STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

Stacy Ash,
Petitioner,

vs.

NOS. 03 WC 43923
03 WC 49089
15 IWCC 612

Bloomington Public Schools,
Respondent.

ORDER OF RECALL UNDER SECTION 19(F)

A Motion to Correct Clerical Error pursuant to Section 19(f) of the Illinois Workers' Compensation Act to correct an error in the Order of the Commission dated April 17, 2019, having been filed by Respondent herein, and the Commission having considered said Motion, hereby grants said Motion.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order dated April, 17, 2019, is hereby recalled pursuant to Section 19(f).

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Order shall be issued simultaneously with this Order.

DATED: APR 25 2019

DLS/rm
46

Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☐ PTD/Fatal denied
☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STACY ASH,
Petitioner,

vs.

No: 03 WC 43923,
03 WC 49089
15 IWCC 612

BLOOMINGTON PUBLIC SCHOOLS,
Respondent

CORRECTED ORDER

This matter comes before the Commission on Petitioner's Motion to Compel Compliance With Order. A hearing was held before Commissioner Luskin on December 11, 2018 in Peoria. The parties were represented by counsel, and a record was taken.

Petitioner filed two separate claims, 03 WC 43923 and 03 WC 49089 alleging accidental injuries to her lower back on June 26, 2003 and April 21, 2003, respectively. On February 2, 2007, an Arbitrator denied compensation in 03 WC 43923, finding that accident caused no permanent injury. Also on that date, the Arbitrator issued another opinion finding Petitioner proved the accident on April 21, 2003 caused the current condition of ill-being of her lower back and awarded her 125 weeks of permanent partial disability benefits representing the loss of the use of 25% of the person-as-a-whole.

Petitioner filed a petition for relief under §8(a) of the Act. On August 10, 2015, the Commission issued an opinion ordering Respondent to authorize and pay for implantation of a trial spinal cord stimulator recommended by Petitioner's treating doctor, Dr. Benyamin. In the decision the Commission found that Petitioner was "entitled to additional medical treatment in the form of a trial spinal cord stimulator and the medical expenses related thereto."

At the instant hearing, Petitioner testified that she went to Dr. Benyamin about the spinal cord stimulator in November 2016. The delay between the Commission Decision on the 8(a) petition and that presentation to Dr. Benyamin was due to Dr. Benyamin's current treatment for a cervical condition. Dr. Benyamin wanted to wait until after he completed treating Petitioner's cervical condition before addressing her lumbar issues. Dr. Benyamin wanted an MRI prior to implantation of the stimulator. Respondent has thus far refused to authorize or pay for the MRI.

On cross, Petitioner agreed that in February 2014 she was a passenger in a vehicle that was struck in the rear. Thereafter, she mostly had neck pain and jaw-pain, but she also had an increase in her lower back pain. She had physical therapy which treated for both her neck and back. She also agreed that Dr. Vales, her primary care physician, had referred her to Dr. Taimoorazy for the spinal cord stimulator, but Petitioner chose to go to Dr. Benyamin because he was her pain doctor. Dr. Vales "was fine with that." Dr. Benyamin had recommended a lumbar spinal cord stimulator prior to the 2014 motor vehicle accident. However, a separate cervical cord stimulator also has been recommended after that accident.

Petitioner submitted into evidence records of Dr. Benyamin from October 14, 2015 through December 4, 2018. On October 14, 2015, Petitioner was referred to Dr. Benyamin on referral from Dr. Vales. She was involved in a motor vehicle accident in February 2014 and had had neck pain, jaw pain, headaches, and blurred vision. Physical therapy had not been beneficial. She had been found not to be a surgical candidate and pain management was recommended. Dr. Benyamin administered numerous injections in Petitioner's cervical spine. In the course of his treatment of Petitioner's neck, on July 7, 2016, Dr. Benyamin noted that he would contact Petitioner's lawyer "about the low back and stimulator approval." On November 23, 2016 Petitioner presented to Nurse Practitioner, Elizabeth Madlem to discuss low back pain. She noted that the last imaging of the lumbar spine was in 2013. Ms. Madlem noted that Petitioner's low back symptoms progressed since she was last treated for her lower back and felt it was "pertinent to order a new lumbar spine MRI." Based on the MRI they would determine whether a spinal cord stimulator was indicated.

Petitioner also submitted records from Dr. Vales. On September 3, 2015, he noted that Petitioner "was recently cleared for a pain similar (sic) for her low back through the disability, and this dates back to a work injury in 2003. They have referred her to Dr. Benyamin for that." Dr. Vales would have preferred Dr. Taimoorazy, "but we may not be able to get around that referral without the risk of getting it withdrawn. So for now, the neck is the priority. We will get her in with Dr. Taimoorazy and go from there."

In its motion, Petitioner requests the "Commission compel Respondent to order the MRI so the spinal cord stimulator trial may be carried out as the commission ordered, and the appropriate attorney fees and penalties to be ordered paid to Petitioner for the necessary enforcement of this order." As the Commission has explained in the past, we do not have any powers to "enforce" an order or "compel" the actions of parties. The Commission can only issue orders and awards and impose penalties when certain condition are met. In the case now before us, the record is a little unclear about whether Dr. Benyamin actually recommended an MRI prior to placement of the lumbar cord stimulator. The record indicates that a nurse practitioner recommended such a study and Petitioner testified that Dr. Benyamin recommended the MRI. In any event, the Commission now orders Respondent to authorize and pay for any prospective treatment recommended by Dr. Benyamin for treatment of her lower back related to her work injury in 2003. In addition, the Commission notes that Petitioner's request for penalties and fees is premature because we do not know what any prospective procedures would cost. If after the issuance of this order, Petitioner believes that Respondent's actions warrant the imposition of penalties and fees, it can pursue such a petition in the future.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for any and all prospective treatment recommended by Dr. Benyamin for treatment of her lumbar spine condition caused by her work related accident on April 21, 2003.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 5 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
R-12/11/18
46

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT DEERE,
Petitioner,

vs.

THE AMERICAN COAL COMPANY,
Respondent.

No. 15WC 11627
19IWCC0185

ORDER

This matter comes before the Commission on its own Petition to Recall the Commission Decision to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical/computational error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated April 8, 2019, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner Thomas J. Tyrrell.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued simultaneously with this Order.

Thomas J. Tyrrell

APR 16 2019

DATED:
TJT/jrc
051

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
☐ Modify	☐ PTD/Fatal denied
	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT DEERE,

Petitioner,

vs.

NO: 15 WC 11627
19IWCC0185

THE AMERICAN COAL COMPANY,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, exposure, arising out of and in the course of employment, causal connection, permanent disability, legal and evidentiary error, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

The Commission adopts the Arbitrator's Statement of Facts in its entirety, however, the Commission views the evidence different from the Arbitrator. The Commission finds no reason to disturb the finding of the Arbitrator as it pertains to coal workers' pneumoconiosis, however, the Commission finds Petitioner contracted a disabling pulmonary occupational disease as a result of an exposure that arose out of and in the course of his employment under the Act. Therefore, the Commission vacates the Arbitrator's Conclusions of Law and substitutes the following:

Petitioner proved by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Commission finds the testimony of Dr. Paul to be credible and most persuasive with regard to the Petitioner's

condition of chronic obstructive pulmonary disease.

Petitioner testified he worked in the coal mine for 40 years and the last 38 being below ground. He testified in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and trowel on, a glue used to put tiles up on the wall. He testified he was exposed to coal dust on the date he retired. Petitioner's medical records reflected treatment for upper respiratory infections, sinusitis and coughs over the years. With these acute conditions, Petitioner complained of cough, sometimes with, and sometimes without, sputum production. Petitioner testified that when he would get a cold his breathing would become labored, or he would cough up black sputum beginning in the early-to-mid 1980's. (T, p. 29-30) Petitioner testified that since he left the mine, his breathing problems "pretty much stayed the same." (T, p. 30) He testified he cannot seem to take a deep breath when trying to do yard work or playing with his grandkids. (T, p. 31) He testified that his hobbies and activities of daily living are now affected. He testified he can no longer ride a bike, or run and or trek into the back woods when hunting. (T, p. 32)

The Commission agrees with the Arbitrator that Dr. Castle's and Dr. Meyer's interpretation of Petitioner's chest x-rays are more persuasive than those of Dr. Smith and Dr. Paul regarding the presence of coal workers' pneumoconiosis in Petitioner's lungs but would not go so far as to say, as the Arbitrator did, that Dr. Paul's opinion regarding Petitioner's chronic bronchitis and chronic obstructive pulmonary disease is not persuasive. To the contrary, Dr. Paul is board certified in allergy, asthma and immunology. Although, by his own admission, Dr. Paul is not a B-reader, the Commission recognizes Dr. Paul's long history of treating coal miners for coal mine-induced lung disease and equally long history of interpreting chest x-rays of coal miners, but those histories cannot be said to be the same as taking the B-reading course and passing the B-reading test. Dr. Paul's experience makes his opinion as credible as one can be without the requisite training that a B-reader possesses.

With respect to the chest x-ray interpretations of Petitioner's certified B-reader, Dr. Smith, the Commission notes that, as Dr. Meyer testified, there can be disagreement between B-readers concerning the presence of small opacities on a chest x-ray. Dr. Meyer disagreed with Dr. Smith's report. (Rx1, Exhibit B). As Dr. Meyer testified, one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film. (Rx1, pp. 35, 36)

Dr. Castle testified that he is a certified B-reader and he reviewed the chest x-ray dated November 12, 2015 and that there were no parenchymal abnormalities consistent with pneumoconiosis. Dr. Castle testified that Dr. Smith interpreted the same film and indicated that there were opacities throughout both lung fields classified as P/P with a profusion of 1/0. He testified that this meant that Dr. Smith also considered that the film may be negative. Dr. Smith did not testify.

The Commission finds it instructive to have testimony of a B-reader that explains the idiosyncrasies of B-reading and, more specifically, a positive and/or negative B-reading finding. For this reason, the Commission finds Dr. Meyer's and Dr. Castle's testimony helpful and more persuasive than the x-ray interpretation reports of Dr. Smith and Dr. Paul with regard to coal workers' pneumoconiosis.

The Commission disagrees with the Arbitrator, however, with respect to the evidence demonstrating pulmonary disease. The Commission is persuaded by Dr. Paul's explanation of his diagnoses of chronic bronchitis and chronic obstructive pulmonary disease. Petitioner was seen by Dr. Paul at the Central Illinois Allergy and Respiratory Service on November 12, 2015 and underwent what was referred to as a black lung evaluation. Dr. Paul testified that he noted in his report that the pulmonary function tests were within normal limits. He further testified that under the AMA Guides to Impairment, Sixth Edition, the pulmonary function testing would not be within normal limits; rather, it would be considered mildly abnormal based on the FEV1/FVC ratio. He testified that it would indicate an obstructive impairment which would be compatible with chronic bronchitis. Dr. Paul also testified that coal dust can cause chronic bronchitis and chronic bronchitis is one of the things that make up the chronic obstructive pulmonary disease syndrome. (Px1, pp. 13,14) Dr. Paul opined that the coal dust environment to which Petitioner was exposed caused his conditions of chronic bronchitis and chronic obstructive pulmonary disease. Dr. Paul also opined Petitioner has significant pulmonary impairment caused by coal dust. (Px1, p. 16)

Dr. Paul noted Petitioner had coughing and wheezing during upper respiratory infections which would hang on about two months and he would get these four or five times per year. Dr. Paul testified that amount of coughing, eight to ten months a year for a number of years, fulfills the definition of chronic bronchitis. Although Dr. Paul did not review Petitioner's medical records, those from Logan Primary Care Services, Inc., support regular visits for coughs that would, at times, linger. (Rx3, 3/15/00 -"cough never really resolved...cough worse at night...deep breath forces him to cough"; 1/17/01-- "cough" prescribed antibiotic for 10 days; 8/27/01- cough; prescribed antibiotic; 2/3/04-5-day history of upper respiratory symptoms, productive cough, Acute Bronchitis; 3/20/06-Assessment: Upper respiratory infection-off-work; 11/3/06-Subjective: nasal discharge, cough, sore throat, green sputum. Duration of symptoms: 2 months on and off. Prescribed antibiotic and cough medicine; 11/7/07- Throat inflamed. Assessment: Upper respiratory infection; 12/4/09- Diagnosis: Upper respiratory infection viral; 9/10/12- congestion, cough; 1/20/18- congestion, cough and sore throat, worsening. Prescribed antibiotic; 1/30/18: Respiratory: Positive for cough)

The Commission finds the records from Logan Primary Care Services, Inc. are not dispositive of Petitioner's entire medical history and do not contradict the history that Petitioner provided to Dr. Paul. Thus, by Dr. Paul's definition, Petitioner has chronic obstructive pulmonary disease.

The Commission notes that Dr. Castle performed a medical records review and concluded Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. Dr. Castle reviewed the Petitioner's medical records noting there was never a diagnosis made of chronic bronchitis or chronic obstructive pulmonary disease. Dr. Castle testified that a cough is not considered an objective determinate of pulmonary impairment. Dr. Castle also testified, however, that having pulmonary function tests within the range of normal does not mean your lungs are free of any long damage, injury or disease. (DepT, p. 62) Dr. Castle also testified there is no objective measure of a cough but that does not mean it is without importance, medically speaking. (DepT, p. 66)

Dr. Castle then testified that if he had taken a patient history he could have asked the right questions and figured out whether Petitioner was giving an accurate history to Dr. Paul and how it squared with his treating records, but at the time he issued his report and at the time of his testimony, he was without that information in his dataset. He conceded on cross-examination chronic bronchitis is a diagnosis determined by patient history and that chronic bronchitis is one of the chronic obstructive pulmonary diseases. Dr. Castle qualified his answer adding, "it is considered chronic obstructive pulmonary disease provided there is evidence of obstruction, and in the absence of obstruction it is simply bronchitis." (DepT, pp. 73-74)

The Commission notes that Dr. Castle was critical of the method Dr. Paul used in his determination of Petitioner's FEV1/FVC ratio. Dr. Castle opined that the Petitioner's FEV1/FVC 74% ratio, which proved Dr. Paul's theory that Petitioner had obstruction, was faulty. Given Dr. Paul's extensive experience, that he examined the Petitioner and took his own history, the Commission finds that Dr. Paul's testimony regarding Petitioner's FEV1/FVC ratio of 74% proving obstruction to be more persuasive than Dr. Castle's testimony because Dr. Castle did not perform his own pulmonary function tests, nor did he cite any studies to support his assertion that Dr. Paul's methodology to arrive at a FEV1/FVC ratio was incorrect, and most important, Dr. Castle did not examine Petitioner and did not have the opportunity to ask Petitioner's questions.

Petitioner testified that his complaints since leave mining on January 30, 2015 have remained stable. The Commission recognizes that although Petitioner's health has remained stable, since his mining career ended, the ill-effects of that career still linger.

The Commission, based on the evidence, finds Petitioner's employment as a coal miner exposed him to coal mine dust and other mining substances that resulted in him developing chronic obstructive pulmonary disease. The Commission finds the evidence supports a finding that Petitioner suffered a permanent partial disability as a result of his employment with Respondent. Thus, the Commission finds that an analysis under Section 8.1b(b) is warranted.

The Commission finds neither party submitted an impairment rating report or opinion into evidence under Section 8.1b(b)(i), thus no weight is given to the first factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Commission notes that the Petitioner is retired, but his occupation at the time of exposure was a coal miner; the Commission gives this factor some weight;

With respect to Section 8.1b(b)(iii), the Commission notes that the Petitioner was 62 years old at the time he retired, the same date as his last exposure. Given that the Petitioner is at the end of his career, and he has remained stable, the Commission gives this factor significant weight;

Under Section 8.1b(b)(iv), as it relates to Petitioner's future earning capacity, the Commission finds that Petitioner has not proven that his future earning capacity will be diminished. Petitioner testified that when he retired from working, he receives a pension, has a 401k and signed up for Medicare. The record is silent regarding any connection between his condition of ill-being and effect on his future earning capacity, thus the Commission gives this factor little weight;

With respect to the treating medical records as corroborative of Petitioner's disability under Section 8.1b(b)(v), the Commission notes Petitioner's treating medical records indicate Petitioner's condition has remained stable since he was last in a mine, but those same medical records indicate Petitioner's chronic bronchitis, characterized by Dr. Paul as chronic obstructive pulmonary disease, is an ongoing issue, to be indicative of Petitioner's disability, and assigns moderate weight to this factor.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after reviewing the entire record, and applying §8.1b(b) of the Act, the Commission concludes Petitioner's forty-plus year career as a coal miner introduced him to exposures that resulted in injuries to his pulmonary system and thus he suffered a 10% loss of use of a person as a whole under Section 8(d)2 as the result of the January 30, 2015 work-related accident.

The Commission further modifies the Arbitrator's Decision to correct a scrivener's error in paragraph four, the fifth line on page four, from "1975" to "2015."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2018, is hereby reversed and modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 16 2019
TJT/bsd
O: 2/5/19
42

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEERE, ROBERT
Employee/Petitioner

Case# **15WC011627**

THE AMERICAN COAL COMPANY
Employer/Respondent

19IWCC0185

On 5/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT DEERE
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 15WC 011627

Consolidated cases: N/A

19IWCC0185

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **January 30, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner's earnings were **$63,921.33** and Petitioner's average weekly wage was **$1,229.26.**

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical or TTD, TPD, or maintenance benefits.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.**

Respondent *is* entitled to a credit of **$0** for any medical bills paid through its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he has an occupational disease due to an occupational exposure on January 30, 2015. Petitioner's claim for compensation is denied and no benefits are awarded.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

May 11, 2018
Date

MAY 16 2018

Findings of Fact and Conclusions of Law

The Arbitrator finds:

Summary of the Medical and Depositions

Medical records of Logan Primary Care were admitted into evidence. Petitioner was seen on December 7, 1999, complaining of cough, cold, congestion, coughing up phlegm and eyes burning. His lungs were clear at the time. The assessment was that of an upper respiratory infection. (Respondent's Exhibit No. 3, p. 45). Petitioner was seen on March 15, 2000, with primary concern of a cough. He related that he was treated in December of 1999, and got better with medication, but his cough never really resolved. He had sinus drainage which was clear. The cough was non-productive and was described as a dry/tickle cough which was worse at night. When Petitioner attempted to take a deep breath, it forced him to cough. Examination of the lungs showed rate and depth were regular and unlabored on auscultation anteriorly and posteriorly. The diagnosis was sinusitis. (Respondent's Exhibit No. 3, p. 44). Petitioner was again seen on January 17, 2001, for congestion and sinusitis. According to the report he had sinusitis annually. His assessment remained that of sinusitis. (Respondent's Exhibit No. 3, pp. 42-43). Petitioner was seen on August 27, 2001, for an upper respiratory infection. He had no cough. Petitioner's lungs were clear to auscultation and percussion bilaterally. The diagnosis was upper respiratory infection. (Respondent's Exhibit No. 2, p. 39).

Petitioner was again seen at Logan Primary Care on February 3, 2004, for acute bronchitis. The physical examination of Petitioner's lungs showed they were clear to auscultation and percussion bilaterally. (Respondent's Exhibit No. 3, p. 36).

Petitioner was again seen at Logan Primary Care on March 20, 2006. At that time he was diagnosed with fatigue and an upper respiratory infection. (Respondent's Exhibit No. 3, p. 34). Petitioner was seen on November 3, 2006, for sinus congestion and cough. His lungs were clear to auscultation bilaterally. The assessment was sinusitis. (Respondent's Exhibit No. 3, pp. 32-33). Petitioner was seen on November 7, 2007, for fatigue and sore throat. His lungs were clear. The assessment was upper respiratory infection. (Respondent's Exhibit No. 3, p. 31). Petitioner was seen on December 4, 2009, for the flu. Physical examination of the lungs showed they were clear to auscultation bilaterally, with no wheezes, rhonchi or rales. The assessment was a viral upper respiratory infection. (Respondent Exhibit No. 3, pp. 29-30).

Petitioner was again seen at Logan Primary Care on September 10, 2012, for an upper respiratory infection. He had a non-productive cough. Physical examination of the

lungs showed they were clear to auscultation and percussion. (Respondent Exhibit No. 3, pp. 27-28).

Petitioner was seen at Logan Primary Care on July 22, 2013, for a kidney stone. On that date his lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales. (Respondent's Exhibit No. 3, pp. 25-26).

Petitioner's last day working for Respondent was January 30, 2015.

Petitioner signed his Application for Adjustment of Claim herein on March 27, 2015. (AX 2)

Petitioner saw Dr. Glennon Paul on November 12, 2015, at the request of his counsel. A written report followed. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). According to the doctor's report, Petitioner was a non-smoker who was retired and didn't expect to go back to work. He was 63 years old and had worked in the coal mines for forty years until he retired in 1975. All of his work had been underground but he mostly worked at the face of the mine as a machine miner. His only problem with his lungs was that he would have coughing and wheezing whenever he had an upper respiratory tract infection which would "hang on" for about two months. He would get these four to five times per year and they had been ongoing for the last several years. Petitioner denied seeking medical treatment for it. Petitioner had a normal physical examination. His chest had normal inspiratory and expiratory effort with no chest wall deformities or dullness to percussion. Auscultation revealed no wheezes or rales. His CBC was normal. His pulmonary function studies were within normal limits. A chest-ray showed some fibronodular lesions through both lung fields to a mild to moderate degree. Dr. Paul's impression was simple type Coal Workers' Pneumoconiosis.

On November 24, 2015, and at the request of Petitioner's attorney, Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray of Petitioner dated November 12, 2015. Dr. Smith interpreted the chest x-ray as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. (Petitioner's Exhibit No. 2).

On February 23, 2016, and at the request of Respondent's counsel, Dr. Christopher Meyer, a B-reader, was asked to review a November 12, 2015 chest x-ray of Petitioner. He deemed the film over-exposed and unacceptable for ILO B-reading interpretation. It was a copy of a film and he noted the original analog examination might be of acceptable quality. (RX 1, Exhibit B)

On April 16, 2016, and at the request of Respondent's counsel, Dr. Christopher Meyer, a B-reader, reviewed a PA and lateral chest radiograph dated November 12, 2015, from Central Illinois Allergy and Respiratory. He interpreted the x-ray as negative for coal

workers' pneumoconiosis. Dr. Meyer further noted that he had reviewed a narrative summary and B-reading form prepared by Dr. Henry Smith regarding the same chest radiograph. Dr. Meyer expressed his disagreement with Dr. Smith's report wherein he found small opacities of size "p" with profusion of 1/0. His lungs were clear and there were no findings of coal workers' pneumoconiosis (cwp). (Respondent's Exhibit No. 1, Exhibit B).

On August 10, 2016, and at the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and chest x-ray regarding Petitioner and issued a written report. Dr. Castle concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as result of his occupational exposure to coal mine dust. He found the pulmonary function study of November 12, 2015 to be entirely normal. He also reviewed the 11/12/15 chest x-ray of Petitioner and found no evidence of any parenchymal abnormalities consistent with pneumoconiosis. He further noted Dr. Smith's interpretation of a profusion of "1/0" stating that meant the doctor acknowledged the film could be negative for cwp. (Respondent's Exhibit No. 2, Exhibit C).

Deposition of Dr. Meyer

The deposition of Dr. Meyer was taken on September 30, 2016. Dr. Meyer has been board certified radiology since 1992. (Respondent's Exhibit No. 1, p. 8). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit No. 1, pp. 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader program. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer has recently been asked to have a more active 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, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty is typically experienced senior level B-readers. (Respondent's Exhibit No. 1, pp. 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion 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 making a distinction between a 0/1 and 1/0 film. (Respondent's Exhibit No. 1, pp. 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. (Respondent's Exhibit No. 1, p. 29). The distribution of the

opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, p. 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 31).

Dr. Meyer testified that at the request of Respondent's counsel, he reviewed a PA and lateral chest radiograph dated November 12, 2015, from Central Illinois Allergy and Respiratory. (Respondent's Exhibit No. 1, p. 41). Dr. Meyer testified that he first received a copy film which he judged to be unreadable for an ILO B-reading interpretation. Subsequently he received the original film for that date. He graded the subsequent original examination as quality 2. It was still a little over exposed but diagnostic. Dr. Meyer noted a wedged deformity of the thoracic spine but there were no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, pp. 41-42).

On cross-examination Dr. Meyer acknowledged that an individual could have CWP pathologically. He was also asked about CT scans and their costs and risks of radiation. (Respondent's Exhibit No.1, pp. 42 – 47, 51- 52). Dr. Meyer was also asked about B-readings, including the reality that B-readers can disagree as to whether a film shows CWP or not. Dr. Meyer explained that it is important that the individual interpreting the film have ample experience in reading them to be able to sort out what is in the background and what is normal. (RX 1, pp. 47 – 51, 79 - 80) He agreed that medical records and pulmonary function studies would not change his opinion regarding what he might see on the x-ray. The x-ray is a piece of hard data and symptoms are symptoms and vary from person to person. He agreed that Category 1 CWP is an x-ray diagnosis. (RX 1, pp. 52-53) Dr. Meyer was also asked general questions about the nature of CWP. (RX 1, pp. 53 – 64, 66 - 67). He was also asked questions about progressive massive fibrosis. (RX 1, pp. 64-65)

Dr. Meyer testified that he does about 160 to 200 B-readings per month. He acknowledged that he is generally retained by the coal company rather than the coal miner. (RX 1, p. 67) The doctor was also asked about histoplasmosis, including where it can be found and how it appears on x-ray. (RX 1, pp. 67- 70, 74)

Dr. Meyer testified that one will find coal dust in all coal miner's lungs. The real question is when is the threshold achieved to result in there being enough coal to show up on an x-ray. (RX 1, p. 72) Dr. Meyer also testified that overexposure of a film makes it more difficult to appreciate the abnormalities of CWP. (RX 1, p. 72)

Dr. Meyer acknowledged that the first time he took the B-reader exam he failed it. (RX 1, p. 74) Dr. Meyer explained the circumstances surrounding the test result the first

time. (RX 1, pp. 87-88, 90 - 91) He testified that the opacities of CWP are found in the mid and lower lung zones. When asked if it can be found in themed and lower lung zones and not the upper lung zones on occasion, he responded, "Very rarely." (RX 1, pp. 77-78) Dr. Meyer was asked about the recent study by Laney and Petsonk. (RX 1, pp. 78, 80 - 85)

Dr. Meyer acknowledged that it is possible for a miner to have pneumoconiosis determined by pathology that was not appreciated on a radiographic study. It's also possible that a miner who has a split opinion on the existence of CWP can have it found on autopsy or biopsy. (RX 1, p. 87) He also acknowledged that there are studies showing that, at autopsy, as much as 50 percent of coal miners are found to have abnormalities of coal workers' pneumoconiosis when it might not have been apparent radiographically during life. (RX 1, p. 88) He also acknowledged that if a B-reading is negative that doesn't necessarily rule out that the miner might have the disease pathologically. (RX 1, p. 89)

On redirect examination Dr. Meyer testified that Petitioner has neither massive fibrosis or cor pulmonale. He had no evidence of bulla or hyperinflation. He further testified that the study by Laney and Petsonk did not address the early disease process. (RX 1, pp. 90 – 93) Dr. Meyer further testified that CWP is typically an upper-zone nodular disease and if a non-B-reader simply makes a diagnosis of pneumoconiosis one still doesn't know if it meets the technical criteria for the diagnosis because it isn't identified. (RX 1, p. 94)

Deposition of Dr. Paul

The deposition of Dr. Paul was taken on February 17, 2017. (PX 1) Dr. Paul was the Director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at the SIU Medical School. (Petitioner's Exhibit No. 1, p. 6). Dr. Paul was the senior physician at the Central Illinois Allergy & Respiratory Clinic. Those physicians specialize in allergy and pulmonary disease. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. (Petitioner's Exhibit No. 1, p. 7). Dr. Paul is semi-retired and occasionally does black lung evaluations. He does not take any new patients. Dr. Paul supervises a DUI clinic's medical treatment program. (Petitioner's Exhibit No. 1, pp. 46-47). Dr. Paul is board certified in asthma, allergy and immunology. (Petitioner's Exhibit No. 1, p. 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease. (Petitioner's Exhibit No. 1, pp. 9-10). Dr. Paul is not an A-reader or a B-reader. He has never been board certified in pulmonary disease. (Petitioner's Exhibit No. 1, p. 46). Dr. Paul has seen hundreds of individuals at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 46).

Dr. Paul testified that it was his understanding that Petitioner was a lifelong non-smoker. He worked for 40 years in the coal mines, all underground. (Petitioner's Exhibit No. 1, p. 11). According to Dr. Paul, Petitioner had coughing and wheezing during upper respiratory infections which would hang on about two months and he would get these four or five times per year. Dr. Paul testified that amount of coughing, eight to ten months a year for a number of years, fulfills the definition of chronic bronchitis. Dr. Paul testified that Petitioner had a negative methacholine challenge. (Petitioner's Exhibit No. 1, p. 12). Dr. Paul also testified that he recorded in his report that the pulmonary function tests were within normal limits. He testified that under the *AMA Guides to Impairment, Sixth Edition* the pulmonary function testing would not be within normal limits; rather, it would be considered mildly abnormal based on the FEV1/FVC ratio. He testified that it would indicate an obstructive impairment which would be compatible with chronic bronchitis. (Petitioner's Exhibit No. 1, p. 13). Dr. Paul also testified that Petitioner's chronic bronchitis was caused by coal dust exposure. He testified that Petitioner had coal workers' pneumoconiosis and COPD caused by the coal dust environment. Dr. Paul testified that in light of these diagnoses. Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, p. 15-16).

Dr. Paul testified that a person could have coal workers' pneumoconiosis and still have a negative chest x-ray. He testified that the gold standard for diagnosing pulmonary disease is pathologic review of the tissue itself. Dr. Paul testified that he had heard of studies that indicate that 50% or more of long term coal miners have coal workers' pneumoconiosis at autopsy even though during life it was never diagnosed radiographically. (Petitioner's Exhibit No. 1, p. 18). Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. The scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. (Petitioner's Exhibit No. 1, p. 20). Dr. Paul testified that, by definition, if one has coal workers' pneumoconiosis, he would have some impairment in the function of the lung at the site of the scarring whether it could be measured by spirometry or not. (Petitioner's Exhibit No. 1, p. 21). A person could have radiographically significant coal workers' pneumoconiosis and normal pulmonary function testing, normal blood gases and normal physical examination of the chest. Coal workers' pneumoconiosis is considered to be a progressive disease. (Petitioner's Exhibit No. 1, p. 24).

Dr. Paul testified that Petitioner did not complain to him of shortness of breath. He was not taking any breathing medications when Dr. Paul saw him. Dr. Paul did not get a history from Petitioner of ever having taken breathing medications. Petitioner did not provide to Dr. Paul any past medical history of black lung. Dr. Paul did not review any treatment records regarding Petitioner. (Petitioner's Exhibit No. 1, p. 42). Dr. Paul's physical examination of Petitioner's chest revealed no sign of disease. Dr. Paul testified

that the FEV1/FVC ratio on the testing performed at his office was 74%. The forced vital capacity was normal at 109%, and the FEV1 was normal at 107%. Dr. Paul testified that under the *AMA Guides*, to be normal the FEV1/FVC ratio would need to be 75% or more. (Petitioner's Exhibit No. 1, p. 43). Petitioner's total lung capacity was normal. He had no restriction. He did not have an impairment in gas exchange. (Petitioner's Exhibit No. 1, p. 44).

Dr. Paul did not know the date of the chest x-ray he reviewed. He testified that the film quality was good. (Petitioner's Exhibit No. 1, p. 44). Dr. Paul testified that there were opacities present. He testified that Petitioner's chest x-ray had multiple different opacity types and they were all coal types. Dr. Paul did not remember what lung zones were involved. Dr. Paul did not give the film a profusion rating. (Petitioner's Exhibit No. 1, pp. 45-46).

Dr. Paul testified that Petitioner did not tell him that he left mining at the time he did due to a breathing problem. He also acknowledged that Petitioner did not tell him that he left mining when he did on the advice of a physician or that he was unable to perform the duties of his last job in the mine. (Petitioner's Exhibit No. 1, p. 46).

Deposition of Dr. Castle

The deposition of Dr. Castle was taken on June 8, 2017. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. (Respondent's Exhibit No. 2, p. 4). Board certification in pulmonary disease was first established in 1941. (Respondent's Exhibit No. 2, p. 32). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. (Respondent's Exhibit No. 2, p. 7). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 8). Dr. Castle has been certified as a B-reader since 1985. (Respondent's Exhibit No. 2, p. 14).

Dr. Castle reviewed a chest x-ray dated November 12, 2015, from Central Allergy and Respiratory Service. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis. He found no evidence of pneumoconiosis or any coal mine dust-induced lung disease on the chest x-ray. (Respondent's Exhibit No. 2, p. 28). Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. Dr. Castle testified that for a proper reading of a chest film for pneumoconiosis, the ILO classification sheet starts with the name of the individual, and the date of the film. He testified that the quality of the film is important. Then the reader determines whether or not there are any opacities, the type of opacities, the size of the opacities and the location of the opacities based upon side by side comparison with the

standard ILO films. (Respondent's Exhibit No. 2, p. 29). Dr. Castle noted that Dr. Henry Smith interpreted the same film and indicated that there were opacities throughout both lung fields classified as P/P with a profusion of 1/0. He testified that this meant that Dr. Smith also considered that the film may be negative. (Respondent's Exhibit No. 2, p. 31).

Dr. Castle testified that the pulmonary function study obtained on November 12, 2015, was valid and was entirely normal. He testified that there was no evidence of any physiologic abnormality of any cause including coal workers' pneumoconiosis and coal mine dust exposure. (Respondent's Exhibit No. 2, pp. 31-32). Dr. Castle concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. (Respondent's Exhibit No. 2, p. 32). Dr. Castle testified that Dr. Paul determined that Petitioner's FEV1/FVC ratio was 74%. Dr. Castle testified that in spirometry testing one is supposed to take the greatest forced vital capacity and the greatest forced expiratory volume in one second to determine what the FEV1/FVC ratio is. He testified that Dr. Paul did not do that. Dr. Castle testified that when the highest FEV1 and the highest FVC are used, Petitioner's FEV1/FVC ratio in the testing performed in Dr. Paul's office was 75%. He testified that this is exactly what was predicted for Petitioner. (Respondent's Exhibit No. 2, p. 26). Dr. Castle testified that the evidence did not indicate an obstruction. Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. Employing Table 5.4 of the Guides, Petitioner would fall under Class 0 impairment. (Respondent's Exhibit No. 2, p. 27).

Dr. Castle also reviewed medical records. In his review of medical records of Petitioner, there was never a diagnosis made of chronic bronchitis or COPD. (Respondent's Exhibit No. 2, pp. 27-28). Dr. Castle testified that cough is not considered an objective determinate of pulmonary impairment. Dr. Castle testified that in his review of medical in this case there was no pathologic evidence of disease in Petitioner. From the objective testing performed on Petitioner, from a respiratory standpoint, he was capable of heavy manual labor. (Respondent's Exhibit No. 2, p. 28).

Dr. Castle agreed with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. He also testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. (Respondent's Exhibit No. 2, p. 32). Dr. Castle testified that to his knowledge, Petitioner had sufficient exposure to the environment of the coal mine to cause coal workers' pneumoconiosis in a susceptible host. He agreed that Petitioner's treatment records did not mention any evidence of pneumoconiosis but that alone would not rule it out. (Respondent's Exhibit No. 2, p. 34). Dr. Castle testified that it is true that one can have disease and have a negative chest x-ray. Dr. Castle testified that recent studies were shown as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not

appreciated by radiographic study during their lives. (Respondent's Exhibit No. 2, p. 40). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology. Dr. Castle described the abnormality of coal workers' pneumoconiosis as basically trapped coal dust in a part of the lung which ends up wrapped in scar tissue and can be accompanied by emphysema around it. (Respondent's Exhibit No. 2, p. 44). Dr. Castle testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring. (Respondent's Exhibit No. 2, p. 45).

Dr. Castle acknowledged that one can have radiographically significant coal workers' pneumoconiosis and yet have normal spirometry and normal pulmonary function and even, possibly, no complaints. If they do have complaints, it is usually shortness of breath. (RX 2, p. 47) Dr. Castle, having reviewed Petitioner's medical records at Logan Primary Care did not see any evidence/documentation that Petitioner was having upper respiratory infections four or five times a year. (RX 2, pp. 72-73) He acknowledged that had he taken a patient history from Petitioner he could have asked the "right questions" to determine if Petitioner was giving an accurate history to Dr. Paul. As it stands, he relied upon the records. (RX 2, p. 73)

Dr. Castle charged $1,200.00 for his forensic review of medical films and $1,900.00 for his deposition. (PX 3)

Additional Medical Care

Petitioner was seen at Logan Primary Care on January 16, 2018, for hypertension. Petitioner reported being active and he was using the elliptical at John A. Logan three to four times a week. Petitioner did not have any shortness of breath. On physical examination, Petitioner's respiratory effort was normal and he had no respiratory disease. (Respondent's Exhibit No. 3, pp. 2-3). Petitioner was again seen on January 20, 2018, with an upper respiratory infection. His presenting symptoms included congestion, non-productive cough and a sore throat. His symptoms had been present for three days. The assessment was pharyngitis and a cough. The PA felt this was an acute condition that could be treated with medication. (Respondent's Exhibit No. 3, pp. 3-7). Petitioner was seen on January 30, 2018, for follow up on his hypertension. Petitioner reported that his acute pharyngitis was better, but he had minor cough. His review of systems was negative for shortness of breath and wheezing. (Respondent's Exhibit No. 3, pp. 7-9).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 14, 2018. Petitioner was the sole witness testifying at the hearing. The issues in dispute were occupational disease, causal connection, Sections 1(d) through 1(f) of the Occupational Diseases Act, and the nature and extent of any injury.

Petitioner testified that he lives in Energy, Illinois. He was 65 years old at the time of arbitration and married to Teresa. Petitioner testified that he attended John A. Logan College for about two years but did not receive certificates or degrees. Petitioner further testified that he worked in the coal mine for 40 years with the first two years being above ground and the last 38 being below ground. Petitioner testified that in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and trowel on. Petitioner described trowel on as a glue used to put tiles up on the wall.

Petitioner's last date in coal mining was January 30, 2015, with Respondent at its Galatia mine. Petitioner was 62 years old on that date. His job classification was mine examiner. Petitioner testified that he was exposed to coal dust on that day. Petitioner testified that this was his last day working at Respondent because he retired. He testified that he had had enough. Petitioner has not looked for work or been employed since retiring from Respondent.

Petitioner testified that he started working for Ruttman in mine construction in 1975. That work was above ground. He was building the Monterey No. 1 mine. The first time he went to work underground was for Inland Steel Coal Company in 1977. He was hired as a shuttle car operator. Petitioner testified that the shuttle car would take the coal that was being cut from the face of the mine and transport it to the conveyor belt. He described this as a fairly dusty job. He worked in that position for one year. Then he became a continuous miner operator. He was actually operating the machine that cuts the coal from the face of the mine. Petitioner worked as a continuous miner operator for 15 years. He next worked as a laborer where he would fill in for anyone who was off and they kept putting him back on the continuous miner. Petitioner testified that he was temporarily assigned to the longwall. He worked in all positions on the longwall including shear operator, shield puller and even repairman. Petitioner testified that the longwall takes the place of the continuous miner. He described the longwall as a shear that runs along the face of the mine. It literally cuts the coal out of the wall. He testified that when that coal drops it is extremely dusty. Petitioner worked in that job for two to three years. Next Petitioner became a mine examiner. His duties were to check the belt lines, escapeways, working units, and ventilation to make sure there was enough air ventilating the faces. He had to make sure everything was up to regulation and code. He was walking all over the mine. He was doing the mine examiner job when he was exposed to the roof bolting glue fumes. As an examiner he was exposed to pretty much every

exposure in the mine. Petitioner was an examiner at Inland Steel for five or six years until he was laid off in July 2002. He was called back as a diesel scoop operator to take equipment out of the mine. His last day at Inland was May 27, 2003.

Petitioner went to work for Respondent in 2004 at the Millennium Portal in Galatia. He was hired in as an operator and then was put on the longwall for a period of time. He worked as an examiner for Respondent. He also ran diesel equipment for six months underground. He has not worked at any mine since his retirement.

Petitioner testified that he first noticed his breathing problems at work after he had been working on the continuous miner. He noticed that when he would get a cold or his breathing would become labored, he would cough up black sputum. He testified that it would have been somewhere early to mid-1980s when he first noticed his breathing problems. Petitioner testified that from the time he first noticed the breathing problems until he left the mines, it did not get any better. He testified that at times it got a little worse. He testified that his breathing problems have stayed pretty much the same since he left the mine. Petitioner does not take any breathing medications. Petitioner testified that he cannot seem to take a deep breath.

Petitioner testified that with yard work or playing with his grandkids he has to stop and rest. Petitioner testified that he has always been very active sports-wise. Petitioner testified that the last time he participated in sports would have been slow pitch softball approximately 20 years ago. While he was still working, he noticed the difference in his breathing ability and that he would get tired. Petitioner testified that he tries to stay active with his grandchildren. He testified that he quit bike riding and cannot run anymore. He tries to walk on the treadmill a little bit to keep himself in as good of shape as he can. Petitioner testified that he hunts. He testified that he did not use to hesitate to trek way back in the woods, but he cannot do that anymore. He tries to stay closer to the edge near the road. Petitioner testified that he deer hunts from a ladder stand. He testified that he killed a deer this past hunting season. Petitioner testified that he goes to John A. Logan College to work on an elliptical three or four times per week. He spends about 30 minutes there each time. He also does some light lifting. Petitioner testified that he spends quite a bit of time with his grandkids watching their sports. Petitioner testified that he lives on about eight acres. He mows the grass with a riding mower.

Petitioner testified that Dr. Mark Smith at Logan Primary Care was his family doctor until he retired a few years ago and now he sees Dr. Workman. He testified that he saw these physicians for breathing difficulties. He testified that when he would get bronchitis, he could not breathe and he would go to these doctors for treatment. He testified that the doctors were aware that he was a miner. Petitioner has never smoked. Petitioner takes medication for blood pressure. Petitioner testified when he treated with Dr. Smith and Dr. Workman at Logan Primary Care, he was honest with him in sharing

whatever respiratory complaints he had or did not have. He testified that he was honest with Dr. Paul in sharing his respiratory problems.

Petitioner testified that from time to time over the years, he underwent chest x-ray screening by NIOSH for black lung. He testified that after the chest x-ray, NIOSH would write to him and tell him what the chest x-ray revealed. Petitioner testified that he had those letters with him in his car at the time of arbitration. He testified that he did not know if he would need them at arbitration.

The Arbitrator concludes:

1. Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Arbitrator finds the B-readings by Drs. Meyer and Castle to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer to be insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis were impressive and beyond that of Petitioner's physicians, Drs. Smith and Paul. Dr. Meyer testified to the training received in the B-reading course. Dr. Paul does not have that training. Drs. Meyer and Castle are both B-readers and have been recertified as same numerous times. Coal Worker's Pneumoconiosis is a diagnosis made by chest x-ray interpretation. Three B-readers interpreted the 2015 chest x-ray. Two of them found it to be negative for CWP.

   Petitioner testified that from time to time over the years, he underwent chest x-ray screening by NIOSH for black lung. He testified that after the chest x-ray, NIOSH would write to him and tell him what the chest x-ray revealed. Petitioner testified that he had those letters with him in his car at the time of arbitration. The Arbitrator reasonably infers that if those letters supported his claim they would have been submitted at arbitration; however, they weren't.

   The Arbitrator notes that over the years Petitioner's medical records have reflected treatment for upper respiratory infections and sinusitis. With these acute conditions, Petitioner complained of cough, sometimes with and sometimes without sputum production. Petitioner testified at arbitration that his breathing would become labored or he would cough up black sputum when he would get a cold. Petitioner continues to hunt from a ladder stand. He also testified that he works on an elliptical three or four times per week. The medical records which were put into evidence do not contain any complaints of shortness of breath. In the most recent treatment records from two months prior to arbitration, Petitioner denied shortness of breath. The Arbitrator gives more

weight to the medical entries than Petitioner's arbitration testimony as the latter may have been motivated to support his claim.

The Arbitrator did not find Dr. Paul's opinions regarding Petitioner's chronic bronchitis and COPD persuasive. Dr. Paul failed to mention their existence in his initial report. He acknowledged that Petitioner had no complaints of shortness of breath when he examined him. Petitioner was not taking any breathing medications. While the doctor testified that under the *AMA Guides to Impairment, Sixth Edition* Petitioner's pulmonary function testing would not be within normal limits; rather, it would be considered "mildly" abnormal based on the FEV1/FVC ratio, that was based upon a ratio of 74 and the *Guides* consider normal to be 75 or more. Other than the ratio, everything else about Petitioner's examination was normal. Dr. Paul took a history of Petitioner having four to five respiratory issues a year; however, he took no steps to obtain Petitioner's medical records to verify the accuracy of that history. The records from Logan Primary don't corroborate Petitioner's history to Dr. Paul.

Petitioner testified that he went to Logan Primary Care for bronchitis and that his doctor knew he was a miner. That, in and of itself, does not establish that mining was the cause of Petitioner's bronchitis. Petitioner could have deposed his primary care doctor but did not do so. While Petitioner further testified to current problems and difficulties with breathing, his testimony was not corroborated by any medical records or other witness. The more recent Logan Primary Care records suggest a fairly fit and active retiree who regularly works out at a gym and denied any shortness of breath.

The Arbitrator also notes that the date of accident/exposure herein is Petitioner's date of retirement from the mine. Petitioner did not associate his retirement with any specific breathing problems.

2. Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being was causally connected to his employment.

3. Petitioner failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

4. Petitioner's claim for compensation is denied and no benefits are awarded.

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