experience a little coughing and some shortness of breath upon exertion, but his pulmonary function tests showed significant improvement. He was advised to quit smoking. When the claimant returned to Springfield for follow-up testing on April 26, 1995, his pulmonary function tests were satisfactory. The claimant was asymptomatic and reported no shortness of breath. The assessment was pneumonitis secondary to dust exposure, completely resolved. The claimant was again advised to quit smoking.

¶ 28 On September 5, 1995, the claimant told one of his treating doctors that he had experienced shortness of breath upon exertion ever since the 1995 incident. The doctor noted that, given the claimant's history of DVT's, pulmonary emboli must be considered. The claimant's lungs were clear upon examination. During a follow-up examination approximately three weeks later, the doctor noted that the claimant had experienced an inflammation, probably from dust exposure, which had improved with steroids. The claimant's lungs were clear, and his oximetries were normal both at rest and with exertion. The claimant was seen again on January

22, 1995. At that time, he again reported experiencing shortness of breath upon exertion since the dust exposure at work in March 1995. He denied having a chronic cough but admitted that he was still smoking. His lungs were clear to auscultation.

¶ 29 In 1997, the claimant returned to Springfield complaining of a nonproductive cough, fever, and other symptoms. He denied experiencing any shortness of breath or wheezing at that time. He was diagnosed with sinusitis and pharyngitis (*i.e.*, inflammation of the pharynx or "sore throat").

¶ 30 On July 27, 2004, the claimant went to the emergency room at St. Vincent with complaints of shortness of breath, chills, and fever. He was initially diagnosed with probable pneumonia, but was ultimately diagnosed with viral bronchitis.

¶ 31 On February 8, 2007, the claimant was seen at St. Vincent due to an abnormal stress test. He reported experiencing intermittent chest discomfort on the left side of his chest for the past two years, but denied any associated shortness of breath. He also denied experiencing a chronic cough. He was still smoking at that time and had a 30-pack-year smoking history. A February 23, 2007, x-ray showed clear lungs with scattered calcified granuloma. On March 29, 2007, the claimant reported a significant improvement in his overall cardiovascular status following a cardiac catheterization. At that time, he denied experiencing chronic cough or shortness of breath upon resting or exertion. He denied these symptoms again during a follow-up examination on January 10, 2008. His chest was again clear to auscultation.

¶ 32 On September 4, 2009, the claimant filled out and signed a patient medical history form at the Springfield Eye Clinic (SEC) in which he indicated that he suffered from congestive heart failure but denied experiencing respiratory problems, including asthma, shortness of breath, or emphysema. When the claimant completed and signed another patient medical history form at

the SEC on September 3, 2010, he did not indicate that he was experiencing any shortness of breath, coughing, or wheezing.

¶ 33 The claimant returned to Springfield on February 7, 2012, with a chief complaint of postphlebitic syndrome and varicose veins. Although he was still smoking at the time, he did not have a chronic cough and his lungs were clear to asculation. His lungs were also clear upon examination during a subsequent visit on September 18, 2013.

¶ 34 The parties also introduced records of the Social Security Administration (SSA) relating to the claimant's October 2007 application for social security disability benefits. In support of that application, the claimant was required to submit a disability report listing the illnesses, injuries, and conditions that limited his ability to work. In his disability report, the claimant referenced congestive heart failure, poor vision in his left eye, two herniated discs, and deep vein blood clots in his right leg, foot, and ankle. In the application's "Activities of Daily Living Questionnaire for Physical Impairments," the claimant indicated that his activities were limited because of pain in his heart, back, legs, and feet. The SSA granted the claimant's application for disability benefits and determined that his disability began on August 28, 2007. The SSA stated that the primary diagnosis for which the claimant received Social Security Disability benefits was varicose veins of the lower extremities/chronic venous insufficiency.

¶ 35 June Blaine, a vocation rehabilitation counselor, testified on the claimant's behalf. After reviewing the claimant's background, education, and work history (but not his medical records), Blaine opined that the claimant was not employable in an open labor market and that, if he could find a job, it would be at a minimum wage level of $8.25 per hour.

¶ 36 The arbitrator found that the claimant proved that he suffered from CWP as a result of his exposure to the hazards of coal mining. The arbitrator resolved the conflicting radiographical

interpretations in the claimant's favor. She found Dr. Cohen's opinions to be more credible than those of Drs. Wiot and Rosenberg because Dr. Cohen had good credentials, he had personally examined the claimant, and he was not paid for his services. Although the arbitrator acknowledged that Dr. Cohen had not reviewed the claimant's medical records before issuing his opinions, she noted that the Commission had previously ruled that medical records "can be of little value when it comes to radiographic [CWP]." Moreover, the arbitrator noted that Dr. Cohen's interpretation of the claimant's x-rays as positive for CWP was corroborated by Drs. Smith and Alexander, both of whom were B-readers.

¶ 37 The arbitrator conceded that the employer's experts were "well qualified." However, she found that they "appear[ed] to have a financial interest in performing examinations for coal companies," a fact which "[went] to the weight of their opinions." In addition, the arbitrator observed that Drs. Wiot and Rosenberg each acknowledged that radiographically significant CWP can exist despite normal physical examination, normal pulmonary testing, and absent any symptoms. Although the arbitrator acknowledged that two NIOSH B-readers found the claimant's May 8, 2007 x-ray film to be negative for CWP, she noted that Dr. Lisa Wichterman (another NIOSH B-reader) found parenchymal abnormalities consistent with CWP in the May 29, 1998, x-ray film.

¶ 38 The arbitrator also found that the claimant had occupationally-related chronic cough and mild pulmonary impairment. The arbitrator concluded that the claimant's medical records supported the diagnosis of these conditions, and that "the credible testimony of Dr. Cohen indicate[d] that exposures in the mine would contribute to the development of these conditions."

¶ 39 Further, the arbitrator found that the claimant had proven "disablement" pursuant to section 1(e) of the Act (820 ILCS 310/1(e) (West 2008)) because it found that the claimant had

proven both that he had CWP and that he could not return to mining without risking the progression of his CWP. In support of the latter finding, the arbitrator relied upon: (1) Dr. Cohen's recommendation that the claimant avoid any exposure to pulmonary toxins, including coal dust; and (2) Dr. Wiot's and Dr. Rosenberg's acknowledgement that, to prevent the progression of CWP, one must minimize his exposure to coal dust.

¶ 40 The arbitrator found that the claimant had failed to prove that he was entitled to a wage differential award under section 8(d)(1) of the Illinois Workers' Compensation Act (IWCA) (820 ILCS 305(8)(d)(1) (West 2008)) because the claimant failed to prove that the respiratory conditions resulting from his coal dust exposure precluded him from working as a coal miner. (The arbitrator stressed that no physician had so testified. To the contrary, in his expert report, Dr. Cohen opined that: (1) the claimant's diffusion impairment was mild and did not totally disable him from working as a coal miner; and (2) an individual with simple CWP may have further exposure to coal dust without causing the disease to progress.) Nevertheless, the arbitrator found that the claimant was permanently partially disabled under section 8(d)(2) of the IWCA (820 ILCS 350/8(d)(2) (West 2008)) to the extent of 10 percent of the person-as-a-whole due to his work-related CWP, chronic cough, and mild pulmonary impairment. Accordingly, the arbitrator awarded the claimant PPD benefits pursuant to that section.

¶ 41 The Commission unanimously reversed the arbitrator's decision. The Commission found that the claimant had "failed to prove he sustained an occupational disease arising out of and in the course of his employment or which had become aggravated and rendered him disabled as result of the exposure of his employment" and "failed to prove there is a causal connection between his current condition of ill-being and the exposure on August 29, 2007." The Commission disagreed with the arbitrator's findings that the claimant suffered from CWP as a

result of his exposure to the hazards of coal mining and that he had a chronic cough and mild pulmonary impairment related to such exposure.

¶ 42 The Commission "to[ok] exception" to the arbitrator's conclusions that Dr. Cohen was not paid for his services and that the employer's experts had a financial interest in performing examinations for the employer. The Commission held that these "[were] not distinctions that should be used as a basis for assigning more weight to one side than the other." Although the Commission acknowledged that Dr. Cohen "may not see a direct remuneration for his services," it inferred that "he does not work for free for the hospital and he draws a salary for his services." The Commission found that this fact placed Dr. Cohen "on an even playing field with the other experts in this case," and that his opinions should therefore be weighed equally with the other doctors' opinions" and not given a greater weight. In any event, the Commission ruled that, "all things being equal[,] the financial interest of the experts should not be a factor in the assignment of weight given to their respective opinions."

¶ 43 Moreover, the Commission found that, "regardless of the experts' representation[s], there is additional evidence contained in the record of independent B-reader interpretations which acts as tie breaker between the paid experts." The Commission found it significant that three of the four NIOSH B-readers who interpreted of the claimant's chest x-rays found them to be negative for CWP. The Commission found that the sole NIOSH B-reader who found evidence of CWP was "the only one [that was] questionable." That B-reader found that the claimant's May 8, 2007, chest x-ray showed parenchymal abnormalities consistent with pneumoconiosis. However, the same B-reader found a category 0/2 protrusion rate, which is deemed to be negative for CWP. The Commission noted that Dr. Cohen testified that the

profusion rating on a film cannot be lower than 1/0 where and still be deemed positive for CWP.[4]

¶ 44 The Commission also found it significant that all of the chest x-rays taken after May 8, 2007, were found to be negative for CWP by Dr. Wiot, Dr. Rosenberg, and two NIOSH B-readers. Although Drs. Cohen and Anderson found the claimant to be positive for CWP, they "found a profusion of 1/0, which is the least rating one can have and have it still be positive." Moreover, the Commission noted that, of all the post May 8, 2007, chest x-rays that were reviewed by NIOSH and the parties' experts, only two of the NIOSH films were rated as "quality 1" films, and both of those films were deemed to be negative for CWP.

¶ 45 Further, the Commission found that the claimant's medical records did not support the claimant's claim of work-related disablement.[5] The medical records revealed only one "acute" incident (the 1995 incident) which occurred twelve years before the claimant's last exposure. The claimant was treated for symptoms following that incident and his pulmonary tests returned to normal. The Commission found that, although the claimant alleged that he experienced shortness of breath from 1995 forward and Dr. Cohen diagnosed a chronic cough, the claimant's medical records did not support these claims. Rather, the records "show[ed] numerous instances of * * * findings of clear lungs, denial of chronic cough and [shortness of breath]." Moreover, the Commission found that there were "other explanations for the mild low diffusion capacity, which was still found within normal limits." In addition, the Commission observed that the B-

[4] The Commission further observed that the B-reader who found evidence of CWP provided a written commentary at the end of her report which "parallel[ed] the findings made by Dr. Rosenberg."

[5] Because Dr. Rosenberg testified that B-readings were meant to serve only as "a screening method for changes on chest x-rays" and were "never developed to be diagnostic tests," the Commission found it was "important to look at all of evidence presented and specifically whether or not the doctors reviewed [the claimant's] * * * medical records." The Commission noted that Dr. Rosenberg reviewed all of the claimant's medical records, while Dr. Cohen did not review the claimant's medical records and instead relied entirely on the history that the claimant provided regarding his work, symptomatology and medical treatment.

readings of the claimant's chest x-rays by both sets of experts "appeared to get better and not worse the closer the readings got to [the claimant's] alleged disablement date," and "the most recent x-rays reviewed only three months prior to [the claimant's] last date of exposure were negative for CWP."

¶ 46 The Commission also pointed to other record evidence that further undermined the claimant's claim that he had suffered a disablement (*i.e.*, a functional disability or an impairment which results in a loss of earning capacity) as a result of his work-related exposure to coal dust. For example, the claimant testified that he bid for semi-surface type jobs such as the outby position because of his vascular issues, not because of CWP. Moreover, the evidence shows that the claimant stopped working in the mine because it closed down and not because he was disabled to the point where he could no longer work. The claimant was working up until and including the date that the mine closed. When the claimant was asked whether he would still be working had the mine not shut down, he answered in the affirmative. After the closure of the mine, the claimant placed himself on a panel to continue working in the mine, albeit on the surface (as was his right given his level of seniority). In addition, the claimant started collecting unemployment while representing to state of Illinois that he was capable of working. Moreover, in his Social Security Disability application (which was filed within one month of the mine's closing), the claimant asserted that he was eligible for disability benefits because of his congestive heart failure, poor vision in the left eye, herniated discs, and DVTs of the right leg; he did not claim disability due to shortness of breath, chronic cough, or CWP.[6] Further, upon retiring from the mine, the claimant applied for and received a full pension, not a disability pension. At the time of arbitration, the claimant was not treating for CWP and he had not

[6] References to shortness of breath and chronic cough appeared only in the application's list of medical histories; these symptoms did not form the basis for the claimant's claim for disability benefits.

received any treatment via a bronchodilator since the 1995 incident. Moreover, although Dr. Cohen opined the claimant was precluded from working as a coal miner due to his CWP, his expert report indicated that the claimant had a mild impairment that did not totally disable him from coal mining employment. The Commission noted that "none of the doctors testified that that the claimant was unable to perform coal miner work."

¶ 47 Accordingly, the Commission found that the claimant "would not have been precluded from working as a coal miner in an above ground position so long as his position no further exposed him to silica/coal mining dust." The Commission also found that the claimant "would not be able to prove up the first prong of a wage differential award in that he is not prevented from pursuing his usual and customary line of employment."

¶ 48 The claimant sought judicial review of the Commission's decision in the circuit court of Sangamon County. The circuit court confirmed the Commission's ruling. The circuit court found that the claimant had urged the court to "re-weigh the medical evidence presented and [to] give greater weight to the testimony" of the claimant's medical experts. The court refused to do so, and found that there was sufficient evidence presented to support the Commission's decision.

¶ 49 This appeal followed.

¶ 50 ANALYSIS

¶ 51 On appeal, the claimant first argues that the Commission's finding that he failed to prove that he suffered from an occupational disease was both against the manifest weight of the evidence and erroneous as a matter of law.

¶ 52 The claimant in an occupational disease case has the burden of proving both that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*,

2013 IL App (5th) 120564WC, ¶ 20; *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467 (2001). Whether an employee suffers from an occupational disease and whether there is a causal connection between the disease and the employment are questions of fact. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 20; *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 597 (2005). It is the function of the Commission to decide questions of fact, judge the credibility of witnesses, assign weight to be accorded the evidence, and resolve conflicting medical evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 20; *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009).

¶ 53 The Commission's determination on a question of fact will not be disturbed on review unless it is against the manifest weight of the evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 20. For a finding to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Id.*; *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 539 (2007). "The test is not whether this or any other tribunal might reach an opposite conclusion but whether there is sufficient factual evidence in the record to support the Commission's determination." *Navistar International Transportation Corp. v. Industrial Comm'n*, 331 Ill. App. 3d 405, 415 (2002). "A reviewing court will not reweigh the evidence, or reject reasonable inferences drawn from it by the Commission, simply because other reasonable inferences could have been drawn." *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64 (2006).

¶ 54 The Commission's finding that the claimant failed to establish that he had CWP was amply supported by the evidence. The Commission's finding rested upon the opinions of the employer's experts, Drs. Wiot and Rosenberg, and on the opinions of two independent NIOSH B-readers, all of whom interpreted various x-rays of the claimant's chest to be negative for CWP.

The claimant's May 8, 2007, x-rays were interpreted as negative for CWP by two independent NIOSH B-readers, and his October 9, 2007, and February 11, 2009, x-rays (his most recent x-rays) were interpreted as negative for CWP by Drs. Wiot and Rosenberg. Although Drs. Cohen, Smith, and Anderson found the claimant to be positive for CWP, they all found the claimant to be at category 1/0, which Dr. Cohen testified is the lowest profusion rating the x-ray films could have been given and still be considered positive for CWP. All of the expert B-readers who rendered opinions in this case were well qualified to opine as to whether the claimant demonstrated radiological CWP, and there was a difference of opinion among them. Unless the evidence on one side is so compelling as to render the opposite conclusion clearly apparent, we must defer to the Commission, which is uniquely situated to weigh competing medical evidence and to resolve any evidentiary conflicts. *Steak 'n Shake v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150500WC, ¶ 43; *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 505 (2004). Here, it cannot be said that the conclusion opposite that reached by the Commission is clearly apparent. Rather, there was credible evidence on both sides, making the Commission the ultimate decision maker.

¶ 55 The claimant argues that the Commission erred by failing to recognize the financial incentives of the employer's expert witnesses when evaluating their credibility. The claimant notes that Drs. Wiot and Rosenberg were paid thousands of dollars for their B-readings and for the expert testimony they provided in this case, while the claimant's chief expert, Dr. Cohen, was paid nothing. The claimant maintains that the Commission erred by finding, based on no evidence, that Dr. Cohen was paid indirectly for the work he performed in this case merely because he drew a salary from the hospital to which he donated the money he earned as an expert witness. According to the claimant, the amount paid to a witness is an "extremely probative

measure of bias," and the Commission's failure to consider the potential financial biases of the employer's witnesses when evaluating their credibility was reversible error.

¶ 56 We do not find these arguments to be persuasive. As an initial matter, the mere fact that a medical expert is paid for the time he spends testifying or preparing an expert report, without more, is not necessarily evidence of bias. See *Illinois Piping Co. v. Industrial Comm'n,* 156 Ill. App. 3d 955, 959 (1987) (ruling that it was "an unfair inference that [a doctor paid by the claimant] was somehow biased in giving his opinion because he was paid for the time spent in preparing [his] report, where "[t]here was no evidence in the record to support a claim of bias or prejudice on the part of [the doctor]"). Accordingly, the Commission was not required to find that the employer's witnesses lacked credibility merely because they were retained and paid by the employer. The Commission's credibility determinations will not be disturbed on review unless they are against the manifest weight of the evidence. *Shafer v. Illinois Workers' Compensation Comm'n,* 2011 IL App (4th) 100505WC, ¶¶ 35–36. Here, we cannot say that the Commission's decision to credit Dr. Wiot's and Dr. Rosenberg's opinions over the opinions of Drs. Cohen, Smith, and Alexander was against the manifest weight of the evidence.

¶ 57 In any event, even assuming *arguendo* that the Commission erred by refusing to consider evidence of potential bias on the part of the employer's retained experts (and by incorrectly assuming that Dr. Cohen was also paid for his work in this case), we would still affirm the Commission's decision. In finding that the claimant had failed to prove that he had CWP, the Commission also relied upon the opinions of two independent NIOSH B-readers who found that the claimant's May 8, 2007, x-ray was negative for CWP. The claimant does not allege that these B-readers were paid for their B-readings or that they were biased in any way.

¶ 58 The claimant also argues that the Commission erred by relying upon x-rays taken in 2007

and 2009 in finding that the claimant did not have CWP. He notes that CWP is a latent and progressive disease that may be detectable only after the cessation of coal mine dust exposure (see 20 C.F.R. § 718.201(c)) and that, under the Act, the claimant had more than two years from the date of his last exposure (*i.e.*, until August 29, 2009) during which his CWP could have become apparent radiographically. The claimant also notes that Dr. Wiot testified that CWP cannot be "ruled out" based solely on negative readings of chest x-rays. From these undisputed facts, the claimant argues that the Commission committed reversible error by finding that he did not have CWP based upon x-rays taken before August 2009.

¶ 59 We disagree. To obtain benefits under the Act, the claimant bears the burden of proving an occupational disease, such as CWP, by a preponderance of the evidence. It is not the employer's burden to prove the absence of CWP (*i.e.*, to "rule out" the existence of CWP). The claimant attempted to carry his burden in this case by presenting the testimony of experts who interpreted certain x-rays of the claimant's chest as positive for CWP. The employer rebutted this evidence by presenting the testimony of other experts who interpreted the same x-rays to be negative for CWP. This created a conflict in the medical opinion evidence which was for the Commission to resolve. The Commission's finding that the claimant failed to prove that he had CWP was sufficiently supported by the evidence. The opposite conclusion was not clearly apparent. Accordingly, we must defer to the Commission's finding even though the employer's evidence did not definitively "rule out" the possibility that the claimant had CWP.

¶ 60 In addition, the Commission's finding that the claimant failed to prove disablement caused by any work-related condition was sufficiently supported by the evidence. To prove disablement under the Act, the claimant must show either an impairment or partial impairment in bodily function or a diminished earning capacity as a result of an occupational disease or

condition. 820 ILCS 310/1(e) (West 2008)). If the claimant had proven that he had CWP, he would have also established disablement as a matter of law. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶¶ 35-36 (Hoffman, J., specially concurring, joined by Holdridge, P.J., and Stewart, J.). As shown above, however, the claimant did not prove that he had CWP. Moreover, although the claimant notes that his medical records show that he was repeatedly diagnosed with acute bronchitis and bronchiospasm, he does not argue that these symptoms were causally related to his work as a coal miner rather than his 31-year history of cigarette smoking or any of his other documented health problems.[7] Nor has he identified any medical opinion to that effect presented by a treater or a testifying expert. To the contrary, Dr. Cohen, one of the claimant's own experts, opined that the claimant did not meet the diagnostic criteria for chronic bronchitis.

¶ 61 There was conflicting evidence as to whether the claimant had any other chronic symptoms or conditions that were causally related to his occupational exposure to coal dust. Although the claimant alleged that he experienced shortness of breath since the 1995 work incident 1995 and Dr. Cohen diagnosed a chronic cough, the claimant's medical records showed that the claimant had repeatedly denied experiencing chronic cough or shortness of breath, particularly during medical appointments occurring between 2007 and 2012. Upon examination, the claimant's lungs were repeatedly found to be clear. Further, although Dr. Cohen related the

[7] In the "Issues" section of his brief on appeal, the claimant identifies the issue presented for review as "[w]hether the Commission's decision finding that [the claimant] did not suffer from an occupational disease in the form of CWP *or chronic bronchitis* was against the manifest weight of the evidence." (Emphasis added.) However, in the argument section of his brief, the claimant focuses almost entirely on CWP and does not present any developed argument that he had work-related chronic bronchitis. He has therefore forfeited any such argument. *Compass Group v. Illinois Workers' Compensation Comm'n*, 2014 IL App (2d) 121283WC, ¶ 33 ("The failure to properly develop an argument and support it with citation to relevant authority results in forfeiture of that argument."); *McCleary v. Board of Fire & Police Commissioners*, 251 Ill.App.3d 998, 995 (1993) ("Mere contentions, without argument or citations of authority, do not merit consideration on appeal.").

claimant's alleged chronic cough to his history of exposure to coal dust, he also related it to the claimant's smoking and to his use of Lisinopril, which the claimant had been taking for high blood pressure. Dr. Cohen also testified that shortness of breath can be related to deconditioning and to congestive heart failure (a condition the claimant had), among other causes. Dr. Rosenberg opined that the claimant's continued cough was most likely caused by his smoking or by the high dose of Lisinopril he had been taking, not by exposure to coal dust while coal mining.

¶ 62 There was also conflicting evidence regarding the causes of the claimant's diffusion impairment. Although Dr. Cohen opined that the claimant's diffusion impairment was related to his alleged CWP, he conceded that it could also be related to the claimant's prior pulmonary embolism. Dr. Rosenberg opined that the claimant's decreased diffusion capacity was caused by his thromboembolic disease (*i.e.*, his predisposition to form blood clots), not by CWP or by any other work-related condition. Dr. Rosenberg also opined that Coumadin, which the claimant had been taking for many years, could contribute to a low diffusion capacity. Moreover, a doctor who treated the claimant at St. Vincent opined that the claimant's reduced diffusion capacity was most likely caused by his smoking.

¶ 63 Given these conflicts in the evidence, the Commission's finding that the claimant had failed to prove disablement from any work-related condition was not against the manifest weight of the evidence.[8]

¶ 64 Regarding the claimant's argument that the Commission erred in not awarding him a wage differential benefit pursuant to section 8(d)(1) of the Workers' Compensation Act (820

[8] The Commission's finding on this issue was further supported by the fact that, in his October 2007 application for Social Security Disability benefits, the claimant listed several disabling conditions (including congestive heart failure, poor vision in his left eye, herniated discs, and deep vein blood clots in his right leg, foot, and ankle) but did not reference any breathing problems.

ILCS 305/8(d)(1) (West 2008)), since we are affirming the Commission's finding that the claimant failed to establish his entitlement to compensation under the Act, there could be no error in the method of calculating the amount of the benefit. *Tower Automotive v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 427, 436 (2011).

¶ 65 CONCLUSION

¶ 66 For the foregoing reasons, we affirm the judgment of the circuit court of Sangamon County, which confirmed the Commission's decision.

¶ 67 Affirmed.