

# Commonwealth Of Kentucky

## Court Of Appeals

NO. 2000-CA-000166-WC

GREAT WESTERN COAL COMPANY

APPELLANT

v. PETITION FOR REVIEW OF A DECISION  
OF THE WORKERS' COMPENSATION BOARD  
ACTION NO. WC-93-10718

JESSE SHELL;  
ROBERT L. WHITTAKER,  
Director of Special Fund;  
RONALD W. MAY,  
Administrative Law Judge; and  
WORKERS' COMPENSATION BOARD

APPELLEES

### OPINION

### AFFIRMING

\*\* \*\* \* \* \* \* \*

BEFORE: GUDGEL, Chief Judge; HUDDLESTON and JOHNSON, Judges.

HUDDLESTON, Judge: Great Western Coal Company appeals from a Workers' Compensation Board decision affirming an Administrative Law Judge's order reopening, pursuant to Kentucky Revised Statute (KRS) 342.732(1)(c), Jesse Shell's claim for coal workers' pneumoconiosis.

Shell, who was born on October 3, 1937, had over twenty years of exposure to the hazards of coal workers' pneumoconiosis.

His last exposure occurred on October 2, 1992. On January 15, 1993, Shell filed a claim for benefits for coal workers' pneumoconiosis.

In his original claim, Shell presented evidence from Dr. Emery Lane, who interpreted an x-ray from July 29, 1992. Dr. Lane found evidence of coal workers' pneumoconiosis, category 2/1. On September 15, 1992, Dr. William Anderson evaluated Shell and interpreted x-rays taken that day. Dr. Anderson concluded that the x-rays showed a positive indication of coal workers' pneumoconiosis, categorizing the films as 1/1. Spirometric testing produced a forced vital capacity (FVC) value of 60% of predicted and a forced expiratory volume in one second (FEV1) result of 46% of predicted. On December 16, 1992, Dr. Glen Baker evaluated Shell and concluded that the claimant had category 1/1 coal workers' pneumoconiosis. Spirometric testing produced an FVC value of 61.5% of predicted and an FEV1 of 53.3% of predicted.

Great Western produced evidence from Dr. Abdul Dahhan, who evaluated Shell on March 18, 1992. Based on his interpretation of x-rays, Dr. Dahhan reported a negative result for coal workers' pneumoconiosis. Spirometric testing revealed an FVC of 81% of predicted and an FEV1 of 65% of predicted. Dr. Dahhan opined that chronic bronchitis and a history of cigarette smoking were the causes of Shell's pulmonary impairment. On March 5, 1993, Dr. Bruce Broudy examined Shell and interpreted an x-ray from that day as being negative for coal workers' pneumoconiosis. Spirometric testing revealed an FVC of 81% of predicted and an FEV1 value of 72% of predicted. Dr. Broudy believed that Shell's pulmonary

impairment was due to his chronic obstructive airway disease caused by cigarette smoking.

After considering the evidence, the ALJ awarded Shell a tier 2 benefits for a period of 425 weeks commencing on October 2, 1992. The ALJ apportioned the benefits one-fourth to Great Western and three-fourths to the Special Fund.

On June 30, 1998, Shell moved to reopen his claim on the basis that his disease condition had worsened, resulting in a greater vocational disability. In support, Shell offered an x-ray reading from Dr. Michael Alexander and a complete examination report from Dr. B.T. Westerfield. Dr. Alexander interpreted an x-ray from August 10, 1998, as a Grade I film that showed q/t opacities of a 1/1 profusion in all zones of both lungs. On June 11, 1998, Dr. Westerfield examined Shell and interpreted an x-ray from that date. Based on the x-ray, Dr. Westerfield believed that the x-ray taken on Grade I film showed q/t opacities of a 1/1 profusion in all zones of both lungs. Spirometric testing resulted in high performance values for FVC of 81% of predicted and an FEV1 of 48% of predicted. While the FVC had been performed satisfactorily, the FEV1 was outside of the 95% confidence levels. Repeating the studies after bronchodilator, the values decreased from an FVC of 67% of predicted and an FEV1 of 36% of predicted. Both results were outside of the 95% confidence level. Dr. Westerfield diagnosed Shell as suffering from coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Westerfield opined that Shell's work environment caused the

diseases and that, at least in part, the work environment also caused the pulmonary impairment.

Both parties also submitted reports and records from Dr. Baker. On February 10, 1998, Dr. Baker conducted spirometric testing, which revealed a high performance value for FVC of 82% of predicted and for FEV1 of 61% of predicted. The FEV1 result was outside of the 95% confidence interval. Dr. Baker repeated the testing on March 22, 1999, and the results were a high performance value for FVC of 61% of predicted and for FEV1 was 38% of predicted. Both results were outside of the 95% confidence level.

Great Western introduced evidence of Dr. Robert Powell's examination of Shell on September 5, 1998. From an x-ray taken on that day, the results were a Grade I film showing some abnormalities, which Dr. Powell rated as consistent with category 0/1 occupational pneumoconiosis. Spirometric testing revealed high performance values for FVC of 68% of predicted and for FEV1 of 40% of predicted. There existed a question from the shape of the flow volume loop as to whether the study represented a fixed obstruction. Dr. Powell concluded that the chest x-ray was consistent with 0/1 occupational pneumoconiosis and moderate obstructive ventilatory defect with hyperinflation physiologically consistent with pulmonary emphysema due to tobacco smoking but with indentation in the trachea areas and with flattening of the flow volume loop raising the possibility of a fixed airway obstruction.

Dr. Powell later testified that Shell made poor efforts during the spirometric testing and was not overly cooperative. Based on Dr. Baker's and Dr. Dahhan's spirometric studies and

assuming that the studies were valid, Dr. Powell opined that Shell's breathing had changed little since 1992. In response to a question regarding why spirometric test results may have lower values at one test and higher at a later session, Dr. Powell stated that illness, such as chronic bronchitis, will cause a varying FEV1 results. Any part of Shell's reduction in FVC or FEV1 that was caused by the inhalation of coal dust or sand dust would not produce a fluctuation in values. Dr. Powell concluded that coal dust exposure could be excluded as a physiological cause of any significant obstructive airway disease.

On March 13, 1998, Dr. Arthur Lieber of the University of Kentucky evaluated Shell. Interpreting the x-ray taken that day, Dr. Lieber found that it was a Grade I film showing p/p opacities of a 1/0 profusion in the upper zones of both lungs and also in the middle zone of the right lung. Dr. N.K. Burki conducted spirometric testing that revealed a high performance value for FVC of 65% of predicted and for FEV1 of 40% of predicted. The studies were repeated post-bronchodilator and produced an FVC of 69% of predicted and an FEV1 of 45% of predicted. The studies indicated an airway obstruction with no restrictive defect with a minimal response to bronchodilator-reduced diffusing capacity and mild hypoxemia.

Dr. Burki testified that he obtained valid spirometric testing results and reiterated his prior interpretation that the studies indicated an airway obstruction with no restricted defect. According to Dr. Burki, Shell's history of cigarette smoking, in and of itself, would have been sufficient to produce the

obstruction noted on pulmonary function testing. Cigarette smoking produces an obstructive impairment. Dr. Burki believed that the obstructive impairment indicated in the spirometric testing was the result of Shell's history of cigarette smoking. An impairment that results from coal workers' pneumoconiosis is usually restrictive; however, a person can have a mild large airway obstruction where an FEV1 might be reduced slightly and the ratio of FEV1 to FVC would not be expected to be reduced below 60% if it were primarily a large airway obstruction due to coal workers' pneumoconiosis. Because Shell's ratio was 49% before bronchodilator and 51% after, Dr. Burki believed that cigarette smoking caused the obstructive impairment. Where coal workers' pneumoconiosis might cause a mild decrease in FEV1, it would be rare that it would drop as low as 75% of predicted and even rarer for it to drop below 55%. When questioned regarding the different performance figures of Dr. Baker in 1996 and 1998, Dr. Burki opined that the most likely cause of the fluctuation was cigarette smoking, which was the biggest contributor to his pulmonary dysfunction.

On cross-examination, Dr. Burki testified that Shell's employment history as an underground coal miner would be sufficiently long to develop radiological changes of pneumoconiosis. Coal workers' pneumoconiosis is a progressive disease only if the exposure continues or if the patient develops progressive massive fibrosis. Dr. Burki stated that coal dust would be one of the factors that caused Shell's pulmonary impairment and that it could not totally be excluded, but that smoking was the major factor. If Shell were 15% impaired from his

breathing problems, less than 2% would be the result of coal dust exposure.

The ALJ concluded that he could not address the issue of the existence of coal workers' pneumoconiosis because prior proceedings had determined that Shell suffered from coal workers' pneumoconiosis category 1/1. In addition, prior proceedings determined whether Shell's impairment in 1992 and 1993 was the result of exposure to coal dust. The ALJ, however, concluded that he could address whether the worsening of Shell's pulmonary condition was caused by coal workers' pneumoconiosis, a history of cigarette smoking or a combination of both.

In evaluating the evidence, the ALJ noted that Shell filed the motion to reopen after the effective date of the 1996 amendments to the Workers' Compensation Act. Accordingly, it was appropriate that a university evaluator examine Shell. Because Shell's last exposure occurred before the effective date of the 1996 amendments, the ALJ did not give the university evaluator's conclusions presumptive weight. The ALJ also applied the provisions of KRS 342.732, which define the division lines between different tiers of awards for coal workers' pneumoconiosis as they existed at the time of Shell's last exposure. Likewise, the ALJ applied KRS 342.125, which describes the proof the claimant must present to receive an increased award as it existed on the date of Shell's last exposure.

The ALJ found that there existed no persuasive evidence to support a claim that the x-ray manifestation of Shell's pneumoconiosis progressed beyond the category 1/1 that a prior ALJ

had already determined. The ALJ noted that all of the physicians reported high performance values on spirometric testing for FVC 55% of predicted or greater. The prior ALJ based the original award on a reduction of FEV1 to 65% of predicted normal, which he found to be due in part to Shell's exposure to coal dust.

In the proceedings to reopen the claim, the ALJ noted that Dr. Baker was the only physician who reported a high performance value that exceeded 54% of predicted normal. The ALJ found that Dr. Baker utilized the wrong predicted normal in his calculations, which the physician based on an examination that preceded the motion to reopen by four months. Correcting Dr. Baker's calculation, the ALJ found that Dr. Baker's performance figure was below 55% of predicted. According to the ALJ, more significant was the fact that all of the high performance figures for FEV1 which were reported by all of the physicians were outside the 95% confidence level, except for Dr. Burki. Dr. Burki found that his spirometric studies were valid and reported an FEV1 value of less than 55% of predicted normal. The ALJ found that Dr. Burki could not exclude exposure to coal dust as a contributing cause of the reduced FEV1 value. Based on this evidence, the ALJ concluded that Shell met his burden of proof to reopen the claim. The ALJ concluded that Shell was entitled to total permanent disability benefits pursuant to KRS 342.732(1)(c). The ALJ awarded Shell \$293.09 per week to continue as long as Shell is disabled, with the employer paying the benefits for the first 245.7 weeks and the



Special Fund paying benefits thereafter, with appropriate credits for payments already made.

Great Western appealed to the Workers' Compensation Board, claiming, inter alia, that the ALJ abused his discretion in finding that Dr. Burki's testimony was sufficient to support an increase in Shell's pulmonary disability due to coal workers' pneumoconiosis. The Board, while acknowledging "a close call," concluded that ALJ properly exercised his discretion in weighing the evidence and choosing to believe a more persuasive witness. The Board noted that ALJ relied on the part of Dr. Burki's evidence which indicated at least a part of Shell's increased pulmonary impairment was due to an occupational cause. The Board affirmed the ALJ's decision, and this appeal followed.

Great Western claims that the ALJ erred in finding that Shell's pulmonary impairment was attributable at least in part to his coal mine work. Great Western notes that Dr. Burki could not exclude coal workers' pneumoconiosis as a possible cause.

In making this argument, Great Western is attempting to revisit the issue of the extent of progression of the disease. However, as stated previously, Shell's last exposure occurred in 1992. For that reason, the issue of Shell's exposure is precluded

from relitigation because the issue has already been litigated.<sup>1</sup> Thus, we will not address this claim.

Great Western also avers that Shell failed to offer proof to substantiate his claim for additional workers' compensation benefits. Great Western focuses on the testimony of Dr. Burki, and it argues that the ALJ essentially shifted the burden to Great Western in accepting Dr. Burki's testimony.

The real issue – as correctly noted by the ALJ – is whether there has been a progression of Shell's respiratory impairment. The parties presented extensive medical evidence as to the progression of the pulmonary impairment, and some of it contradictory. When parties present conflicting proof, "the administrative law judge as fact-finder, can believe part of the evidence and disbelieve other parts, even if such proof comes from the same witness or the same adversary party's total proof."<sup>2</sup>

While Great Western seeks to characterize the ALJ's decision to believe Dr. Burki's testimony as a shifting of the burden of proof, the ALJ simply chose to believe part of Dr. Burki's testimony and rejected other proof. Dr. Burki could not rule out cigarette smoking as a cause of the progression in the

---

<sup>1</sup> See Godbey v. University Hosp. of Albert B. Chandler Med. Ctr., Inc., Ky. App., 975 S.W.2d 104, 105 (1998) ("The doctrine of res judicata prohibits the relitigation of matters which actually were, or could have been, litigated to a conclusion in an earlier action").

<sup>2</sup> Kentucky Harlan Coal Co. v. Holmes, Ky., 872 S.W.2d 446, 456 (1994) (citing Caudill v. Maloney's Discount Stores, Ky., 560 S.W.2d 15 (1977)).

disease. In addition, the other physicians' reports supported Shell's claim.

In Western Baptist Hospital v. Kelly,<sup>3</sup> the Supreme Court stated that we should "correct the Board only where the [ ] Court perceives the Board has overlooked or misconstrued controlling statutes or precedent, or committed an error in assessing the evidence so flagrant as to cause gross injustice."<sup>4</sup> Because the ALJ's decision is supported by substantial evidence, the Board did not err in affirming it.

The Board's decision is affirmed.

ALL CONCUR.

BRIEF FOR APPELLANT:

Denise M. Davidson  
BARRET, HAYNES, MAY, CARTER &  
ROARK, P.S.C.  
Hazard, Kentucky

BRIEF FOR APPELLEE JESSE  
SHELL:

Ronald C. Cox  
JOHNNIE L. TURNER, P.S.C.  
Harlan, Kentucky

BRIEF FOR APPELLEE ROBERT L.  
WHITTAKER:

David R. Allen  
Frankfort, Kentucky

---

<sup>3</sup> Ky., 827 S.W.2d 685 (1992).

<sup>4</sup> Id. at 687.