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In the Matter of the Compensation of  
**GERALD SMITH, Claimant**  
WCB Case No. 12-01315  
ORDER ON REVIEW  
Unrepresented Claimant  
Law Office Of Thomas A Andersen PDX, Defense Attorneys

Reviewing Panel: Members Langer and Lanning.

Claimant, *pro se*,<sup>1</sup> requests review of Administrative Law Judge (ALJ) Sencer's order that upheld the insurer's denial of his medical services claim (cervical laminectomy). Claimant has also submitted an additional document that was not admitted at hearing. We treat this submission as a motion to remand to the ALJ for the taking of additional evidence. *See Juan H. Mendez*, 60 Van Natta 3150 (2008); *Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand and medical services.

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

Claimant has submitted a letter from Dr. Griess, his attending physician, stating that "It seems to reason" that the surgery in question was required as a result of claimant's original injury.<sup>2</sup> We consider this additional document only for the purpose of determining whether remand is appropriate.

Our review is limited to the record developed by the ALJ. We may remand to the ALJ if we find that the case has been "improperly, incompletely or otherwise insufficiently developed[.]" ORS 656.295(5). There must be a compelling reason for remand to the ALJ for the taking of additional evidence. *SAIF v. Avery*, 167 Or App 327, 333 (2000). A compelling reason exists when the new evidence (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *Id.*; *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). For the following reasons, we deny the motion to remand.

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<sup>1</sup> Inasmuch as claimant is unrepresented, he may wish to consult the Ombudsman for Injured Workers. He may contact the Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES  
OMBUDSMAN FOR INJURED WORKERS  
PO BOX 14480  
SALEM OR 97309-0405

<sup>2</sup> The letter was dated "April 20, 2013." However, we received the letter on *February 22, 2013*.

First, claimant does not explain why he could not have obtained the report before the October 2012 hearing. In any event, as explained below, the insurer is not responsible for claimant's medical services unless those services were directed to conditions caused in major part by the compensable injury. ORS 656.245(1)(a); ORS 656.005(7)(a)(A)(B). Dr. Griess's letter did not address the issue of major contributing cause. Under such circumstances, consideration of the report is not likely to affect the outcome of this case. Accordingly, remand is not warranted.

We turn to the compensability of claimant's medical services. He sustained a compensable injury on June 22, 2007. (Ex. 2). The insurer accepted cervical and left shoulder strains, a facial/scalp contusion, left shoulder superior labral anterior posterior tear, and left shoulder impingement. (Exs. 4, 6, 15). It denied claimant's claim for C5-6 and C6-7 disc protrusions. (Ex. 14).

On February 18, 2009, Dr. Rosenbaum performed a micro posterior laminectomy at C5-6 and C6-7 left, with a postoperative diagnosis of cervical spondylosis with left cervical radiculopathy. (Ex. 20).

Claimant entered into a stipulation with the insurer which was approved in March 2009. (Ex. 21). The insurer agreed to accept "cervical radicular syndrome due to disc injury combined with preexisting cervical spondylosis at C5-6 and C6-7." *Id.* at 4. Subsequently, claimant entered into a Claim Disposition Agreement regarding his June 2007 injury claim that was approved in February 2010. (Ex. 29).

In May 2011, claimant sought treatment from Dr. Rosenbaum for an exacerbation of pain, numbness, and weakness in his left arm. (Ex. 33). An MRI showed a new herniated disc at C6-7 left. *Id.* Dr. Rosenbaum performed a micro posterior cervical laminectomy at C5-6 and C6-7 left, with removal of the herniated C6-7 disc. (Ex. 35).

The insurer denied payment for the medical services claim, stating that the surgery was necessitated by claimant's preexisting spondylosis and not the June 2007 work injury. (Ex. 39). Claimant requested a hearing.

In upholding the insurer's denial, the ALJ found Dr. Rosenbaum's opinion persuasive. Claimant argues that the surgery performed was the same procedure as the one performed by Dr. Rosenbaum in 2009, and at the same site. Thus, he contends, it was necessitated by his accepted injury and, as such, the insurer is responsible for the surgical procedure. Based on the following reasoning, we disagree.

ORS 656.245(1)(a) provides, in relevant part:

“For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and *combined conditions* described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions *caused in major part by the injury.*” (Emphasis added).

We acknowledge that the surgery, which is the subject of the current claim, is almost identical to that which claimant underwent in 2009 (for which the insurer paid). However, to satisfy the statutory requirement for compensability, the record must establish that the medical services are “directed to medical conditions caused in major part by the injury.” ORS 656.245(1)(a).

Here, none of Dr. Griess’s medical reports (including the one submitted by claimant on review) addresses the major cause of his need for the 2011 cervical laminectomy. (Ex. 44). In contrast, Dr. Rosenbaum specifically stated that claimant’s 2009 laminectomy “did not destabilize the cervical disc nor (sic) the spine, so that any contribution from the injury and subsequent surgery at that level related to the industrial injury would be considered minimal. In essence, the treatment was necessitated by [claimant’s] underlying cervical spondylosis.” (Ex. 38-1). He also opined that claimant’s subsequent herniated disc occurred independently. *Id.*

Under such circumstances, we conclude that the disputed medical services claim is not compensable. Accordingly, we affirm.

#### ORDER

The ALJ’s order dated November 1, 2012 is affirmed.

Entered at Salem, Oregon on May 7, 2013