
In the Matter of the Compensation of
MICHELLE A. GRIFFITH, Claimant
Own Motion No. 15-00012OM; 12-00123OM
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Black Chapman et al, Claimant Attorneys
Olson & Dickson LLP, Defense Attorneys

Reviewing Panel: Members Johnson and Lanning.

Claimant requests review of the October 5, 2012 and December 31, 2014 Own Motion Notices of Closure that did not award additional unscheduled permanent partial disability (PPD) for her “post-aggravation rights” new/omitted medical conditions (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11; and lower lumbar instability at L2-3).¹ On review, claimant contends that she is entitled to a permanent total disability (PTD) award. Based on the following reasoning, we grant PTD.

FINDINGS OF FACT

In 1984, claimant underwent a left knee arthroscopy. (*See* Exs. 73-2, 93-4, 96-3). There is no indication that this surgery caused any preexisting disability before October 2, 1986 (the date of her compensable injury).

On October 2, 1986, claimant compensably injured her back, left hip, and left elbow. (Ex. 1). A June 30, 1987 Determination Order did not award permanent disability. (Ex. 5). Her aggravation rights expired June 30, 1992.

¹ Claimant’s October 2, 1986 claim was accepted as a disabling claim and was first closed on June 30, 1987. Thus, her aggravation rights expired on June 30, 1992. Therefore, when claimant sought claim reopening in November 2009 and February 2014, the claim was within our Own Motion jurisdiction. ORS 656.278(1). On June 7, 2012, the self-insured employer voluntarily reopened claimant’s Own Motion claim for “post-aggravation rights” new/omitted medical conditions (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11). (Ex. 166). On October 5, 2012, the employer issued an Own Motion Notice of Closure for these “post-aggravation rights” new/omitted medical conditions. (Ex. 168). On December 23, 2014, the employer voluntarily reopened claimant’s Own Motion claim for a “post-aggravation rights” new/omitted medical condition (lower lumbar instability at L2-3). (Ex. 187). On December 31, 2014, the employer issued its Own Motion Notice of Closure for that “post-aggravation rights” new/omitted medical condition. (Ex. 188). On July 6, 2015, we referred the October 2012 and December 2014 claim closures to the Director for the appointment of a medical arbiter, noting that the medical arbiter examination for these two claims may be conducted in conjunction with each other. (WCB Case Nos. 12-0123M and 15-00012OM). We review the October 2012 and December 2014 closures in tandem.

In December 1987, claimant underwent a T6-7 laminectomy, discectomy, and facetectomy. (Ex. 9). A July 20, 1988 Determination Order awarded 29 percent (92.8 degrees) unscheduled PPD for the thoracic spine, which was eventually reduced to 27 percent (86.4 degrees) unscheduled PPD for the cervical and thoracic spine by a December 1988 Board order. (Exs. 11, 12, 13).

In May 1990, Dr. Carr performed a T4 to T10 fusion with CD instrumentation for post-surgical instability of claimant's thoracic spine. (Ex. 15). A January 10, 1991 Determination Order did not award additional unscheduled PPD. (Ex. 17-1). The evaluator determined that claimant had 23 percent impairment value based on her thoracic spine prior surgeries and decreased range of motion (ROM), and 4 percent "social-vocational" value based on a residual functional capacity (RFC) of "light," which resulted in a total of 27 percent unscheduled PPD. (Ex. 17-2). A June 5, 1992 Opinion and Order increased claimant's unscheduled PPD award to 32 percent (102.4 degrees) based on loss of lumbar ROM. (Ex. 21).

Meanwhile, in April 1992, the employer reopened an aggravation claim based on Dr. Carr's diagnosis of kyphosis of the thoracic spine and surgery for removal of the CD instrumentation. (Exs. 19, 20). A February 17, 1993 Determination Order did not award additional permanent disability. (Ex. 27).

On February 6, 1996, claimant underwent a T4 through T11 discectomy, performed by Dr. Carr. (Ex. 32).

In a February 16, 1996 Own Motion Recommendation, the employer listed claimant's accepted conditions as a thoracic strain, T6-7 laminectomy, and T4-10 facetectomy and fusions, and recommended reopening of claimant's Own Motion claim for "Same. Surgery to refuse T4-10." (Ex. 34-2). On February 23, 1996, we issued an Own Motion Order authorizing the reopening of claimant's Own Motion claim for a "worsening" of her compensable injury. (Ex. 35).

On February 28, 1996, Dr. Carr performed T5 through T10 osteotomies of the previous fusion mass, and a T1 through L2 fusion with CD instrumentation. (Exs. 36, 37). In September 1996, Dr. Carr released claimant to full work duties. (Ex. 39). Claimant continued to seek treatment with Dr. Carr through August 2000.

From May 2001 through July 2002, she treated with Dr. Lawlor, who diagnosed chronic low back pain status-post multiple surgeries, and chronic cervical and thoracic pain. (Exs. 73 through 79, 81, 85, 87, 88, 92). On May 8,

2002, claimant underwent a physical capacity evaluation/work capacity evaluation (PCE/WCE) at Dr. Lawlor's request, which determined that she was capable of performing "light" work for an 8-hour day and noted that her reported low back pain and right-side upper back pain were limiting factors. (Ex. 86-1-7). Thereafter, Dr. Lawlor opined that claimant's "true capacity" for work on an ongoing basis was "sedentary work on a part time basis," which was a reflection of a decline and additional impairment as a direct consequence of her 1986 injury and resultant surgeries. (Ex. 87-2).

On August 6, 2002, Dr. Gripekoven, who examined claimant at the employer's request, stated that claimant had extensive surgical disruption of her back that immobilized the entire spine, and that a major disruption of the mechanics of the entire spine, including accelerated breakdown of discs and above and below the fusion and symptoms at those levels, would be expected. (Ex. 93-8). Dr. Gripekoven opined that claimant's current condition was the result of her 1986 compensable injury and subsequent surgeries. (*Id.*) He also noted that claimant had findings suggestive of "some S1 residuals perhaps related to her prior surgical exposures." (*Id.*)

That same day, claimant underwent a PCE, which concluded that she was capable of performing "sedentary" work, but that it was difficult to predict whether she could sustain that level of work for an 8-hour day. (Ex. 94).

On September 30, 2002, claimant began treating with Dr. Lorber, who became her attending physician. (Ex. 96). At that time, she was working 20 hours per week at a retail tobacco store.² (Ex. 96-4). Dr. Lorber agreed with Dr. Gripekoven's report and assessments and provided ongoing conservative care. (Ex. 96-5-6).

On October 23, 2003, Dr. Lorber noted that claimant was involved in a motor vehicle accident (MVA) on October 19, 2003. (Ex. 107-1). Dr. Lorber diagnosed cervical, thoracic, and lumbar sprains/strains attributed to the MVA. (Ex. 107-3). Thereafter, he provided injections to claimant's right and left trapezius and right C6-7. (Exs. 109, 110, 111, 112-2, 115, 116, 117, 120).

On July 26, 2005, Dr. Lorber opined that claimant was medically stationary with regards to her MVA, commenting that she may require periodic trigger point injections for flare-ups. (Ex. 121-2). Thereafter, Dr. Lorber periodically performed trapezius trigger point injections.

² Claimant worked for this employer from 1993 to 2007. (Ex. 192-2). She initially worked full-time, then transitioned to working part-time after the 1996 fusion surgery. (*Id.*)

In October 2007, Dr. Lorber noted that claimant had progressive difficulties lifting and using stairs, and expressed surprise that she had not “[gone] out on total disability.” (Ex. 129-1).

On March 13, 2008, based on myelograms and CT scans of claimant’s entire spine, Dr. Lorber found a C6-7 disc bulge, multilevel minor retrolisthesis in the lumbar spine below the fusion levels that caused indentation of the thecal sac resulting in mild central canal stenosis, but no obvious neurological impingement. (Ex. 136-1). He stated that claimant had no additional pathology to explain her reflex changes, and declared her to be medically stationary. (Ex. 136-2).

In November 2008, Dr. Lorber stated that it “would be reasonable for [claimant] to be deemed permanently totally disabled.” (Ex. 143-2).

A January 7, 2009 Own Motion Notice of Closure closed claimant’s “worsened condition” claim (thoracic strain, T6-7 laminectomy, and T4-10 facetectomy and fusions), which had remained reopened since February 23, 1996. (Exs. 35, 144). Claimant requested review of the closure notice seeking a PPD/PTD award. On June 18, 2009, we affirmed the 2009 Own Motion Notice of Closure, noting that claimant was not entitled to a PPD/PTD award for a “worsened condition” in Own Motion status. (Ex. 147).

In March 2009, Dr. Lorber noted that an MRI and January 2009 bone scan showed abnormalities at L3-4 and L4-5. (Ex. 146-1). He also reported that claimant had received a right L5-S1 facet joint injection on February 11, 2009, which substantially decreased her low back symptoms, although she continued to have left leg weakness that caused her to fall. (*Id.*)

On November 6, 2009, claimant requested that the employer accept the following new/omitted medical conditions as related to her 1986 injury: T1-L2 fusion; chronic low back pain syndrome; S-1 nerve root irritation; thoracic spine instability, T1-T11; facet syndrome, L3-4 to L5-S1; post-operative degenerative disc disease of the cervical spine; and post-operative degenerative disc disease of the lumbar spine, L2 to L5-S1. (Ex. 149).

In a January 2010 summary letter, Dr. Lorber agreed that the T1-L2 fusion and lumbar spine degenerative disc disease at L2-3 were compensably related to claimant’s 1986 work injury and surgeries. (Ex. 152-1, -3). However, he opined that the claimed chronic low back pain syndrome was not an appropriate diagnosis because claimant did not present with significant psychosocial factors. (Ex. 152-2-3). Dr. Lorber also stated that the proper diagnosis for the claimed S-1 nerve root

irritation would be S-1 radiculitis, which he did not diagnose, and that any S-1 nerve root irritation was not caused by the work injury and resultant surgeries but, rather, degenerative disc disease at that level. (Ex. 152-2). According to Dr. Lorber, the T1-T11 thoracic spine instability was no longer an accurate diagnosis because claimant's entire thoracic spine was already fused. (*Id.*)

Dr. Lorber also took issue with the diagnosis of L3-4 to L5-S1 facet syndrome, clarifying that the proper diagnosis would be facet arthritis or arthropathy, and that the claimant's work injury was not the major contributing cause of the condition. (Ex. 152-2). Instead, he opined that the cause of claimant's facet arthritis was multifactorial, including the work injury, aging, genetics, and the 2003 MVA. (*Id.*) Finally, Dr. Lorber concluded that claimant's work injury was not the major contributing cause of the claimed post-operative degenerative disc disease of the cervical spine and lumbar spine, with the exception of the L2-3 disc level, when compared with her age, genetics, and MVA. (Ex. 152-2-3).

On January 26, 2010, the employer accepted claimant's claim for the following "post-aggravation rights" new/omitted medical conditions: T1 through L2 fusion; post-operative degenerative disc disease at L2-3; and thoracic spine instability at T1-T11. (Ex. 153). On January 27, 2010, the employer denied claimant's claim for the following conditions: chronic low back pain syndrome; S-1 nerve root irritation; facet syndrome, L3-4 to L5-S1; post-operative degenerative disc disease of the cervical spine; and post-operative degenerative disc disease of the lumbar spine, excluding the L2-3 disc level. (Ex. 155).³

In February 2010, Dr. Lorber opined that claimant's L2-3 degenerative changes were due to her fusion, but had difficulty stating that her work injury was the major contributing cause of the degenerative changes in her lower lumbar levels. (Ex. 157-1).

In a September 6, 2011 summary letter, Dr. Lorber stated that claimant was not capable of "regular, competitive, 8 hour a day employment given her spinal condition." (Ex. 160-1). According to Dr. Lorber, claimant would likely miss several days or more a month, and have to go home early at least several times a month, on an unpredictable basis. (*Id.*) Additionally, Dr. Lorber believed that claimant would need to take more breaks than allowed in an 8-hour shift to walk and move around, a sit/stand option, and that her pain could impact her concentration, persistence, and pace in a competitive work environment. (*Id.*)

³ On March 18, 2010, claimant requested a hearing challenging that denial. An April 30, 2015 Order of Dismissal indicated that the request for hearing was withdrawn and, therefore, dismissed. (WCB Case No. 10-01510).

In a September 27, 2011 summary letter, Dr. Lorber adhered to his January 2010 causation opinion. (Ex. 161-1). He also clarified that claimant was capable of working part-time or modified work that accommodated her hours and physical restrictions, as she did at her last employment. (Ex. 161-2). Finally, Dr. Lorber stated that his treatment of claimant since September 2002 had been “for her ‘entire’ condition flowing from her injury and her surgeries, including the 1996 fusion from T1-L2[,]” which included the newly accepted conditions, and that all of her conditions were medically stationary in March 2008. (*Id.*)

On June 7, 2012, the employer voluntarily reopened claimant’s Own Motion claim for these accepted “post-aggravation rights” new/omitted medical conditions (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11). (Ex. 166).

An October 5, 2012 Own Motion Notice of Closure did not award additional PPD for the aforementioned “post-aggravation rights” new/omitted medical conditions. (Ex. 168). Claimant requested review, seeking additional permanent disability up to and including PTD and the appointment of a medical arbiter.

On April 5, 2013, Dr. Lorber noted that claimant’s “left leg will give out.” (Ex. 170-1). Based on the x-rays, he noted slight instability at L2-3 and raised the possibility of extending the fusion to that level. (Ex. 170-1-2).

On April 26, 2013, Dr. Lorber noted that there was minor instability at both L2-3 and L3-4, which could be responsible for claimant’s left “leg giving out.” (Ex. 171-2). However, based on electrodiagnostic testing that he performed that day, Dr. Lorber did not believe that claimant had yet suffered significant neurologic damage. (*Id.*) He opined that a fusion could include both levels, but could also cause further problems at L4-5 and L5-S1. (*Id.*)

In a February 20, 2014 deposition, Dr. Lorber testified that, when he first began treating claimant for her 16-year-old work injury, he focused on her “whole back,” most of which had been fused. (Ex. 178-5). Dr. Lorber concurred with Dr. Gripekoven’s August 6, 2002 report, who opined that claimant’s extensive surgery caused a major disruption of the mechanics of her “entire spine” that would be expected to accelerate degeneration of discs above and below the fusion. (Exs. 93-8, 178-25-26).

Dr. Lorber confirmed claimant’s work restrictions, as expressed in his September 2011 opinion, and stated that her work limitations were unchanged since he began treating her. (Ex. 178-39-40, -53-55, -64-68). According to

Dr. Lorber, claimant was permanently and totally disabled from a vocational standpoint, but not from a medical standpoint. (Ex. 178-63-64). He testified that claimant was permanently and totally disabled in 2002. (Ex. 178-54-55).

According to Dr. Lorber, claimant was permanently precluded from working due to her “whole back” that he had been treating since 2002, with the exception of the C6-7 disc protrusion related to the 2003 MVA involving her neck from which she had recovered. (Ex. 178-66-67). He stated that the L2-3 lumbar spine instability did not contribute to her inability to work. (Ex. 178-66).

On February 21, 2014, claimant requested acceptance of lower lumbar instability at L2-3. (Ex. 178A). On April 18, 2014, the employer accepted a claimant’s claim for the “post-aggravation rights” new/omitted medical condition (lower lumbar instability at L2-3). (Ex. 179).

On April 28, 2014, Dr. Lorber opined that claimant’s L2-3 instability condition was medically stationary as of December 14, 2013. (Ex. 179A).

On December 19, 2014, after reviewing November 2014 x-rays, Dr. Lorber diagnosed, *inter alia*, “[m]ild instability at L2-3 greater than L3-4 with potential worsening compared to prior[,]” and “L5-S1 degenerative changes, likely normal age-related changes, not nearly as significant as the instability at L2-3 or L3-4.” (Ex. 186-2).

On December 23, 2014, the employer voluntarily reopened the Own Motion claim for the L2-3 instability condition. (Ex. 187). On December 31, 2014, the employer issued an Own Motion Notice of Closure that declared claimant’s L2-3 instability medically stationary as of December 14, 2013 and awarded no additional PPD benefits. (Ex. 188-1). Claimant requested review, contending that the claim was prematurely closed or, alternatively, that she was entitled to additional permanent disability up to and including PTD. She subsequently requested the appointment of a medical arbiter.

On April 20, 2015, Mr. Potocki, a vocational consultant, relied on Dr. Lorber’s opinions and work restrictions to conclude that: (1) claimant is precluded from gainful employment because “[t]here is no normal competitive employment situation in the general labor market which would accommodate [her] extremely restrictive profile”; and (2) it would be “futile for her to seek employment in the labor market based upon medical findings by Dr. Lorber.” (Ex. 192-3-4).

On July 6, 2015, we issued two separate Interim Orders regarding the October 2012 and December 2014 Own Motion Notices of Closure. We referred the claims to the Director for the appointment of a medical arbiter, noting that the medical examination for the two claims may be conducted in conjunction with each other. *Michelle A. Griffith*, 67 Van Natta 1185 (2015); *Michelle A. Griffith*, 67 Van Natta 1190 (2015).

On September 3, 2015, Dr. Di Paola performed a medical arbiter examination. He offered no opinion regarding claimant's residual functional capacity.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, by this reference, we adhere to, and republish, our reasoning in our prior decision that the December 31, 2014 Own Motion Notice of Closure for the "post-aggravation rights" new/omitted medical condition (lower lumbar instability at L2-3) was not prematurely closed. *Griffith*, 67 Van Natta at 1194-95.⁴

Claimant's 1986 injury claim was reopened for the processing of "post-aggravation rights" new/omitted medical conditions (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11; and lower lumbar instability at L2-3). Such claims may qualify for payment of permanent disability compensation, including PTD. ORS 656.278(1)(b); *Goddard v. Liberty Northwest Ins. Corp.*, 193 Or App 238 (2004); *James S. Daly*, 58 Van Natta 2355 (2006); *Sherlee M. Samel*, 56 Van Natta 931, 938 (2004).

Because the claims are in Own Motion status, the Notices of Closure issued under ORS 656.278(6), not ORS 656.206 or ORS 656.268. Nevertheless, where consistent with the provisions of ORS 656.278, the 2005 amendments to ORS

⁴ Claimant initially sought a full evidentiary hearing to further develop the record, including presentation of vocational assessments, depositions, and cross-examination of witnesses. However, before our July 6, 2015 Interim Order, claimant's counsel submitted additional evidence (which included medical reports, Mr. Potocki's vocational report, and claimant's affidavit regarding her willingness to seek work). Furthermore, on review, claimant asserts that there is sufficient evidence to establish entitlement to PTD, noting that the employer has neither requested depositions to cross-examine claimant's affidavit nor Mr. Potocki's vocational report, nor submitted its own vocational evidence.

Because both parties have had a full opportunity to develop the record, and because we find the record sufficiently developed to determine claimant's entitlement to PTD benefits, we conclude that a "fact finding" hearing is unnecessary. *Adolfo S. Lopez*, 57 Van Natta 1056, 1062 n 6 (2005) (referral for fact finding hearing unnecessary where record sufficiently developed).

656.206 apply to Own Motion Notices of Closure that issue on or after January 1, 2006. *David C. Drader*, 58 Van Natta 3093, 3098 (2006). Thus, because these Own Motion Notices of Closure issued after January 1, 2006, the 2005 amendments to ORS 656.206 apply. *Boyd W. Jensen*, 65 Van Natta 2156, 2162 (2012).

ORS 656.206(1)(d) (2005) provides that PTD “means, notwithstanding ORS 656.225, the loss, including preexisting disability, of use or function of any portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation.” “‘Regularly performing work’ means the ability of the worker to discharge the essential functions of the job” and “‘[s]uitable occupation’ means one that the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation.” ORS 656.206(1)(e), (f) (2005). Claimant must also establish that she is “willing to seek regular gainful employment” and that she has “made reasonable efforts to obtain such employment.” ORS 656.206(3) (2005).⁵ Finally, claimant has the burden of proving PTD status. *Id.*

In *Daly*, we analyzed ORS 656.206, in conjunction with ORS 656.278, to reach the following conclusions. 58 Van Natta at 2374. First, disability for a previously accepted condition⁶ is considered as it existed at the last claim closure that preceded the expiration of claimant’s 5-year aggravation rights.⁷ *Daly*, 58 Van

⁵ *SAIF v. Stephen*, 308 Or 41, 47-48 (1989), interpreted statutory language in ORS 656.206(3) that remains unchanged and held that “before a claimant is entitled to PTD he or she must establish that, but for the compensable injury, he or she (1) is or would be willing to seek gainful employment and (2) has or would have made reasonable efforts to obtain such employment” unless seeking such work would have been futile.

⁶ Here, claimant’s previously accepted conditions regarding the “post-aggravation rights” new/omitted medical condition claims (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11; and lower lumbar instability at L2-3) currently being rated were the “thoracic strain; laminectomy at T6-7; facetectomy at T4-T10; and fusion from T4-T10,” which was last closed on January 10, 1991 (before the expiration of her 5-year aggravation rights on June 30, 1992.) (*See Exs. 17, 34-2, 155-1, 178-7*). A June 5, 1992 Opinion and Order ultimately awarded 32 percent (102.4 degrees) unscheduled PPD for claimant’s thoracic and lumbar spine for the previously accepted conditions. (Ex. 21). Thus, that permanent disability resulting from the last claim closure of the accepted conditions that preceded the expiration of claimant’s aggravation rights may be considered in evaluating PTD on the closures of the aforementioned “post-aggravation rights” new/omitted medical conditions.

⁷ We reasoned that, under this method, the PTD evaluation would include consideration of permanent disability from the accepted conditions occurring before the expiration of aggravation rights, but would not include consideration of permanent disability from any “worsened condition” after the expiration of aggravation rights, which would be contrary to the statutory scheme and the rationale

Natta at 2361. Second, any disability that predates the initial compensable injury is also considered. *Id.* at 2364-65. Third, when such disabilities exist, they are considered with any disability from the “post-aggravation rights” new/omitted medical conditions to determine whether the claimant has established entitlement to PTD. *Id.* at 2371.

Considering those factors, claimant may establish entitlement to PTD by proving that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prevents gainful employment under the “odd lot” doctrine. *Id.* at 2368; *see also Clark v. Boise Cascade*, 72 Or App 397, 399 (1985); *Richard L. Elsea*, 66 Van Natta 493, *recons*, 66 Van Natta 727 (2014), *aff’d*, *Elsea v. Liberty Mutual Ins.*, 277 Or App 475 (2016); *Nancy J. Ferguson*, 64 Van Natta 2315 (2012); *Drader*, 58 Van Natta at 3099.

The record does not establish that claimant is completely *physically* disabled.⁸ Therefore, we turn to the “odd lot” doctrine. *See Clark*, 72 Or App at 399; *Adolfo Lopez*, 57 Van Natta 1056, 1063 (2005). Under the “odd lot” doctrine, a disabled person, capable of performing work of some kind, may still be permanently disabled due to a combination of her physical condition and certain non-medical factors, such as age, education, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the conditions of the labor market. *See Elsea*, 277 Or App at 478; *Clark*, 72 Or App at 399; *Welch v. Banister Pipeline*, 70 Or App 699, 701 (1984); *Joseph P. Hapka*, 61 Van Natta 1148, 1161 (2009).

Here, although claimant underwent a 1984 left knee arthroscopy, there is no evidence that it (or any other condition) caused “disabling effects” before her October 1986 compensable injury. *See Fimbres v. SAIF*, 197 Or App 613 (2005); *Timothy C. Guild*, 68 Van Natta 741, 748 (2016). Thus, she has no preexisting disability that may be considered in determining her entitlement to PTD.

expressed in *Goddard, Samel, and Jimmy O. Dougan*, 54 Van Natta 1213, *recons*, 54 Van Natta 1552 (2002), *aff’d Dougan v. SAIF*, 193 Or App 767 (2004), *vacated*, 339 Or 1 (2005). *Daly*, 58 Van Natta at 2362.

⁸ Dr. Lorber explained that claimant was permanently partially disabled from a medical aspect, but she was permanently totally disabled considering her vocational limitations. (Ex. 178-63-64).

As previously noted, the January 10, 1991 Determination Order, as modified by the June 5, 1992 Opinion and Order, was the last claim closure that preceded the expiration of claimant's 5-year aggravation rights (*i.e.*, June 30, 1992). (Exs.17, 21). At that time, she was awarded 32 percent unscheduled PPD for the previously accepted conditions (thoracic strain, T6-7 laminectomy, and T4-10 facetectomy and fusions) based on her thoracic spine surgeries, loss of lumbar ROM, and "social-vocational" factors with an RFC of "Light." (*Id.*) Thus, claimant's permanent disability resulting from the previously accepted conditions at the last claim closure that preceded the expiration of her aggravation rights may be considered in evaluating PTD.

The employer argues that claimant's restrictions and inability to work are due to a "worsening" of her previously accepted conditions, for which her Own Motion claim was previously reopened in 1996 for a "worsened condition" (thoracic strain, T6-7 laminectomy, and T4-10 facetectomy and fusions) and subsequently was closed in January 2009 and affirmed by a June 2009 Board order. (Exs. 35, 144, 147). Basically, the employer contends that, because claimant was unable to work *before* her "post-aggravation rights" new/omitted medical condition claims were accepted, reopened, and closed, her current inability to work is due to the "worsening" of her previously accepted conditions, for which she is not entitled to a PTD award. Based on the following reasoning, we disagree with the employer's analysis.

The employer relies on Dr. Lorber's November 2008 report, as reiterated in his February 2014 deposition testimony, that claimant was permanently and totally disabled and was unable to work since he began treating her in 2002. (Exs. 143-2, 178-53-55, 178-64-68). However, Dr. Lorber did not attribute claimant's condition to a worsening of her previously accepted back conditions. Moreover, as explained below, Dr. Lorber's opinion establishes that claimant's impairment was due to conditions that were ultimately determined compensable as "post-aggravation rights" new/omitted medical conditions.

In February 1996, claimant underwent extensive spinal surgery that included T5 through T10 osteotomies of the previous fusion mass and a T1 through L-2 fusion with CD instrumentation. (Exs. 36, 37). This 1996 surgery prompted claimant's request for acceptance of "post-aggravation rights" new/omitted medical conditions, which ultimately resulted in the employer's acceptance and reopening of several new/omitted medical conditions (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11; and lower lumbar instability at L2-3) on which the October 2012 and December 2014 claim closures were based. (Exs. 153, 161-2, 179).

Furthermore, in September 2011, Dr. Lorber explained that he began treating claimant in September 2002, well after the February 1996 surgery. He attributed his treatment throughout this time to her entire condition flowing from her injury and surgeries, including the 1996 fusion from T1-L2. (Ex. 161-2). He noted that, even though those “new” medical conditions subsequently had been formally accepted under the claim, his treatment had always included those “new” conditions. (*Id.*)

In his February 2014 deposition, Dr. Lorber further explained that “I’d love to say there was a specific area [of back treatment], but it was her whole back, because her whole back is – well, most of the back has been fused.” (Ex. 178-5). He also found that the L2-3 changes were related to the fusion surgery. (Ex. 178-16). In addition, Dr. Lorber agreed with Dr. Gripekoven’s August 2002 opinion that claimant “has had extensive surgical disruption of her back, which has immobilized the entire spine. One can expect a major disruption of mechanics of the entire spine.” (Exs. 93-8, 178-26).

Finally, Dr. Lorber clarified that, although claimant’s neck injury from an intervening motor vehicle accident had previously contributed to her inability to work, she had recovered from that neck injury (C6-7 disc protrusion) and yet remained unable to work. (Ex. 178-66-67). In addition, he stated that the L2-3 instability added no additional impairment. (Exs. 178-66, 181).

Based on our review of Dr. Lorber’s opinions (particularly his subsequent clarifications), we consider his reference to the “whole spine” to focus on her fused spinal condition as well as her previously accepted conditions (which were the basis for her 32 percent unscheduled PPD award prior to the expiration of her aggravation rights). Moreover, the accepted and reopened “post-aggravation rights” new/omitted medical conditions (T1 through L2 fusion; post-operative degenerative disc disease at L2-3; thoracic spine instability T1-11; and lower lumbar instability at L2-3) on which the October 2012 and December 2014 claim closures are based explicitly include the entire spinal fusion and related conditions to which we interpret Dr. Lorber’s opinion to be addressing.

Therefore, this record does not persuasively support the proposition that claimant’s disability and inability to work were due to a worsening of her previously accepted conditions. *See Ferguson*, 64 Van Natta at 2325 (the claimant’s disability and inability to work were not due to a worsening of the previously accepted conditions where record established that impairment was due to conditions that were ultimately determined compensable as “post-aggravation

rights” new/omitted medical conditions). Furthermore, our review of the record leads us to conclude that claimant is entitled to a PTD award. We reason as follows.

In September 2011, Dr. Lorber reported that claimant was unable to perform regular work due to her spinal condition, noting that she would likely miss several days or more per month on an unpredictable basis, as well as having to leave work early on an unpredictable basis several times per month. (Ex. 160-1). He also reported that she would need to take breaks outside the standard break schedule allowed in an eight hour shift to walk and move around and would likely need a stand/sit option. He noted that her pain would impact her concentration, persistence and pace in a competitive work environment. (*Id.*) Although he felt that she was capable of part-time or modified work that would accommodate her hours and physical restrictions, Dr. Lorber believed that she still would be subject to unpredictable absences due to her symptoms. (Exs. 161-2, 163).

In his February 2014 deposition, Dr. Lorber reiterated that claimant was limited to part-time work and would have problems with absenteeism and scheduling. (Ex. 178-64). He explained that claimant had the same limitations on her physical capacity since he began treating her in 2002. (Ex. 178-53-54). He felt that she was permanently totally disabled when he started treating her in 2002, although she was working part-time then.⁹ (Ex. 178-54-55).

Furthermore, in April 2015, Mr. Potocki, a vocational rehabilitation consultant, evaluated claimant’s employability based, in part, on Dr. Lorber’s opinion, including his February 2014 deposition. (Ex. 192). Mr. Potocki considered that, although claimant could possibly perform part-time work, Dr. Lorber’s restrictions presented an extremely limited medical profile.¹⁰ (Ex. 192-3). Based on those restrictions, Mr. Potocki concluded that claimant was not capable of working in a “gainful occupation” nor would she be able to attain “gainful

⁹ In response to a question regarding his 2007 statement that he was “surprised that she’s not permanent total already,” Dr. Lorber stated: “So I think she’s probably been, by definition standards, permanent total. Certainly, if she could handle her work three hours a day, three days a week, God bless her. Go for it.” (Ex. 178-55).

¹⁰ Specifically, Mr. Potocki noted that Dr. Lorber opined that claimant would likely “miss several days or more a month on an unpredictable basis...probably have to go home early on an unpredictable basis at least several times a month....need the option to take breaks outside the standard breaks allowed....likely need a sit/stand option for tolerance....her pain could impact her concentration, persistence, and pace in a competitive work environment.” (Ex. 192-3).

employment earnings.” (*Id.*) He stated that, from a vocational standpoint, it would be futile for claimant to seek employment competitively in the labor market based on Dr. Lorber’s restrictions. (*Id.*) Mr. Potocki’s opinion is unrebutted.

Based on the opinions of Dr. Lorber and Mr. Potocki, we are persuaded that claimant’s physical impairment (attributable to the previously accepted conditions, for which claimant was awarded 32 percent unscheduled PPD, and the new/omitted medical conditions, on which these claim closures are based), combined with her vocational factors, effectively prohibits her from gainful employment under the “odd lot” doctrine. *Daly*, 58 Van Natta at 2368.

Finally, we turn to claimant’s work force status. In an April 2015 affidavit, she attested that she did not retire from the work force. (Ex. 194-1). She stated that, although she began receiving Social Security disability benefits in November 2007, those benefits were not what she wanted. Instead, she attested that she wanted to continue to work until she was 65 (or as long as possible), and that she remains willing to work. (*Id.*) She stated that she would work if she could, but due to her back pain and instability, she cannot maintain a reliable work schedule. (*Id.*)

In addition, in 2002, at a time when Dr. Lorber considered claimant permanently totally disabled, she was working part-time at a retail tobacco store. (Ex. 192-2). She continued working at this job until 2007, when she began receiving Social Security disability benefits. (*Id.*, Ex. 194-1).

Based on this record, including claimant’s persuasive, unrebutted affidavit, we are persuaded that she is “willing to seek regular gainful employment” and that she has “made reasonable efforts to obtain such employment.” ORS 656.206(3) (2005); *SAIF v. Stephen*, 308 Or 41, 48 (1989); *Elsea*, 277 Or App at 482-84. Claimant is therefore entitled to PTD benefits.

Accordingly, we modify the October 5, 2012 and December 31, 2014 Own Motion Notices of Closure, to award PTD, effective as of March 13, 2008 (claimant’s medically stationary date).¹¹

¹¹ The parties do not dispute that the conditions that resulted in permanent disability were medically stationary as of March 13, 2008. (Ex. 168). Furthermore, although finding claimant’s L2-3 instability to be medically stationary as of December 14, 2013, Dr. Lorber did not consider that instability to have added to her permanent impairment. (Exs. 178-66, 179A, 181).

Because our decision results in increased compensation, claimant's counsel is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed \$12,500, to be paid out of the permanent total disability award, payable directly to claimant's counsel. ORS 656.386(2); OAR 438-015-0040(2); OAR 438-015-0080(3).

IT IS SO ORDERED.

Entered at Salem, Oregon on September 16, 2016