2022 IL App (5th) 210301WC-U
No. 5-21-0301WC
Order filed October 11, 2022

IN THE

APPELLATE COURT OF ILLINOIS

FIFTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

JERRY FIELD, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION, *et al*. (Michael W. Frerichs, State Treasurer and Ex Officio Custodian of the Rate Adjustment Fund; and The American Coal Company, Appellees).	)))))))))))	Appeal from the Circuit Court of Williamson County. No. 21 MR 133 Honorable Jeffrey A. Goffinet, Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court.
Justices Hoffman, Cavanagh, and Barberis concurred in the judgment.
Presiding Justice Holdridge dissented.

ORDER

¶ 1 *Held*: (1) The Illinois Workers' Compensation Commission's decision that claimant failed to prove that he suffered from an occupational disease arising out of and occurring in the course of his employment with respondent was not contrary to the manifest weight of the evidence where the record contained a conflict in the opinions of the medical experts and resolving that conflict was primarily a matter for the Commission; and (2) the Illinois Workers' Compensation Commission's finding that claimant failed to prove by a preponderance of the evidence that he

suffered a timely disablement pursuant to section 1(f) of the Workers' Occupational Diseases Act was not against the manifest weight of the evidence. Affirmed.

¶ 2 I. INTRODUCTION

¶ 3 Claimant, Jerry Field, a former coal miner, filed an application for adjustment of claim pursuant to the Workers' Occupational Diseases Act (Act) (820 ILCS 310/1 *et seq*. (West 2016)) seeking benefits from respondent, The American Coal Company. The arbitrator denied benefits, finding that claimant failed to prove by a preponderance of the evidence that he suffered an occupational disease arising out of and occurring in the course of his employment with respondent. The arbitrator also found that claimant failed to prove by a preponderance of the evidence that he suffered a timely disablement pursuant to section 1(f) of the Act (820 ILCS 310/1(f) (West 2016)). A majority of the Illinois Workers' Compensation Commission (Commission) affirmed and adopted the decision of the arbitrator. On judicial review, the circuit court of Williamson County confirmed the decision of the Commission. In this appeal, claimant argues that the Commission's findings with respect to occupational disease and timely disablement were incorrect. We affirm.

¶ 4 II. BACKGROUND

¶ 5 On or about July 27, 2016, claimant filed an application for adjustment of claim seeking benefits from respondent. In his application, claimant alleged that due to the inhalation of coal-mine dust for a period in excess of 30 years, he experiences shortness of breath and exercise intolerance. An arbitration hearing on claimant's application for adjustment of claim was held on March 13, 2020, before arbitrator Douglas Steffenson. The issues in dispute included occupational disease, causal connection, disablement, and the nature and extent of the injury. The following factual recitation is taken from the evidence presented at the arbitration hearing.

¶ 6 Claimant testified that he worked as a coal miner for 30 years, all of which were underground. In addition to coal dust, claimant was regularly exposed to and breathed silica dust

and roof-bolting-glue fumes. Claimant's last coal mining exposure occurred on May 22, 2015, at respondent's New Future mine. On that date, claimant, then 62 years of age, was laid off from his position as a mine examiner. Claimant was recalled to the same mine about a month after being laid off. However, he turned down the position for health reasons and because he had started his United Mine Workers of America (UMWA) pension. Claimant cited breathing difficulties as one of the health reasons. The mine where claimant was recalled subsequently closed.

¶ 7 Claimant testified that he first noticed breathing problems at work during the last six months of his employment with respondent. He stated that the more he walked, the shorter of breath he would become. He testified that his breathing problems stayed about the same from the time he first noticed them until he left the coal mine. Claimant further testified that since leaving the mine and through the date of arbitration, his breathing problems have stayed about the same. Claimant testified that he can walk a mile or two on level ground at a normal pace before becoming short of breath and that he can climb 10 stairs before having to take a break. He stated that if he is playing with his grandchildren, he must stop to rest and catch his breath. Claimant also stated that push mowing his yard causes problems as does lifting heavy objects.

¶ 8 Claimant identified his treating physician as Dr. James Alexander. He testified, however, that he did not talk much about his breathing problems with Dr. Alexander. Claimant testified that he has other health issues, including a bad knee, gout, and high cholesterol. Claimant testified he has not had any employment since leaving mining and that he does not take any medications for his breathing problems. He also indicated that he was never a smoker.

¶ 9 On cross-examination, claimant was asked whether he would have reported for his next shift of work at the coal mine had he not been laid off. Claimant responded that he "was going to be off with foot surgery when [respondent] laid [him] off." Claimant admitted, however, that he

never underwent foot surgery. Claimant testified that when he was recalled to respondent's mine, he was already collecting his pension. He testified that he had 21 years with UMWA which qualified for a full pension, but it was reduced because he took it early.

¶ 10 Despite testifying on direct examination that he did not have any employment after leaving mining, claimant acknowledged on cross-examination that after he left respondent's employ, he registered for unemployment. Claimant also testified that after he was laid off, he worked for Professional Records Destruction. This position involved driving a shredding truck, replacing a customer's full shredding cart with an empty one, and putting the full cart on the truck for recycling. Claimant also worked for Galatia Township driving a truck. Claimant testified that the income that he earned in these two positions did not offset his pension or any other benefits.

¶ 11 Claimant testified that he was always honest with Dr. Alexander. Claimant told Dr. Alexander that he had black lung, a diagnosis dating back to 2004 or 2005. That diagnosis arose from claimant's position at the Black Beauty Mine where claimant worked for six months while employed with Custom Staffing Services. After claimant was laid off from this position, he filed a black lung claim against Custom Staffing Services. Claimant testified that his current counsel represented him in that claim. Claimant settled the claim for 12.5% of the person as a whole. In conjunction with that claim, Dr. Robert Cohen interpreted a chest X ray taken on November 9, 2004, as positive for pneumoconiosis, profusion 1/0 with Q/Q opacities in the bilateral upper and middle lung zones.

¶ 12 Claimant further testified that from time to time over the years that he was employed in coal mining, he underwent chest X ray screenings for black lung by the National Institute for Occupational Safety and Health (NIOSH). He testified that after an X ray was taken, NIOSH would notify him of the results. Claimant did not bring any correspondence from NIOSH to the arbitration

hearing. However, records from NIOSH were admitted into evidence. A chest X ray dated April 26, 1999, was interpreted by an A-reader as not having any parenchymal abnormalities consistent with pneumoconiosis. However, the A-reader did observe tiny benign calcified granulomas in the right lung base. The same film was interpreted by a B-reader as being completely negative. A chest X ray dated April 8, 2009, was interpreted by an A-reader and a B-reader as having no abnormalities consistent with pneumoconiosis. A chest X ray dated July 19, 2011, was interpreted by two B-readers as not having any abnormalities consistent with pneumoconiosis.

¶ 13 At the request of his attorney, claimant saw Dr. Suhail Istanbouly on June 21, 2016. Dr. Istanbouly authored a report of his findings and testified by evidence deposition to the same. Dr. Istanbouly is a physician specializing in pulmonary and critical care medicine. He is board certified in internal medicine, pulmonary medicine, and critical care medicine. During the course of his practice, Dr. Istanbouly has had numerous occasions to work with and treat current and former coal miners. Dr. Istanbouly treats the full spectrum of lung disease, including emphysema, chronic obstructive pulmonary disease, chronic bronchitis, asthma, coal workers' pneumoconiosis (CWP), and lung cancer.

¶ 14 Upon examination, Dr. Istanbouly noted that claimant was a coal miner for 31 years and a lifelong "never smoker." Dr. Istanbouly described claimant as having an intermittent cough for the prior few weeks which was mild without significant sputum and triggered by strenuous activity. Dr. Istanbouly also documented mild exertional dyspnea. Dr. Istanbouly noted in his report that claimant had a mild non-specific ventilatory limitation. Dr. Istanbouly testified that by non-specific ventilatory defect, he meant it could have both obstructive and restrictive elements. He testified that claimant had a forced expiratory volume in one second (FEV1) of 78% and a forced vital capacity (FVC) of 76%, both of which were below the lower limit of normal under the

American Medical Association (AMA) guidelines. Dr. Istanbouly personally reviewed a chest X ray of claimant taken on March 28, 2016.

¶ 15 Based on claimant's history, physical examination, pulmonary function testing, and chest X ray, Dr. Istanbouly concluded that claimant had early stage simple CWP. Dr. Istanbouly testified that CWP is a chronic, slowly progressive disease. Dr. Istanbouly's only recommendation was for claimant to avoid any further coal dust inhalation to prevent the progression of his pulmonary disease. Dr. Istanbouly testified that claimant's intermittent cough and mild exertional dyspnea are indications that he has damage to his lungs as a result of his coal mine exposure. He testified that the damage has been confirmed on the chest X ray and via pulmonary function testing.

¶ 16 Dr. Istanbouly testified that if he reads an X ray as positive for CWP and knows that the patient had a sufficient exposure to coal mine dust to cause the disease, those two things combined suffice for him to make a diagnosis of CWP. If, on the other hand, the chest X ray is negative, that would not necessarily rule out the existence of CWP. Dr. Istanbouly testified that the gold standard for diagnosing CWP is pathologic review. He agreed that a recent study showed that 50% or more of long-term coal miners are found to have CWP at autopsy even though the disease is not found radiographically during life.

¶ 17 On cross-examination, Dr. Istanbouly testified that he saw claimant only one time at the request of claimant's attorney. Dr. Istanbouly admitted that claimant provided no past history of respiratory disease. In this regard, claimant related to Dr. Istanbouly that his last job in the mine was fairly physical. Claimant did not tell Dr. Istanbouly that he had any problems completing his job duties at the mine. Moreover, claimant did not indicate that he left his employment at the mine because of problems due to or a diagnosis of respiratory disease. Further, claimant was not taking any breathing medications and there was no history of him having ever done so in the past.

Although claimant related mild dyspnea on exertion, Dr. Istanbouly acknowledged that there are causes for dyspnea other than respiratory disease. Deconditioning would be one such cause. Dr. Istanbouly was not sure what claimant had done since leaving the mine to remain physically fit. Dr. Istanbouly testified that he did not review any treatment records regarding claimant.

¶ 18 Dr. Istanbouly further testified on cross-examination that claimant's oxygen saturation at rest was 94% which is normal. Dr. Istanbouly testified that the spirometry performed on claimant revealed an FEV1/FVC ratio of 76% which is normal. The only chest image claimant provided Dr. Istanbouly was one taken on March 28, 2016. Dr. Istanbouly admitted that he is neither an A-reader nor a B-reader. When he interprets a film for black lung, he determines whether the film is positive or negative for black lung and if it is positive, then he characterizes it as mild, moderate, or severe. Dr. Istanbouly could not say that the film he reviewed had a profusion of 0/1 or 1/0. He explained that he does not provide profusion ratings for the films he interprets. Rather, he graded the film he reviewed as early pneumoconiosis based on the whole clinical picture including symptoms, physical examination, pulmonary function testing, and chest X ray. Dr. Istanbouly testified that the abnormality on claimant's chest X ray could have been present for years or decades. Dr. Istanbouly did not know how long claimant had suffered from the non-specific ventilatory limitation that he found. He testified that it could have been present for decades.

¶ 19 Dr. Henry Smith, a board-certified radiologist and B-reader, also read the chest X ray of claimant dated March 28, 2016. Dr. Smith interpreted the film as positive for simple CWP, profusion 1/0 with P/P opacities in the mid to lower lung zones bilaterally. He found the film to be quality one.

¶ 20 At the request of respondent's attorney, Dr. Christopher Meyer reviewed the chest radiograph of claimant dated March 28, 2016. Dr. Meyer is a radiologist and a B-reader. He has

been board certified in radiology since 1992 and been a B-reader since 1999. Dr. Meyer testified by evidence deposition that he was asked to take the B-reading examination by Dr. Jerome Wiot, who was part of the original committee that designed the teaching course which is called the B-reader program. Dr. Meyer had recently been asked to have a more academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course and submitting cases for the B-reader training module and examination. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading examination than other specialties. In Dr. Meyer's view, this is because radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is distinguishing between a 0/1 or 0/0 film, which is a normal examination, and a 1/0 film, which is a slightly abnormal examination.

¶ 21 Dr. Meyer testified that to become a B-reader, one takes the weekend course which includes a series of lectures describing the B-reading classification system. The instructors of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing them. Dr. Meyer testified that the faculty typically consists of experienced senior level B-readers. Typically, after one takes the course, he or she then takes the B-reading examination. Dr. Meyer testified that the certifying examination lasts 6 hours and involves a review of 120 chest X rays. The pass rate for the examination is about 60%.

¶ 22 Dr. Meyer testified that a B-reader looks at the lungs to decide whether there are any small nodular or linear opacities and based on the size and appearance of those opacities, they are given a letter score. Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. CWP is characteristically described by small round opacities. Diseases that cause

pulmonary fibrosis, like asbestosis, are characterized by small linear opacities. Nodular opacities are assigned the letters P, Q, or R and linear opacities are assigned the letters S, T, or U. A P-type opacity is the smallest nodular opacity while an R-type opacity is the largest nodular opacity. Similarly, an S-type opacity is the smallest linear opacity and a U-type opacity is the largest linear opacity. The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. CWP is typically an upper lung zone predominant process. The last component of the interpretation is the extent of lung involvement, or the so-called profusion. Dr. Meyer testified that the profusion relates to the density of the small opacities in the lung.

¶ 23 Dr. Meyer testified that the March 28, 2016, film was quality two due to underinflation. He testified, however, that there was no significance to the underinflation. Dr. Meyer testified that claimant's lungs were clear and there were no small or large opacities on the film. He concluded that there were no radiographic findings of CWP.

¶ 24 On cross-examination, Dr. Meyer testified that in some coal miners, CWP can progress even after the coal miner leaves the exposure. Dr. Meyer also acknowledged that, inasmuch as the only thing that causes CWP is coal mining exposure, a coal miner would probably have CWP at some level when he or she leaves the mine. Dr. Meyer testified that the only thing one can do for a person who has CWP when he or she does not want to take any chance that the condition will progress is to remove the individual from further exposure. Dr. Meyer stated that while the abnormalities of CWP can be found only in the mid and lower lung zones, this is rare. Dr. Meyer acknowledged that simple CWP is a "very slow and insidious disease in its onset" and that it may take 10 years or more to develop. Dr. Meyer admitted that he failed the B-reader examination the first time he took it. He also admitted that two qualified and competent B-readers may reasonably

disagree when a radiographic film might be 1/0 or 0/0 and that a negative radiographic film does not necessarily rule out that a miner has pneumoconiosis pathologically. On redirect examination, Dr. Meyer testified that simple CWP typically does not progress once exposure ceases.

¶ 25 At the request of respondent's counsel, Dr. James Castle reviewed the medical records and a chest X ray of claimant. Dr. Castle authored a report of his findings and testified to same by evidence deposition as follows. Dr. Castle is a pulmonologist. He is board certified in internal medicine and the subspeciality of pulmonary disease. Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. Dr. Castle treated patients with occupational lung disease, including some with CWP. Dr. Castle was first certified as a B-reader in 1985 and was continually certified as a B-reader through June 30, 2017. Dr. Castle testified that he passed all the B-reading certification examinations.

¶ 26 The chest X ray of claimant that Dr. Castle reviewed was dated March 28, 2016. He reviewed it on June 27, 2017, prior to the expiration of his certification. Dr. Castle testified that for a proper reading of a chest X ray for pneumoconiosis, the reader needs to identify the patient and the date on which the X ray was done and then determine the quality of the film. Next, the reader must determine whether there are any opacities present. This is determined by comparing the subject film to the standard International Labour Organization (ILO) classification films. If there are opacities, they are classified according to their shape and size. Round opacities are labeled P, Q, and R, with P-type opacities being the smallest and R-type opacities being the largest. Linear opacities are labeled S, T, and U, with S-type opacities being the smallest and U-type opacities being the largest. The reader also notes the lung zones in which the opacities are located as well as the profusion. Dr. Castle testified that the reader compares the average amount that is seen in

the lung zones to the standard ILO films and classifies it as 0/1, 1/0, 1/1, or the appropriate profusion. Dr. Castle testified that the profusion is important because that determines whether the X ray is positive or negative. Dr. Castle testified that 1/0 is the lowest profusion for a film to be positive.

¶ 27 Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. He testified that he is familiar with the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition (AMA Guides). Dr. Castle testified that the AMA Guides state in section 5.4(b) that the correlation of chest imaging with physiologic measures of impairment is poor. Dr. Castle testified that the AMA Guides does not use chest imaging as a factor, let alone a key factor, in the assessment of impairment.

¶ 28 Dr. Castle testified that generally there is no clinical significance to sub-radiographic pneumoconiosis. He testified that sub-radiographic means that one has a finding of pneumoconiosis usually pathologically that does not show up on X ray. Dr. Castle noted that claimant had a diffusion capacity of 89%. That means that he has a normal or intact alveolar-capillary membrane. Since the scarring of pneumoconiosis occurs in the alveolar-capillary membrane, one would expect the diffusion capacity to be abnormal if an individual has impairment related to CWP. Dr. Castle testified that it is extremely unlikely for simple pneumoconiosis to progress once the exposure ceases. Dr. Castle testified that the scarring of pneumoconiosis is permanent and will not disappear over time. In addition, the opacity size will not shrink over time. Dr. Castle agreed with the official statement of the American Thoracic Society that an older worker with mild pneumoconiosis may be at low risk for working in currently permissible dust levels in the mine until he reaches retirement age. The only treatment for CWP is to remove the miner from any further exposure.

¶ 29 Dr. Castle testified that in regard to the medical records that he reviewed, there was not any basis for the diagnosis of pneumoconiosis noted by Dr. Alexander in a progress note of April 3, 2014. Dr. Castle testified that if one does not have pathology, then one would be looking for an abnormal chest X ray which would be expected to show changes of pneumoconiosis. There was no indication in the records that Dr. Alexander had made that diagnosis based upon an abnormal X ray.

¶ 30 Dr. Castle testified that according to the American Thoracic Society, one looks at the ratio of the FEV1 and the FVC to determine if an obstruction is present. If the ratio is reduced below the lower limit of normal, then it would be an indicator of some degree of obstruction. Dr. Castle testified that in testing by Dr. Istanbouly, claimant's FEV1/FVC ratio was 76% which would be above the lower limit of normal. Dr. Castle testified that this ratio ruled out obstruction for claimant according to the American Thoracic Society/European Respiratory Society guidelines. Dr. Castle testified that on spirometry performed at Methodist Hospital after Dr. Istanbouly's testing, claimant's FVC was in excess of 92% predicted. Based upon that finding, Dr. Castle opined that claimant had no indication of restriction. Dr. Castle testified that if he applied Table 5.4 of the AMA Guides to the results of the pulmonary function testing performed on claimant at Methodist Hospital, he would fall in Class 0 impairment. Based upon that testing, claimant was capable of heavy manual labor from a respiratory standpoint.

¶ 31 Dr. Castle testified that if claimant related an onset of intermittent cough approximately one year after he left the mine, as he told Dr. Istanbouly, it would not be causally related to his employment as a coal miner. Dr. Castle testified that a cough is not considered to be an objective determinate of pulmonary impairment.

¶ 32 Ultimately, Dr. Castle testified that, based upon a thorough review of all the data, claimant

does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. He testified that claimant worked in or around the underground mining industry for a sufficient enough time to have possibly developed CWP if he were a susceptible host. He worked for 31 years in the mining industry and last worked in 2015 as a mine examiner. Dr. Castle noted that claimant was a lifelong non-smoker. Claimant did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. Dr. Castle testified that in the pulmonary function testing performed by Dr. Istanbouly, the post-bronchodilator study was normal. There was a minimal reduction in the FVC and FEV1 in the pre-bronchodilator study. Dr. Castle testified that while the study from Methodist Hospital was technically invalid, when best efforts were reviewed, this study was entirely normal showing no evidence of obstruction, restriction, or diffusion abnormality. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film he reviewed. Thus, in Dr. Castle's opinion, claimant does not suffer from any pulmonary disease or impairment as a result of his occupational exposure to coal mine dust.

¶ 33 On cross-examination, Dr. Castle testified that under Table 5.4 of the AMA Guides, the results of Dr. Istanbouly's testing—the FEV1 of 78% and the FVC of 76%—would both be considered category 1 impairment. Dr. Castle further testified that no matter what he saw on the chest X rays, he could not rule out the possibility that claimant could have pneumoconiosis that could be found pathologically or at autopsy. Dr. Castle acknowledged that recent studies have shown as many as 50% of long-term coal miners have pathological CWP that was not appreciated by radiographic study during their lives. Dr. Castle testified that the abnormality of CWP is coal dust trapped in part of the lung which ends up wrapped in scar tissue and can be accompanied by emphysema around it. He testified that the affected tissue itself cannot perform the function of

normal healthy lung tissue. Therefore, by definition, if a person has CWP, he or she would have an impairment in the function of his lungs at the site of the scarring. Dr. Castle also acknowledged that having pulmonary function tests within the range of normal does not mean that a person's lungs are disease or injury free.

¶ 34 Medical records for claimant from HMC Clinic were admitted into evidence. Claimant underwent a chest X ray on April 26, 1999, which was interpreted by Dr. Hisham Youssef as revealing benign calcified granuloma in the right lung base. He gave the film a profusion rating of 0/0. Claimant presented for evaluation of possible lung disease on March 20, 2000. He reported a history of working in the coal mine for approximately 20 years. Physical examination of the chest was clear without rales, rhonchi, or wheeze. It was noted that claimant had abnormal pulmonary functions, but Dr. Alexander indicated that he thought this was a result of poor calibration of the machine he was tested on as well as the incorrect age entered for claimant. Spirometry performed the same day was normal. Dr. Alexander did not believe claimant had any underlying pulmonary dysfunction.

¶ 35 Claimant underwent a preemployment physical for respondent on April 8, 2009. At that time, claimant denied a history of asthma, emphysema, frequent lung infections, or tuberculosis. He also denied frequent chest colds, constant bothersome cough, sputum or phlegm between colds, difficulty breathing, shortness of breath, and wheezing. A chest X ray performed on April 8, 2009, was interpreted by Dr. Hisham Youssef as negative with a profusion of 0/0. Spirometry performed on April 7, 2009, was normal. Dr. Alexander's assessment was a normal physical.

¶ 36 Claimant was seen on March 28, 2014, with a complaint of a headache. A review of claimant's pulmonary system revealed no dyspnea. Physical examination of the chest revealed the lungs were clear to auscultation. Assessment was migraine headache. Claimant returned on April

3, 2014, with another headache complaint. His active problems were noted to be anal fistula, basal cell face, CWP-state, hearing loss, and internal derangement of the right knee. Physical examination of the chest revealed his lungs clear to auscultation. Assessment was temporomandibular joint pain dysfunction syndrome and episodic tension type headache. Claimant returned on April 14, 2014, at which time his active problems remained the same. Claimant denied dyspnea. Review of symptoms, however, revealed dyspnea but no cough or wheezing. Physical examination of the chest revealed rales and crackles without wheeze or rhonchi. Assessment was normal physical.

¶ 37 Claimant was seen on May 11, 2015, for a pre-surgery physical. Active problems were noted to include CWP. Claimant was noted to have never smoked. It was documented that, from a functional standpoint, claimant had no physical disability and no difficulty with the activities of daily living. Review of claimant's pulmonary system revealed no dyspnea or cough. Physical examination of the chest revealed no adventitious sounds. Claimant was seen on January 25, 2016, for evaluation of possible gout. Review of claimant's pulmonary system revealed no dyspnea, cough, or wheeze. Physical examination of the chest revealed no adventitious sounds. Assessment was acute primary gout. Claimant returned to the office on February 15, 2016. His active problems again included CWP. A review of claimant's pulmonary system revealed no dyspnea or cough. Claimant was seen on February 6, 2017. It was charted that he suffered from no dyspnea or chronic cough. A review of claimant's respiratory system was negative for dyspnea, cough, or wheeze. Physical examination of the chest was normal with no adventitious sounds. The assessment included CWP, hyperlipidemia, and gout.

¶ 38 Claimant was seen in the office on May 8, 2017, for a Department of Transportation (DOT) physical. Claimant was noted to have no systemic symptoms, including pulmonary-related

symptoms. A review of claimant's pulmonary system was negative for dyspnea, cough, or adventitious sounds. The assessment was routine history and physical. He was found fit for work and approved for a two-year DOT certificate. Claimant was seen on July 10, 2017, complaining of back pain. He was noted to be working full time. A review of claimant's pulmonary system was negative. Physical examination of the chest was normal with no adventitious sounds. When claimant was seen on February 7, 2018, he denied dyspnea, shortness of breath, or wheeze. It was charted that claimant was retired from work. A review of claimant's respiratory system was negative for dyspnea or cough. Physical examination of the chest was normal with no adventitious sounds. The assessment was CWP, hyperlipidemia, and gout.

¶ 39 Claimant was seen on February 18, 2019, for follow up regarding his hyperlipidemia and gout. A review of claimant's respiratory system revealed no dyspnea or cough. Physical examination of the chest revealed normal breath sounds with no adventitious sounds. Dr. Alexander's assessment was CWP, elevated liver enzymes, hyperlipidemia, and gout. Claimant was seen on August 14, 2019. A review of claimant's respiratory system revealed no dyspnea or cough. Physical examination of the chest revealed normal breath sounds with no adventitious sounds. Dr. Alexander's assessment included CWP, hyperlipidemia, gout, and osteoarthritis of the right knee.

¶ 40 Based on the foregoing record, the arbitrator concluded that claimant failed to prove by a preponderance of the evidence that he suffers from an occupational disease arising out of and occurring in the course of his employment. The arbitrator found the B-readings of Dr. Meyer and Dr. Castle, as well as the B-readings by NIOSH, to be persuasive. In particular, the arbitrator found the testimony of Dr. Meyer "insightful, informative and persuasive." The arbitrator explained that Dr. Meyer's background and experience in radiology, B-reading, and CWP "were impressive and

beyond that of [claimant's] physician, Dr. Istanbouly, who is not a B-reader." Additionally, the arbitrator was not persuaded by the B-readings of Dr. Cohen and Dr. Smith. The arbitrator noted that Dr. Cohen interpreted a chest X ray dated November 9, 2004, for claimant's prior black lung claim, finding only Q-type opacities in the bilateral upper and mid lung zones. Dr. Smith interpreted a chest X ray dated March 28, 2016, as showing only P-type opacities in the bilateral mid and lower lung zones. The arbitrator observed that if Dr. Cohen's and Dr. Smith's readings were accurate, it would mean that over time the opacities present shrank in size and disappeared from the upper lung zones. This contradicted the evidence presented at the arbitration hearing, which was that CWP is permanent and the opacities which result from the disease will not shrink in size or disappear from lung zones over time.

¶ 41 The arbitrator also concluded that claimant failed to prove by a preponderance of the evidence that he suffered a timely disablement under section 1(f) of the Act (820 ILCS 310/1(f) (West 2016)). The arbitrator noted that to prove disablement under the Act, a claimant must show that he or she suffered an impairment in the function of the body or the event of becoming disabled from earning full wages as a coal miner as the result of an occupational disease. The arbitrator found that claimant failed to meet either prong. First, the arbitrator noted that Dr. Castle testified that if the results from the last pulmonary function testing performed on claimant were applied to Table 5.4 of the AMA Guides, claimant would fall in Class 0 impairment. Dr. Castle further testified that, from a respiratory standpoint, claimant is capable of heavy manual labor. The arbitrator found that claimant failed to meet the second prong because there was no evidence that any physician took claimant off work as a coal miner as a result of an occupational disease. Rather, claimant testified that he worked for respondent until he was laid off on May 22, 2015.

¶ 42 A majority of the Commission affirmed and adopted the decision of the arbitrator.

Commissioner Parker dissented. He found the opinions of Dr. Alexander and Dr. Istanbouly more persuasive than the opinion of Dr. Castle. In support, Commissioner Parker noted that the treatment notes of Dr. Alexander, claimant's primary care physician, contain numerous entries diagnosing claimant with CWP. Commissioner Parker also noted that Dr. Istanbouly also diagnosed claimant with CWP. Commissioner Parker rejected the opinion of Dr. Castle because he "failed to notice most, if not all, of Dr. Alexander's entries diagnosing [claimant] with CWP." On judicial review, the circuit court of Williamson County confirmed the decision of the Commission. This appeal by claimant ensued.

¶ 43 III. ANALYSIS

¶ 44 On appeal, claimant raises two issues. First, he argues that the Commission's finding that he failed to prove that he suffers from an occupational disease arising out of and occurring in the course of his employment with respondent was against the manifest weight of the evidence and incorrect as a matter of law. Second, he argues that the Commission erred by finding that he failed to prove that he suffered a timely disablement pursuant to section 1(f) of the Act (820 ILCS 310/1(f) (West 2016)). We address these claims *seriatim*.

¶ 45 A. Occupational Disease

¶ 46 Claimant first argues that the Commission's finding that he failed to prove that he suffers from an occupational disease arising out of and occurring in the course of his employment with respondent was against the manifest weight of the evidence and incorrect as a matter of law.

¶ 47 The claimant in an occupational disease case has the burden of proving both that he or she suffers from an occupational disease and that a causal connection exists between the disease and his or her employment. *American Coal Co. v. Illinois Workers' Compensation Comm'n*, 2020 IL App (5th) 190522WC, ¶ 50; *Freeman United Coal Mining Co. v. Illinois Workers' Compensation*

Comm'n, 2013 IL App (5th) 120564WC, ¶ 21. Whether a claimant suffers from an occupational disease and whether there is a causal connection between the disease and the employment are questions of fact. *American Coal Co.*, 2020 IL App (5th) 190522WC, ¶ 50; *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21. It is the function of the Commission to decide questions of fact, judge the credibility of the witnesses, and resolve conflicting medical evidence. *American Coal Co.*, 2020 IL App (5th) 190522WC, ¶ 50; *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21; *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). This is especially true with respect to medical issues, to which we owe the Commission heightened deference because of the experience it possesses in the medical arena. *Long v. Industrial Comm'n*, 76 Ill. 2d 561, 566 (1979); *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*, 386 Ill. App. 3d 779, 782-83 (2008).

¶ 48 The Commission's determination on a question of fact will not be disturbed on appeal unless it is against the manifest weight of the evidence. *American Coal Co.*, 2020 IL App (5th) 190522WC, ¶ 51. A decision is against the manifest weight of the evidence only if an opposite conclusion is clearly apparent. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564, ¶ 21; *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 539 (2007). As a court of review, we cannot reject or disregard permissible inferences drawn by the Commission simply because different or conflicting inferences may also reasonably be drawn from the same facts, nor may we substitute our judgment for that of the Commission on such matters unless the Commission's findings are against the manifest weight of the evidence. *Zion-Benton Township High School District 126 v. Industrial Comm'n*, 242 Ill. App. 3d 109, 113 (1993). The test is whether the evidence is sufficient to support the Commission's findings, not whether this court or any other tribunal might reach an opposite conclusion. *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d

582, 597 (2005). Moreover, we may affirm the Commission's decision on any basis supported by the record regardless of the Commission's findings or its reasoning. *Dukich v. Illinois Workers' Compensation Comm'n*, 2017 IL App (2d) 160351WC, ¶ 43 n.6.

¶ 49 Applying these deferential standards, we cannot conclude that the Commission's finding that claimant failed to prove that he suffers from the occupational disease of CWP was against the manifest weight of the evidence. Claimant attempted to carry his burden of proving he suffers from CWP by presenting evidence from experts (Dr. Istanbouly, Dr. Smith, and Dr. Cohen) who interpreted certain X rays of claimant's chest as positive for CWP. Claimant also relied on the treatment records of Dr. Alexander, which, by claimant's count, contain 17 entries diagnosing CWP. Respondent rebutted this evidence by presenting the evidence of other experts (Dr. Meyer, Dr. Castle, and the NIOSH readers) who interpreted some of the same X rays interpreted by claimant's experts as negative for CWP. This created a conflict in the evidence, which was for the Commission to resolve. *Hosteny*, 397 Ill. App. 3d at 674. Ultimately, the Commission adopted the reasoning and rationale of the arbitrator, who rested upon the opinions of Dr. Meyer and Dr. Castle as well as those of the NIOSH B-readers. In doing so, the Commission articulated specific reasons for weighing the conflicting evidence against a finding of an occupational disease. The Commission found that Dr. Meyer's background and experience in radiology, B-reading, and CWP "were impressive and beyond that of [claimant's] physician, Dr. Istanbouly, who is not a B-reader." The Commission also identified inconsistencies between the X ray readings of Dr. Cohen and Dr. Smith. Dr. Cohen interpreted a chest X ray dated November 9, 2004, for claimant's prior black lung claim, finding only Q-type opacities in the bilateral upper and mid lung zones. Dr. Smith interpreted a chest X ray dated March 28, 2016, finding only P-type opacities in the bilateral mid and lower lung zones. The Commission noted that if the readings of Dr. Cohen and Dr. Smith

were accurate, it would mean that over time the opacities once present shrank in size and disappeared from the upper lung zones. However, the evidence presented at the arbitration hearing was that CWP is permanent and the opacities resulting therefrom will not shrink in size or disappear from lung zones over time. In other words, this evidence was inconsistent with the usual progression of CWP.

¶ 50 As the foregoing discussion illustrates, the Commission was presented with conflicting medical evidence as to whether claimant demonstrated CWP. Unless the evidence on one side is so compelling as to render the opposite conclusion clearly apparent, we must defer to the Commission, which, as noted above, is uniquely situated to weigh competing medical evidence and to resolve any evidentiary conflicts. *Long*, 76 Ill. 2d at 566; *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21. The Commission in this case resolved the conflict in the evidence in respondent's favor. Given the evidence of record and the Commission's role in weighing it, we cannot say that an opposite conclusion is clearly apparent.

¶ 51 Nevertheless, claimant argues that the Commission erred in relying on X rays taken in 2016 and prior in finding that he did not have CWP. He observes that CWP is a latent and progressive disease that may be detectable only after the cessation of coal mine dust exposure and that, under the Act, he had more than two years from the date of his last exposure, *i.e.*, May 21, 2017, during which his CWP could have become apparent radiographically. See 820 ILCS 310/1(f) (West 2016) ("No compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease."). Claimant therefore reasons that it was impossible for the X rays relied on by respondent's experts to prove the absence of CWP within the statutory time frame. As noted previously, however, to obtain benefits under the Act, the employee bears the burden of proving

an occupational disease, such as CWP, by a preponderance of the evidence. *American Coal Co.*, 2020 IL App (5th) 190522WC, ¶ 50; *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21. It is *not* the employer's burden to prove the absence of CWP. Indeed, claimant cites no case law or statutory authority in support of his suggestion that it is respondent's burden to prove the absence of CWP within the statutory time frame. Absent some authority supporting claimant's position, we are not inclined to accept it here and, indeed, deem it forfeited. *Ameritech Services, Inc. v. Illinois Workers' Compensation Comm'n*, 389 Ill. App. 3d 191, 208 (2009).

¶ 52 Claimant also points out that a greater number of physicians interpreted his X rays to be positive for CWP than negative. However, the weight to be accorded medical opinion testimony is not simply a matter of adding up the number of experts. See *Cinch Manufacturing Corp. v. Industrial Comm'n*, 393 Ill. 131, 134 (1946) (holding that the weight of the evidence in a workers' compensation case does not lie with the party producing a greater number of expert witnesses on its behalf); *ABF Freight System v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 141306WC, ¶ 22 (holding that the number of witnesses testifying to a particular fact is not controlling). As such, this argument is unpersuasive.

¶ 53 Claimant also argues that the Commission's reliance on the X-ray interpretations of the NIOSH readers was improper for multiple reasons. First, he points out that not all of the NIOSH readings were B-readings. While true, the Commission specifically cited only the B-readings in support of its finding. Second, claimant notes that the date of the most recent NIOSH X ray was taken four years prior to the date he last worked as a coal miner and six years before the running of the two-year limit of section 1(f) (820 ILCS 310/1(f) (West 2016)). While older X ray interpretations may not be entitled to as much weight as more recent ones, we still find them relevant to demonstrate the progression, or lack thereof, of CWP in claimant during the years of

his employment as a coal miner. Claimant also suggests that the most recent NIOSH X ray interpretation cannot rule out CWP because the disease may have developed in the time period subsequent to his final NIOSH X ray. This argument is also unconvincing. We reiterate that to obtain benefits under the Act, the employee bears the burden of proving an occupational disease by a preponderance of the evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21. It is not the employer's burden to prove the absence of an occupational disease. As noted previously, claimant's case relied greatly on experts who interpreted certain X rays of claimant's chest as positive for CWP. Respondent rebutted this evidence by presenting the testimony of other experts who interpreted some of the same X rays as negative for CWP. This created a conflict in the medical opinion evidence which was for the Commission to resolve. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21; *Hosteny*, 397 Ill. App. 3d at 674. The Commission's finding that claimant failed to prove that he had CWP was not against the manifest weight of the evidence. Accordingly, we must defer to the Commission's finding.

¶ 54 Claimant asserts that the Commission's "most egregious factual error" was its "complete disregard for the medical records of [his] primary care physician, Dr. Alexander." According to claimant, Dr. Alexander's treatment records are significant because they contain 17 entries diagnosing him with CWP and Dr. Alexander was the physician with "the least motive to slant his opinions." Claimant's reliance on Dr. Alexander's records is unpersuasive for multiple reasons. First, the Commission did not completely disregard Dr. Alexander's medical records. The Commission affirmed and adopted the decision of the arbitrator. The arbitrator's findings of fact contain an extensive discussion of claimant's visits to Dr. Alexander. While the arbitrator does not mention every single visit, this was unnecessary as some of the visits were for illnesses unrelated to the reason claimant is seeking benefits. Second, we fail to see the significance to the number of

times Dr. Alexander diagnosed CWP. It is undisputed that Dr. Alexander diagnosed claimant with CWP. In our view, the number of times he diagnosed the disease is not in and of itself significant. Indeed, many of the references to CWP were merely as an "active problem" without any further discussion of the disease. Third, and most importantly, the Commission could reasonably find Dr. Alexander's diagnosis unpersuasive in light of the fact that (1) claimant acknowledged that he infrequently discussed his breathing problems with Dr. Alexander and (2) Dr. Alexander's treatment records for claimant do not explain the basis of his diagnosis. Indeed, as Dr. Castle observed, in the absence of pathology, one would be looking for an abnormal chest X ray to show changes of pneumoconiosis. However, there was no indication in the records that Dr. Alexander had made that diagnosis based upon an abnormal X ray.

¶ 55 Claimant also contends that the Commission's decision to reject the X ray interpretations of Dr. Cohen and Dr. Smith was improper. As noted above, the Commission identified inconsistencies between the X ray readings of Dr. Cohen and Dr. Smith. Dr. Cohen interpreted a chest X ray dated November 9, 2004, for claimant's prior black lung claim, finding only Q-type opacities in the bilateral upper and mid lung zones. Dr. Smith interpreted a chest X ray dated March 28, 2016, finding only P-type opacities in the bilateral mid and lower lung zones. The Commission reasoned that if the readings of Dr. Cohen and Dr. Smith were accurate, it would mean that over time the opacities present shrank in size and disappeared from the upper lung zones. However, the evidence presented at the arbitration hearing was that CWP is permanent and the opacities resulting therefrom will not shrink in size or disappear from lung zones over time. In other words, this evidence was inconsistent with the usual progression of CWP. Claimant argues that the Commission failed to recognize that the X rays were taken 12 years apart, were likely taken by different labs, used different types of film, and were taken with different hardware. Claimant also

posits that the differences in Dr. Cohen's and Dr. Smith's interpretations could be explained by the fact that one of the physicians was a more conservative reader than the other. This argument is essentially an invitation for us to reweigh the evidence and substitute our judgment for that of the Commission. This, of course, we may not do. *Setzekorn v. Industrial Comm'n*, 353 Ill. App. 3d 1049, 1055 (2004).

¶ 56 In short, the record contains sufficient evidence to support the Commission's finding that claimant failed to prove by a preponderance of the evidence that he suffers from an occupational disease arising out of and occurring in the course of his employment as a coal miner with respondent. Accordingly, we affirm the Commission's finding in this regard.

¶ 57 B. Disablement

¶ 58 Claimant next argues that the Commission erred by finding that he failed to prove that he suffered a timely disablement pursuant to section 1(f) of the Act (820 ILCS 310/1(f) (West 2016)).

¶ 59 Section 1(f) of the Act (820 ILCS 310/1(f) (West 2016)) provides in relevant part that "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." Section 1(e) of the Act (820 ILCS 310/1(e) (West 2016)) provides two ways to establish disablement. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 25; *Forsythe v. Industrial Comm'n*, 263 Ill. App. 3d 463, 470 (1994). A claimant can establish disablement by showing "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e) (West 2016). Alternatively, section 1(e) defines disablement as "the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal

wages in other suitable employment." 820 ILCS 310/1(e) (West 2020). Whether a claimant has provided sufficient evidence of timely disablement is a question of fact for the Commission, and its decision in this regard will not be reversed on appeal unless it is against the manifest weight of the evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 25. As noted earlier, a decision is against the manifest weight of the evidence only if an opposite conclusion is clearly apparent. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21; *Westin Hotel*, 372 Ill. App. 3d at 539. Moreover, we may affirm the Commission's decision on any basis supported by the record regardless of the Commission's findings or its reasoning. *Dukich*, 2017 IL App (2d) 160351WC, ¶ 43 n.6.

¶ 60 Applying these deferential standards, we cannot conclude that the Commission's finding that claimant failed to prove that he suffered a timely disablement pursuant to section 1(f) of the Act was against the manifest weight of the evidence. First, the Commission determined that claimant failed to establish an impairment in the function of the body. The evidence of record supports the Commission's finding. As shown above, the Commission found that claimant failed to establish that he had CWP. It is true that claimant described experiencing breathing problems at work during the last six months of his employment with respondent (around late 2014). Claimant explained that the more he walked, the shorter of breath he would become. He stated that he could walk a mile or two on level ground at a normal pace before becoming short of breath and that he could climb 10 stairs before having to take a break. He also described respiratory issues when playing with his grandchildren, mowing his yard, and picking up heavy objects. However, claimant does not assert that he related these issues to his physicians. To the contrary, claimant acknowledged that he infrequently discussed his breathing problems with Dr. Alexander. More significantly, claimant's medical records after he left mining routinely document *the absence* of

dyspnea, cough, and adventitious sounds, and claimant was not prescribed any breathing medications. In addition, Dr. Castle testified that, under Table 5.4 of the AMA Guides and based on the pulmonary function testing performed on claimant, claimant would fall in Class 0 impairment. Dr. Castle added that, from a respiratory standpoint, claimant is capable of heavy manual labor. Considering the foregoing, we conclude that the Commission's finding that claimant failed to prove disablement under the first prong of the statutory definition was not against the manifest weight of the evidence.

¶ 61 We also conclude that the Commission's finding that claimant failed to meet the second prong of disablement was not against the manifest weight of the evidence. Again, we note that there was conflicting evidence regarding whether claimant had CWP, which the Commission resolved against claimant. Moreover, claimant did not cease working at the mine because of a diagnosis of CWP—he was laid off and declined a recall. After that, the mine shut down. Indeed, although claimant told Dr. Istanbouly that his last job in the mine was fairly physical, he did not relate any problems completing his job duties at the mine or that he left his employment because of problems due to or a diagnosis of respiratory disease. Further, despite the fact that Dr. Alexander included CWP as a diagnosis in claimant's treatment records, he never restricted claimant's work duties as a result of the disease. Additionally, claimant underwent a DOT physical in May 2017—two years after he left mining—and was noted not to have any systemic symptoms, including pulmonary symptoms. At that time, claimant was found fit for work and given a two-year DOT certificate. We also observe that claimant found work with two employers after he left coal mining. Although, the length of those stints is not clear from the record, there is no indication that claimant left the positions due to any breathing problems. Based on this evidence, the Commission could have reasonably concluded that claimant failed to establish that he was disabled from earning full

wages at the work in which he was engaged when last exposed to the hazards of the occupational disease or equal wages in other suitable employment. 820 ILCS 310/1(e) (West 2020).

¶ 62 Claimant nevertheless argues that the Commission did not accurately apply the definition of "disablement" to this case. Claimant argues that when there is a diagnosis of CWP, there is an impairment in the function of the respiratory system by definition, whether such can be measured by pulmonary function testing or not. See *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 35 (Hoffman, J., specially concurring) (concluding that once a claimant has established that he suffers from CWP, he has also satisfied the statutory definition of disablement as a matter of law). Claimant's argument rests on a serious flaw—the Commission found that claimant did *not* establish that he suffers from CWP. Thus, claimant's position finds no support in the record.

¶ 63 Claimant also directs us to the following language from *Freeman United Coal Mining Co. v. Industrial Comm'n*, 283 Ill. App. 3d 785, 790 (1996):

> "[S]ection 1(e) of the Diseases Act defines two ways in which an employee may become disabled. He or she may suffer *a purely functional disability or suffer an impairment which results in a loss of earning capacity. Under this definition, an employee may incur a job-related functional disability yet still perform his or her usual job.* Although there is no loss of earning capacity, the employee is disabled pursuant to Section 1(e). On the other hand, when an employee suffers a loss of earning capacity, he necessarily suffers from some impairment because he is precluded from performing his job functions." (Emphasis supplied by claimant.)

Claimant, however, does not explain how the language he emphasizes supports his argument that the Commission erred in finding that he failed to prove by a preponderance of the evidence that he

suffered a timely disablement. As such, we find this argument forfeited. Ill. S. Ct. R. 341(h)(7) (eff. Oct. 1, 2020) (requiring the appellant's brief to include argument, "which shall contain the contentions of the appellant and the reasons therefor"); *McCleary v. Board of Fire & Police Commissioners*, 251 Ill. App. 3d 988, 995 (1993) ("Mere contentions, without argument or citations of authority, do not merit consideration on appeal.").

¶ 64 Claimant points out that the Commission cited *Dawson v. Illinois Workers' Compensation Comm'n*, 382 Ill. App. 3d 581 (2008), for the premise that a claimant must prove but for his occupational lung disease, he or she would have continued coal mining employment. In a recent decision this court noted that the holding in *Dawson* is applicable only to cases seeking a wage-differential award. See *American Coal Co.*, 2020 IL App (5th) 190522WC, ¶ 64 n.4. Claimant notes that the citation to *Dawson* was improper because he did not seek a wage-differential award in this case. However, setting aside the Commission's citation to *Dawson*, claimant still failed to meet his burden of proving a timely disablement. The event which caused claimant to stop working in the coal mines was not CWP, it was his layoff and the cessation of mining operations at the facility where he worked. See *Forsythe*, 263 Ill. App. 3d at 470-71 (holding that the claimant had not proven disablement where the event which caused him to stop working was a heart attack, not pneumoconiosis).

¶ 65 Claimant makes various other arguments against the Commission's disablement finding. All of these arguments are premised on a finding that claimant suffers from CWP. The Commission, however, found that claimant failed to prove by a preponderance of the evidence that he suffers from an occupational disease arising out of and occurring in the course of his employment as a coal miner with respondent. We determined that the Commission's finding was not against the manifest weight of the evidence. Thus, we must reject claimant's remaining

arguments that the Commission erred in finding that he failed to prove a timely disablement.

¶ 66 IV. CONCLUSION

¶ 67 For the reasons set forth above, we affirm the judgment of the circuit court of Williamson County, which confirmed the decision of the Commission.

¶ 68 Affirmed.

¶ 69 PRESIDING JUSTICE HOLDRIDGE, dissenting:

¶ 70 I respectfully dissent. I find the reasoning provided by Commissioner Parker persuasive and would reverse the Commission's decision.