

In the Matter of the Compensation of  
**JERRY W. BREAZEAL, Claimant**  
Own Motion No. 04-0192M  
OWN MOTION ORDER REVIEWING CARRIER CLOSURE  
Malagon Moore et al, Claimant Attorneys  
Julie Masters, SAIF Legal, Defense Attorneys

Reviewing Panel: Members Biehl and Lowell.

Claimant requests review of the SAIF Corporation's March 24, 2004 Notice of Closure that awarded no additional permanent disability for his "post-aggravation rights" new/omitted medical condition ("lumbar spinal stenosis with radiculopathy, L3, L4, L5").<sup>1</sup> See ORS 656.278(1)(b) (2001). We modify the Notice of Closure to award an additional 2 percent (6.4 degrees) unscheduled permanent partial disability (PPD) for the low back and an award of 12 percent (18 degrees) scheduled PPD for loss of use or function of the right leg.<sup>2</sup>

FINDINGS OF FACT

On November 16, 1979, claimant sustained a compensable low back injury. SAIF accepted an L5-S1 herniated disc. On December 7, 1979, claimant underwent surgery consisting of a hemilaminectomy, L-5, S-1 on the right with removal of extruded intervertebral disc. (Ex. 5).

Claimant's claim was closed by an October 24, 1980 Determination Order awarding 10 percent (32 degrees) unscheduled PPD for the low back.<sup>3</sup> (Ex. 12). Claimant's aggravation rights expired on October 24, 1985.

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<sup>1</sup> Claimant's November 16, 1979 claim was accepted as a disabling claim and was first closed on October 24, 1980. Thus, claimant's aggravation rights expired on October 24, 1985. Therefore, when claimant sought claim reopening on June 2003, the claim was within our Own Motion jurisdiction. ORS 656.278(1) (2001). On July 11, 2003, SAIF voluntarily reopened the claim by issuing a 3501 form for acceptance of the "post-aggravation rights" new medical conditions of "lumbar spinal stenosis with radiculopathy at L3, L4, and L5." On March 24, 2004, SAIF issued its Notice of Closure.

<sup>2</sup>With this modification, claimant's total unscheduled PPD award to date is 42 percent (134.4 degrees) and his total scheduled PPD award is 12 percent (18 degrees) for loss of use or function of the right leg.

<sup>3</sup> This award was based on an impairment value of 5 for "L5-S1 disc." Claimant also received a value of 10 for "education." These values were combined for a total value of 14. The labor market classification was 34 percent. Therefore, claimant received "25" for "labor [market]." Claimant's value of 14 was multiplied by 25 percent for a value of 3.5, which was then subtracted from 14 for a total impairment value of 10.5 percent. This was rounded to a final unscheduled PPD award of 10 percent (32 degrees). (Ex. 12-2).

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On July 16, 1986, claimant underwent a second surgery consisting of a laminectomy and removal of a recurrent L5-S1 herniated disc. (Ex. 18).

On July 30, 1987, in a Second Own Motion Order on Reconsideration, we increased claimant's unscheduled PPD award to 40 percent (128 degrees) for injury to the low back, in lieu of his prior award of 10 percent. (Ex. 35).

In July 1997, claimant underwent a decompressive lumbar surgery with laminectomy, L3, L4 and partial L5, with medial facetectomy, L3-4, L4-5 bilaterally. (Ex. 49).

On April 8, 1999, Dr. Hacker performed a fourth surgery consisting of a facetectomy L3-4, left, with far lateral discectomy and scar revision. (Ex. 74).

On June 6, 2000, Dr. Hacker performed a fifth surgery consisting of a "redo lumbar discectomy; fasciectomy L3-4, L4-5 bilateral with instrumented interbody fusion, autograft, posterolateral fusion and pedicle screw fixation multilevel without autogenous bone graft." (Ex. 85).

On April 17, 2002, Dr. Hacker saw claimant in follow-up after his last evaluation eleven months previously. Claimant had returned to his regular work but was having increased low back symptoms with "vigorous work activities." At that time, claimant had been off work for seventeen days and his symptoms had completely resolved. Dr. Hacker recommended that claimant obtain "films of his lumbar spine," and stated:

"[a]lso, I recommend that he pursue only sedentary work at this time until we assess his films and reach a determination regarding whether or not additional treatment strategies are necessary. It may be that he simply cannot tolerate vigorous physical work without a significant exacerbation of his symptoms and that a permanent limitation of work activities would better preserve his ability to pursue gainful employment." (Ex. 94).

On July 11, 2003, SAIF voluntarily reopened claimant's "post-aggravation rights" new medical condition ("lumbar spinal stenosis with radiculopathy, L3, L4, L5") by filing a 3501 form. (Ex. 102). ORS 656.278(1)(b) (2001); ORS 656.278(5) (2001); OAR 438-012-0030.

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On July 23, 2003, Dr. Hacker referred claimant to Dr. Karasek for treatment of claimant's "failed back surgery syndrome." (Exs. 100; 103). Claimant began treatment with Dr. Karasek on August 22, 2003. (Ex. 105). Dr. Karasek performed a lumbar facet joint block on September 2, 2003, and a lumbar bone graft donor site block/lumbar hardware block on October 8, 2003. (Exs. 106; 108).

On October 29, 2003, Dr. Hacker saw claimant for follow-up after the hardware and donor site blocks. Dr. Hacker felt that hardware removal was not appropriate given claimant's improvement. He did not discuss whether claimant remained released to sedentary work. (Ex. 109).

On December 5, 2003, claimant was examined by Dr. Karasek, who reported that claimant's low back pain was "much better." Claimant was to return on a "p.r.n. basis." (Ex. 109).

On December 15, 2003, Dr. Hacker reported that claimant was medically stationary on October 29, 2003. (Ex. 111).

On February 12, 2004, claimant underwent a Physical Capacity Evaluation (PCE). Claimant demonstrated the ability to lift and carry 35 pounds on an "occasional" basis. However, claimant had restrictions on performing activities that required squatting, crouching, balancing on unlevel surfaces, crawling, and climbing. Accordingly, the PCE determined that claimant demonstrated the ability to work at the "light physical demand level." (Ex. 112-1).

On February 23, 2004, Dr. Karasek concurred with the February 12, 2004 PCE. (Ex. 113). On March 15, 2004, Dr. Karasek agreed with Dr. Hacker's determination regarding claimant's medically stationary status. Additionally, Dr. Karasek considered claimant's flexion ROM loss to be valid. (Ex. 114-2).

On March 24, 2004, SAIF issued an Own Motion Notice of Closure that awarded no additional unscheduled PPD beyond the 40 percent previously awarded.<sup>4</sup> (Ex. 115).

In an April 2004 response to claimant's attorney regarding the February 12, 2004 PCE, Dr. Hacker indicated that: (1) he agreed with the PCE's assessment of

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<sup>4</sup> The Notice of Closure worksheet included 18 percent impairment for the surgeries, but no values for ROM or strength loss. Claimant received a value of 12 for social/vocational/adaptability factors. (Ex. 115-2).

claimant's low back ROM; (2) he agreed that claimant's loss of leg strength was most likely a consequence of his accepted low back condition, which included an L5-S1 disc herniation, as well as lumbar spinal stenosis and radiculopathy at L3, L4, and L5; (3) he was unable to apportion "the reduced ROM between the originally accepted condition, a herniated disc at L5-S1, and the subsequently-accepted conditions, the spinal stenosis at L3-4, L4-5, and L5-S1 with radiculopathy, and the surgeries at L4-5 and L3-4;" and (4) he apportioned the loss of strength as being more than 51 percent due to the "new accepted conditions with subsequent surgeries" and less than 51 percent due to the "original accepted condition – L5-S1 herniated disc." (Ex. 116). On April 23, 2004, Dr. Karasek concurred with Dr. Hacker's April 19, 2004 report. (Ex. 117).

Claimant requested review of the Own Motion Notice of Closure, disagreeing with the impairment findings and requesting the appointment of a medical arbiter to assess permanent disability. (Ex. 118). On June 4, 2004, we referred the claim to the Director to appoint a medical arbiter.

A medical arbiter examination was performed on July 27, 2004 by Dr. Fechtel, a neurologist. Dr. Fechtel found lumbar ranges of motion of flexion (36 degrees), extension (6 degrees), right lateral flexion (22 degrees), and left lateral flexion (16 degrees).

Although claimant did not meet the SLR validity test for lumbar flexion, Dr. Fechtel opined:

"There are invalid findings based upon mechanical concerns. The validity criteria of the AMA Guides is, in this circumstance, probably inappropriate. That is to say, [claimant's] measured straight leg raising is consistent both sitting and at formal evaluation and the internal consistency criteria are undoubtedly not met due to the surgical intervention of the lumbar spine limiting sacral motion. There were no findings of 'nonorganic' pain behavior during the course of the examination and therefore I would consider this formal invalid findings (sic) spurious."

Claimant's sensation in the lower extremities was intact to light touch and pinprick.

Dr. Fechtel was asked to “describe” any muscle strength loss due to the newly accepted conditions, and any medical sequelae in the 0-5/5 method.” In response, Dr. Fechtel referred to the muscle strength findings cited in his examination, which included the following: right iliopsoas, 5-/5, left, 5/5; right thigh abductors and adductors, 5-/5, left, 5/5; right quadriceps and hamstrings, 5-/5, left, 5/5; right ankle dorsiflexors, 4/5, left, 5/5; right ankle plantar flexors, 5/5, left, 5/5; right ankle invertors, 4/5, left, 5/5; right ankle evertors, 4/5, left, 5/5; right extensor hallucis longus, 4-/5, left, 5/5; and right toe flexors, 4-/5, left, 5/5.

Dr. Fechtel opined that claimant was “totally unable to repetitively use his spinal area.” He attributed this finding to “the lumbar spinal stenosis with radiculopathy L3, L4, L5.”

Under “Impression,” Dr. Fechtel listed claimant’s residual losses as including: (1) marked atrophy of the right side; (2) muscle weakness on the right side; (3) stable sensory function; and (4) loss of reflex function. He stated that “[t]hese represent multiple radiculopathies.”

Dr. Fechtel considered claimant’s degenerative disc disease to be of “genetic origin” and “occupational aggravation leading to multiple disc herniations with reherniations, multiple surgical interventions, and spinal stenosis.” He described claimant’s lumbar spinal stenosis as “a combination of hardware, bone, and surgical soft tissue residuals.”

The Appellate Review Unit (ARU) asked Dr. Fechtel the following question:

“[p]lease state whether any findings are a result of preexisting or other unrelated causes. If the findings are due to the newly accepted conditions and due to other unrelated conditions, provide, based on your medical judgment, the percentage of the findings or the specific findings that are due to the accepted conditions.”

Dr. Fechtel responded:

“[t]he findings are a result of a combination of occupational related and preexisting conditions. The specific preexisting condition is degenerative disc disease. This undoubtedly has a genetic background. However, the occupational impact on this clearly did lead

to multiple disc herniations, subsequently the discs reherniated. His present condition then is a combination of the occupational impact on the degenerative process, the subsequent surgical interventions and their consequences. At this juncture I would agree that it is difficult to precisely attribute a specific incident to his present condition and would agree that the combination of occupational incidence and surgical interventions represent at least 51 [percent] of the present problem and that the preexisting or degenerative and genetic component is less than 49 [percent].”

Claimant was 63 years old at the time of issuance of the March 24, 2004 Notice of Closure. He does not have a high school diploma or GED. Claimant’s job-at-injury was “Boiler Operator” (DOT# 950.382-010) which has a strength of “medium.” Therefore, claimant’s highest strength in the five years prior to the date-of-injury was “medium.” See OAR 436-035-0310(4)(a).

In the five years prior to issuance of the Notice of Closure, claimant was employed doing “general mechanic-type” building maintenance at a university. (Ex. 53-1). The most appropriate job description for this job is “Powerhouse-Mechanic Helper (utilities)” (DOT# 631.684-010). This job has Specific Vocational Preparation (SVP) time of 5.

At the time of claim closure, claimant had not been released to, nor had he returned to regular work. (Exs. 94; 95).

#### CONCLUSIONS OF LAW AND OPINION

Because the aggravation rights on claimant’s November 16, 1979 injury claim expired on October 24, 1985, the claim is within our Own Motion jurisdiction. *Miltenberger v. Howard’s Plumbing*, 93 Or App 475 (1988). The claim was reopened for the processing of a “post-aggravation rights” new medical condition (“lumbar spinal stenosis with radiculopathy, L3, L4, L5”). Such claims may qualify for payment of permanent disability compensation. ORS 656.278(1)(b) (2001); *Goddard v. Liberty Northwest Ins. Corp*, 193 Or App 238 (2004); *Jimmy O. Dougan*, 54 Van Natta 1213, *on recon* 54 Van Natta 1552 (2002).

In *Cory L. Nielsen*, 55 Van Natta at 3206, we interpreted the permanent partial disability limitation set forth in ORS 656.278(2)(d) (2001) and determined that it applies where there is (1) “additional impairment” to (2) “an injured body part” that has (3) “previously been the basis of a permanent partial disability award.”<sup>5</sup> We found that the first step is to determine whether the conditions that require application of the ORS 656.278(2)(d) (2001) limitation are satisfied. If those conditions are satisfied, the Director’s standards for rating new and omitted medical conditions related to non-Own Motion claims apply to rate “post-aggravation rights” new or omitted medical condition claims.

Here, all three factors are satisfied regarding claimant’s unscheduled impairment related to the accepted low back condition. Dr. Fechtel’s medical arbiter examination revealed decreased lumbar ranges of motion which qualify for an impairment rating. Additionally, claimant underwent surgery which qualifies for an impairment rating. Moreover, claimant’s new medical condition (“lumbar spinal stenosis with radiculopathy, L3, L4, L5”) involves the same “injured body part” (lumbar spine) that was the basis of his previous 40 percent unscheduled PPD award for his initially accepted “L5-S1 herniated disc” condition. Therefore, the limitation in ORS 656.278(2)(d) (2001) applies to claimant’s unscheduled permanent disability.

However, all three factors are not satisfied regarding claimant’s right leg impairment. Claimant has not previously been awarded a scheduled PPD award for the right leg. Thus, the limitation in ORS 656.278(2)(d) (2001) does not apply to claimant’s scheduled PPD for loss of use or function of the right leg.

Claimant’s claim was closed by an Own Motion Notice of Closure dated March 24, 2004. Thus, the applicable standards are found in WCD Admin. Order 03-050 (eff. February 1, 2003).

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<sup>5</sup> ORS 656.278(2)(d) (2001) provides:

“(2) Benefits provided under subsection (1) of this section:

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“(d) May include permanent disability benefits for additional impairment to an injured body part that has previously been the basis of a permanent partial disability award, but only to the extent that the permanent partial disability rating exceeds the permanent partial disability rated by the prior award or awards.”

Under OAR 436-035-0007(15), when a medical arbiter is used on reconsideration, impairment is established by the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should be used. We do not automatically rely on a medical arbiter's opinion in evaluating claimant's impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994). Impairment findings made by a consulting physician may be used only if the attending physician concurs with those findings. OAR 436-035-0007(14). Otherwise, in addition to the medical arbiter's findings, only the attending physician at the time of claim closure may make impairment findings. ORS 656.245(3)(b)(B); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994).

Here, the parties do not dispute the impairment findings of the medical arbiter, Dr. Fechtel. Accordingly, we rely on Dr. Fechtel's impairment findings to rate claimant's scheduled and unscheduled impairment.<sup>6</sup>

#### Scheduled PPD

To be entitled to scheduled permanent disability compensation, claimant must establish that the impairment is due to his compensable injury. ORS 656.214(2). Conditions that are the direct medical sequelae to the original accepted condition are included in the rating of permanent disability, unless they have been specifically denied. *See* ORS 656.268(14); OAR 436-035-0005(5).

Here, SAIF has accepted the "post-aggravation rights" new medical condition of "lumbar spinal stenosis with radiculopathy, L3, L4, L5." Therefore, any direct medical sequelae of the new medical condition of "lumbar spinal stenosis with radiculopathy, L3, L4, L5" may also qualify for payment of permanent disability compensation. *See* ORS 656.268(14); ORS 656.278(1)(b) (2001); *Shelley Viggiano*, 56 Van Natta 1221, 1225 (2004).

Dr. Fechtel attributed claimant's muscle weakness in the right lower extremity to the newly accepted condition, specifically the "multiple radiculopathies."<sup>7</sup> Therefore, we find that claimant's right leg strength losses are

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<sup>6</sup> For the reasons discussed herein, we do not rely on Dr. Fechtel's opinion regarding apportionment of impairment findings.

<sup>7</sup> Additionally, the treating surgeon, Dr. Hacker (as concurred with by Dr. Karasek) attributed claimant's loss of strength in the right lower extremity to his "accepted low back condition which

direct medical sequelae of his accepted conditions of L5-S1 disc herniation and lumbar spinal stenosis with radiculopathy at L3, L4, and L5. *See Norman T. Smith*, 55 Van Natta 4324, 4327 (2003); *Robert A. Moon*, 51 Van Natta 242, 244 n3 (1999) (medical evidence is necessary to establish that impairment is consistent with, or a direct medical sequela of, the accepted condition).

Because we are required to apply the Director's standards under ORS 656.278(1)(b) (2001), and because "direct medical sequelae" is included in those standards (OAR 436-035-0005(5)), we include the leg weakness in rating claimant's permanent disability resulting from the "post-aggravation rights" new medical condition. *See* ORS 656.268(14); OAR 436-035-0005(5); *Shelley Viggiano*, 56 Van Natta at 1226.

OAR 436-035-0007(20)(b) provides in relevant part:

"When a physician reports a loss of strength with muscle action (e.g. flexion, extension, etc.) or when only the affected muscle(s) is identified, current anatomy texts \*\*\* may be referenced to identify the specific muscle(s), peripheral nerve(s) or spinal nerve root(s) involved."

Per Dr. Fechtel, claimant demonstrated the following muscle strength findings: right iliopsoas,<sup>8</sup> 5-/5, right thigh abductors and adductors,<sup>9</sup> 5-/5, right quadriceps and hamstrings, 5-/5, right ankle dorsiflexors,<sup>10</sup> 4/5, right ankle plantar flexors, 5/5, right ankle invertors,<sup>11</sup> 4/5, right ankle evertors,<sup>12</sup> 4/5,

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includes an L5-S1 disc herniation, as well as lumbar spinal stenosis and radiculopathy at L3, L4, and L5." (Exs. 116; 117).

<sup>8</sup> The iliopsoas is a compound muscle, consisting of the iliacus musculus and psoas major musculus. *See Stedman's Electronic Medical Dictionary*, v. 4.0 (1998).

<sup>9</sup> The right thigh abductor muscles include the tensor fasciae latae, the gluteus medius, the gluteus minimus, and the piriformis. The right thigh adductor muscles include the gracilis, the adductor longus, the adductor magnus, the adductor brevis, and the pectineus. *See Gray's Anatomy* 896 (38th ed 1999).

<sup>10</sup> The right ankle dorsiflexor muscles include the tibialis anterior, the extensor digitorum longus, the extensor hallucis longus, and the peroneus tertius. *See Gray's Anatomy* 896 (38th ed 1999).

<sup>11</sup> The right ankle invertors include the tibialis anterior and the tibialis posterior. *See Gray's Anatomy* 896 (38th ed 1999).

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right extensor hallucis longus, 4-/5, and right toe flexors, 4-/5.<sup>13</sup>

Per the medical arbiter, Dr. Fechtel, claimant's right lower extremity weakness is due to his "multiple radiculopathies." The compensable new medical condition includes radiculopathies at L3, L4, and L5. Claimant's previous accepted condition of L5-S1 disc herniation involved the S1 nerve root. Therefore, we conclude that claimant's accepted conditions involve injury to unilateral nerve roots at L3, L4, L5, and S1. Accordingly, OAR 436-035-0230(8) is used to rate claimant's strength loss in the right lower extremity.

The above spinal nerve roots receive the following leg impairment percentages: L3 (20 percent); L4 (34 percent); L5 (37 percent); and S1 (20 percent). OAR 436-035-0230(8).

Where muscles are innervated by the same nerve, the loss of strength is determined by averaging the percentages of impairment for each involved muscle to arrive at a single percentage of impairment for the involved nerve. *See* OAR 436-035-0007(21).

Under OAR 436-035-0007(20), a strength grade of 5-/5 receives a value of 5 percent, 4/5 receives a value of 20 percent, and 4-/5 receives a value of 30 percent.

We next determine which muscles are innervated by each involved spinal nerve root and multiply the percentage value of the nerve root by the grade of strength loss attributed to each muscle.

The L3 nerve root (20 percent) innervates the following muscles (grade) for the following percentage values: psoas major (5-/5) (5 percent times 20 percent) equals 1 percent; iliacus (5-/5) (5 percent times 20 percent) equals 1 percent; gracilius (5-/5) (5 percent times 20 percent) equals 1 percent; adductor longus (5-/5) (5 percent times 20 percent) equals 1 percent; adductor magnus (5-/5) (5 percent times 20 percent) equals 1 percent; adductor brevis (5-/5) (5 percent times 20 percent) equals 1 percent; pectineus (5-/5) (5 percent times 20 percent)

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<sup>12</sup> The right ankle evertors include the peroneus longus, the peroneus tertius, and the peroneus brevis muscles. *See Gray's Anatomy* 896 (38th ed 1999).

<sup>13</sup> Loss of strength in a toe receives a value of zero. OAR 436-035-0230(10). Accordingly, claimant receives no value for the right toe flexors strength loss.

equals 1 percent; and quadriceps (5-/5) (5 percent times 20 percent) equals 1 percent. OAR 436-035-0007(21); *See Gray's Anatomy* 896 (38th ed 1999). These percentages are added for a total of 8 percent. This is then averaged by dividing 8 percent by 8 (number of involved muscles), for a final L3 nerve root strength loss of 1 percent. *See* OAR 436-035-0007(21).

The L4 nerve root (34 percent) innervates the following muscles (grade) for the following percentage values: tensor fasciae latae (5-/5) (5 percent times 34 percent equals 1.7 percent; adductor longus (5-/5) equals 5 percent times 34 percent) equals 1.7 percent; adductor magnus (5-/5) (5 percent times 34 percent) equals 1.7 percent; quadriceps (5-/5) (5 percent times 34 percent) equals 1.7 percent; tibialis anterior (4/5) (20 percent times 34 percent) equals 6.8 percent; tibialis posterior (4/5) (20 percent times 34 percent) equals 6.8 percent; gluteus minimus (5-/5) (5 percent times 34 percent) equals 1.7 percent; and gluteus medius (5-/5) (5 percent times 34 percent) equals 1.7 percent. OAR 436-035-0007(21); *See Gray's Anatomy* 896 (38th ed 1999). These percentages are added for a total of 23.8 percent. This is then averaged by dividing 23.8 percent by 8 (number of involved muscles), for an L4 nerve root strength loss of 2.97 percent. This is then rounded to a final value of 3 percent for L4 nerve root strength loss. *See* OAR 436-035-0007(16); OAR 436-035-0007(21).

The L5 nerve root (37 percent) innervates the following muscles (grade) for the following percentage values: tensor fasciae latae (5-/5) (5 percent times 37 percent) equals 1.85 percent; gluteus minimus (5-/5) (5 percent times 37 percent) equals 1.85 percent; gluteus medius (5-/5) (5 percent times 37 percent) equals 1.85 percent; piriformis (5-/5) (5 percent times 37 percent) equals 1.85 percent; hamstrings (5-/5) (5 percent times 37 percent) equals 1.85 percent; tibialis anterior (4/5) (20 percent times 37 percent) equals 7.4 percent; tibialis posterior (4/5) (20 percent times 37 percent) equals 7.4 percent; extensor digitorum longus (4/5) (20 percent times 37 percent) equals 7.4 percent; peroneus tertius (4/5) (20 percent times 37 percent) equals 7.4 percent; peroneus longus (4/5) (20 percent times 37 percent) equals 7.4 percent; peroneus brevis (4/5) (20 percent times 37 percent) equals 7.4 percent; and extensor hallucis longus (4-/5) (30 percent times 37 percent) equals 11.1 percent. OAR 436-035-0007(21); *See Gray's Anatomy* 896 (38th ed 1999). These percentages are added for a total of 64.75 percent. This is then averaged by dividing 64.75 percent by 12 (number of involved muscles), for an L5 nerve root strength loss of 5.39 percent. This is then rounded to a final value of 5 percent for L5 nerve root strength loss. *See* OAR 436-035-0007(16); OAR 436-035-0007(21).

The S1 nerve root (20 percent) innervates the following muscles (grade) for the following percentage values: tensor fasciae latae (5-/5) (5 percent times 20 percent) equals 1 percent; gluteus minimus (5-/5) (5 percent times 20 percent) equals 1 percent; gluteus medius (5-/5) (5 percent times 20 percent) equals 1 percent; piriformis (5-/5) (5 percent times 20 percent) equals 1 percent; hamstrings (5-/5) (5 percent times 20 percent) equals 1 percent; extensor digitorum longus (4/5) (20 percent times 20 percent) equals 4 percent; peroneus tertius (4/5) (20 percent times 20 percent) equals 4 percent; peroneus longus (4/5) (20 percent times 20 percent) equals 4 percent; peroneus brevis (4/5) (20 percent times 20 percent) equals 4 percent; and extensor hallucis longus (4-/5) equals 30 percent times 20 percent) equals 6 percent. OAR 436-035-0007(21); *See Gray's Anatomy* 896 (38th ed 1999). These percentages are added for a total of 27 percent. This is then averaged by dividing 27 percent by 10 (number of involved muscles), for an S1 nerve root strength loss of 2.7 percent. This is then rounded to a final value of 3 percent for S1 nerve root strength loss. *See* OAR 436-035-0007(16); OAR 436-035-0007(21).

The nerve root values are then combined as follows: 5 percent (L5) combined with 3 percent (L4) equals 8 percent; 8 percent combined with 3 percent (S1) equals 11 percent; 11 percent combined with 1 percent (L3) equals a total value of 12 percent for right leg strength loss. OAR 436-035-0007(22).

Because Dr. Fechtel specifically attributed claimant's right leg weakness to the multiple radiculopathies, we do not apportion the 12 percent value for right leg strength loss.

As discussed above, because claimant has not previously received an award of scheduled PPD for the right leg, the limitation in ORS 656.278(2)(d) (2001) does not apply to claimant's scheduled PPD award. Accordingly, we modify the March 24, 2004 Notice of Closure to award claimant 12 percent (18 degrees) scheduled PPD for the loss of use or function of the right leg.

### Unscheduled PPD

The March 24, 2004 Notice of Closure worksheet indicated that claimant was entitled to a total of 18 percent for his five surgeries. This was based on a value of 5 percent for the December 7, 1979 surgery; 3 percent for the July 21, 1986 surgery; 3 percent for the July 23, 1997 surgery; 3 percent for the April 8, 1999 surgery; and 4 percent for the June 5, 2000 surgery. (Ex. 115-2).

On review, claimant contends that he is entitled to an increased value for his multiple surgical procedures. Specifically, claimant argues that the value of his multiple surgeries should receive the values allowed under OAR 436-035-0350(2).

SAIF responds that claimant's five surgeries were correctly rated at 18 percent. SAIF argues that the principle of "issue preclusion" prevents claimant from receiving a value of 9 percent for his first surgical procedure at this claim closure, because the October 24, 1980 Determination Order awarded 5 percent, under the rules in effect at that time. (*See* Ex. 12-2). We disagree with SAIF's contentions, based on the following reasoning.

In *Nielsen*, we determined that where there is additional impairment to an injured body part that has previously been the basis of a PPD award, the limitation in ORS 656.278(2)(d) (2001) applies to the unscheduled permanent disability. Moreover, claimant's unscheduled PPD is redetermined using the Director's standards in effect at the time of claim closure of the "post aggravation rights" new medical condition. Here, those standards are found in WCD Admin Order 03-050 (eff. February 1, 2003). Consequently, we redetermine claimant's impairment for his five lumbar surgeries under OAR 436-035-0350(2) (2003).<sup>14</sup>

Claimant receives a value of 9 percent for his December 1979 surgery consisting of a hemilaminectomy, L-5, S-1 on the right with removal of extruded intervertebral disc. OAR 436-035-0350(2) (2003). The second surgery in July 1986 (laminectomy and removal of a recurrent L5-S1 herniated disc) receives a value of 1 percent. OAR 436-035-0350(2) (2003). The third surgery in July 1997 (decompressive lumbar surgery with laminectomy, L3, L4 and partial L5, with medial facetectomy, L3-4, L4-5 bilaterally) receives a value of 3 percent. OAR 436-035-0350(2) (2003). The fourth surgery in April 1999 (facetectomy L3-4, left, with far lateral diskectomy and scar revision) receives a value of 3 percent. OAR 436-035-0350(2) (2003). Finally, the fifth lumbar surgery in June 2000 (redo lumbar diskectomy; fasciectomy L3-4, L4-5 bilateral with instrumented interbody fusion, autograft, posterolateral fusion and pedicle screw fixation multilevel without autogenous bone graft) receives a value of 5 percent. OAR 436-035-0350(2) (2003). These values are added for a total surgical value of 21 percent. *See* OAR 436-035-0350(2) (2003).

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<sup>14</sup> In reaching this conclusion, we note that the "plus 5" impairment value shown on the Evaluation Division worksheet was for "L5-S1 Disc" rather than for a specific surgical value. (Ex. 12-2).

Dr. Fechtel's lumbar ranges of motion were: flexion, 36 degrees; extension, 6 degrees; right lateral flexion, 22 degrees; and left lateral flexion, 16 degrees. Although claimant's SLR test did not meet the validity criteria of the AMA Guides, Dr. Fechtel opined that the lumbar ROM finding was valid because the validity criteria was "inappropriate," due to claimant's lumbar surgery which limited sacral motion. *See Kyle S. Wilson, 56 Van Natta 2619 (2004)* (although the claimant failed the SLR validity test, the medical arbiter reported that the findings were valid; the arbiter's findings were ratable because failure of the SLR validity test could not be the sole criteria for invalidating a lumbar ROM finding).

Accordingly, claimant receives a value of 4 percent for flexion, a value of 5.8 percent for extension, a value of 0.6 percent for right lateral flexion, and a value of 1.8 percent for left lateral flexion. OAR 436-035-0360(8), (9), and (10). Adding these values results in a total of 12.2 percent for decreased lumbar ROM. OAR 436-035-0360(11). This is rounded to a final value of 12 percent for decreased lumbar ROM. *See OAR 436-035-0007(16)(a)*.

On review, SAIF argues that claimant's range of motion value should be apportioned.<sup>15</sup> We disagree for the following reasons.

The Appellate Review Unit (ARU) asked Dr. Fechtel the following question:

"[p]lease state whether any findings are a result of preexisting or other unrelated causes. If the findings are due to the newly accepted conditions and due to other unrelated conditions, provide, based on your medical judgment, the percentage of the findings or the specific findings that are due to the accepted conditions."

Dr. Fechtel responded:

"[t]he findings are a result of a combination of occupational related and preexisting conditions. The specific preexisting condition is degenerative disc disease. This undoubtedly has a genetic background. However, the occupational impact on this clearly did lead

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<sup>15</sup> SAIF concedes, and we agree, that claimant's surgical value should not be apportioned because it is an "irreversible finding" due to the compensable condition. *See OAR 436-035-0007(2)(d) (2001)*.

to multiple disc herniations, subsequently the discs reherniated. His present condition then is a combination of the occupational impact on the degenerative process, the subsequent surgical interventions and their consequences. *At this juncture I would agree that it is difficult to precisely attribute a specific incident to his present condition and would agree that the combination of occupational incidence and surgical interventions represent at least 51 [percent] of the present problem and that the preexisting or degenerative and genetic component is less than 49 [percent].*” (Emphasis added).

We find Dr. Fechtel’s opinion confusing in light of his discussion of Dr. Hacker’s opinion in the “Records Review” section of his report. Dr. Fechtel observed that Dr. Hacker:

“[c]ould not apportion the reduced range of motion between specific factors involved in the back. Felt a percent due to the new accepted conditions to subsequent surgeries was greater than 51 [percent] and percent due to the original accepted condition of L5-S1 herniated disc less than 51 [percent]. Dr. Karasek agreed with these conclusions.”

In his response to ARU’s question 4, Dr. Fechtel seemed to be agreeing with Dr. Hacker’s statement that it is difficult to apportion the specific factors in the back. He also seemed to adopt Dr. Hacker’s attribution of 51 percent due to the “new accepted condition.” However, he failed to explain his reasoning on why he attributed “less than 49 percent” to preexisting degenerative and genetic components, whereas Dr. Hacker (and Dr. Karasek) had attributed “less than 51 percent” to the initially accepted L5-S1 disc herniation condition.

In other words, Drs. Hacker and Karasek did not attribute any of claimant’s impairment findings to unrelated preexisting conditions, but rather, they apportioned what impairment was due to the “post-aggravation rights” new medical condition and what was due to the previously accepted L5-S1 disc herniation.

Under such circumstances, we rely on the opinion of Dr. Hacker (concurred with by Dr. Karasek) in concluding that claimant’s range of motion findings should

not be apportioned. Accordingly, claimant receives a total value of 12 percent for decreased lumbar ROM. *See* OAR 436-035-0007(16)(a).

Dr. Fechtel found that claimant was totally unable to repetitively use his lumbar spine secondary to the accepted lumbar spinal stenosis with radiculopathy L3, L4, and L5 condition. However, claimant does not receive a value for chronic condition because his other impairment findings are greater than 5 percent. *See* OAR 436-035-0320(5)(a).

There were no other ratable impairment findings. Therefore, 21 percent (surgeries) is combined with 12 percent (ROM) for a total impairment value of 30 percent. OAR 436-035-0007(19)(a).

Claimant has not been released to his regular work by the attending physician. Under such circumstances, we conclude that claimant's social/vocational values for age, education, and adaptability are considered in evaluating his unscheduled permanent disability. OAR 436-035-0270(3); *Edward A. Miranda*, 55 Van Natta 4241, 4246 (2003). We now assemble the social/vocational values.

Claimant was 64 years old at the time of claim closure. Therefore, claimant receives a value of 1 for age. OAR 436-035-0290(2). Claimant does not have a high school diploma or GED. Therefore, claimant receives a value of 1 under OAR 436-035-0300(2)(a). Claimant's highest SVP in the 5 years prior to issuance was for his job as "Powerhouse-Mechanic Helper (utilities)" (DOT# 631.684-010). This job has an SVP of 5. An SVP of 5 receives a value of 2. OAR 436-035-0300(3). The age/education values are added for a total of 4. OAR 436-035-0300(4).

Claimant's job-at-injury was "Boiler Operator" (DOT# 950.382-010). "Boiler Operator" has a strength of "medium." Therefore, claimant's highest strength in the five years prior to the date-of-injury was "medium." *See* OAR 436-035-0310(4)(a). Accordingly, claimant's BFC is "medium." *See* OAR 436-035-0310(3)(a).

Claimant contends that his RFC is "restricted sedentary" based on Dr. Fechtel's "analysis that [claimant] is able to work at a sedentary level, but is not able to work the same number of hours that he was working at the time of injury." We disagree for the following reasons.

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When asked by the ARU to describe claimant's RFC, Dr. Fechtel stated:

“[t]he [RFC] has been very well described by the [PCE]. I would incorporate the findings of that exam in the answer to this question. Finally, the worker has permanent restrictions in working eight hours a day. While Dr. Hacker released [claimant] to eight hours of sedentary work, I doubt that he could work on an eight-hour day basis five days a week without significant aggravation of his back and leg pain and I suspect [claimant] would lose a considerable amount of time. Therefore, based on all of the above I think that he is unable to work at the same number of hours that he worked prior to his injury.”

First, we note that Dr. Hacker's release to sedentary work in April 2002 was done prior to Dr. Karasek's treatment in September and October 2003, which improved claimant's low back symptoms. Second, Dr. Hacker did not give an opinion regarding claimant's RFC when he determined that claimant was medically stationary in October 2003. Additionally, SAIF requested Dr. Karasek's concurrence with the February 2004 PCE but did not seek Dr. Hacker's concurrence. Under these circumstances, we find Dr. Hacker's April 2002 “sedentary” work release to be an unreliable indication of claimant's actual RFC at the time of claim closure on March 24, 2004.

Furthermore, Dr. Fechtel incorporated the findings of the February 2004 PCE in response to the ARU's question regarding claimant's RFC. Accordingly, we rely on the PCE's findings (as did Drs. Fechtel and Karasek) to determine claimant's RFC.

Per the PCE, claimant is currently capable of lifting and carrying 35 pounds occasionally which places claimant in the “medium/light” category. (Ex. 112-1). *See* OAR 436-035-0310(3)(g). However, the PCE also placed restrictions on squatting, stooping, crouching, crawling, and climbing. (Ex. 112-1). Accordingly, claimant is placed in the “light” category. *See* OAR 436-035-0310(3)(1)(C). Although Dr. Fechtel opined that claimant also had permanent restrictions in working eight hours a day, this additional restriction does not place claimant in the next lower category (“sedentary/light”). *See* OAR 436-035-0310(7).<sup>16</sup>

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<sup>16</sup> This rule provides:

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Under such circumstances, we conclude that claimant's restrictions place claimant in the "light" category. Accordingly, we find that claimant's RFC is "light." See OAR 436-035-0310(3)(1)(B) and (C).

"Medium" to "light" receives an adaptability value of 3. OAR 436-035-0310(6). Claimant's age/educational value of 4 times the adaptability value of 3 equals 12. OAR 436-035-0280(6).

Adding the impairment value of 30 percent to the social/vocational value of 12 equals 42 percent unscheduled PPD.

Claimant has received a prior award of 40 percent unscheduled PPD. As addressed above, the limitation in ORS 656.278(2)(d) (2001) applies to claimant's unscheduled PPD award. Therefore, claimant is entitled to additional unscheduled PPD only to the extent that the PPD rating exceeds that rated by prior awards. ORS 656.278(2)(d) (2001); *Nielsen*, 55 Van Natta at 3208. In this instance, claimant's prior 40 percent unscheduled PPD award is less than his current 42 percent unscheduled PPD. Consequently, claimant is entitled to an award of an additional 2 percent (6.4 degrees) unscheduled PPD.

Accordingly, we modify the March 24, 2004 Notice of Closure to award an additional 2 percent (6.4 degrees) unscheduled PPD, for a total award to date of 42 percent (134.4 degrees) unscheduled PPD, and an award of 12 percent (18 degrees) scheduled PPD for loss of use or function of the right leg. Because our decision results in increased compensation, claimant's counsel is entitled to an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order (the 2 percent increased unscheduled PPD award and 12 percent scheduled PPD award granted by this order), not to exceed \$4,600, payable directly to claimant's counsel. ORS 656.386(2); OAR 438-015-0080(2).

IT IS SO ORDERED.

Entered at Salem, Oregon on October 15, 2004

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"[f]or those workers determined by these rules to have a RFC established between the two categories and also have restrictions, the next lower classification shall be used. (For example, if a worker's RFC is established at S/L but also has restrictions, use S)."