
In the Matter of the Compensation of
KEITH E. TESTERMAN, Claimant
WCB Case No. 06-05354
ORDER ON REVIEW
Bailey & Yarmo LLP, Claimant Attorneys
Julie Masters, SAIF Legal, Defense Attorneys

Reviewing Panel: Members Langer and Weddell.

Claimant requests review of Administrative Law Judge (ALJ) Riechers' order that upheld the SAIF Corporation's compensability and responsibility denials, on behalf of KTM, Inc., of his occupational disease claim for cervical stenosis at C3, C4 and C5. On review, the issue is responsibility.¹ We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and provide the following summary.

Claimant has worked as a mason for several years. From 1978 to 1987, he worked at Professional Masonry in California. From 1987 until 1999/2000, he worked for Testerman Masonry, his own business. Claimant worked as supervising bricklayer for KTM (SAIF's insured) from late 1999/early 2000 into part of 2004. He worked with structural block that weighed 25 to 40 pounds each. Claimant usually set 300 or more blocks per day.

On May 21, 2003, claimant sought treatment from Dr. Andrews for numbness in the second, third and fourth digits of the left hand. Claimant indicated that the tingling had been going on for the last year, but it was getting worse and it was numb. Dr. Andrews diagnosed left carpal tunnel syndrome (CTS). (Ex. 1). SAIF accepted left CTS. (Ex. 6).

On November 11, 2003, Dr. Mara performed a left endoscopic carpal tunnel release. (Ex. 7). Claimant's symptoms continued, and October 26, 2004 nerve conduction studies showed persistent left median neuropathy at the carpal tunnel. (Ex. 15). On October 29, 2004, Dr. Mara reported that claimant's nerve

¹ The ALJ noted that, although the cervical condition was compensable, because SAIF's December 22, 2006 compensability denial was an amendment of the July 20, 2006 responsibility denial, rather than a "stand-alone" denial, both denials were upheld. (Exs. 86, 96). Neither party challenges the ALJ's compensability determination.

conduction tests continued to show significant CTS, and that he “has also got some question of a radiculopathy.” (Ex. 16). Dr. Mara recommended additional surgery for the left CTS. (Ex. 17).

On September 6, 2005, Dr. Mara performed an open carpal tunnel release. (Ex. 26).

As a result of the compensable left CTS claim, claimant was involved in an Authorized Training Plan (ATP). The plan included online courses, and the professional skills component was overseen by Portland Community College (PCC). (Ex. 30). SAIF and PCC entered into an agreement whereby claimant was to be in training from October 24, 2005 to July 21, 2006. (Ex. 33).

After the September 2005 surgery, claimant’s condition improved, but he had some remaining symptoms. On December 9, 2005, Dr. Mara reported that claimant had some subjectively decreased sensation to the index and long fingers. (Ex. 42). Similarly, on January 20, 2006, Nurse Practitioner (NP) Stahly (with Dr. Mara’s office) reported that claimant still reported some subjective decrease in sensation along his index and long finger. (Ex. 49). At claimant’s March 13, 2006 closing examination, Dr. Mara reported mild loss of grip strength, mild loss of range of motion, and one grade loss of sensation. (Ex. 53).

On May 2, 2006, claimant sought treatment with NP Stahly, who reported worsening symptoms that included the upper arm, and some numbness and tingling in the right hand. Claimant reported that when he moved his head backwards, he noticed increased pain shooting down his left arm. NP Stahly expressed concerns for radicular symptomatology. (Ex. 64).

Claimant was referred to another provider, who recommended a cervical MRI. NP Parker-Cullen reported that the MRI showed multilevel degenerative changes with facet hypertrophy and chronic disc bulges resulting in severe neuroforaminal narrowing on the left at C2-3, and bilaterally at C5-6 and C6-7. There was cord signal change at C4-5 with a suggestion of myelomalacia.² (Ex. 68, 73).

² “Myelomalacia” is “softening of the spinal cord.” *Stedman's Electronic Medical Dictionary*, v. 7.0 (2007).

Dr. Griffin performed electrodiagnostic studies on June 12, 2006, and found evidence of mild median neuropathy at the left wrist, and left C6 and C7 chronic radiculopathy. (Ex. 74). Claimant was referred to Dr. Yundt, who performed a C3-4 and C4-5 cervical decompression on August 10, 2006. (Ex. 91). After the cervical surgery, claimant treated with Dr. Carroll, a physical medicine physician. (Ex. 97).

SAIF denied compensability and responsibility for claimant's occupational disease claim for cervical stenosis at C3, C4 and C5. (Ex. 86, 96). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the portion of the ALJ's order that concluded that claimant's occupational disease claim was compensable.

Responsibility

The ALJ applied the last injurious exposure rule (LIER) to determine responsibility for claimant's cervical condition. The ALJ acknowledged that the medical evidence indicated that at least some of claimant's symptoms in 2003 were due to the cervical condition, rather than to the left CTS. The ALJ explained, however, that there was no indication in any of the medical records until April 6, 2006 and May 2, 2006, that claimant required treatment or had disability due to the cervical condition.

Based on the medical evidence, vocational records, and claimant's testimony, the ALJ determined that the "onset of disability" under the LIER occurred in April/May 2006, when claimant first missed work and sought treatment for the cervical condition. Because PCC was on the risk at that time, the ALJ concluded that PCC was the presumptively responsible employer. *See Clarence W. Allen*, 47 Van Natta 898 (1995). The ALJ found that the medical evidence was not sufficient to shift responsibility to SAIF, as the previous carrier on the risk. Because PCC was not joined as a party, however, the ALJ concluded that it could not be assigned responsibility for the cervical condition.

On review, claimant argues that the ALJ incorrectly determined the "onset of disability." Claimant contends that the medical record establishes that the triggering date for the onset of disability of the cervical condition was May 21,

2003, when SAIF was on the risk. He argues that the medical evidence establishes that he first sought treatment for symptoms of his cervical stenosis condition (along with symptoms of his left CTS) on that date.

On the other hand, SAIF argues that claimant's treatment for CTS in 2003 did not include treatment directed to the cervical area. SAIF contends that he did not seek or receive any treatment for his cervical condition until 2006, and that there is no indication in the contemporaneous chart notes that he had a cervical radiculopathy before 2006. According to SAIF, claimant's cervical condition was merely mentioned incidentally.³

Under the LIER, initial or presumptive responsibility for a condition is assigned to the last period of employment where conditions could have caused claimant's disability. *Bracke v. Baza'r*, 293 Or 239, 248-49 (1982). The onset of disability is the "triggering date" for determining the last potentially causal employment. *Agricom Ins. v. Tapp*, 169 Or App 208, 211, *rev den*, 331 Or 244 (2000). If the claimant receives treatment before experiencing time loss due to the condition, the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment. *Id.* at 212.

Thus, we must determine when claimant first sought or received medical treatment for his cervical stenosis condition. The issue of a claimant's first medical treatment for purposes of the LIER is a complex medical question. *Felix C. Miranda*, 54 Van Natta 719, 724 (2002); *see also Robert L. Coleman*, 58 Van Natta 285, 293 (2006).

The objective in designating a triggering date is to identify a point where the condition generally becomes a disability. *Tapp*, 169 Or App at 212-13. In *SAIF v. Carey*, 63 Or App 68, 70 (1983), the court explained that "the most logical triggering event in the case of a non-disabling injury or disease is the date when medical treatment is first sought." The court selected that date because "the date when a claimant first sought medical treatment, at least in most cases, has some objective relationship to the date when claimant's condition became a disability, because it is usually documented." *Id.*

³ SAIF relies on the court's comments in *Agricom Ins. v. Tapp*, 169 Or App 208, 214-15, *rev den*, 331 Or 244 (2000): "when a claimant does not seek treatment for a condition, and the symptoms are simply noted incidentally as part of an examination for another condition, but are not diagnosed or treated in any other way--the date of the medical examination generally would not have a sufficient objective relationship to the date of disability to make it an appropriate triggering date for assignment of initial responsibility under the LIER."

In *SAIF v. Kelly*, 130 Or App 185 (1994), the issue was when the claimant first sought treatment for de Quervain's tenosynovitis. The claimant worked for the first employer until January 1991, when he changed jobs. The tenosynovitis condition was first diagnosed in February 1991. The court held that the triggering date for assigning responsibility under the LIER is the date the claimant first sought treatment for symptoms, even if not correctly diagnosed until later. *Id.* at 188. The court remanded for us to apply that standard.

In *Joseph E. Kelly*, 46 Van Natta 2474 (1994) (on remand), we explained that the claimant began treating for pain in both elbows in April 1990, and also had pain in both wrists. His treating physician diagnosed bilateral CTS and performed a bilateral carpal ligament release. After surgery, the claimant continued to have right wrist and left elbow pain, for which he sought treatment. On February 12, 1991, the treating physician diagnosed left ulnar nerve irritability and right de Quervain's tenosynovitis as separate and distinct from the bilateral CTS. We explained that, with the benefit of hindsight, the treating physician opined that the claimant's left ulnar nerve irritability and right de Quervain's tenosynovitis conditions arose during his employment with the first employer. We determined that, although the treating physician did not arrive at the new diagnoses in 1990, he ultimately concluded that the conditions arose during the first employer's coverage. There was no contrary medical evidence. Under those circumstances, we assigned responsibility to the first employer because the claimant first sought and received treatment for his compensable left elbow and right wrist symptoms during that employment.

In other cases, we have decided the "triggering date" based on medical evidence that indicated, in hindsight, that the claimant sought treatment for a condition before it was diagnosed. In *Robert L. Coleman*, 58 Van Natta at 293, we found that the medical evidence established that the claimant first sought treatment for his right cubital syndrome in 1991, when he was treated for numbness and tingling in his little, ring and middle fingers of the right hand and discomfort at his elbow on the ulnar groove. Although the physician at that time did not diagnose cubital tunnel syndrome, later medical reports from three physicians indicated that the claimant was treated for cubital tunnel syndrome in 1991. *See also Felix C. Miranda*, 54 Van Natta at 728 (although the first medical opinion to refer specifically to de Quervain's syndrome was in March 2000, we based the "triggering date" on a medical opinion that relied on an October 12, 1998 chart note to establish the date of the first treatment for that condition).

SAIF argues, however, that this is not a case in which the symptoms of the condition were treated but the correct diagnosis was not arrived at until later. SAIF contends that claimant did not seek or receive any treatment for his cervical condition until April 2006, at the earliest, when he returned to treatment for a generalized numbness in his palm and all of his fingers, which were different symptoms than he had reported before.

Claimant points out that SAIF's analysis focuses on when he specifically sought treatment for a "cervical" condition. Claimant asserts that he did not seek treatment for a specific condition, *i.e.*, CTS or cervical stenosis. Rather, he presented on May 21, 2003 for diagnosis and treatment of left upper extremity symptoms that included symptoms caused by cervical stenosis. For the following reasons, we agree with claimant.

In *Tapp*, the court clarified that an "express request for treatment" was not required under *SAIF v. Kelly*. 169 Or App at 214. Therefore, we do not base the triggering date on when claimant expressly requested medical treatment for cervical stenosis.

In *Tapp*, the condition at issue was the claimant's left CTS. The claimant sought treatment in 1991 for recurrent headaches and pain in his left eye and, as part of the investigation, the physician asked the claimant if he had experienced any wrist pain. The claimant responded that for several years he had been experiencing numbness and tingling in his hands. Nerve conduction tests were performed on both wrists and claimant was diagnosed with right CTS.

On review, we adopted the ALJ's finding that the claimant did not complain of or seek care for hand or wrist problems in 1991. We acknowledged that the claimant had related a prior history of left hand/wrist numbness when he was examined in 1991. However, the claimant did not have any left-sided problems at that time, although nerve studies were performed on both wrists. The court agreed that the claimant neither sought nor received treatment for his left CTS in 1991.

Here, claimant sought medical treatment for left upper extremity symptoms in 2003. The medical evidence establishes that claimant's 2003 symptoms reflected two conditions, only one of which (CTS) was diagnosed at that time. The cervical diagnosis was not made until after claimant had been treated for the CTS and had continuing symptoms. The critical issue is when claimant first *sought* treatment for his cervical condition. *See Tapp*, 169 Or App at 213 ("Because both the date that a claimant first *seeks* medical treatment and the date

that the claimant first *receives* treatment generally have an objective relationship to when the claimant's condition becomes a disability, we believe that it is appropriate to designate a triggering date based on either event, whichever occurs first.") (Emphasis in original).

Dr. Rosenbaum's opinion supports the conclusion that claimant's 2003 left upper extremity symptoms reflected both CTS and cervical pathology. He examined claimant in November 2006, on behalf of SAIF. Dr. Rosenbaum explained:

"[Claimant] had a left [CTS] but a portion of his symptoms likely related to a cervical compressive myelopathy. The level involved as well as the bright signal within the spinal cord would be consistent with numbness in the median distribution of the hands. The documenting nerve conduction studies however, and the lack of response make it reasonable to presume that even with the claimant's initial symptomatology, there was a relationship to his cervical spine. It progressed over time as one would expect with cervical spondylosis and cervical spinal cord compression manifesting itself to the point where it was diagnosable by his treating physicians and has subsequently undergone surgery." (Ex. 95-9).

In response to a question as to when claimant first sought medical care for the cervical condition, Dr. Rosenbaum explained:

"* * * [Claimant] likely had his cervical conditions back in March of 2003. There was an overlap between his carpal tunnel and his cervical pathology. That would explain fully in retrospect why he did not obtain relief with an endoscopic carpal tunnel release and with the repeat carpal tunnel release. He first actively sought treatment referable to the neck when his symptoms became progressive after his left carpal tunnel release and it was evident that there was enough pathology occurring." (Ex. 95-10).

We find that Dr. Rosenbaum's opinion supports the conclusion that claimant's left upper extremity symptoms in 2003, for which he sought medical treatment, included symptoms of his later-diagnosed cervical condition.

Dr. Rosenbaum's opinion is supported by Dr. Carroll, one of claimant's treating physicians, who explained: "It is common for one diagnosis (*e.g.*, [CTS]) to be addressed, if symptoms persist then other diagnoses or etiologies for the problem must be considered." (Ex. 100-3).

Similarly, Dr. Griffin's opinion supports the conclusion that claimant's 2003 symptoms reflected both CTS and a cervical condition. He explained:

"[Claimant's] symptoms, while it took a period of time to come to the full diagnosis, certainly began while performing work for KTM. And as Dr. Rosenbaum and Dr. Carroll mention in their reports that I reviewed, it takes a process to arrive at the correct diagnosis. And he was originally diagnosed with [CTS] which electrodiagnostically he had and was treated for, but when there was persistence of symptoms they appropriately investigated further leading to imaging and then electromyography testing showing nerve root and spinal cord injury, which was no doubt there at the time of the original symptoms and at the time of his work but just had not yet been clearly diagnosed and fully manifested symptomatically." (Ex. 103-35).

Thus, Dr. Griffin indicated that there was "no doubt" that claimant's cervical condition existed at the time of the original symptoms, for which he sought medical treatment in 2003, but the cervical condition was not clearly diagnosed until later. Dr. Griffin's opinion supports the conclusion that claimant first sought treatment for cervical symptoms in 2003, although the condition was not correctly diagnosed until later. *See SAIF v. Kelly*, 130 Or App at 188; *Joseph E. Kelly*, 46 Van Natta at 2475.

Dr. Yundt, another treating physician, explained in a concurrence letter from claimant's attorney:

"While [claimant] clearly suffered from a left-sided [CTS], dating back to 2003, it also seems clear, based on his medical history, that a component of his left-sided symptomatology was caused by his cervical stenosis all along. Based on this history, it is evident that while [claimant] has not been employed in the masonry business since 2004, a significant cervical stenosis causing nerve compression had already developed by that time." (Ex. 99-3, -4).

In a deposition, Dr. Yundt testified that he did not believe claimant's 2003 cervical MRI would have looked "a whole lot different" than his 2006 MRI. (Ex. 104-22). He explained that it was "not unreasonable" to say that there was probably a pathology related to cervical stenosis back in 2003. (Ex. 104-21, -22). He testified that claimant "could have had symptoms related to the foraminal stenosis and symptoms related to the [CTS] sort of like with the last EMG where he had changes related to nerve [root] problems and carpal tunnel." (Ex. 104-22). Dr. Yundt agreed that the cervical spinal stenosis could account for the reason why the endoscopic surgery and open release did not work, although he said it could be that there was "too much damage there as well." (*Id.*)

Thus, the opinions of Drs. Rosenbaum, Carroll, Griffan and Yundt all indicate that, when claimant sought medical treatment for left upper extremity symptoms in 2003, he was experiencing symptoms caused by cervical stenosis.

According to SAIF, however, none of those physicians considered the history that, after claimant's second CTS surgery, he had a "dramatic resolution" of symptoms.

Although claimant's condition improved after the September 2005 left open carpal tunnel release, we do not agree that the record establishes that he had a "dramatic resolution" of his left upper extremity symptoms after that surgery.

After the first CTS surgery in November 2003, Dr. Mara considered the possibility of cervical pathology in October and November 2004 when claimant had continued symptoms and his nerve conduction studies showed significant CTS. (Exs. 16, 17; *see* Ex. 15).

Claimant testified that his symptoms were "immediately better" after the second CTS surgery in September 2005 and that he had more feeling. However, he said the symptoms seemed to come back and he experienced numbness. (Tr. 23). Claimant's later symptoms included the small finger. (Tr. 24).

The medical record indicates that claimant noted improvement in his numbness and tingling after the September 2005 surgery. (Exs. 28, 31). However, Dr. Mara reported on December 9, 2005, that claimant "has some subjectively decreased sensation to the index and long fingers." (Ex. 42). Similarly, on January 20, 2006, FNP Stahly (with Dr. Mara's office) reported that claimant "still does report some subjective decrease in sensation along his index and long finger, but does feel that this has had some improvement." (Ex. 49). At claimant's March 13, 2006 closing examination, Dr. Mara reported

that claimant had mild loss of grip strength, mild loss of range of motion, and one grade loss of sensation. (Ex. 53). Based on these medical reports, we do not agree with SAIF's assertion that claimant had a "dramatic resolution" of his left upper extremity symptoms after the September 2005 surgery.

Moreover, we find that, in any event, Drs. Rosenbaum, Yundt, Carroll and Griffin had a sufficiently complete history of claimant's symptoms after the second CTS surgery. Dr. Rosenbaum reported that after the second CTS surgery, claimant had improvement in numbness. (Ex. 95-5). He explained that, after that surgery, claimant then "slowly evolved symptoms of cervical compression myelopathy." (Ex. 95-9). We find that Dr. Rosenbaum's history was sufficiently complete. *See Jackson County v. Wehren*, 186 Or App 555, 560 (2003) (a history need only contain relevant information and is thus complete if it includes sufficient information on which to base the opinion and does not exclude information that would make the opinion less credible).

In concurrence letters from claimant's attorney, Drs. Yundt and Carroll were aware that, after the second CTS surgery, claimant experienced considerable improvement in his condition, but he continued to describe symptoms in the left hand. (Exs. 99-3, 100-2, -3). Dr. Griffin agreed with Dr. Yundt's concurrence letter and adhered to that opinion in a deposition. (Exs. 101, 103-33). We find that Drs. Rosenbaum, Yundt, Carroll and Griffin had a sufficiently complete history of claimant's symptoms after the second CTS surgery. *See Jackson County v. Wehren*, 186 Or App at 560.

Next, we address SAIF's argument that claimant's cervical condition was asymptomatic until 2006. SAIF relies in part on Dr. Griffin's statement that the cord signal on claimant's 2006 cervical MRI indicated that his condition was relatively "recent." We agree with SAIF that Dr. Griffin made that statement. However, when read in context, Dr. Griffin's statement does not support SAIF's assertion that claimant's cervical condition did not become symptomatic until 2006.

Claimant's 2006 cervical MRI was interpreted as showing increased T2 signal intensity in the left side of the spinal cord along the lateral aspect at the C4-5 level. (Ex. 73). Dr. Griffin testified that the signal seen on the MRI suggested "something relatively recent." He explained that "contrast" was not used with the MRI, which would have tended to show if it was very recent. Dr. Griffin said that if there had been a cord injury that occurred many years ago, there would be cord atrophy, but that was not mentioned in the MRI. (Ex. 103-29).

Dr. Griffin was asked what he meant by “recent” and he replied:

“I don’t think I could put a number on it. But I think it’s interesting in the MRI that there is not a specific disc herniation impinging the cord and causing the cord signal change, so that it wasn’t a specific event * * *. It was something that occurred over time with the cervical spondylosis resulting in cervical stenosis and neuroforaminal stenosis causing injury to the spinal cord and the nerve roots in a gradual manner and in my opinion related to the sustained repetitive intense upper extremity activity required at work.” (Ex. 103-30).

Dr. Griffin explained that the T2 signal intensity on the MRI at the C4-5 disc impacted the spinal cord, and that meant it had happened sometime in the past, but it was not so long ago that there was cord atrophy. Dr. Griffin testified that it was “[p]robably in the range of several years as opposed to decades.” (*Id.*)

Dr. Griffin was asked: “So we don’t know how acute or how recent it is. We know its years, is not decades is about all we can tell from the MRI report?” He responded:

“Right. Although it can have been more recent than that. In a person who has an acute injury we can see signal change within a few days, so there is quite a range as far as the soonest it can occur.”

Dr. Griffin agreed that based on the MRI (without the contrast), it was more than a few days, but not decades old. (Ex. 103-31).

When viewed in context, given Dr. Griffin’s opinion that claimant did not have an acute cervical injury, we find that his testimony supports the conclusion that the “recent” T2 signal intensity on the MRI meant that it was in the range of years old, but not decades old. *See SAIF v. Strubel*, 161 Or App 516, 521-22 (1999) (medical opinions are evaluated in context and based on the record as a whole to determine sufficiency). Our conclusion is supported by Dr. Griffin’s opinion that claimant’s cervical pathology was “no doubt” there at the time of the original symptoms in 2003. (Ex. 103-35). In addition, our conclusion is consistent with Dr. Yundt’s comment that he believed claimant’s cervical MRI in 2003 would not have looked much different than the 2006 cervical MRI. (Ex. 104-22).

SAIF relies on *Marjorie A. Ramirez*, 54 Van Natta 1894 (2002) (on remand), and *Pamela M. Christman*, 54 Van Natta 1992 (2002) (on remand), to support its position that the medical evidence does not establish that claimant sought treatment for a cervical condition before 2006. For the following reasons, we find that SAIF's reliance on those cases is misplaced.

In *Ramirez*, we determined that the claimant's earlier medical visit did not trigger responsibility for a trigger thumb condition because the physician at that time considered the claimant's thumb condition not significant enough to chart, and mild enough to resolve on its own, without treatment, while she was off work for carpal tunnel releases. In that case, we only discussed one physician's opinion and there is no indication that there was any other medical evidence relating the claimant's earlier symptoms to the later-claimed trigger thumb condition. *Ramirez*, 54 Van Natta at 1896.

Here, in contrast, the aforementioned medical evidence persuasively establishes that claimant's left upper extremity symptoms in 2003, for which he sought medical treatment, represented CTS *and* a cervical condition.

In *Christman*, we concluded that earlier chart notes were inadequate to establish that the claimant had previously sought or received medical treatment for right CTS before 1998, when she was diagnosed with that condition. Among other records, the carrier relied on two medical concurrence letters concluding that it was medically probable that the condition treated on March 14, 1994 and February 7, 1995 was CTS. However, we explained that, because both letters included inaccurate information from the carrier, we did not rely on those concurrence letters. *Christman*, 54 Van Natta at 1996-97.

Unlike *Christman* and *Ramirez*, we find that the medical evidence here is well reasoned and based on complete and relevant information. The aforementioned medical opinions establish that when claimant sought medical treatment in 2003, some of his upper extremity symptoms, which were diagnosed first as CTS, were a result of his cervical stenosis condition.

In summary, we conclude that the persuasive medical evidence establishes that claimant first sought medical treatment for his cervical stenosis in May 2003, when SAIF was on the risk. SAIF is therefore presumptively responsible for claimant's cervical stenosis condition.

A carrier can transfer liability to a previous insurer by establishing that it was impossible for its employer to have caused the condition or that a prior period of employment was the sole cause of the condition. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). Here, the medical evidence does not establish that it was impossible for claimant's employment with SAIF's insured to have caused his cervical condition or that a prior employment exposure was the sole cause of his condition.

SAIF may shift responsibility to a subsequent carrier if claimant's employment at the later employment actually contributed to a worsening of the condition. *See Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998), *rev den*, 328 Or 365 (1999). However, in order to shift responsibility to a subsequent carrier, the claimant must suffer a worsening of the condition; a mere increase in symptoms is not sufficient. *Id.*

The medical evidence does not establish that claimant's later employment with PCC in the vocational program actually contributed to a worsening of his cervical condition. Dr. Carroll was asked whether claimant's later employment contributed to his cervical condition. Dr. Carroll responded: "I think it is highly unlikely that it had anything to do with it." She could not reach that conclusion with absolute certainty, but she "would say better than 95 percent." (Ex. 102-15).

Dr. Yundt was asked whether claimant's work as a project manager in his later employment would have contributed to his cervical condition if he was flexing/extending his neck. He responded: "If it's heavy lifting, yes. It would play a component." (Ex. 104-12).

The record, however, does not support the conclusion that claimant's later employment involved heavy lifting, except on rare occasions. Claimant testified that a laborer performed the physical work during his vocational program. (Tr. 27; Ex. 83A-2, -3, -4). He described his vocational job as light duty. (Tr. 28). Claimant was involved in rolling some hay, but he was not injured performing that work and did not experience a significant change in symptoms. (*Id.*)

We conclude that the medical evidence does not establish that claimant's later employment actually contributed to a worsening of his cervical condition. Therefore, responsibility for claimant's cervical stenosis condition remains with SAIF. We therefore reverse the ALJ's order that upheld SAIF's compensability and responsibility denials of claimant's cervical stenosis condition.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability and responsibility denials. ORS 656.386(1); ORS 656.308(2)(d). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is \$8,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, because our order issues after the effective date of *amended* ORS 656.386(2) and OAR 438-015-0019, and because claimant has finally prevailed over a denied claim, we consider it appropriate to award reasonable expenses and costs to claimant for records, expert opinions, and witness fees. *See Nina Schmidt*, 60 Van Natta 169 (2008); *Barbara Lee*, 60 Van Natta 1, *on recons*, 60 Van Natta 139 (2008).

Consequently, in accordance with the aforementioned statute and rule, claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by SAIF. The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

ORDER

The ALJ's order dated June 12, 2008 is reversed. SAIF's denials are set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of \$8,500, to be paid by SAIF. Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denials, to be paid by SAIF.

Entered at Salem, Oregon on January 12, 2009