

In the Matter of the Compensation of
RAMONA M. JOHNSON, Claimant

WCB Case No. 08-06658, 08-05511

ORDER ON REVIEW

Philip H Garrow, Claimant Attorneys
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Reviewing Panel: Members Biehl, Langer, and Herman. Member Langer dissents.

CNA ClaimPlus, on behalf of Wyndham Worldwide (CNA/Wyndham), requests review of those portions of Administrative Law Judge (ALJ) Sencer's order that set aside its denials of claimant's occupational disease claim for bilateral cubital tunnel syndrome. AIG, on behalf of Peninsula Development (AIG/Peninsula), cross-requests review those portions of the ALJ's order that: (1) set aside its denials of claimant's new/omitted medical condition claim for bilateral carpal tunnel syndrome (CTS) as an occupational disease; and (2) awarded claimant's counsel a total of \$12,000 attorney fees for prevailing over both carriers' denials, to be shared equally by the carriers. On review, the issues are compensability, responsibility, and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the following summary and supplementation.

Claimant worked as a housekeeper since approximately 1989 or 1990. (Exs. 26-1-2, 32-2; Tr. 16-19). From October 2004 through October 2005, she worked for AIG/Peninsula cleaning an average of 12 to 20 hotel rooms per day. (Tr. 17, 20). Her job required her to change linens, scrub bathroom surfaces, dust, and vacuum. (Tr. 20-22). Claimant mainly used her right hand, but used her left hand when needed. (Tr. 22).

In June 2005, claimant sought treatment for bilateral hand/wrist pain. (Ex. 1). Dr. Gingold diagnosed bilateral CTS. (*Id.*) In July 2005 and September 2005, she also sought treatment for right elbow pain, which Dr. Gingold diagnosed as lateral epicondylitis. (Exs. 3, 4). AIG/Peninsula accepted claimant's occupational disease claim for nondisabling bilateral wrist sprains.¹ (Ex. 5).

¹ The claim was closed in November 2005. (Ex. 6).

In October 2005, claimant began working for CNA/Wyndham cleaning an average of four condominiums per day. (Tr. 23). Her job duties were more difficult than those at AIG/Peninsula because of the larger size of the condominiums and different surfaces. (Tr. 23, 46). In addition to dusting, vacuuming, and scrubbing bathrooms, she cleaned kitchens, refrigerators, and ovens, washed dishes and windows, and scrubbed tile surfaces and spa-style bathtubs. (Tr. 23-27).

In May 2008, claimant sought treatment for ongoing bilateral wrist problems, which were ultimately diagnosed as bilateral CTS and bilateral cubital tunnel syndrome. (Exs. 9, 11, 12). A June 2008 nerve conduction study (NCS) also suggested a possible diagnosis of peripheral polyneuropathy. (Ex. 11). Claimant filed an occupational disease claim with CNA/Wyndham for her 2008 bilateral wrist conditions. (Ex. 7).

In July 2008, Dr. Eckman examined claimant at CNA/Wyndham's request. (Ex. 13). He noted that claimant's hands and feet were "remarkably cool," and found decreased sensation in a glove-like distribution of both hands, as well as decreased sensation in both legs. (Ex. 13-4-5). Based on examination findings, Dr. Eckman believed that claimant had "a more disseminated sensory polyneuropathy involving not only the upper extremities, as well as the lower extremities." (Ex. 13-5). He opined that claimant's symptoms and conditions were not related to her work activities. (Ex. 13-6).

Dr. Gingold did not concur with Dr. Eckman's opinion, commenting, "Etiology of symptoms still unclear; could be caused by [claimant's] employment." (Ex. 15).

On July 9, 2008, CNA/Wyndham denied claimant's claim. (Ex. 14). Claimant requested a hearing.

In September 2008, Dr. Gingold performed right wrist median nerve and right elbow ulnar nerve decompression surgery. (Ex. 17). Claimant reported that her right hand symptoms were "essentially diminished." (Ex. 19).

In October 2008, Dr. Radecki examined claimant at AIG/Peninsula's request. (Ex. 22). He diagnosed bilateral median nerve compromises in the wrists, bilateral ulnar nerve compromises at the elbows, and a "question of diffuse peripheral neuropathy with prolonged ulnar sensory responses at each wrist." (Ex. 22-6). Dr. Radecki opined that "idiopathic factors" were the major contributing cause of claimant's conditions. (Ex. 22-6-7). He stated that

claimant's housekeeping work activities were not the type to cause her median and ulnar entrapment neuropathies. (Ex. 22-6). Dr. Radecki also noted that claimant stopped drinking alcohol two years ago, but that she drank about 10 drinks per week for 10 years. (Ex. 22-2). He explained that alcohol is a nerve toxin, and that claimant's past alcohol use, in light of her weight, was enough to cause a diffuse neuropathy and "maybe that is what has caused her to develop these entrapment syndromes." (Ex. 22-7). Dr. Radecki further opined that, because claimant's symptoms improved while working, her conditions were most likely due to idiopathic factors or past alcohol use. (*Id.*)

Dr. Gingold did not concur with Dr. Radecki's report. He stated, "I don't believe [claimant's] 'idiopathic' factors caused her symptoms." (Ex. 24).

Thereafter, claimant filed a new/omitted medical condition claim for bilateral cubital tunnel syndrome under the 2005 claim with AIG/Peninsula. (Ex. 25). AIG/Peninsula *de facto* denied the bilateral cubital tunnel condition. It also denied the compensability of and responsibility for claimant's new/omitted medical condition claim for bilateral CTS. (Ex. 31). Claimant requested a hearing, which was consolidated with the pending hearing against CNA/Wyndham.

In a November 26, 2008 "check-the-box" report, Dr. Gingold stated that the NCS, clinical examination findings, and surgery confirmed the diagnoses of bilateral CTS and cubital tunnel syndrome. (Ex. 26-3). He noted that he was not prepared to diagnose a polyneuropathy, but that, if it existed, the condition would be distinct from the CTS and cubital tunnel syndrome, and was not a contributing factor to those syndromes. (*Id.*) Dr. Gingold explained that CTS and cubital tunnel syndrome were entrapment neuropathies, resulting from the nerve becoming compressed or entrapped at the carpal or cubital tunnels, generally due to repetitive injury and trauma to the nerve. (Ex. 26-4). He opined that claimant's repetitive grasping and forceful gripping activities while cleaning over the last 15 years were the major contributing cause of her bilateral CTS and cubital tunnel syndrome. (*Id.*) Dr. Gingold further explained that "[claimant's] work activities between 2005 and 2008 continued to cause compression of the ulnar and median nerves in her bilateral upper extremities eventually resulting in her need for treatment, including surgery." (Ex. 26-4-5).

On November 26 and December 4, 2008, Dr. Gingold signed a summary letter from CNA/Wyndham. He opined that claimant probably had bilateral cubital tunnel syndrome in June 2005, the symptoms of which he was providing treatment. Dr. Gingold agreed that claimant's work activities for CNA/Wyndham caused a temporary flare-up of her symptoms in relation to the bilateral CTS and cubital

tunnel syndrome, but did not actually cause or pathologically worsen those conditions. He further agreed that the work activities at CNA/Wyndham did not cause any type of objective, physiological disorder. (Exs. 27, 28).

On January 8, 2009, Dr. Bell examined claimant at AIG/Peninsula's request. (Ex. 32). Dr. Bell diagnosed bilateral median and ulnar entrapment neuropathies. (Ex. 32-9). She noted that claimant had decreased vibration and cold sensation in her lower extremities, and pes cavus deformity in her feet. (*Id.*) Based on the severity of the NCS findings, as well as her lower extremity findings, Dr. Bell also diagnosed peripheral neuropathy/polyneuropathy. (Ex. 32-9-10). She opined that claimant's work activities were not the major contributing cause of the entrapment neuropathies. (Ex. 32-10). Instead, Dr. Bell concluded that the entrapment neuropathies were caused by the preexisting peripheral neuropathy. (*Id.*)

In a January 2009 supplemental report, Dr. Radecki opined that claimant's work activities at CNA/Wyndham neither caused any objective physiological disorder, nor worsened her underlying bilateral upper extremity conditions. (Ex. 34). He explained that Dr. Gingold's 2005 examination findings did not establish the existence of cubital tunnel syndrome, and that Dr. Gingold's 2008 examination findings showed no evidence of a worsening of claimant's CTS. (Ex. 34-1-4). Dr. Radecki noted that claimant's symptoms of numbness improved with work and, therefore, her work activities did not cause a symptomatic worsening of her underlying conditions. (Ex. 34-4-7). Dr. Radecki stated that claimant had a history of alcohol abuse and hypothyroidism, which cause diffuse peripheral neuropathies, and that she had clinical examination findings of peripheral neuropathy, which was a predisposing and contributing factor to the development of entrapment neuropathies. (Ex. 34-5-6).

Dr. Gingold disagreed with the opinions of Drs. Eckman, Bell and Radecki. (Exs. 37, 41). He opined that claimant had a combination of diagnoses, but needed more objective evidence and evaluation to confirm the diagnosis of peripheral neuropathy. (Exs. 37-1, 41-1-2). Dr. Gingold stated that peripheral neuropathy may cause slowing of the medial and ulnar nerve conductions, making the nerves more susceptible to entrapment, but did not cause entrapment. (Ex. 41-2). He explained that claimant's improvement of symptoms while working supported a conclusion that work activities were the cause of her entrapment conditions because the muscles were working properly and the tendons slid through the carpal and cubital tunnel openings, but swelled and pinched the nerves when those activities stopped. (Ex. 41-2-3). Dr. Gingold noted that, although he did not diagnose cubital tunnel syndrome in 2005, he diagnosed lateral epicondylitis, which had similar symptoms. (Ex. 41-3). He acknowledged that alcohol use and

a thyroid condition may affect nerve conditions and cause peripheral neuropathy, but stated that claimant's remote alcohol use and thyroid condition did not cause or affect the carpal or cubital tunnel syndromes, other than a minor contribution. (Ex. 41-3-4). Dr. Gingold concluded that claimant's work activities were the major contributing cause of her bilateral CTS and cubital tunnel syndrome. (Exs. 37-2, 41-2).

CONCLUSIONS OF LAW AND OPINION

Compensability

In setting aside the compensability denials of claimant's occupational disease claims for CTS and cubital tunnel syndrome, the ALJ found that Dr. Gingold's opinion persuasively established that work activities were the major contributing cause of the claimed conditions. The ALJ reasoned that Drs. Eckman, Bell, and Radecki presumed that claimant had peripheral neuropathy, and that they neither explained how the possible peripheral neuropathy caused CTS or cubital tunnel syndrome, nor explained how her work activities did not contribute to those conditions. We agree that claimant's occupational disease claims are compensable, although our reasoning differs from the ALJ's.

To establish a compensable occupational disease, claimant must establish that employment conditions were the major contributing cause of the claimed CTS and cubital tunnel syndrome. ORS 656.266(1); ORS 656.802(2)(a). The last injurious exposure rule (LIER) allows a claimant to prove compensability without proving the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease; rather, a claimant need only prove that the disease was caused, in major part, by employment-related exposure. *Roseburg Forest Prods. v. Long*, 325 Or 305, 309 (1997); *Dana L. Folmsbee*, 61 Van Natta 911, 913 (2009).

The determination of major contributing cause involves the evaluation of the relative contribution of the different causes of claimant's diseases and a decision as to which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed*, 321 Or 416 (1995); *Linda E. Patton*, 60 Van Natta 579, 581 (2008). Because of the possible alternate causes of claimant's conditions, expert medical opinion must be used to resolve the question of causation. *Uris v. Comp. Dep't*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). We give more weight to those opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986); *Patton*, 60 Van Natta at 582. We properly may or may not give greater weight to the opinion of the treating

physician, depending on the record in each case. *See Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001); *Darwin B. Lederer*, 53 Van Natta 974 n 2 (2001) (absent persuasive reasons to the contrary, the Board generally gives greater weight to the opinion of the claimant's attending physician).

To establish compensability, claimant relies on Dr. Gingold's opinion, who opined that claimant was diagnosed with bilateral CTS in 2005, and likely had cubital tunnel syndrome at that time because he diagnosed lateral epicondylitis, which had similar symptoms. (Exs. 27, 28, 41-3). He noted that claimant's symptoms persisted and worsened since 2005, as she got busier with work. (Exs. 9-1, 26-3-4). Dr. Gingold explained that CTS and cubital tunnel syndrome were entrapment neuropathies, resulting from the nerve becoming compressed or entrapped at the carpal or cubital tunnels, generally due to repetitive injury and trauma to the nerve. (Ex. 26-4). According to Dr. Gingold, CTS and cubital tunnel syndrome were distinct from peripheral neuropathy/polyneuropathy. (Exs. 26-3, 37-2). Dr. Gingold concluded that claimant's repetitive grasping and forceful gripping activities while cleaning over the last 15 years were the major contributing cause of her bilateral CTS and cubital tunnel syndrome, and that her work activities between 2005 and 2008 continued to cause compression of the ulnar and median nerves in her bilateral upper extremities eventually resulting in her need for treatment, including surgery. (Exs. 26-4-5, 37-2, 41-2).

The carriers argue that Dr. Gingold's opinion is inconsistent. Specifically, they contend that Dr. Gingold initially opined that claimant's work activities over the last 15 years were the major contributing cause of her bilateral CTS and cubital tunnel syndrome and that her work activities between 2005 and 2008 continued to cause bilateral ulnar and median nerve compression, but later agreed that the work activities for CNA/Wyndham caused a temporary flare-up of her bilateral CTS and cubital tunnel syndrome symptoms, but did not actually cause or pathologically worsen those conditions, or cause any type of objective, physiological disorder.² (Exs. 27, 28).

However, the LIER allows claimant to prove compensability without proving the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused her claimed occupational diseases, so long as she proves that her employment-related exposure was the major contributing cause of her diseases. *Long*, 325 Or at 309; *Folmsbee*, 61 Van Natta at 913. Because Dr. Gingold opined that claimant's employment-related exposure (*i.e.*, her

² Claimant began working for CNA/Wyndham in October 2005. (Tr. 23).

work activities as a housekeeper over the last 15 years) was the major contributing cause of her diseases, we do not find his opinion addressing the compensability issue to be inconsistent.

In reaching this conclusion, we acknowledge that Dr. Gingold's opinion regarding whether claimant's subsequent work activities at CNA/Wyndham caused an actual worsening, rather than a mere increase in symptoms, appears to be inconsistent. However, those statements pertain to the responsibility issue, not the compensability issue. Thus, the carriers' arguments regarding Dr. Gingold's allegedly inconsistent statements will be addressed in determining responsibility.

The carriers also argue that Dr. Gingold did not identify a specific work activity that caused claimant's conditions. However, Dr. Gingold described claimant's work activities as a housekeeper. (Ex. 26-1-2). He explained that the "repetitive grasping and forceful gripping *while cleaning*, particularly over a number of years," caused claimant to develop entrapment syndromes. (Ex. 26-4) (emphasis added). Therefore, we find that Dr. Gingold identified the employment-related exposure that caused claimant's claimed conditions.

The carriers further contend that Dr. Gingold did not address the relative contribution from peripheral neuropathy as a cause of claimant's bilateral CTS and cubital tunnel syndrome.³ For the following reasons, we disagree.⁴

Assuming the existence of peripheral neuropathy, Dr. Gingold opined that the condition was not a contributing factor to the development of CTS and cubital tunnel syndrome. (Exs. 26-3, 41-2). Dr. Gingold explained that peripheral

³ Dr. Gingold acknowledged the possibility of a diagnosis of peripheral neuropathy, but stated that the condition was not definitively diagnosed. (Exs. 26-3, 37-1, 41-1-2). However, Drs. Eckman, Radecki, and Bell agreed that claimant had clinical examination findings (in addition to the NCS) of the condition, such as glove/stocking numbness in the hands and feet. (Exs. 11, 13, 32, 34). Therefore, we find that the record establishes more than a "possible" diagnosis of peripheral neuropathy.

⁴ Dr. Gingold agreed that prolonged alcohol use and a thyroid condition may contribute to the possible peripheral neuropathy, but did not believe that those factors actually caused CTS or cubital tunnel syndrome. (Ex. 41-3-4). Dr. Radecki opined that claimant's past alcohol use "is certainly enough to cause a *diffuse neuropathy* and *maybe* that is what caused her to develop" the entrapment syndromes. (Ex. 22-7) (emphases added). He cited medical studies that "mention" that patients with bilateral ulnar neuropathies had a significant history of alcohol abuse. (Ex. 34-5). Yet, neither Dr. Radecki nor the medical studies indicated that alcohol use caused *entrapment neuropathies*. (Ex. 34-5, -24). Dr. Radecki also opined that medical literature indicated that hypothyroidism caused *diffuse neuropathies*. (Ex. 34-5-7). According to Dr. Radecki, the diffuse *peripheral neuropathy* was a predisposing factor or causative factor to the development of *entrapment neuropathies*. (*Id.*) Therefore, the pertinent question is whether Dr. Gingold addressed the relative contribution of the *peripheral neuropathy* as a cause of claimant's claimed entrapment conditions. *Dietz*, 430 Or App at 401.

neuropathies caused some slowing of nerve conductions, making the nerves more susceptible to entrapment, but did not specifically cause nerve entrapment. (Ex. 41-2).

Dr. Eckman opined that peripheral neuropathy “would make [claimant] more susceptible to the development of a [CTS].” (Ex. 30-2). Dr. Bell concluded that claimant’s preexisting peripheral neuropathy was the cause of the entrapment neuropathies, but did not offer further explanation. (Ex. 32-9-10). Dr. Radecki expressly stated that peripheral neuropathy is a “predisposing” condition, but subsequently concluded that the peripheral neuropathy is a “predisposing factor or causative factors of entrapment neuropathies.” (Ex. 34-5). Yet, the medical literature cited by Dr. Radecki did not address causation; instead, it specifically identified peripheral neuropathy (polyneuropathy) as “a definite predisposing condition.” (Ex. 34-24).

Because Dr. Gingold’s opinion that peripheral neuropathy was not a *causal* contributing factor to entrapment neuropathies is consistent with the medical evidence that peripheral neuropathy is a *predisposing* factor, we find that Dr. Gingold adequately addressed the relative contribution of the peripheral neuropathy in determining the major contributing cause of claimant’s CTS and cubital tunnel syndrome. *Dietz*, 430 Or App at 401.

Furthermore, Dr. Gingold rebutted Dr. Radecki’s contrary medical opinion regarding the diagnoses of entrapment neuropathies and the relationship between claimant’s work activities and her symptoms. Dr. Gingold explained that the examination findings, NCS, and surgical findings supported the diagnoses of bilateral CTS and cubital tunnel syndrome. (Exs. 26, 37, 41). He also explained that claimant’s symptoms initially improved with work activities, but worsened when those activities stopped because the muscles and tendons swelled, which caused pinching of the nerves. (Ex. 41-2-3). Therefore, we find that Dr. Gingold’s opinion is well reasoned and persuasive. *Somers*, 77 Or App at 263.

In contrast, we do not find the opinions of Drs. Eckman, Bell, and Radecki to be as well reasoned. Dr. Radecki disagreed with Dr. Gingold’s diagnoses of CTS and cubital tunnel syndrome based on clinical examination and surgical findings.⁵ (Exs. 34, 36, 40). Yet, Dr. Radecki also diagnosed bilateral median and ulnar nerve compromises, which he stated were equivalent to CTS and cubital tunnel syndrome, respectively. (Exs. 22-6, 36, 40). Drs. Eckman and Radecki also did not explain why peripheral neuropathy, which they identified as a “predisposing” factor, *causally* contributed to the entrapment neuropathies.

⁵ Dr. Gingold found significant compression of the median and ulnar nerves at the September 2008 surgery, which confirmed the diagnoses of right CTS and cubital tunnel syndrome. (Exs. 17, 26).

(Exs. 13, 30, 34). Likewise, Dr. Bell offered no explanation why peripheral neuropathy caused the entrapment neuropathies. (Ex. 32). Therefore, we do not find the opinions of Drs. Eckman, Bell, and Radecki to be more persuasive than that of Dr. Gingold. *See Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained or conclusory opinion); *see also Howard L. Allen*, 60 Van Natta 1423, 1424-25 (2008) (internally inconsistent medical opinion, without explanation for the inconsistencies, was unpersuasive).

Based on the aforementioned reasoning, we find that Dr. Gingold's opinion persuasively establishes that claimant's work activities were the major contributing cause of her bilateral CTS and cubital tunnel syndrome. ORS 656.266(1); ORS 656.802(2)(a); *Somers*, 77 Or App at 263. Consequently, we affirm the ALJ's compensability determination.

Responsibility

The ALJ applied the LIER to determine responsibility. The ALJ assigned initial responsibility for the bilateral CTS to AIG/Peninsula, and found that it did not establish that the subsequent employment at CNA/Wyndham actually contributed to a worsening of the condition. The ALJ assigned initial responsibility for the bilateral cubital tunnel syndrome to CNA/Wyndham, and found that it did not establish that it was impossible for CNA/Wyndham to have caused the condition, or that the prior employment at AIG/Peninsula was the sole cause of the condition. Thus, the ALJ determined that AIG/Peninsula was responsible for the bilateral CTS, and that CNA/Wyndham was responsible for the bilateral cubital tunnel syndrome.

On review, AIG/Peninsula argues that, even if it is presumptively responsible for the bilateral CTS and cubital tunnel syndrome, responsibility should shift to CNA/Wyndham. CNA/Wyndham argues that initial or presumptive responsibility should be assigned to AIG/Peninsula, and that responsibility should remain with AIG/Peninsula.

We find that AIG/Peninsula is initially responsible for the bilateral CTS condition, and that CNA/Wyndham is initially responsible for the bilateral cubital tunnel syndrome. However, we conclude that CNA/Wyndham is ultimately responsible for both conditions. We reason as follows.

Under the LIER, initial or presumptive responsibility for the disease is assigned to the carrier during the last period of employment when conditions could have contributed to the claimant's disability. *AIG Claim Servs. v. Rios*, 215 Or App 615, 619-20 (2007). The "onset of disability" is the triggering date for

determining the last potentially causal employment. *Agricomps Ins. v. Tapp*, 169 Or App 208, 211-12, *rev den*, 331 Or 244 (2000). If the claimant receives treatment before experiencing time loss due to the condition, the triggering date for assignment of responsibility is the time when the worker first seeks medical treatment for symptoms, even if not correctly diagnosed until later. *Oregon Boiler Workers v. Lott*, 115 Or App 70, 74 (1998), *rev den*, 328 Or 365 (1999); *SAIF v. Kelly*, 130 Or App 185, 188 (1994); *Derek T. McCulloch* 59 Van Natta 1049, 1053 (2007).

In June 2005, claimant sought treatment for bilateral hand/wrist pain, which Dr. Gingold diagnosed as bilateral CTS. (Ex. 1). Dr. Gingold consistently opined that claimant was first diagnosed and treated for bilateral CTS in 2005, when AIG/Peninsula was on the risk. (Exs. 26-2, 27, 28, 41-3). Therefore, we assign initial or presumptive responsibility for the bilateral CTS to AIG/Peninsula. *Rios*, 215 Or App at 619-20; *Tapp*, 169 Or App at 211-12.

In 2008, Dr. Gingold opined that “[claimant] also probably had bilateral cubital tunnel syndrome back in June of 2005 (the symptoms from which [he was] providing treatment).” (Ex. 27, 28). In 2009, Dr. Gingold acknowledged that claimant was not diagnosed with the condition in 2005, but considered it possible that she had early symptoms of the condition. (Ex. 41-3). He explained that claimant was diagnosed with lateral epicondylitis, “which may be a related diagnosis in that some of the symptoms are similar.” (*Id.*)

However, in 2005, Dr. Gingold diagnosed only right-sided lateral epicondylitis. (Exs. 3, 4). He also reported that the cubital tunnel examinations were negative bilaterally. (Exs. 1, 3). Dr. Gingold did not indicate or discuss the possibility that claimant’s examination findings might be related to bilateral cubital tunnel syndrome, or that she was being treated for symptoms of the condition. Thus, we are not persuaded that claimant first sought medical treatment for symptoms of bilateral cubital tunnel syndrome in 2005. *Lott*, 115 Or App at 74; *Kelly*, 130 Or App at 188.

In contrast, Dr. Gingold first discussed the possible diagnosis of bilateral cubital tunnel syndrome in May 2008, based on cubital tunnel examination findings. (Ex. 9). He later confirmed the diagnosis based on clinical examination, NCS, and surgical findings. (Exs. 11, 12, 17). Under these particular circumstances, we find that the weight of the medical evidence indicates that the “onset of disability” for bilateral cubital tunnel syndrome was in 2008, when CNA/Wyndham was on the risk. Therefore, we assign initial or presumptive responsibility for the bilateral cubital tunnel syndrome to CNA/Wyndham. *Rios*, 215 Or App at 619-20; *Tapp*, 169 Or App at 211-12.

AIG/Peninsula may transfer liability for the bilateral CTS to CNA/Wyndham by establishing that the claimant's work activities for CNA/Wyndham actually contributed to a worsening of the condition. *Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998), *rev den*, 328 Or 365 (1999). However, in order to shift responsibility to CNA/Wyndham, claimant must suffer a worsening of the condition; a mere increase in symptoms is not sufficient. *Id.* CNA/Wyndham may transfer liability for the bilateral cubital tunnel syndrome to AIG/Peninsula 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. *Long*, 325 Or at 313; *Rogers*, 157 Or App at 153.

As explained above, we have found Dr. Gingold's causation opinion to be the most persuasive. The carriers agree that, if Dr. Gingold's opinion persuasively establishes compensability of the claimed occupational diseases, then his opinion should be used to determine responsibility for those conditions.

Both carriers contend that Dr. Gingold's opinion was inconsistent. Nevertheless, AIG/Peninsula argues that, despite the alleged inconsistencies, Dr. Gingold's explanation supports a conclusion that claimant's work activities for CNA/Wyndham actually contributed to a worsening of her bilateral CTS, and does not establish that it was impossible for her employment at CNA/Wyndham to have caused the bilateral cubital tunnel syndrome, or that a prior period of employment was the sole cause of that condition. We agree.

Initially, Dr. Gingold opined that "[claimant's] work activities between 2005 and 2008 continued to cause compression of the ulnar and median nerves in her bilateral upper extremities eventually resulting in her need for treatment, including surgery." (Ex. 26-4-5). Later, however, he agreed that claimant's work activities for CNA/Wyndham caused a temporary flare-up of her symptoms in relation to the bilateral CTS and cubital tunnel syndrome, but did not actually cause and did not pathologically worsen those conditions, and "did not cause any type of objective, physiological disorder." (Ex. 27, 28).

We acknowledge that Dr. Gingold expressly agreed that claimant's work activities at CNA/Wyndham did not *actually cause* or *pathologically worsen* her claimed conditions, and did not *cause* any type of disorder. (Exs. 27, 28). However, incantation of "magic words" is not controlling if the opinion otherwise meets the appropriate legal standard. *See e.g., SAIF v. Strubel*, 161 Or App 516, 521-22 (1999) (holding that an expert's opinion need not be ignored because it fails to include the magic words "major contributing cause"); *see also e.g., Brian*

Velazquez, 62 Van Natta 1451, 1452 (2010) (a physician's opinion that no objective findings are present is not controlling if findings satisfying the statutory definition are nevertheless present).

Here, the standard to be met for transferring liability for the bilateral CTS from AIG/Peninsula to CNA/Wyndham is whether claimant's subsequent work exposure at CNA/Wyndham "actually contributed to a worsening of the condition." *Rogers*, 157 Or App at 153; *Lott*, 115 Or App at 74. The standard to be met for transferring liability for the bilateral cubital tunnel syndrome from CNA/Wyndham to AIG/Peninsula is whether 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. *Long*, 325 Or at 313; *Rogers*, 157 Or App at 153. Thus, we evaluate Dr. Gingold's opinion in context and based on the record as a whole to determine whether the standards have been met. *Strubel*, 161 Or App at 521-22.

In November 2008, Dr. Gingold stated that, when claimant sought treatment in 2008, she reported that her symptoms were getting worse as she was busier with work. (Ex. 26-3-4). He noted that her clinical examination findings and NCS confirmed the diagnoses of bilateral CTS and cubital tunnel syndrome. (Ex. 26-3). Dr. Gingold considered claimant's overall work activities as a housekeeper for over 15 years to be the most important factor in the development of her conditions. (Ex. 26-4). He also opined that "[claimant's] work activities between 2005 and 2008 *continued to cause compression* of the ulnar and median nerves in her bilateral upper extremities eventually resulting in her need for treatment, including surgery." (Ex. 26-4-5) (emphasis added).

In July 2009, Dr. Gingold explained that, "[CTS] and cubital tunnel syndrome are primarily clinical diagnoses, which are diagnosed based on the patient's report of symptoms and specific tests on exam. Nerve conductions can help confirm the diagnosis and 'objectify' the severity." (Ex. 41-3). Dr. Gingold did not disagree with Dr. Radecki's opinion that claimant did not have motor or sensory deficits during her 2005 examinations. (Ex. 34-1-3). However, Dr. Gingold stated that the 2008 NCS did, in fact, reveal motor deficits, which suggested that her median nerve compression "had reached the severe stage." (Ex. 41-3).

We find that Dr. Gingold's opinion supports a conclusion that claimant's work activities at CNA/Wyndham actually contributed to a worsening of her bilateral CTS. We also find that his opinion does not establish that it was impossible for her employment at CNA/Wyndham to have caused the bilateral cubital tunnel syndrome, or that a prior period of employment was the sole cause of the condition. We reason as follows.

We have found that claimant was first diagnosed with, and treated for, bilateral CTS in 2005, and first sought treatment for symptoms of bilateral cubital tunnel syndrome in 2008. We have also found that Dr. Gingold's opinion persuasively establishes that claimant's work activities as a housekeeper over the last 15 years were the major contributing cause of her bilateral CTS and cubital tunnel syndrome.

In June 2005, Dr. Gingold found positive Tinel's test and equivocal flexion compression test in claimant's wrists, and negative Tinel's test at the cubital tunnels.⁶ (Ex. 1). In July 2005, claimant reported a significant improvement in symptoms, but pain in her forearms. (Ex. 3). Dr. Gingold found negative Tinel's test at the wrists and elbows, negative Phalen's test, and negative flexion compression. (*Id.*) At Dr. Gingold's last examination of claimant in 2005 (September), claimant reported that her bilateral hand/wrist and forearm/elbow symptoms were significantly improved. (Ex. 4). Again, Dr. Gingold found negative Tinel's test, Phalen's test, and flexion compression test in the wrists. (*Id.*) Dr. Gingold did not report any motor or sensory deficits in 2005. (Exs. 1, 3, 4).

In May 2008, however, Dr. Gingold found positive Tinel's test, mildly positive flexion compression test, and negative Phalen's test in claimant's wrists, and positive Tinel's test in claimant's left cubital tunnel. (Ex. 9). In June 2008, Dr. Gingold reported positive flexion compression test and "grossly positive Tinel's test and Phalen's test" in claimant's right wrist, mildly positive flexion compression test and positive Tinel's test and Phalen's test in the left wrist, and mildly positive Tinel's test in the left cubital tunnel. (Ex. 12). The June 2008 NCS findings revealed motor and sensory deficits in the medial and ulnar nerves, which were interpreted as severe bilateral median neuropathy at the carpal tunnel and moderate-to-severe bilateral ulnar neuropathy at the elbow. (Ex. 11).

We acknowledge Dr. Gingold's statement that claimant's work activities for CNA/Wyndham caused a temporary flare-up of her symptoms of her diseases but did not actually cause or pathologically worsen them, and that he referred to

⁶ Drs. Gingold, Radecki, and Bell agreed that CTS and cubital tunnel syndrome are diagnosed based on a patient's report of symptoms and responses to clinical examinations. (Exs. 26-3, 32-9, 34-1-3, 41-3). According to Dr. Gingold, such clinical examination findings include positive Tinel's test over the wrist and cubital tunnel. (Ex. 26-3). Dr. Radecki opined that physical findings of CTS include sensory and motor deficits, positive Tinel's test, positive Phalen's test, and positive flexion compression test in the median nerve distribution. (Ex. 34-1-2). He also stated that physical findings of cubital tunnel syndrome include sensory and motor deficits, and positive Tinel's test at the cubital tunnel. (Ex. 34-2-3). According to Dr. Bell, claimant's complaints of bilateral upper extremity paresthesia in 2005 were consistent with CTS. (Ex. 32-9).

claimant's worsened "symptoms" in 2008. (Exs. 26-3-4, 27, 28, 41). However, his explanation, particularly regarding the positive Tinel's tests in 2008 and motor and sensory deficits in the 2008 NCS, addressed increased physical examination findings and nerve pathology findings. (Exs. 26-3-4, 41-3). He also noted that, when claimant sought treatment in 2008, she attributed her bilateral upper extremity complaints to her busier work activities at CNA/Wyndham. (Exs. 9-1, 26-3; Tr. 36).⁷

Reading his opinion in context and based on the record as a whole, we find that Dr. Gingold's opinion, particularly that "[claimant's] work activities between 2005 and 2008 continued to cause compression of the ulnar and median nerves in her bilateral upper extremities eventually resulting in her need for treatment, including surgery," establishes that the work activities at CNA/Wyndham actually contributed to a worsening of claimant's bilateral CTS. *Strubel*, 161 Or App at 521-22. His opinion that claimant's work activities as a housekeeper over the last 15 years were the major contributing cause of her bilateral CTS and cubital tunnel syndrome also does not establish that it was *impossible* for her employment at CNA/Wyndham to have caused the bilateral cubital tunnel syndrome, or that a prior period of employment was the sole cause of the condition. *Id.* Therefore, CNA/Wyndham is responsible for both conditions. *Long*, 325 Or at 313; *Rogers*, 157 Or App at 153. Consequently, we reverse that portion of the ALJ's order that found AIG/Peninsula responsible for the bilateral CTS.

Attorney Fees

We adopt and affirm the ALJ's attorney fee award of \$10,000 for prevailing over the compensability denials under ORS 656.386(1).

Because CNA/Wyndham is now responsible for both occupational disease claims, it is likewise responsible for the ALJ's \$10,000 attorney fee awards related to compensability. The ALJ's attorney fee award under ORS 656.386(1) is modified accordingly. *See Gerald T. Fisher*, 58 Van Natta 2597, 2602 (2006). However, because we reverse the ALJ's responsibility determination concerning the bilateral CTS, the ALJ's \$1,000 attorney fee award under ORS 656.308(2)(d), assessed against AIG/Peninsula, is also reversed. The ALJ's \$1,000 attorney fee award under ORS 656.308(2)(d), payable by CNA/Wyndham, is affirmed.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find

⁷ Claimant's employment at CNA/Wyndham involved heavier work activities and longer work weeks than her employment at AIG/Peninsula. (Ex. 9-1, 22-2, 32-2; Tr. 19-26, 36).

that a reasonable fee for claimant's attorney's services on review is \$4,000, payable by CNA/Wyndham. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's respondent's brief, and her counsel's uncontested fee request), the complexity of the issue, and the value of the interest involved.⁸

Finally, 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 CNA/Wyndham. 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 September 10, 2009, as amended on September 17, 2009, is affirmed in part, modified in part, and reversed in part. CNA/Wyndham's denial concerning the bilateral CTS claim is set aside and the claim is remanded to it for processing in accordance with law. AIG/Peninsula's responsibility denial for that condition is reinstated and upheld. The ALJ's \$1,000 and \$5,000 attorney fee awards assessed against AIG/Peninsula, are reversed. In lieu of the ALJ's attorney fee awards, for services at the hearing level, claimant's counsel is awarded a total of \$11,000, to be paid by CNA/Wyndham. The remainder of the ALJ's order is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of \$4,000, payable by CNA/Wyndham. 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 CNA/Wyndham.

Entered at Salem, Oregon on August 31, 2010

Member Langer dissenting.

Relying on Dr. Gingold's opinion, the majority concludes that claimant established the compensability of her occupational disease claims for bilateral carpal tunnel syndrome (CTS) and bilateral cubital tunnel syndrome. Only Dr. Gingold arguably supports claimant's claim. Because I do not find Dr. Gingold's opinion persuasive, I respectfully dissent.⁹

⁸ Claimant's counsel is not entitled to a fee for services devoted to defending the ALJ's attorney fee award. *Dotson v. Bohemia*, 80 Or App 233, rev den 302 Or 35 (1986).

⁹ Because I would find that claimant has not established the compensability of her claimed occupational diseases, I do not address the responsibility issue.

The majority concludes that Dr. Gingold's opinion establishes that claimant's overall employment-related exposure (*i.e.*, her work activities as a housekeeper for over the last 15 years) was the major contributing cause of her diseases. The majority reasons that the last injurious exposure rule (LIER) allows claimant to prove compensability without proving the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the diseases, so long as she proves that her diseases were caused, in major part, by employment-related exposure. *Roseburg Forest Prods. v. Long*, 325 Or 305, 309 (1997); *Dana L. Folmsbee*, 61 Van Natta 911, 913 (2009).

Although claimant need not prove, under the LIER, the degree to which a particular employment-related exposure actually caused the disease, she must establish by persuasive medical evidence that her work activities were the major contributing cause of her claimed conditions. ORS 656.266(1); ORS 656.802(2)(a); *Long*, 325 Or at 309; *Folmsbee*, 61 Van Natta at 913. Unlike the majority, I find Dr. Gingold's opinion internally inconsistent, unexplained, unpersuasive and, thus, insufficient to establish compensability.

In the November 26, 2008 "check-the-box" summary letter from claimant's attorney, Dr. Gingold agreed that "[claimant's] work activities between 2005 and 2008 *continued to cause compression* of the ulnar and median nerves in her bilateral upper extremities eventually resulting in her need for treatment, including surgery." (Ex. 26-4-5) (emphasis added). Yet, in the November 26 and December 4, 2008 "check-the-box" summary letter from CNA/Wyndham, Dr. Gingold agreed that claimant's work activities for CNA/Wyndham caused a temporary flare-up of her symptoms in relation to the bilateral CTS and cubital tunnel syndrome, but did not actually cause, and "*did not pathologically worsen*" those conditions.¹⁰ (Exs. 27-1, 28-1) (emphasis in originals). He further agreed that the work activities at CNA/Wyndham "*did not cause any type of objective, physiological disorder.*" (Exs. 27-2, 28-2) (emphasis added).¹¹

Moreover, in his July 2009 report, Dr. Gingold opined that the nerve conduction studies (NCS) findings indicated that claimant's "forearm and hand muscles are not able to function properly." (Ex. 41-3). Yet, in that same report, he stated that claimant's symptoms improved with work activities because "the muscles groups are working properly[.]" (Ex. 41-2).

¹⁰ Claimant began working for CNA/Wyndham in October 2005. (Tr. 23).

¹¹ Dr. Eckman also agreed that claimant's work activities at CNA/Wyndham caused a temporary flare-up of symptoms of the underlying bilateral CTS and cubital tunnel syndrome, but did not cause or pathologically worsen those conditions. (Ex. 30).

Dr. Gingold never explained these inconsistencies. Accordingly, despite the application of the LIER to determine compensability, I find that his whole opinion is unpersuasive. *Howard L. Allen*, 60 Van Natta 1423, 1424-25 (2008) (internally inconsistent medical opinion, without explanation for the inconsistencies, was unpersuasive).

There are other shortcomings in Dr. Gingold's opinion. He opined that claimant likely had bilateral cubital tunnel syndrome in 2005 because, although he did not diagnose the condition at that time, he diagnosed lateral epicondylitis, which had similar symptoms. (Exs. 27, 28, 41-3). Nonetheless, in 2005, Dr. Gingold only diagnosed *right-sided* lateral epicondylitis. (Exs. 3, 4). He had also reported that the cubital tunnel examinations were "negative bilaterally." (Exs. 1-1, 3). Therefore, I find that Dr. Gingold had an inaccurate history of claimant's bilateral cubital tunnel syndrome condition. *Somers v. SAIF*, 77 Or App 259, 263 (1986) (in evaluating the medical evidence, we rely on those opinions that are both well reasoned and based on accurate and complete information).

Furthermore, I find Dr. Gingold's discussion of the relative contribution of claimant's peripheral neuropathy and hypothyroidism to be inadequately explained. In his July 2009 report, Dr. Gingold agreed that claimant most likely had a combination of diagnoses in effect, which included peripheral neuropathy. (Ex. 41-2). Although he acknowledged that the NCS suggested a diagnosis of peripheral neuropathy/polyneuropathy, Dr. Gingold stated that he needed additional objective evidence and evaluation to confirm the diagnosis. (Exs. 11-3, 26-3, 37-1, 41-1-2).

Other medical evidence persuasively shows, however, that claimant has peripheral neuropathy. At his July 2008 examination, Dr. Eckman noted that claimant's hands and feet were "remarkably cool," found decreased sensation in a glove-like distribution of both hands, and decreased sensation in her lower extremities, which he considered to be consistent with a disseminated sensory polyneuropathy. (Ex. 13-4-6). Drs. Bell and Radecki agreed that those findings were consistent with peripheral neuropathy/polyneuropathy. (Exs. 32-9, 34-5). Based on the 2008 NCS, as well as her own examination findings of decreased vibration and cold sensation in the lower extremities, Dr. Bell also diagnosed peripheral neuropathy/polyneuropathy. (Ex. 32-8-10). Dr. Bell further noted that claimant had "pes cavus deformity in the feet (high arch and some hammertoe deformity), a finding common in patients with hereditary peripheral neuropathies." (Ex. 32-9). To the extent Dr. Gingold's opinion could be interpreted as not endorsing the diagnosis of peripheral neuropathies, I find it unpersuasive, because

he did not address the examination findings of other physicians. *Cf. Timothy L. O'Dore*, 59 Van Natta 1404, 1406 (2007) (opinion of physician who did not believe that the disputed condition existed was unpersuasive when the medical evidence established the existence of that condition).

In response to Dr. Radecki's report, Dr. Gingold stated, in a conclusory fashion, that he did not "believe [claimant's] 'idiopathic' factors caused her symptoms." (Ex. 24). At one time, Dr. Gingold opined that peripheral neuropathy was a distinct condition and not a contributing factor to the development of CTS or cubital tunnel syndrome. (Ex. 26-3). However, he later admitted that peripheral neuropathy "would likely have some effect on [claimant's] nerve conductions" by causing slowing in the median and ulnar nerves and making them more susceptible to entrapment. (Ex. 41-2).

Relying on Dr. Gingold's "susceptibility" opinion and parts of other medical evidence using the words "susceptibility" and "predisposing factor" in describing claimant's peripheral neuropathy, the majority finds that this condition was not a causal contributing factor to entrapment neuropathies. It is well settled, however, that we do not appraise opinions based on "magic words" or particular word-choices. *SAIF v. Alton*, 171 Or App 491, 502 n 6 (2000); *SAIF v. Strubel*, 161 Or App 516, 521-22 (1999); *Liberty N.W. Ins. Corp. v. Cross*, 109 Or App 109, 112 (1991), *rev den*, 312 Or 676 (1992); *Urbano C. Garibay*, 61 Van Natta 1018, 1022 (2009).

Dr. Gingold did not explain a difference, if any, between "susceptibility" and an actual contribution of peripheral neuropathy to the claimed conditions. This lack of explanation is particularly significant in light of the doctor's opinion that there was "a 'combination' of diagnoses in effect" and that peripheral neuropathy could cause slowing in the nerve condition of the median and ulnar nerves (Ex. 41-2), as well as in light of other expert medical opinions that described peripheral neuropathy as a cause of nerve entrapment conditions.

In sum, I find Dr. Gingold's conclusions to be inadequately explained and unpersuasive.¹² *See Somers*, 77 Or App at 263; *see also Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained or conclusory opinion); *Lanora J. Rea*, 60 Van Natta 1058, 1064 (2008) (same).

¹² Thus, his opinion does not outweigh Dr. Bell's opinion, which the majority dismisses as unexplained.

Claimant testified that she began experiencing symptoms of hypothyroidism in approximately 2004. (Tr. 43, 46). She was diagnosed with, and treated for, the condition before Dr. Gingold's June 2005 examination. (Ex. 1). Dr. Radecki attributed claimant's entrapment neuropathies to hypothyroidism. (Exs. 34, 36). In doing so, he noted the temporal relationship between claimant's diagnosis of hypothyroidism and the onset of her bilateral CTS symptoms in 2005. (Ex. 34-5-7). He explained that untreated hypothyroidism occurred with CTS. (Ex. 34-5). Citing medical literature, Dr. Radecki opined that hypothyroidism was a risk factor in the development of entrapment syndromes because it caused diffuse neuropathies, which contributed to entrapment neuropathies. (Ex. 34-5-7).

Dr. Gingold acknowledged that a thyroid condition may have an effect on nerve conditions, but did not actually cause CTS or cubital tunnel syndrome. (Ex. 41-3-4). He stated that a thyroid condition may contribute to "possible peripheral neuropathy," but stated that it did not "have an effect on the carpal tunnel or cubital tunnel conditions, other than possible minor contribution as discussed above." (Ex. 41-4). However, like his discussion concerning the relative contribution of peripheral neuropathy, I find Dr. Gingold's opinion that claimant's hypothyroidism was not a contributing factor to the development of her claimed conditions to be inadequately explained and conclusory. *Somers*, 77 Or App at 263; *Moe*, 44 Or App at 433. Moreover, unlike Dr. Radecki, Dr. Gingold did not address claimant's situation in particular (the temporal relationship between the diagnosis of hypothyroidism and the onset of her bilateral CTS symptoms in 2005). *Sherman v. Western Employer's Ins.*, 87 Or App 602 (1987) (physician's comments that were general in nature and not addressed to the claimant's situation in particular were not persuasive).¹³

Based on the aforementioned reasoning, I find Dr. Gingold's opinion to be unpersuasive. Because no other physicians support the compensability of claimant's occupational disease claims, I would find she has not established that her work activities were the major contributing cause of her CTS and cubital tunnel syndrome. ORS 656.266(1); ORS 656.802(2)(a). Because the majority concludes otherwise, I respectfully dissent.

¹³ In addition, the medical evidence identifies claimant's alcohol consumption as a potential contributor to the development of her diseases. Dr. Radecki stated that alcohol is a nerve toxin. He considered claimant's past alcohol use to be sufficient to cause her peripheral neuropathy, which was a contributing factor in the development of entrapment syndromes. (Exs. 22-7, 34-5). Claimant, however, did not provide a consistent history of her alcohol consumption. Dr. Gingold referred to it as "remote" and dismissed it as a factor contributing to claimant's entrapment neuropathies. (Ex. 41-4). Dr. Gingold's assumption, however, is inconsistent with claimant's hearing testimony and the history she provided to Dr. Radecki. (Tr. 52-53; Exs. 1, 22, 41). Thus, I am not persuaded that Dr. Gingold's opinion was based on a complete history. See *Jackson County v. Wehren*, 186 Or App 555, 561 (2003) (a history is complete if it includes sufficient information on which to base the physician's opinion and does not exclude information that would make the opinion less credible).