
In the Matter of the Compensation of
LUCILA DELOS-SANTOS, Claimant
WCB Case No. 11-03363
ORDER ON REVIEW
Schoenfeld & Schoenfeld, Claimant Attorneys
MacColl Busch Sato PC, Defense Attorneys

Reviewing Panel: Members Weddell, Langer, and Somers. Member Weddell concurs in part and dissents in part.

Claimant requests review of Administrative Law Judge (ALJ) Sencer's order that: (1) denied claimant's request to reopen the hearing record; and (2) upheld the insurer's denials of her new/omitted medical condition claims for "L4-5 pathologies" including an "L4-5 disc bulge protrusion and annular tear," and "radiculopathy/radiculitis." On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant was previously represented by another attorney and a hearing was scheduled for January 26, 2012. On January 25, 2012, claimant's former attorney advised a prior ALJ that the parties had agreed to mediation and requested that the record be frozen. (Ex. 43). As a result, the January 26, 2012 hearing was postponed. The mediation, however, was not successful.

Claimant retained another attorney, who moved to reopen the record, arguing that the agreement to freeze the record should be set aside. The insurer's attorney opposed the motion. (*See* Tr. 4, 5).¹ In a conference call, the ALJ denied claimant's motion, reasoning that the prior agreement was valid and that the employer had relied on freezing the record in agreeing to the postponement. (Hearings file). The hearing convened on February 11, 2013. The issue regarding the insurer's June 9, 2011 denial was decided based on the "frozen" record and claimant's testimony.

¹ The citations to the transcript refer to the February 11, 2013 hearing, unless otherwise stated.

On review, claimant argues that her new attorney was not a party to the agreement to freeze the record. She contends that she is entitled to develop her case with a new attorney.

ORS 656.283(6) provides that an ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. Moreover, the ALJ has broad discretion with regard to the admissibility of evidence at hearing. *Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *SAIF v. Kurcin*, 334 Or 399 (2002).

Claimant was represented by counsel at the time of the parties' January 25, 2012 agreement to freeze the record. The fact that her later attorney was not a "party" to that agreement is not relevant. See ORS 656.005(21) ("party" means a "claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer"). In agreeing to postpone the January 26, 2012 hearing, the insurer reasonably relied on the parties' stipulation to "freeze" the record. Under these circumstances, we find no abuse of discretion in the ALJ's decision not to reopen the hearing record regarding the insurer's June 9, 2011 denial. See *Mika T. Poe*, 49 Van Natta 495 (1997) (no abuse of ALJ discretion where record was frozen as of the originally scheduled hearing date; ALJ reasoned that the parties should not be in any better position than they would have been had the originally scheduled hearing been convened).

June 9, 2011 Denial of "L4-5 Pathologies"

On January 1, 2011, claimant was compensably injured when she picked up a box of lard weighing 50 pounds. She sought medical treatment on January 4, 2011, and was initially diagnosed with a lumbar strain with sciatica. (Ex. 1). The insurer accepted lumbar and sacroiliac strains. (Exs. 10, 31).

Claimant began treating with Dr. Kane in February 2011. Dr. Sobota became her attending physician in late 2012.

Dr. Radecki examined claimant on behalf of the insurer in April 2011. (Ex. 23). In July 2011, Dr. Rosenbaum performed an insurer-arranged medical examination. (Ex. 37). Dr. Green examined claimant on behalf of the insurer in January 2013. (Ex. 49).

On June 9, 2011, the insurer denied claimant's new/omitted medical condition claims for "L4-5 pathologies" including an "L4-5 disc bulge protrusion and annular tear." (Ex. 32). Claimant requested a hearing.

The ALJ determined that the medical evidence was not sufficient to establish compensability of claimant's new/omitted medical condition claim for "L4-5 pathologies" including an "L4-5 disc bulge protrusion and annular tear." (Ex. 32).

On review, claimant relies on the opinions of Drs. Kane and Sobota, including their reports submitted after the record was frozen, to establish compensability of the L4-5 disc and annular tear. The insurer contends that, based on the "frozen" evidentiary record for the L4-5 disc and annular tear, the only persuasive medical evidence supports its denial.

Based on the parties' January 2012 agreement, we analyze the L4-5 disc condition and annular tear based only on the "frozen" record (Exhibits 1- 42). Based on that evidence, the record does not support the conclusion that claimant's work injury was at least a material contributing cause of her disability/need for treatment for the L4-5 disc condition and annular tear. *See* ORS 656.005(7)(a); *Tricia A. Somers*, 55 Van Natta 462, 463 (2003). Dr. Rosenbaum opined that claimant did not have any disc pathology related to the work injury. (Ex. 37-5, -6). Dr. Kane concurred with Dr. Rosenbaum's findings. (Ex. 39). Because the record does not include any persuasive medical opinions establishing compensability of the L4-5 disc condition and annular tear, we uphold the insurer's denial of that condition.

December 14, 2012 Denial of "Radiculopathy/Radiculitis"

On December 14, 2012, the employer denied claimant's new/omitted medical condition claim for "radiculopathy/radiculitis." (Ex. 45A). Claimant requested a hearing.

Claimant relied on the opinions of Drs. Sobota and Kane to support her claim for "radiculopathy/radiculitis." The ALJ explained that both physicians believed that claimant had sustained an injury to her L4-5 disc, which caused the "radiculopathy/radiculitis." The ALJ reasoned that a condition caused by a denied condition, *i.e.*, the L4-5 disc pathology, was not compensable. Concluding that the L4-5 disc condition was not compensable, the ALJ also upheld the insurer's denial of "radiculopathy/radiculitis."

On review, claimant argues that the ALJ should have decided the issue of “radiculopathy/radiculitis” based on the merits, without regard to the L4-5 disc condition. She contends that the insurer’s denial did not assert that radiculopathy was a symptom of a condition or was caused by another condition. Claimant relies on the opinions of Drs. Kane and Sobota to establish compensability.

The insurer argues that the “radiculopathy/radiculitis” condition is not compensable because claimant’s physicians opined that it was caused by the non-compensable L4-5 disc condition. In any event, the insurer relies on the opinions of Drs. Radecki, Rosenbaum, and Green and contends that the medical evidence is insufficient to establish compensability.

To prove compensability of her new/omitted medical condition claim, claimant must establish that the claimed “radiculopathy/radiculitis” exists and that the work injury was at least a material contributing cause of the disability or need for treatment for that condition. ORS 656.005(7)(a); ORS 656.266(1); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005).

Because we are deciding the issue of “radiculopathy/radiculitis” based on the merits, we need not address claimant’s procedural argument.² We begin with the “existence” issue. Dr. Kane treated claimant from February 2011 until January 2012. As explained above, Dr. Kane concurred with the “findings” in Dr. Rosenbaum’s July 2011 report. (Ex. 39). Dr. Rosenbaum reviewed claimant’s lumbar MRI and determined that the L4-5 disc bulge did not compress the nerve roots on either side. (Ex. 37-4, -5). He explained that, although claimant had radiation toward the right side, she did not have any objective findings of radiculopathy. (Ex. 37-5). He found functional overlay during the examination. (Ex. 37-5, -6). Dr. Rosenbaum concluded that the lumbar/sacroiliac strain from the work injury had resolved and that her ongoing symptoms were related to her preexisting spondylosis and functional component. (*Id.*)

² In any event, to the extent that claimant is arguing that we must decide the issue of “radiculopathy/radiculitis” without any regard to the L4-5 disc condition, our standard of review is based on the medical evidence and the record. *E.g.*, *Daniel Suing*, 56 Van Natta 2600, 2601 (2004) (citing *Dibrito v. SAIF*, 319 Or 244, 248 (1994)); *Daniel S. Field*, 47 Van Natta 1457, 1458 (1995) (“it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker’s claim.”). In other words, our analysis depends on whether the *medical evidence* relates the “radiculopathy/radiculitis” to the L4-5 disc condition.

Claimant contends that Dr. Kane's agreement with Dr. Rosenbaum's "findings" should not be construed as agreement with Dr. Rosenbaum's conclusions. We disagree. Because Dr. Rosenbaum's report did not include a specific section entitled "findings" and Dr. Kane did not explain what he meant by his agreement with the "findings," we find no basis for determining that Dr. Kane agreed with only part of Dr. Rosenbaum's report. Instead, we conclude that Dr. Kane concurred with Dr. Rosenbaum's entire report. (Ex. 39).

Dr. Kane subsequently opined that claimant had presented with reliable and consistent findings in a specific and known dermatome pattern, which was consistent with radiculopathy/radiculitis. (Ex. 51-1; *see* Ex. 48A). He referred to claimant's positive response to the L5 nerve root block, which occurred in March 2011, almost four months *before* Dr. Rosenbaum's examination. (Ex. 48A-2). Dr. Kane later disagreed with the medical opinions finding functional overlay, asserting that he did not find any such evidence. (Ex. 48A-2). He opined that claimant's examinations were consistent during his treatment. (*Id.*) However, Dr. Kane's initial February 14, 2011 chart note reported that claimant denied a "radicular pain pattern in any extremity." (Ex. 13). He found "nonspecific pain in the entire thoracolumbar spine." (*Id.*)

The insurer argues that Dr. Kane changed his opinion and is therefore less persuasive. For the following reasons, we agree.

When a physician has changed an opinion, we review the record to determine whether there is a reasonable explanation for the change of opinion. *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). Here, we are unable to reconcile Dr. Kane's opinions regarding the existence of claimant's radiculopathy/radiculitis.³ Because Dr. Kane did not explain his change of opinion and the record does not provide a reasonable explanation for such a change, his opinion is entitled to little weight. *See John C. McCullough*, 63 Van Natta 2157, 2159 (2011) (changed opinion found unpersuasive where there was no reasonable explanation for the change).

³ In light of Dr. Kane's concurrence with Dr. Rosenbaum's opinion, the record does not provide a reasonable basis for the evolution of his opinion, such as new information or a clarification of his previously expressed opinion. *See Emory M. Schaffer*, 66 Van Natta 441 (2014) (because a physician's opinion was based on new information, his ultimate opinion was not an unexplained change of opinion); *Carl R. Hale*, 65 Van Natta 2316 (2013) (because a physician's later opinion was based on a review of another physician's subsequent report, the changed opinion was reasonably explained).

Claimant also relies on the opinion of Dr. Sobota, who began treating her in October 2012, almost two years after the work injury. Dr. Sobota disagreed with the medical opinions referring to claimant's nonphysiologic presentation and functional overlay. (Ex. 50-4). She had evaluated claimant multiple times and was able to communicate with her in Spanish. (Ex. 50-3). Dr. Sobota concluded that claimant's positive straight leg tests, reflex loss, and clinical complaints of radiating pain in a reliable and consistent dermatome pattern added up to a reliable and valid presentation, which allowed her to make a valid diagnosis of lumbar radiculopathy. (Ex. 50-3, -4, 52). In a deposition, Dr. Sobota adhered to her opinion regarding the existence of claimant's radiculopathy. (Ex. 59).

For the following reasons, however, we are more persuaded by the opinions of Drs. Rosenbaum and Green, as supported by Dr. Radecki, who concluded that claimant did not have radiculopathy or radiculitis.

When Dr. Radecki examined claimant on April 5, 2011, he found a non-physiologic presentation with widespread pains from her neck and right shoulder girdle to her lumbar region, which was inconsistent with the mechanism of injury and with any actual anatomic injury. (Ex. 23-11). He reported that she had a very remarkable magnification of pain that was unexplainable by any persisting injury. (Ex. 23-12). Dr. Radecki found no evidence of radiculopathy. (Ex. 23-11).

Dr. Rosenbaum reviewed claimant's lumbar MRI and found that the L4-5 disc bulge did not compress the nerve roots on either side. (Ex. 37-4, -5). Although he noted that there had been radiation toward the right side, he found no objective findings of radiculopathy and reported functional overlay on the examination. (Ex. 37-5).

Similarly, Dr. Green examined claimant in January 2013 and found no objective evidence of radiculopathy or any other condition caused by the work injury. (Ex. 49-8). He noted that claimant's reported symptoms were "markedly discrepant with the objective abnormality." (*Id.*) Dr. Green reviewed claimant's January 2011 lumbar MRI and determined that the nerve root exited above the L4-5 disc bulge without any apparent impingement on the nerve root itself. (*Id.*) He found that the March 2012 MRI presented a nearly identical appearance. (*Id.*) Based on his examination and review of the records, Dr. Green concluded that claimant did not have either radiculopathy or radiculitis. (Ex. 49-11). He explained that the lumbar strain indicated an "overstretch" injury to the paravertebral muscles, which were not in an anatomic position that allowed for a muscle strain to cause radiculopathy or radiculitis. (Ex. 49-9).

Thus, Drs. Rosenbaum and Green personally reviewed claimant's lumbar MRI and found no evidence of impingement or compression of a nerve root. Dr. Green explained that, in either radiculitis or radiculopathy, the nerve root affected should be specified. (Ex. 49-11).

In contrast, Dr. Sobota testified that the MRI "suggested" to her that there was one area where claimant had "significant disc bulging mapped onto the L5 nerve." (Ex. 59-15). She opined that the nerve root affected is often identified by practitioners, but it was not required. (Ex. 52-2).

Dr. Sobota is board-certified in internal medicine, whereas Dr. Rosenbaum is a neurosurgeon and Dr. Green is a neurologist. (Exs. 37, 49, 59-4). Based on their expertise and their personal review of claimant's MRI, we are more persuaded by the opinions of Drs. Rosenbaum and Green. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980) (physician with greater expertise more persuasive); *Lynnetta R. Evans*, 61 Van Natta 1372 (2009) (neurologist and hand surgeon had more expertise than the attending physician and were more persuasive). Moreover, because Dr. Sobota did not begin treating claimant until almost two years after the January 2011 injury, her opinion is not entitled to deference as a treating physician. *See McIntyre v. Standard Util. Contractors*, 135 Or App 298 (1995) (a treating physician's opinion is less persuasive when the physician did not examine the claimant immediately following the injury); *Dennis W. Cavitt*, 62 Van Natta 1477 (2010) (physician who did not begin treating the claimant until more than two years after the work injury was not entitled to deference). We conclude that the medical evidence is not sufficient to establish the existence of radiculopathy/radiculitis.

Alternatively, even assuming the existence of radiculopathy/radiculitis, claimant has not established that her work injury was a material contributing cause of her disability/need for treatment for that condition. We reason as follows.

Dr. Sobota testified that, based on medical probability, claimant's radiculopathy was caused by the L4-5 herniated disc. (Ex. 59-9, -10, -11). Her reports consistently documented a herniated lumbar disc with radiculopathy. (Exs. 44A, 44B, 46, 47A, 48, 49A, 60).

Dr. Sobota's opinion does not support the conclusion that claimant's radiculopathy arose directly from the work injury. *See Margaret O. Henry*, 65 Van Natta 1447 (2013) (because the medical opinion supported the conclusion that the sciatic nerve injury arose directly from the work injury, a material contributing

cause standard applied). Instead, Dr. Sobota opined that the radiculopathy/radiculitis arose as a consequence of the L4-5 disc condition, which implicates a “consequential condition” theory of compensability. *See* ORS 656.005(7)(a)(A) (“[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition”); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (distinguishing between a condition caused by the industrial accident, and a consequential condition, which is caused in turn by the compensable injury).

For the reasons explained above, we have determined that the L4-5 disc condition is not a “compensable injury.” Furthermore, Dr. Sobota’s opinion does not support the conclusion that the accepted lumbar or sacroiliac strain was the major contributing cause of claimant’s radiculopathy/radiculitis. *See* ORS 656.266(1); ORS 656.005(7)(a)(A). Under these circumstances, Dr. Sobota’s opinion is not sufficient to establish compensability of claimant’s radiculopathy/radiculitis.

Claimant also relies on the opinion of Dr. Kane to establish the necessary causal connection. However, for the reasons explained earlier, because Dr. Kane did not explain his change of opinion regarding his concurrence with Dr. Rosenbaum’s findings and the record does not provide a reasonable explanation for such a change, his opinion is entitled to little weight. Dr. Kane’s opinion is insufficient to establish that the work injury was at least a material contributing cause of the disability/need for treatment for claimant’s radiculopathy/radiculitis.

The record does not include other persuasive medical opinions supporting the necessary causal connection. Dr. Rosenbaum did not diagnose radiculopathy arising from claimant’s work injury. (Ex. 37-5). Dr. Green concluded that claimant did not have radiculopathy or radiculitis related to the work injury. (Ex. 49-11).

In summary, we conclude that the medical evidence is insufficient to establish the existence of radiculopathy/radiculitis and that claimant’s work injury was at least a material contributing cause of her disability/need for treatment for that condition. Therefore, we affirm.

ORDER

The ALJ’s order dated September 26, 2013 is affirmed.

Entered at Salem, Oregon on May 21, 2014

Member Weddell concurring in part and dissenting in part.

I agree with the majority's evidentiary ruling and its decision to uphold the insurer's denial of claimant's new/omitted medical condition claim for "L4-5 pathologies." However, I would find the new/omitted medical condition claim for "radiculitis" compensable for the following reasons.

At hearing, claimant relied on the opinions of Drs. Sobota and Kane to support her claim for "radiculopathy/radiculitis." The ALJ explained that both physicians believed that claimant had sustained an injury to her L4-5 disc, which caused the "radiculopathy/radiculitis." The ALJ reasoned that a condition caused by a denied condition, *i.e.*, the L4-5 disc pathology, was not compensable. Concluding that the L4-5 disc condition was not compensable, the ALJ also upheld the insurer's denial of "radiculopathy/radiculitis."

On review, claimant argues that the ALJ should have decided the issue of "radiculopathy/radiculitis" based on the merits, without regard to the L4-5 disc condition. She contends that the insurer's denial did not assert that radiculopathy was a symptom of a condition or was caused by another condition. For the following reasons, I agree with claimant.

In May 2011, claimant filed a new/omitted medical condition claim for "L4-5 disc conditions," including a bulge and annular tear, which was denied. (Exs. 28, 32). Claimant subsequently filed a new/omitted medical condition claim for "radiculopathy/radiculitis," which was denied on December 14, 2012. The insurer's denial explained that the "medical evidence fails to support that the claimed conditions are compensably related to your industrial injury." (Ex. 45A).

OAR 438-005-0055(1) provides that, except for a denial issued under ORS 656.262(15), the notice of denial "shall specify the factual and legal reasons for denial" and shall contain a notice of hearing rights. It is well-settled that a carrier is bound by the express language of its denial. *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993).

Here, the insurer denied the claim for "radiculopathy/radiculitis" on the basis that the medical evidence did not establish that the claimed conditions were compensably related to the work injury. (Ex. 45A). The insurer did not deny that claim because it was a consequential condition of a denied condition or because it was not a "condition" or because it was "encompassed" in the denied claim for an L4-5 disc condition. At hearing, the parties agreed to litigate two separate

conditions, *i.e.*, the L4-5 disc condition and the radiculopathy/radiculitis. (Tr. 3-4). The insurer did not attempt to amend the “radiculopathy/radiculitis” denial. Under these circumstances, it was necessary to decide that claim based on the express language of the denial, *i.e.*, on the basis of the medical evidence. I agree with claimant that the ALJ should have decided this issue based on the merits.

Turning to the merits of the “radiculopathy/radiculitis” claim, I disagree with the majority’s evaluation of the medical evidence and would find the claim compensable.

I begin with the “existence” issue. Claimant had not experienced pain in her back or right leg before the work injury. (Tr. 13). On January 1, 2011, she lifted a 50-pound box from the floor, turned, and had immediate pain in her back and right leg. She dropped the box. (Tr. 12, 13).

When claimant sought emergency medical treatment on January 4, 2011, she described severe lumbar pain radiating to the right thigh. Her straight leg raising (SLR) test⁴ was positive on the left with contralateral pain. Dr. Samu noted that claimant had severe pain after lifting and “may have herniated disc,” but no neurological deficit was noted. He diagnosed lumbar strain with sciatica. (Ex. 1). The nurse noted that claimant spoke minimal English and that she had a Spanish interpreter with her. (Ex. 2).

On January 5, 2011, Dr. Reichle reported that claimant had low back pain, but “has had no radicular symptoms.” He explained that “[s]traight leg raise in a supine position suggests low back pain on the right at 40 degrees bilaterally.” (Ex. 4). He diagnosed a lumbar strain and reported “[n]o clear evidence of nerve root impingement or disk herniation.” (*Id.*)

On January 13, 2011, claimant treated with Dr. Walters, who reported that she had back pain with occasional radiation to the right gluteal region. He noted “negative bilateral leg raise” and diagnosed a lumbar strain. (Ex. 7). He recommended a lumbar MRI, which was performed on January 18, 2011. The MRI revealed a disc bulge with a superimposed rightward protrusion at L4-5. The MRI report explained that the bulge “moderately narrows the right lateral recess, the traveling right L5 nerve root running nearby.” (Ex. 9).

⁴ A “straight-leg raising test” is defined as “passive dorsiflexion of the foot in the supine patient with the knee and hip extended; back pain with this indicates nerve root compression or impingement.” *Stedman’s Electronic Medical Dictionary*, version 7.0 (2007).

On January 31, 2011, Dr. Walters noted more pain over the right SI joint and diagnosed a sacroiliac strain. He referred claimant to Dr. Kane, a physical medicine specialist. (Ex. 11).

Dr. Kane treated claimant from February 2011 until January 2012. In March 2011, he reported that claimant had a lumbar strain and radicular pain from the work injury and referred her for an injection. (Ex. 19).

On March 28, 2011, Dr. Desai performed an epidural injection/nerve root block at right L5. (Ex. 22). In May 2011, Dr. Kane reported that claimant had a “lasting benefit” from the injection. He explained that the SLR on the right was again positive. (Ex. 27). Dr. Kane had reviewed Dr. Radecki’s April 2011 report and was aware that some nonphysiologic examination findings had been reported.⁵ (Ex. 27; *see* Ex. 23). Nevertheless, Dr. Kane explained that “there remain some reproducible and credible exam and clinical evidence for right LS radiculopathy, probably affecting the L5 root.” (Ex. 27).

Dr. Kane’s chart notes continued to document a positive SLR on the right and radiating pain down the right leg, even after he determined that the lumbar and sacroiliac strains had resolved. (Exs. 29, 30, 34, 35, 36, 38, 40, 41, 42). He referred to “right radiculopathy,” “right sciatica,”⁶ and “right L5 radiculitis.” (*Id.*) On October 3, 2011, Dr. Kane reported that claimant had an asymmetric heel walk and that her right foot tended to drop and invert. (Ex. 40).

In a January 2013 concurrence letter from claimant’s attorney, Dr. Kane reviewed claimant’s medical records shortly after the 2011 work injury. He explained that her condition was best described as radiculitis, which implies irritation of the lumbar nerve root. He noted that “radiculitis” was often used interchangeably with “radiculopathy,” but he differentiated between them. Dr. Kane explained that radiculopathy included motor loss, sensory loss, reflex loss, and often a positive EMG. He described radiculitis as a “clinical diagnosis” characterized by a positive SLR, as well as complaints of radiating pain and numbness in a recognized dermatome pattern. (Ex. 48A-1).

⁵ Dr. Kane’s May 2011 chart note referred to the “recent IME,” rather than Dr. Radecki’s report. (Ex. 27). However, the only “IME” at that time had been performed by Dr. Radecki on April 5, 2011. (Ex. 23). Dr. Radecki found no evidence of radiculopathy, but did not specifically comment on whether claimant had radiculitis. (*Id.*)

⁶ “Sciatica” is defined as “pain in the lower back and hip radiating down the back of the thigh into the leg, initially attributed to sciatic nerve dysfunction (hence the term), but now known to usually be due to herniated lumbar disk compressing a nerve root, most commonly the L5 or S1 root.” *Stedman’s Electronic Medical Dictionary*, version 7.0 (2007).

Dr. Kane concluded that claimant had a valid diagnosis of radiculitis. In reaching that conclusion, he relied on his multiple examinations of her, which gave him an advantage in understanding her symptoms. (Exs. 48A, 51). Dr. Kane also relied on claimant's response to Dr. Desai's injection. (Exs. 48A-2, 51). He explained that the right L5 nerve root block provided excellent relief and correlated with her symptoms, which supported his conclusion that the nerve root was irritated. (Ex. 48A-2). Based on Dr. Desai's injection, he believed that her irritated nerve root was likely at L5. (Ex. 51-2). He did not find any evidence of functional overlay and noted that his opportunity to examine claimant over time gave him excellent insight into her pain threshold and pain patterns. (Ex. 48A-2).

In a February 2013 concurrence letter from claimant's attorney, Dr. Kane had reviewed Dr. Green's January 2013 report. (Ex. 51; *see* Ex. 49). Based on his consistent and reliable findings of nerve root irritation during claimant's examinations, Dr. Kane disagreed with Dr. Green's conclusion that she did not have radiculitis. (Ex. 51).

I disagree with the majority's conclusion that Dr. Kane changed his opinion without explanation, for the following reasons.

In August 2011, Dr. Kane concurred with the "findings" in Dr. Rosenbaum's July 2011 report. (Ex. 39). Dr. Rosenbaum's report did not include a specific section entitled "findings." (Ex. 37). Dr. Rosenbaum explained that, although "there has been radiation toward the right side," claimant did not have objective findings of radiculopathy "[o]n the basis of this assessment." (Ex. 37-5). He concluded that claimant's symptoms were consistent with functional overlay and lumbar strain/preexisting lumbar spondylosis. (*Id.*) He reviewed the lumbar MRI and opined that the L4-5 disc bulge did not specifically compress the nerve roots. (*Id.*)

Dr. Rosenbaum's report did not address whether or not claimant had "radiculitis." He reported that claimant's right straight leg raising demonstrated right low back pain with discomfort in the right buttock and lateral thigh region. (Ex. 37-4). However, he did not comment whether or not that finding could represent "radiculitis." As discussed above, Dr. Kane explained that claimant's condition was best described as radiculitis, which was a "clinical diagnosis" characterized by a positive SLR, as well as complaints of radiating pain and numbness in a recognized dermatome pattern. (Ex. 48A-1). Because Dr. Rosenbaum did not address "radiculitis," Dr. Kane's later reports did not represent an unexplained "change of opinion."

Dr. Rosenbaum found functional overlay based on his July 2011 examination. Dr. Kane's concurrence with his report may have been an acknowledgment of Dr. Rosenbaum's finding on that date. However, Dr. Kane previously disagreed with Dr. Radecki's April 2011 "nonphysiologic" examination findings and specifically found that there had been "reproducible and credible exam and clinical evidence for right LS radiculopathy, probably affecting the L5 root." (Ex. 27). That opinion is consistent with Dr. Kane's later concurrence letter, which explained that he did not find any evidence of functional overlay. (Ex. 48A-2). In reaching that conclusion, he relied on all of his examinations of claimant, including those after Dr. Rosenbaum's report, which gave him excellent insight into her pain threshold and pain patterns. (*Id.*)

Under these circumstances, I am not persuaded that Dr. Kane "changed" his opinion. Even assuming that he did, his ultimate opinion was based on new information from his later examinations. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (changed opinion persuasive where there was a reasonable explanation for the change); *Donna C. Miller*, 61 Van Natta 836, 838-39 (2009) (finding a physician's changes of opinion to be reasonably explained where the subsequent opinions were based on new information obtained after the physician's earlier opinions).

As claimant's attending physician, Dr. Kane had an opportunity to examine and observe her condition over time. Thus, I am most persuaded by his opinion regarding claimant's reliability and symptoms and the existence of radiculitis. *See Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001) (we may give greater weight to the opinion of the treating physician, depending on the record in each case); *Weiland v. SAIF*, 64 Or App 810 (1983) (in some situations, a treating physician's opinion is entitled to greater weight because of a better opportunity to observe and evaluate a claimant's condition over an extended period of time).

In addition, Dr. Sobota's opinion supports Dr. Kane's opinion regarding the existence of "radiculitis."

Dr. Sobota became claimant's attending physician in October 2012. (Exs. 44, 44A, 44B). Claimant testified that Dr. Sobota spoke Spanish and she was able to communicate directly with her. (Tr. 14).

Dr. Sobota reported that claimant had persistent low back pain radiating to the right leg, along with right leg weakness. (Ex. 44). On December 3, 2012, she referred to "sciatica pain," explaining that claimant had low back pain with

radiation down the back of the right thigh into the foot, with numbness and tingling and an occasional sensation of giving way/weakness in the right leg. (Ex. 45). On December 31, 2012, Dr. Sobota documented a positive right SLR in sitting and lying positions. (Ex. 48).

In a February 2013 concurrence letter from claimant's attorney, Dr. Sobota reviewed claimant's early medical records after the injury. She explained that a diagnosis of "sciatica" was essentially the same as her diagnosis of lumbar radiculopathy, noting that both terms indicated an irritated lumbar nerve root. (Ex. 50-2). She stated that Dr. Kane distinguished between radiculopathy and radiculitis, but she used the terms interchangeably, although she preferred the term "radiculopathy." (*Id.*) Dr. Sobota explained that when claimant presented in the emergency room, she had a positive SLR test on the left with contralateral pain, which meant that when her left leg was raised, she developed pain on the right side. (Ex. 50-2; *see* Ex. 1). She opined that this was good clinical evidence by way of an orthopedic test that claimant had pain from an irritated nerve as early as January 4, 2011. (*Id.*) Dr. Sobota also referred to Dr. Reichle's January 5, 2011 chart note, which explained that claimant had a positive straight leg test. (Ex. 50-2; *see* Ex. 4). She concluded that the early examination findings made it clear that claimant had sustained an injury that caused irritation of a lumbar nerve root. (Ex. 50-2).

Dr. Sobota explained that her examination findings of claimant included positive straight leg tests and demonstrated loss of strength in the right foot, which was clinically consistent with right lumbar radiculopathy. (Exs. 50-2, 52-2). She also determined that claimant's response to the epidural injection provided excellent evidence that her nerve root was irritated. (Exs. 50-3, 52-2).

Furthermore, Dr. Sobota strongly disagreed with the medical opinions finding a nonphysiologic presentation and functional overlay. She had evaluated claimant multiple times and she was able to communicate with her in Spanish. Dr. Sobota concluded that claimant's positive straight leg tests, reflex loss, and clinical complaints of radiating pain in a reliable and consistent dermatome pattern constituted a reliable and valid presentation, which allowed her to make a valid diagnosis of lumbar radiculopathy. (Ex. 50-3, -4).

In a March 2013 concurrence letter from claimant's attorney, Dr. Sobota had reviewed Dr. Green's January 2013 report. (Ex. 52; *see* Ex. 49). She disagreed with Dr. Green's conclusion that claimant did not have radiculopathy, explaining that she had clear evidence of nerve irritation within days after the work

injury and reflex loss and foot drop, which provided evidence of nerve irritation. (Ex. 52-1, -2). In a deposition, Dr. Sobota adhered to her opinion regarding the existence of claimant's radiculopathy. (Ex. 59).

I am persuaded by Dr. Sobota's well-reasoned opinion, which is based on her ability to communicate directly with claimant in Spanish, as well as her opportunity to examine and observe her condition over time. Dr. Sobota supports Dr. Kane's conclusion that claimant has established the existence of "radiculitis."

The opinions of Drs. Rosenbaum and Green are not persuasive. The insurer contends that they were the only physicians who had personally reviewed claimant's lumbar MRI scans. However, Drs. Kane and Sobota explained that the diagnosis of radiculopathy/radiculitis was a "clinical diagnosis." (Exs. 48A, 50, 59). Dr. Sobota testified that an MRI by itself cannot establish whether a patient has radiculopathy, although it can support the diagnosis. (Ex. 59-14, -16). She explained that a diagnosis of radiculopathy is clinical, made on objective grounds with mostly motor testing. (Ex. 59-14). Dr. Sobota opined that claimant's MRI showed an area where she had significant disc bulging mapped onto the L5 nerve. (Ex. 59-15). In light of Dr. Sobota's persuasive testimony, I decline to discount her opinion and that of Dr. Kane because they did not personally review claimant's MRI, rather than the MRI report.

Turning to medical causation of the radiculitis condition, Dr. Kane concluded that claimant's lifting a 50-pound box and twisting at work was consistent with irritating a lumbar nerve root. He determined that the work injury was the major contributing cause of claimant's disability/need for treatment for radiculitis. (Exs. 48A-1, 51). Dr. Kane relied on the fact that claimant's symptoms developed shortly after the work injury. He reported that she had mild degenerative changes, but he concluded that they were not responsible for her sudden onset of nerve root irritation. (Ex. 51). Dr. Kane's opinion establishes that claimant's radiculitis condition arose directly from the 2011 work injury.⁷ *See Albany Gen. Hosp. v. Gasperino*, 113 Or App 411,414-15 (1992) (for conditions arising directly from the work injury, a claimant must prove that the work injury was a material contributing cause of the disability/treatment of the condition); *Margaret O. Henry*, 65 Van Natta 1447 (2013) (material contributing cause standard applied because the sciatic nerve injury arose directly from the work injury).

⁷ Dr. Sobota provided support for the causal relationship between claimant's work injury and her disability/need for treatment for radiculopathy/radiculitis. (Exs. 50, 52, 59). However, Dr. Sobota attributed the radiculopathy/radiculitis to the L4-5 disc condition, which I find is not compensable.

The insurer relies on Drs. Rosenbaum and Green, who attributed claimant's complaints to preexisting lumbar spondylosis, unrelated to her work injury, and functional overlay, but those opinions are not persuasive for the following reasons.

Dr. Rosenbaum reported that claimant denied low back problems before the work injury, which is consistent with her testimony. (Ex. 37-3). As explained above, he did not diagnose radiculopathy. (Ex. 37-5). He determined that the work-related lumbar/sacroiliac strains had resolved and that her symptoms were consistent with preexisting lumbar spondylosis and a functional overlay. (Ex. 37-5, -6).

Similarly, Dr. Green concluded that claimant did not suffer from radiculopathy or radiculitis based on his examination and review of the medical records. (Ex. 49-11). In reaching that conclusion, however, he did not adequately respond to the well-reasoned opinions from Drs. Kane and Sobota. Like Dr. Rosenbaum, Dr. Green concluded that claimant's lumbar strain had resolved, leaving only the lumbar spondylosis or other factors, including possible psychogenic causes, to explain her persistent symptoms. (Ex. 49-12).

For the reasons discussed above, I am not persuaded that claimant's symptoms were merely caused by a functional component and "possible psychogenic causes." The opinions of Drs. Kane and Sobota are more persuasive regarding claimant's clinical presentation, based on their opportunity to examine her on multiple occasions.

Furthermore, neither Dr. Rosenbaum nor Dr. Green adequately explained the cause of claimant's sudden onset of low back and right leg symptoms and need for treatment after the work injury, particularly since she had no such symptoms before the injury. *See Allied Waste Indus., Inc. v. Crawford*, 203 Or App 512, 518 (2005), *rev den*, 341 Or 80 (2006) (temporal relationship between a work injury and the onset of symptoms is one factor that should be considered, and may be the most important factor); *Shirley Fong*, 63 Van Natta 1632, 1634 (2011) (medical opinion not persuasive that did not adequately explain the cause of the claimant's acute onset of right knee symptoms and need for treatment in a previously asymptomatic knee, which occurred alongside a work incident of twisting her knee). Moreover, their opinions are not persuasive because they did not respond to Dr. Kane's opinion that the mechanism of claimant's injury was sufficient to cause her radiculitis. *See Richard A. Lowe*, 60 Van Natta 2886, 2892 (2008), *aff'd*

without opinion, 234 Or App 785 (2010) (medical opinions not persuasive that did not address the relative contribution from the mechanism of injury or the opinions regarding the temporal relationship between the work incident and onset of symptoms).

In summary, I would find the new/omitted medical condition claim for radiculitis compensable. Because the majority concludes otherwise, I dissent from that portion of the majority's decision.