

In the Matter of the Compensation of
MELANIE L. WHITEAKER, Claimant

WCB Case No. 09-04909

ORDER ON REVIEW

Dodge Law Firm, Claimant Attorneys
Andersen & Nyburg, Defense Attorneys

Reviewing Panel: Members Weddell and Lowell.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Fisher's order that set aside its denial of claimant's new/omitted medical condition claim for a left hip labral tear condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant performed physically intensive manual labor for the insured building motor homes. Her work activities often involved physical exertion in awkward positions. These activities included buffing and routing while bent over at the hip to reach foot level. She also rotated back and forth in this position, while also applying pressure against a twelve-pound hand held tool. (*See Ex. 13; Tr. 22-24*).

In October 2008, claimant began experiencing sharp pain in her left hip, buttock, and hamstring area, down to the knee, as well as signs of impingement with internal rotation in the groin. Her physicians ruled out a lumbar condition, considering her benign MRI and lack of relief following a lumbar epidural spinal injection. X-rays and an MRI of the left hip revealed some hip dysplasia and a left acetabular labral tear with anterior and lateral cysts. Claimant also had findings of left hamstring tendinosis.

Dr. Bollom became claimant's treating physician. Based on claimant's apparent lack of response to an intra-articular hip injection, Dr. Bollom initially recommended against surgery for the labral tear. (*See Ex. 16*).

The insurer accepted a left hamstring sprain and periformis syndrome. It denied claimant's claim new/omitted medical condition claim for a left hip labral tear.

When apprised that claimant had experienced brief relief from pain after the March 2009 injection, Dr. Bollom changed his opinion. Based on the acute appearance of the labral tear (on the MRI) and the new information that claimant had experienced some short term relief following the March 2009 injection, Dr. Bollom attributed her ongoing symptoms to the tear and opined that surgical repair would be appropriate. (*See Exs. 33A, 36, -8, -14*).

Based on Dr. Bollom's changed opinion, the ALJ found that claimant carried her burden of proving that work activities were the major contributing cause of her left hip labral tear. Consequently, the ALJ set aside the insurer's denial.

The insurer argues that Dr. Bollom's opinion is unpersuasive because he relied on a materially inaccurate history regarding claimant's symptoms. Specifically, the insurer contends that Dr. Bollom incorrectly believed that claimant experienced some relief after the March 2009 intra-articular cortisone injection.¹ We disagree, reasoning as follows.

Dr. Bollom explained that his changed opinion was based on corrected information, whereas his initial opinion had been based on miscommunication regarding injection results. Specifically regarding the March 2009 injection, Dr. Bollom related, "Unfortunately there was some miscommunication with her response to injection [*i.e.*,] she got no long-term relief from steroid injection but believes that the lidocaine did improve her pain for a short period of time." (*Ex. 33A-1; see Exs. 17-1, 32A-1, 36-7, -14*).

Thus, Dr. Bollom explained that his initial inaccurate history resulted from miscommunication. We find his explanation persuasive.² We also find that Dr. Bollom's changed opinion is well-explained and based on new, accurate information, as confirmed by claimant in April 2010.³ (*See Ex. 33A*).

¹ The insurer relies on claimant's testimony and her initial histories that injections "didn't seem to change" her condition and she got "essentially no relief" from injections. (*See Tr. 37; Ex. 16*). We do not find this initial reporting inconsistent with the later-obtained (corrected) history of short term relief following the March 2009 injection, because Dr. Bollom explained how the initial misinformation arose. That is, because claimant was unaware that she was expected to report her short term or "anesthetic" response, she did not discuss it with Dr. Bollom until April 2010. (*See Ex. 33A*).

² Examination and cross-examination of Dr. Bollom, during a "post-hearing" deposition, elicited no concern about the accuracy of claimant's clarified history. (*See Ex. 36-14-15*). Under such circumstances, we find Dr. Bollom's opinion, which was based on that history, to be persuasive.

³ Dr. Bollom's corrected history is also supported by Dr. Hill's contemporaneous documentation of claimant's "anesthetic response" in April 2009. (*See Ex. 17-1*).

Under these circumstances, we find Dr. Bollom's changed opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630, 634 (1987) (where there was a reasonable explanation in the record for a physician's change of opinion, that opinion was persuasive); *Donna C. Miller*, 61 Van Natta 836, 839 (2009) (physician's changes of opinion reasonably explained where the subsequent opinions were based on new information). Accordingly, we affirm.

Claimant 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 \$2,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), 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 insurer. *See* ORS 656.386(2); OAR 438-015-0019; *Gary Gettman*, 60 Van Natta 2862 (2008).

ORDER

The ALJ's order dated October 15, 2010 is affirmed. For services on review, claimant is awarded an assessed fee of \$2,500, payable by the insurer. 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 insurer.

Entered at Salem, Oregon on April 28, 2011