

In the Matter of the Compensation of
DOUG R. COOLEY, Claimant
Own Motion No. 14-00068OM
OWN MOTION ORDER
Guinn & Dalton, Claimant Attorneys
Law Offices of Kathryn R Morton, Defense Attorneys

Reviewing Panel: Members Weddell and Johnson.

The insurer has submitted its Own Motion Recommendation against the reopening of claimant's "worsened condition" claim concerning his previously accepted low back condition. *See* ORS 656.278(1)(a). The insurer contends that his compensable condition does not require any medical treatment that qualifies for claim reopening. Based on the following reasoning, we deny reopening.

FINDINGS OF FACT¹

On September 25, 1995, claimant sustained a compensable low back injury, which the insurer accepted for a "herniated nucleus pulposus on left side at L4-5 with L5 radiculopathy" and a "herniated disc L4-5." (Exs. 2, 4, 5). Claimant's aggravation rights expired on February 18, 2002.

In February 2010, Dr. Kellogg performed an L4-5 microdiscectomy. (Exs. 10A-2, 10B-1).

On August 5, 2014, claimant sought treatment from Dr. Mitchell, his then-attending physician, for low back pain. (Exs. 9A, 10-1). Before this, claimant was treating with Dr. Stapleton for pain management. (Ex. 10A-1). Dr. Mitchell

¹ With its Carrier's Own Motion Recommendation, the insurer submitted evidence marked as exhibits, arranged in chronological order, and accompanied by an exhibit list. OAR 438-012-0030(1)(b). However, both parties subsequently submitted multiple unnumbered exhibits. For ease of reference, we chronologically number those submissions as follows: Exhibit 9A – Dr. Mitchell's August 5, 2014 chart note; Exhibit 10B – Dr. Kellogg's August 20, 2014 letter; Exhibit 13 – Dr. Stapleton's September 9, 2014 discography; Exhibit 14 – Dr. Stapleton's September 18, 2014 chart note; Exhibit 15 – Carrier's September 19, 2014 Own Motion Recommendation; Exhibit 16 – Dr. Kellogg's November 25, 2014 surgery request; Exhibit 17 – Dr. Kellogg's July 22, 2015 letter; Exhibit 18 – Dr. Kellogg's September 9, 2015 response; Exhibit 19 – the insurer's September 28, 2015 inquiry to Dr. Stapleton; and Exhibit 20 – Dr. Stapleton's October 26, 2015 chart note. Finally, for chronological numbering purposes, Exhibit 13 (Dr. Stapleton's August 19, 2014 medical report) as submitted by the insurer, is renumbered as "Exhibit 10A."

released claimant from work due to worsening pain and weakness; however, he did not recommend any specific treatment. (Exs. 9A, 10). On August 11, 2014, Dr. Mitchell filed a form 827 that reported an “aggravation.” (Ex. 10-1).

On August 19, 2014, claimant returned to Dr. Stapleton for a “medication management visit.” (Ex. 10A-1). Dr. Stapleton renewed claimant’s pain medication at the same dosage and noted that he was employed full-time. (Ex. 10A-3, -4).

On August 20, 2014, claimant returned to Dr. Kellogg due to worsening low back pain. (Ex. 10B). Dr. Kellogg recommended a diagnostic provocative lumbar discogram, noting that, if it was positive at L4-5, “he may be a candidate for an L4-5 ALIF procedure.” (Ex. 10B-1).

On September 8, 2014, Dr. Mitchell requested ongoing medical care to evaluate claimant’s current condition and determine if curative care would eventually be needed. (Ex. 11-2). He also noted that claimant would need further diagnostic testing, including a discogram, and that he may need further surgery. (Ex. 11-3).

On September 9, 2014, Dr. Stapleton performed a provocative discography. (Ex. 13).

On September 19, 2014, the insurer submitted its recommendation against the reopening of claimant’s Own Motion claim for a “worsening” of his previously accepted low back condition. The insurer contended that the compensable condition did not require any medical treatment that qualified for claim reopening. (Ex. 15).

On November 25, 2014, Dr. Kellogg recommended that claimant undergo an L4-5, L5-S1 anterior lumbar interbody fusion. (Ex. 16).

On July 22, 2015, claimant returned to Dr. Kellogg, who noted that the September 2014 diskogram demonstrated concordant back pain at L4-5 and L5-S1. (Ex. 17-1). However, after reviewing a 2014 MRI, he stated that there was not any obvious surgical approach that would resolve claimant’s symptoms. (*Id.*) He also noted that claimant had degenerative disease at L3-4, which would be accelerated by an L4-5 fusion. (*Id.*) Instead, Dr. Kellogg thought that claimant might be a good candidate for physical therapy and consideration for a spinal cord stimulator (SCS) trial to see if that would provide him with reduction of his symptoms. (*Id.*)

On September 9, 2015, Dr. Kellogg agreed that he recommended an SCS trial and that implantation of the SCS was a surgical procedure. (Ex. 18-1). He also agreed that implantation of the SCS would likely result in a period of temporary disability and that an SCS is “‘curative treatment’ that relates to or is used in the cure of diseases, tends to heal, restore to health, or bring about recovery.” (Ex. 18-2).

In response to a September 28, 2015 inquiry from the insurer, Dr. Stapleton indicated that he considered the SCS trial or permanent stimulator was “palliative care.” (Ex. 19).

On October 26, 2015, claimant returned to Dr. Stapleton, who noted that he had undergone the SCS trial, which provided 50 percent relief and good coverage of his bilateral buttock and leg pain. (Ex. 20-2). However, Dr. Stapleton reported that claimant was undecided about implantation and was unsure whether the SCS device would provide relief while he was riding his motorcycle or performing other activities that usually aggravated his pain. (Ex. 20-4). Dr. Stapleton noted that claimant “plans to discuss his trial with Dr. Kellogg and go from there.” (Ex. 20-4).

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.278(1)(a), there are three requirements for the reopening of an Own Motion claim for a worsening of a compensable injury. First, the worsening must result in an inability of the worker to work. *See James J. Kemp*, 54 Van Natta 491 (2002). Second, the worsening must require hospitalization, surgery (either inpatient or outpatient), or other curative treatment prescribed in lieu of hospitalization that is necessary to enable the worker to return to work.² *Id.* Third, the worker must be in the “work force”

² The three qualifying medical treatments listed in ORS 656.278(1)(a) are defined as follows: (1) “Surgery” is an invasive procedure undertaken for a curative purpose that is likely to temporarily disable the worker; and (2) “hospitalization” is a nondiagnostic procedure that requires an overnight stay in a hospital or similar facility. *Larry D. Little*, 54 Van Natta 2536, 2541-42 (2002). The third type of qualifying treatment requires establishment of three elements: (1) curative treatment (treatment that relates to or is used in the cure of diseases, tends to heal, restore to health, or to bring about recovery); (2) prescribed (directed or ordered by a doctor) in lieu of (in the place of or instead of) hospitalization; and (3) is necessary (required or essential) to enable (render able or make possible) the injured worker to return to work. *Little*, 54 Van Natta at 2546. If any of these three qualifying medical treatments is satisfied, a “worsening condition” claim meets the “medical treatment” requirement for reopening in Own Motion. *Little*, 54 Van Natta at 2540-41.

at the time of disability as defined under the criteria in *Dawkins v. Pacific Motor Trucking*, 308 Or 254 (1989). *Id.* If a claimant meets these requirements, his or her Own Motion claim qualifies for reopening either by the Board or the carrier.

Here, there is no dispute that claimant was in the work force and that the worsening resulted in an inability to work. Instead, the dispute focuses on whether the requisite medical treatment under ORS 656.278(1)(a) is satisfied.

The requirement that the worsening require hospitalization, surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable the worker to return to work may be satisfied by a recommendation for any of the requisite treatments. *Thurman M. Mitchell*, 54 Van Natta 2607, 2615 (2002). A delay of a recommended surgery does not necessarily vitiate the surgery recommendation. *See Steven L. Traister*, 65 Van Natta 1295, 1300, *recons*, 65 Van Natta 1615 (2013) (requisite treatment found where the claimant cancelled the recommended surgery for “financial reasons,” but remained willing to proceed with the surgery if he received temporary disability benefits, and the surgery recommendation was not withdrawn). However, the requirement is not satisfied by a recommendation for a requisite treatment that has subsequently been withdrawn. *See Andrew E. Shipman*, 64 Van Natta 1000, 1001 (2012); *Edwin V. Johnson*, 58 Van Natta 2294, 2296 (2006).

Here, on November 25, 2014, Dr. Kellogg recommended surgery (an L4-5, L5-S1 anterior lumbar interbody fusion). (Ex. 16). However, in July 2015, he withdrew that recommendation. (Ex. 17-1). Therefore, Dr. Kellogg’s withdrawn surgery recommendation does not satisfy the “medical treatment” requirement under ORS 656.278(1)(a). *See Shipman*, 64 Van Natta at 1001; *Johnson*, 58 Van Natta at 2296.

In July 2015, Dr. Kellogg also recommended an SCS trial to determine whether that would provide claimant with some reduction in his symptoms. (Exs. 17-1, 18-1). In addition, Dr. Kellogg considered the SCS implantation to constitute surgery. (Ex. 18-1).

In October 2015, claimant underwent an SCS trial, which provided 50 percent relief and good coverage of his bilateral buttock and leg pain. (Ex. 20-2). However, claimant was “undecided” about implantation of the SCS and planned to “discuss his trial with Dr. Kellogg and go from there.” (Ex. 20-4). The record is silent as to whether claimant decided to go forward with the implantation surgery.

Under such circumstances, the record, as presently developed, does not establish that claimant has chosen to proceed with the recommended implantation surgery. Therefore, the recommendation for SCS implantation did not satisfy the surgical requirement under ORS 656.278(1)(a).³ See *Gonzalo C. Sanchez*, 64 Van Natta 941, 942 (2012) (where the claimant chose not to proceed with a recommended surgery, the “surgery” requirement under ORS 656.278(1)(a) was not satisfied); *Todd P. Shelton*, 61 Van Natta 1578, 1579 (2009) (where surgery was recommended and authorization requested, but the claimant chose not to proceed with the surgery at that time, the surgical requirement under ORS 656.278(1)(a) was not satisfied).

Furthermore, although Dr. Kellogg recommended non-surgical treatment (physical therapy) and Dr. Stapleton was providing prescription pain medication, the record does not establish that this treatment constitutes “other curative treatment prescribed in lieu of hospitalization that is necessary to enable the injured worker to return to work.” ORS 656.278(1)(a); see *Stephen Jackson*, 55 Van Natta 2421, 2422 (2003) (although treatment (prescription medication) was arguably curative and necessary to enable the claimant to return to work, there was no evidence that the treatment was prescribed in lieu of hospitalization); *Mark R. Gescher*, 55 Van Natta 1956 (2003) (same). Therefore, we conclude that this Own Motion “worsened condition” claim does not satisfy the requisite medical treatment criteria required under ORS 656.278(1)(a).

Accordingly, the request for claim reopening is denied. Claimant’s entitlement to medical expenses pursuant to ORS 656.245 regarding his accepted conditions is not affected by this order.

IT IS SO ORDERED.

Entered at Salem, Oregon on April 22, 2016

³ All qualifying medical treatment (including surgery) must be curative. See ORS 656.278(1)(a); *George M. Moore*, 60 Van Natta 2777 (2008). We acknowledge that Drs. Kellogg and Stapleton differ in their opinions as to whether an SCS is curative or palliative treatment. However, in light of our determination that the record does not establish that claimant has chosen to proceed with the recommended SCS implantation, we need not definitively decide the curative/palliative issue.