
In the Matter of the Compensation of
BARBARA L. JANSEN, Claimant
WCB Case No. 07-02346
ORDER ON REVIEW
J Michael Casey, Claimant Attorneys
Cummins Goodman et al, Defense Attorneys

Reviewing Panel: Members Langer, Weddell, and Herman. Member Langer dissents.

The self-insured employer requests review of Administrative Law Judge (ALJ) Sencer's order that set aside its denial of a combined condition involving carpal tunnel syndrome (CTS) and a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has a history of panic attacks and anxiety. (Exs. A-4, 1-1, 3, 5-2, 6-1). Before the onset of her claimed CTS, she was diagnosed with "psychological stress" (Ex. 4-1), "adjustment disorder with anxiety" (Ex. 5-1), and had test results suggestive of "depression." (Ex. 4-2).

In January 2005, claimant complained of tingling on the right side of her face down to her right hand. (Ex. 8-5). A nerve conduction study (NCS) revealed bilateral median neuropathy. (Exs. 10-1, 11). Claimant filed a claim for bilateral CTS, which the employer accepted. (Exs. 15, 20).

In March 2006, claimant underwent a right carpal tunnel release performed by Dr. Smith. (Ex. 22). She had initial relief of symptoms, but aggravated her extensor tendons after returning to work. (Ex. 29-2).

In July 2006, claimant complained that her right thumb would "dislocate" and that it had an inability to support "anything." (Ex. 33-2). Dr. Smith noted instability and 4/5 weakness in the thumb's MP joint. (*Id.*)

Dr. Ingle, a treating physician, did not relate claimant's symptoms to the CTS or the CTS release. (Ex. 36-2). Dr. Ingle opined that claimant's pain might be due to repeated dislocations.

A July 2006 NCS found that claimant's CTS was "much improved" from the pre-surgery NCS. (Exs. 40, 41).

In September 2006, claimant was examined by Dr. Cober. (Ex. 50). Ultimately, Dr. Cober found no objective evidence relating claimant's symptoms to the surgery or median nerve.

In December 2006, Dr. Van Allan, a consulting hand surgeon, did not find a thumb joint problem. (Ex. 62-1). After reviewing the post-surgical NCS, Dr. Van Allen opined that claimant's "inability or refusal" to move her thumb appeared to be a "conversion reaction of some type." (Ex. 63-2).

In February 2007, Dr. Davies, a psychologist, performed an evaluation at the employer's request, opining that claimant had "significant emotional contributions to her disability behaviors." (Ex. 68-8). Lacking claimant's previous medical records regarding her prior psychological condition, Dr. Davies could not determine if she had a "pre-existing psychological condition." (*Id.*) Despite noting that "all the patient's mental status findings were within normal limits," Dr. Davies opined that claimant had an "abnormal psychological condition that fuels symptom magnification," and that the psychological condition was the major contributing cause of her disability and pursuit of medical treatment. (Ex. 68-9).

Dr. Zinsmeister, a neurologist, and Dr. Nolan, a hand surgeon, also examined claimant at the employer's request. (Ex. 68-17). Noting that claimant's right CTS improved after surgery and attributing her current loss of function on the right to psychogenic hand syndrome, they opined that claimant's CTS was no longer a material contributing cause of her need for treatment. (Ex. 68-19). Additionally, Dr. Nolan subsequently opined that the CTS was no longer the major contributing cause of claimant's disability or need for treatment. (Ex. 77).

Dr. Thomas agreed with the opinions of Drs. Van Allen and Cober. (Ex. 71-2). Dr. Thomas opined that claimant's psychological or personality disorder combined with the accepted CTS to cause or prolong her disability and need for treatment. (*Id.*) Finding claimant's bilateral CTS was medically stationary, Dr. Thomas concluded that, but for her psychological condition, she could return to regular work. (*Id.*)

In March 2007, after reviewing claimant's previous medical record regarding her psychological condition, Dr. Davies concluded that she had a "preexisting abnormal psychological condition," which "is currently playing a primary role in her disability behaviors." (Ex. 72-3). He diagnosed "pain disorder

with both psychological factors (primary) and in general medical condition,” “dysthymia with a primary somatoform presentation, chronic,” and “personality disorder not otherwise specified, with histrionic and passive-dependent features.” (*Id.*)

On April 10, 2007, the employer issued a modified notice of acceptance of “disabling bilateral carpal tunnel syndrome combined with preexisting personality disorder, dysthymia with chronic somatoform presentation, and psychological pain disorder.” (Ex. 74). The same date, the employer denied the ongoing compensability of the combined condition, asserting that the accepted bilateral CTS ceased to be the major contributing cause of the disability and need for treatment of the combined condition. (Ex. 75). Claimant requested a hearing.

In May 2007, Dr. Thomas opined that claimant’s disability and inability to work were partially due to the accepted conditions, and partially due to the psychological condition, but that he could not assign a percentage to the contribution of each. (Ex. 82). Dr. Thomas referred claimant to Dr. Grass, a psychiatrist.

Dr. Grass considered claimant’s psychological history, including anxiety attacks and treatment, and opined that there was no major psychiatric component to claimant’s symptoms. (Ex. 88-2, -3). He recommended an evaluation by Dr. Reiter, a psychologist. He further doubted the accuracy of the previous psychological testing due to tension between claimant and the examiner, and potentially, shortened testing time. (*Id.*)

At a deposition, Dr. Thomas testified that, when he first examined claimant, he believed the surgery could have injured the nerve to the “opponens” muscle, because the thumb was in the palm of her hand (adducted). (Ex. 90-9, -10). After referring claimant to Dr. Cober, Dr. Thomas agreed that claimant’s thumb complaints related to the radial nerve, as opposed to the median. (Ex. 90-13). Dr. Thomas opined that there was no connection between the radial nerve condition and the accepted CTS. (Ex. 90-14, -16).

Dr. Reiter reviewed claimant’s medical history and Dr. Davies’s report. (Ex. 94-1). Dr. Reiter disagreed that there was evidence of somatization, in the absence of evidence of secondary gain. Dr. Reiter noted that claimant had maintained an active role in the home, compensating for her thumb limitations. (Ex. 94-3). Reviewing Dr. Davies’s psychological testing, Dr. Reiter opined that claimant’s personality testing was within normal range and not indicative of either

somatization or an Axis II personality disorder. (Ex. 94-3). Noting mildly elevated “positive impression management” indicators on two personality tests, Dr. Reiter opined that it was elevated “only to the degree that one would expect the normal population to deny negative psychological conflict.” Dr. Reiter reiterated that neither test scale indicated somatization, conversion, or an Axis II personality disorder. (Ex. 94-4).

Dr. Reiter testified, by deposition, that he had reviewed two of Dr. Davies’s reports. (Ex. 100F-8). Dr. Reiter believed that claimant may have somatization disorder with regard to her thumb, but that did not equate to a personality disorder. (Ex. 100F-45). Dr. Reiter disagreed with Dr. Davies’s conclusion that claimant had a preexisting psychological condition, as his testing and interviewing did not reveal such a condition. (Ex. 100F-47). Ultimately, Dr. Reiter was unable to state in terms of medical probability that there was a psychological explanation for the thumb presentation. (Ex. 100F-53).

Dr. Grass, who was also deposed, testified that Dr. Davies’s test results were “normal.” (Ex. 101A-22). Dr. Grass did not evaluate the medical evidence, because he was not qualified to evaluate it. (Ex. 101A-25). Nonetheless, Dr. Grass concluded that claimant did not have a psychiatric component. (Ex. 101A-26). Dr. Grass noted claimant’s history of anxiety and depression, but maintained that she did not have somatization or personality disorder. (Ex. 101A-30). Dr. Grass diagnosed adjusted reaction with mixed features, explaining that it is an intermediary diagnosis between minor depression and minor anxiety. (Ex. 101A-48).

Describing “dysthymia” as a long-standing chronic minor depressive state, Dr. Grass did not agree with Dr. Davies’s diagnosis and did not believe that claimant had a “personality disorder.” (Ex. 101A-50, -51). Dr. Grass ruled out “conversion disorder” because it did not “come across” in testing, nor in her functioning. (Ex. 101A-55). Concerning evaluator’s descriptions of claimant’s “bizarre” clinical presentation, Dr. Grass did not consider claimant’s symptoms indicative of a psychological condition. (Ex. 101A-57).

In September 2008, Dr. Klecan, a psychiatrist who examined claimant at the employer’s request, noted claimant’s history of panic attacks. (Ex. 101B-5). In recounting a previous panic attack, Dr. Klecan stated:

“This symptom [face and left arm tingling], obviously indicating a psychosomatic anxiety attack and hyperventilation, is relevant past history because it previewed what would recur several years later at time of her present claim, and be called ‘carpal tunnel syndrome,’ leading to much trouble.” (Ex. 101B-10).

Dr. Klecan further noted that claimant’s most recent symptoms began in the face and “migrated” to the fingertips, an indication of psychogenic somatization, not CTS. (Ex. 101B-12). While the nerve conduction studies were “suggestive” of CTS, Dr. Klecan opined that, due to inconsistent symptomology, it was a clinical probability that the condition was psychosomatic rather than CTS. (Ex. 101B-13).

Additionally, Dr. Klecan explained that “somatization disorder” is not diagnosed from psychological testing and normal or nearly normal examinations are not relevant to the diagnosis. (Ex. 101B-20). Dr. Klecan diagnosed conversion disorder, with motor and sensory deficits, somatization or somatoform disorder, but deferred a personality diagnosis. Regarding his “conversion disorder” diagnosis, Dr. Klecan noted that the non-working thumb “matche[d] almost perfectly” the diagnostic criteria for a conversion disorder. (Ex. 101B-23).

Dr. Klecan further opined that claimant’s “electrophysiologic carpal tunnel median nerve slowing did combine with, and coexisted harmoniously with her psychiatric condition to cause and prolong the disability associated with her bilateral upper extremity complaints.” (Ex. 101B-27). He further opined that, regardless of nerve conduction findings, her upper extremity complaints were more likely caused by a psychiatric disorder “in the first place,” as evidenced by the symptom origination in her face. (*Id.*)

Dr. Thomas opined that claimant’s current thumb condition involved a childhood elbow condition, because both involve the radial nerve. (Ex. 102-19). Acknowledging that he had previously believed that claimant’s major problem was mental, Dr. Thomas explained that he initially was focused on her hand, as opposed to the elbow. (Ex. 102-19, -20, -21). Based on additional consideration of the medical evidence, Dr. Thomas changed/clarified his opinion that claimant’s right hand/thumb condition physically originated from her elbow. (Ex. 102-30).

Dr. Davies, after reviewing Drs. Grass’s and Reiter’s reports, maintained that claimant had a “personality disorder not otherwise specified, with histrionic

and passive-dependent features.” He explained that the diagnosis did not mean that claimant satisfied the criteria for both histrionic and passive-dependent personality disorders, but having the qualities of both resulted in a personality disorder. (Ex. 103-3). Absent an “organic” explanation, Dr. Davies maintained that claimant’s “disability” was primarily psychological. (*Id.*)

Dr. Nolan noted that the carpal tunnel release was successful; meaning the function of the median nerve was shown to be improved.¹ (Ex. 105-16). Dr. Nolan explained that the diagnosis of psychogenic hand syndrome meant a hand dysfunction that was not due to a physical problem. (Ex. 105-20). Dr. Nolan acknowledged that, because he was not a mental health professional, he was not qualified to address nonphysical reasons for claimant’s condition. (Ex. 105-20). However, in doing so, Dr. Nolan used the diagnosis to state that there was no physical problem present that would explain the hand dysfunction. (Ex. 105-21).

CONCLUSIONS OF LAW AND OPINION

In setting aside the employer’s denial, the ALJ concluded that: (1) there was no statutory “preexisting condition;” and (2) to the extent there was a combined condition, it involved claimant’s thumb and/or “psychogenic hand syndrome,”² not the CTS. Thus, in the absence of a combined condition, the ALJ reasoned that the denial should be set aside.

On review, the employer argues that claimant’s psychological condition was a preexisting condition and that it became the major contributing cause of the disability or need for treatment of the compensable combined CTS condition. In doing so, the employer asserts that, with regard to the combined condition, even if the psychological condition did not “play a direct or indirect causal role in the underlying syndrome at all,” it nonetheless “combined” with the CTS to contribute to the ongoing disability and need for treatment. (App. Brief, p. 12). Based on the following reasoning, we affirm.

¹ Drs. Nolan and Zinsmeister disagreed with Dr. Thomas’s theory regarding the involvement of the elbow. (Exs. 104-27, -33, -34, 105-9, -10).

² A denial of “psychogenic hand syndrome” has become final by operation of law. (Ex. 81).

The employer accepted an occupational disease claim, which consists of bilateral CTS combined with psychological conditions.³ The employer's denial asserts that the accepted bilateral CTS has ceased to be the major contributing cause of the combined condition. Thus, we apply ORS 656.262(6)(c) in determining the ongoing compensability of claimant's disputed combined condition. *Kevin W. Moreno*, 61 Van Natta 2107, 2108 (2009).

Under ORS 656.262(6)(c), a carrier may deny an accepted combined condition if the otherwise compensable injury ceases to be the major contributing cause of the combined condition. *Oregon Drywall Sys. v. Bacon*, 208 Or App 205, 210 (2006). A carrier may deny a previously-accepted combined or consequential condition "if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition." ORS 656.262(6)(c) (emphasis added). The word "ceases" presumes a change in circumstances or the claimant's condition. *State Farm Ins. Co. v. Lyda*, 150 Or App 554, 559 (1997); *Kandy S. Russell*, 55 Van Natta 2861, *on recon* 55 Van Natta 3657, 3659 (2003). In the absence of evidence showing such a change at the time of the denial's issuance, a denial based on ORS 656.262(6)(c) is procedurally invalid. *Lyda*, 150 Or App at 559.

In support of its denial, the insurer relies on the opinions expressed by Drs. Davies and Klecan. Based on the following reasoning, we find those opinions to be unpersuasive.

Despite noting that "all the patient's mental status findings were within normal limits," Dr. Davies opined that claimant had an "abnormal psychological condition that fuels symptom magnification," and that the psychological condition was the major contributing cause of her disability and pursuit of medical treatment.

³ ORS 656.802(2) provides:

"(2)(a) The worker must prove that employment conditions were the major contributing cause of the disease.

"(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease."

(Ex. 68-9).⁴ Dr. Grass also testified that Dr. Davies's test results were "normal," and thereby, concluded that the psychological condition was not a major component of claimant's condition. (Exs. 88-2, -3, 101A-22).

Dr. Davies, after reviewing Drs. Grass's reports, maintained that claimant had a "personality disorder not otherwise specified, with histrionic and passive-dependent features." Absent an "organic" explanation, Dr. Davies described claimant's "disability" as primarily psychological. (*Id.*)

Dr. Davies, however, did not discuss the status of claimant's CTS with regard to whether there was a "change" in claimant's accepted compensable combined CTS/psychological condition. Absent such an explanation, Dr. Davies's opinion is insufficient to meet the requisite standard for a "ceases" denial under ORS 656.262(6)(c).

Additionally, Dr. Klecan opined that, while the nerve conduction studies were "suggestive" of CTS, due to inconsistent symptomology, it was a clinical probability that the condition was psychosomatic rather than CTS. (Ex. 101B-13). However, it is undisputed that the employer has previously accepted bilateral CTS. (Ex. 74). Because the basis of Dr. Klecan's opinion is premised on the absence of a CTS condition (a position that is contrary to the legal posture of this claim), we do not consider the opinion sufficiently persuasive to establish that claimant's accepted CTS ceased to be the major contributing cause of her combined condition. *Lyle E. Sherburn*, 59 Van Natta 632, 635 (2007) (finding opinion unpersuasive where it was contrary to the legal posture of the claim).

Furthermore, claimant had objective findings of CTS, which is also supported by the opinions of Drs. Thomas, Smith, Nolan, and Zinsmeister. (Exs. 10-, 11, 22, 40, 41, 68-17, 105-15). Dr. Nolan also noted that the carpal tunnel release was successful, meaning the function of the median nerve was shown to be surgically improved. (Ex. 105-16). Consequently, because Dr. Klecan's opinion is founded on the proposition that claimant did not have CTS, we find his opinion unpersuasive. *Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2009) (medical opinion unpersuasive when it did not address contrary opinions).

⁴ Dr. Davies also diagnosed "pain disorder," and "histrionic and passive-dependent personality traits. (Ex. 68-8). Dr. Davies's opinion, however, is contradicted by Dr. Kelan, who ruled out "pain disorder" because symptoms other than pain were present. (Ex. 101B-26, -27).

Therefore, the medical record is insufficient to support the requisite “change” in condition that the employer must establish to support its “ceases” denial pursuant to ORS 656.262(6)(c).⁵ Accordingly, we affirm.

Claimant’s attorney is entitled to an assessed fee for services on review. ORS 656.382(2). 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 on review is \$5,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant’s respondent’s brief and her counsel’s uncontested fee request), the complexity of the issue, and the value of the interest involved.

Finally, 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 the employer. *See* ORS 656.386(2); OAR 438-015-0019; *Gary Gettman*, 60 Van Natta 2862 (2008). The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

ORDER

The ALJ’s order dated December 10, 2008 is affirmed. For services on review, claimant’s counsel is awarded an assessed fee of \$5,000, to be paid by the employer. 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 the employer.

Entered at Salem, Oregon on November 10, 2009

⁵ The dissent relies on opinions from Drs. Nolan and Zinsmeister. Yet, neither physician is a mental health professional. Because the accepted combined condition includes psychological components, we do not consider the opinions expressed by physicians in this case lacking a mental health expertise sufficiently persuasive to establish the requisite “change” in claimant’s combined condition to support the “ceases” denial pursuant to ORS 656.262(6)(c). In particular, Dr. Nolan has acknowledged his lack of qualification to address nonphysical reasons for claimant’s condition. Moreover, Dr. Zinsmeister opined that claimant’s CTS was no longer a material contributing cause of her need for treatment; he did not address whether the CTS had ceased to be the major contributing cause of claimant’s previously accepted combined CTS/psychological condition.

Member Langer dissenting.

The majority affirms the ALJ's order that set aside the self-insured employer's denial of the combined carpal tunnel condition. Because I would find that the medical evidence establishes that the otherwise compensable carpal tunnel condition had ceased to be the major contributing cause of the combined condition, I respectfully dissent. I reason as follows.

Despite the majority's discounting of the opinions of Drs. Davies and Klecan, the medical evidence unequivocally establishes that claimant has a psychological disorder that influences her physical presentation. Moreover, the opinions of the orthopedic surgeons, in conjunction with the employer's mental health experts, persuasively support the employer's denial.

On March 16, 2007, Dr. Thomas, claimant's attending physician, opined that the right carpal tunnel syndrome ceased to be the major contributing cause of claimant's need for treatment. (Ex. 71-2). Although Dr. Thomas later indicated that he believed that claimant's right thumb complaints were related to her right elbow, he did not change his opinion that the right carpal tunnel condition had ceased to be the major contributing cause. (Ex. 90-9, 10). Moreover, Dr. Thomas further explained that there was no connection between the right carpal tunnel (median nerve) injury and ongoing right thumb complaints, which he related to the radial nerve. (Ex. 90-14). Consequently, despite Dr. Thomas's varied opinions regarding claimant's psychological and radial nerve conditions, his opinion regarding the carpal tunnel syndrome consistently and persuasively establishes that the otherwise compensable carpal tunnel condition had "ceased" to be the major contributing cause of the combined carpal tunnel syndrome condition, and that there had been a "change" in circumstances sufficient to support the denial.

Moreover, the opinions of Dr. Zinsmeister, a neurologist, and Dr. Nolan, a hand surgeon, who examined claimant at the employer's request, support the employer's denial. The doctors diagnosed bilateral carpal tunnel syndrome and psychogenic hand syndrome, right. (Ex. 68-17). The doctors noted that claimant's right CTS improved after surgery, with "good relief" and that the current loss of function on the right was likely caused by psychogenic hand syndrome, the denial of which is final. (Exs. 68-18, 77, 81). Consequently, the doctors opined that claimant's carpal tunnel syndrome was no longer a material contributing cause of her need for treatment. (Ex. 68-19).

In light of the foregoing, I would find the medical evidence sufficient to establish that there had been a requisite “change” in the combined condition such that the otherwise compensable injury had ceased to be the major contributing cause of the combined carpal tunnel condition. Because the majority concludes otherwise, I respectfully dissent.