
In the Matter of the Compensation of
MARTIN BURNETTE, Claimant
WCB Case No. 13-06231
ORDER ON REVIEW
Julene M Quinn LLC, Claimant Attorneys
Holmes Weddle & Barcott PC, Defense Attorneys

Reviewing Panel: Members Johnson and Weddell.

Claimant requests review of Administrative Law Judge (ALJ) Ogawa's order that: (1) allowed the insurer to amend the issues to include a "combined condition" theory for its denial; (2) admitted a "redacted" copy of the nurse case manager's computer notes and reports to the insurer's claim administrator; (3) admitted, in their entirety, a physician's deposition and another physician's report, both of which addressed a "combined condition"; (4) upheld the insurer's denial of claimant's injury claim for a right foot/toe condition; and (5) declined to award penalties/attorney fees for allegedly unreasonable claim processing. In its respondent's brief, the insurer challenges the ALJ's admission of a prescription card/letter and a physician's report (which included the physician's recollection of comments from the nurse case manager, who attended claimant's medical visit). On review, the issues are the ALJ's procedural and evidentiary rulings, back-up denial, compensability, penalties, and attorney fees.

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

Claimant, a self-employed delivery truck driver, contracted with a home improvement store to deliver appliances to its customers. (Tr. II-71). On October 7, 2013, his right foot slipped and "popped" as he stepped out of the truck. (Tr. II-72, -75). His foot became swollen and he thought he had sprained his ankle. (Tr. II-79).

On October 18, 2013, claimant visited an urgent care clinic for bleeding from the bottom of his right foot. (Ex. 3-1). A physician's assistant diagnosed extensive cellulitis with abscess over a fracture dislocation of the right mid foot and directed claimant to go to the emergency room. (Ex. 3-2). Claimant called the insurer, stating that he did not have a primary care physician and did not know what to do. (Ex. 1A-19). The insurer gave claimant a claim number, directed him to go to the emergency room, and told him that he would hear from a claim adjuster. (Tr. II-82; Ex. 1A-19).

At the emergency room, Dr. Lin, an orthopedist, diagnosed a right foot plantar abscess/ulcer beneath chronic Charcot midfoot rocker bottom deformity, and right fifth toe abscess/ulcer. (Exs. 8, 9A). Dr. Lin drained the abscesses and performed right foot irrigation and debridement. (Ex. 9A).

On October 21, 2013, the insurer's claim administrator interviewed claimant. (Ex. 1A-16). Claimant stated that he had diabetes and "couldn't feel [his] feet."¹ (Ex. 1A17). The administrator referred the claim to Ms. Versteeg, a nurse case manager employed by Genex Services, Inc., to obtain medical information and assist in the coordination of claimant's care.² (Tr. I-60, -105; Exs. 1A-15, 29A).

On October 22, 2013, the administrator sent claimant a "welcome letter," which acknowledged receipt of the claim, explained the claim process, and advised that upon completion of an investigation, he would be notified in writing whether his claim was being accepted or denied.³ (Ex. 20B). The administrator also triggered the issuance of a prescription drug card.⁴ (Ex. 1A-10).

On November 5, 2013, claimant followed-up with Dr. Lin. (Ex. 38-1). Ms. Versteeg attended the appointment. (Ex. 1A-1). Dr. Lin found an ongoing deep infection in the right fifth toe and recommended amputation. (Ex. 38-1). He obtained the insurer's authorization and performed the surgery the following day. (Exs. 39A, 42).

¹ Claimant was previously diagnosed with type 2 diabetes when he had development of a foot ulcer. (Ex. H-1). He was also diagnosed with diabetic neuropathy. (Ex. H-4).

² Genex Services, Inc. was under contract with the insurer to provide managed care services to the insurer's policyholders/claimants. (Ex. 62).

³ The letter stated, "**THIS IS NOT AN ACCEPTANCE OF YOUR CLAIM. YOUR CLAIM WILL REMAIN IN A DEFERRED STATUS UNTIL WE NOTIFY YOU OF OUR DECISION.**" (Ex. 20B-2) (emphasis in original).

⁴ Cypress Care mailed the prescription drug card on November 7, 2013. (Ex. 46B-1). A letter accompanying the card stated that the insurer had selected Cypress Care to assist claimant in acquiring prescription drugs. (*Id.*) The letter further stated that the card had been authorized for claimant's current workers' compensation prescriptions and any new prescriptions from his authorized workers' compensation physician. (*Id.*)

On December 3, 2013, the insurer's claim administrator issued a denial, asserting that the work incident was not a material contributing cause of claimant's disability and need for treatment. (Ex. 49). Claimant requested a hearing.

On February 17, 2014, Dr. Yodlowski, an orthopedic surgeon, performed an examination at the insurer's request. Dr. Yodlowski diagnosed a right foot Charcot arthropathy with fragmentation, fracturing, and dislocation across the midfoot, a plantar ulcer centered at the rocker bottom deformity, amputation of the right fifth toe, and diabetic neuropathy. (Ex. 56A-13). She concluded that the work event was not a material contributing cause of any of the diagnoses or of claimant's need for treatment/disability. (Ex. 56A-15, -16). She also opined that the preexisting condition was solely responsible for the development of claimant's Charcot foot (which she identified as "arthritis") and ulcer. (*Id.*)

On February 29, 2014, Dr. Lin concluded that claimant's right fifth toe infection and right foot abscess were caused by his diabetes and neuropathy. (Ex. 57-2).

On March 18, 2014, Dr. Lin opined that claimant's "industrial shoes" may have contributed to the fifth toe abscess and resulting amputation. (Ex. 57A-1). He also recalled that Ms. Versteeg attended an office visit and was "very reassuring and relayed that the surgery would be covered as part of the workers compensation claim." (Ex. 57A-2).

On March 27, 2014, Dr. Lin concurred with Dr. Yodlowski's findings and conclusions. (Ex. 59).

In a June 17, 2014 deposition, Dr. Lin testified on cross-examination that, if claimant heard a "pop of some kind," he had probably sprained his foot. (Ex. 60-15). Dr. Lin further surmised that the work incident may have made the Charcot condition worse, which may have contributed to the development of the ulcer and abscess, the need for surgery, and the infection in the fifth toe.⁵ (Ex. 60-48).

During a June 23, 2014 conference call with the ALJ and claimant's attorney, the insurer's counsel asserted a "combined condition" defense based on Dr. Lin's deposition. At the June 24, 2014 hearing, the ALJ allowed the insurer's

⁵ The deposition was not completed due to time constraints. (Ex. 60-37).

oral amendment to its denial, raising the “combined condition” defense, over claimant’s objection.⁶ (Tr. I-5). The ALJ also allowed a continuance of the hearing for the insurer’s redirect and re-cross examination of Dr. Lin and Dr. Yodlowski’s rebuttal on the “combined condition” defense. (Tr. I-31, -32).

In addition, the ALJ admitted a “redacted” copy of Ms. Versteeg’s computer notes and reports (over claimant’s objection) and Dr. Lin’s March 18, 2014 report (over the insurer’s hearsay objection to his recollection of Ms. Versteeg’s statements about workers’ compensation coverage for claimant’s toe amputation). (Tr. I-8, -9, -10, -12, -31, -32; Exs. 57A, 58). After the presentation of testimony from Ms. Versteeg and some of the witnesses, the hearing was continued.⁷

On redirect examination in an August 19, 2014 continuation of his deposition, Dr. Lin opined that the work incident contributed 20 percent or less to claimant’s need for treatment. (Ex. 60-82, -85). He also opined that the work injury combined with the preexisting condition (*i.e.*, the diabetes associated with peripheral neuropathy resulting in Charcot arthropathy and rocker bottom deformity) and was never the major cause of claimant’s need for treatment/disability of the combined condition. (Ex. 60-88).

On September 24, 2014, after reviewing Dr. Lin’s deposition transcript, Dr. Yodlowski maintained that the work injury was not a material cause of claimant’s right foot conditions, need for treatment, or disability. (Ex. 61-2). Alternatively, she agreed with his opinion that the work injury combined with preexisting conditions to cause disability/need for treatment and was never the major contributing cause of the disability/need for treatment of the combined condition. (Ex. 61-3).

At the continued hearing, claimant objected to the admission of Dr. Lin’s redirect/re-cross examination deposition and Dr. Yodlowski’s report.⁸ The ALJ deferred ruling on their admissibility until issuing an order. (Tr. II-3). The ALJ

⁶ In opposing the insurer’s motion to amend its denial, claimant’s counsel argued that the evidence did not support a combined condition and that, under OAR 438-006-0055, a denial was required to be in writing, state its factual and legal bases, and include hearing rights. (Tr. I-2, -3, -6).

⁷ Witness testimony was not completed due to time constraints. (Tr. I-154).

⁸ Claimant’s counsel objected to the admission of Dr. Lin’s redirect examination on the ground that it exceeded the scope of cross-examination. (Tr. II-1). Specifically, claimant’s counsel objected to those questions that addressed a combined condition, arthritis, and major contributing cause. (Tr. II-1,

admitted into evidence, over claimant's objection, a "welcome letter" submitted by the insurer, and allowed claimant's request for discovery of the prescription card/letter. (Tr. II-10, -12, -17; Ex. 20B). Additional testimony was taken, but was not completed in the time allocated for the hearing. (Tr. II-185).

At a third hearing date, the ALJ admitted, over the insurer's timeliness objection, a prescription card/letter that had been in claimant's possession from the outset of the initial hearing.⁹

In upholding the insurer's denial, the ALJ determined that Ms. Versteeg was not the insurer's agent and concluded that neither her acts nor those of the insurer/claim administrator resulted in an acceptance of the claim or estopped the insurer from denying the claim. The ALJ also concluded that the medical evidence did not persuasively establish that the work incident was a material contributing cause of the disability/need for treatment of claimant's right foot condition. In addition, the ALJ admitted Dr. Lin's deposition and Dr. Yodlowski's rebuttal report in their entirety. The ALJ relied on their opinions in alternatively determining that the insurer had proved that claimant's "combined condition" was not compensable. Lastly, the ALJ found that penalties or attorney fees were not justified.

On review, claimant challenges the ALJ's evidentiary rulings regarding the admission of the "redacted" nurse case manager's computer notes/reports, Dr. Lin's deposition, and Dr. Yodlowski's report. He maintains that the insurer's acts and those of Ms. Versteeg, its alleged agent, resulted in an acceptance of his claim and an impermissible "back-up" denial. He also contests the ALJ's procedural ruling allowing the insurer to orally amend its denial at hearing to raise a "combined condition" defense and submit evidence concerning the combined condition. Claimant contends that the material contributing cause standard applies and relies on Dr. Lin's opinion to satisfy his burden of proof. The insurer

-2). Claimant's counsel's objection to the admission of Dr. Yodlowski's report asserted that Dr. Lin's testimony did not "trigger" a right to rebuttal. (Tr. II-2). Claimant's counsel also submitted written objections to the admission of Dr. Yodlowski's report, asserting that Dr. Yodlowski's rebuttal of Dr. Lin's material contributing cause opinion was not allowed and her remarks regarding his major contributing cause opinion were cumulative. (Hearing File).

⁹ The insurer's counsel argued that the prescription card/letter should have been submitted earlier. (Tr. III-2). In overruling the insurer's objection, the ALJ reasoned that the insurer's counsel should have earlier raised the objection when it was directed to procure the card and that the document was relevant concerning penalty issues. (Tr. III-5, -9).

challenges the ALJ's admission of the prescription card/letter and that portion of Dr. Lin's report that describes Ms. Versteeg's statements about workers' compensation coverage for claimant's fifth toe amputation.

For the following reasons, we find no abuse of discretion in the ALJ's rulings and conclude that the insurer satisfied its burden to prove that the otherwise compensable injury was not the major contributing cause of claimant's disability/need for treatment of the combined right foot condition.

Procedural Ruling

Claimant contends that the amended denial is a "nullity" because it did not conform to the Board's rules requiring that a denial be in writing, served by registered or certified mail, and provide 60 days appeal rights. *See* OAR 438-005-0055(1); OAR 438-005-0065. Claimant also argues that the Board's rule allowing issues to be raised during the hearing does not negate the "due process" requirements of a denial. *See* OAR 438-006-0031. For the following reasons, we disagree with claimant's contentions.

It is well settled that a carrier may amend its denial at hearing. *See SAIF v. Ledin*, 149 Or App 94 (1997) (a carrier may amend its denial at hearing); *Pamela S. Smith*, 51 Van Natta 828, 829 (1999) (rejecting the claimant's argument that the carrier's mid-hearing attempt to amend the denial was improper under OAR 438-005-0055). The opportunity to respond to newly raised issues affords due process. OAR 438-006-0036; OAR 438-006-0091; *Larry L. Ledin*, 50 Van Natta 115, 117 (1998).¹⁰

Here, claimant's hearing request concerned the insurer's denial, which asserted only that the work incident was not a material contributing cause of the disability/need for treatment. (Ex. 49). The opinions of Drs. Lin and Yodlowski (which indicated that claimant's right foot condition was not materially related to the work injury) supported the denial. (Exs. 56A-15, 57-2). Dr. Lin's subsequent cross-examination testimony at deposition (that claimant had probably sprained his foot, which led to the development of the wound on the bottom of his foot) and written statement (that the treatment for the fifth toe "has a material relationship") supported the existence of an "otherwise compensable injury" and shifted the

¹⁰ Claimant filed his hearing request on December 16, 2013. (Hearing File). Therefore, the former versions of this and the other administrative rules apply. (WCB Admin. Order 2-2013 eff. 4/1/14).

burden to the insurer to prove that the otherwise compensable injury was not the major contributing cause of the disability/need for treatment of the combined condition. (Ex. 60-15, -29, -48). *See* ORS 656.266(2)(a).

Considering the aforementioned evidence, we find no abuse of discretion in the ALJ's allowance of the insurer's amendment of its denial to include a "combined condition" defense. In reaching this conclusion, we note that claimant did not seek a continuance of the hearing or other opportunity to respond to the newly raised issues. (Tr. I-6). Therefore, after considering the ALJ's evidentiary rulings, we address the merits of the amended denial.

Evidentiary Rulings

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. ORS 656.283(6). The ALJ has broad discretion on determinations concerning the admissibility of evidence. *See Id.; Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for an abuse of discretion. *SAIF v. Kurcin*, 334 Or 399 (2002). For the following reasons, we find no abuse of discretion in the ALJ's evidentiary rulings.

Claimant challenges the ALJ's admission of a "redacted" copy of Ms. Versteeg's computer notes and reports to the claim administrator. (Ex. 58). Claimant argues that Ms. Versteeg reviewed the redacted documents in preparing for her testimony, which waived any "discovery privilege."¹¹

On June 14, 2014, ten days before the scheduled June 24 hearing, claimant's counsel submitted Exhibit 58, which had been redacted, for admission into the record. (Hearing File). On June 17, 2014, in response to claimant's counsel's objection to the redaction, the insurer's counsel sent the ALJ copies of the disputed exhibit, with and without redaction. (*Id.*) On June 23, 2014, the insurer's counsel also sent the ALJ copies of claim notes. (*Id.*) After conducting an *in camera* review, the ALJ redacted copies of e-mails between the insurer's attorney and the claim administrator, as well as those reflecting the administrator's thought processes. (Tr. I-10, -11). *See* OAR 438-007-0015(7) (materials that are "attorney-client privileged" or reflect the claimant's or insurer's mental impressions, case value or merit, plans or thought processes are not discoverable).

¹¹ Ms. Versteeg acknowledged that she had reviewed her electronic file in preparation for her testimony, whereupon claimant's counsel requested discovery of the document. (Tr. I-110). Claimant's counsel ultimately stated that she would issue a subpoena. (Tr. I-151).

At hearing, Ms. Versteeg acknowledged that she reviewed her electronic file in preparation for her testimony, whereupon claimant's counsel requested discovery of the documents that Ms. Versteeg had reviewed. (Tr. I-145). Claimant's counsel ultimately stated that she would subpoena Ms. Versteeg's file. (Tr. I-151). The record does not indicate that a subpoena issued or that further discussion concerning Ms. Versteeg's file occurred before the ALJ closed the evidentiary record (without objection from the parties). Under these circumstances, we find no error in the ALJ's admission of Exhibit 58.

Next, claimant challenges the admissibility of those portions of Dr. Lin's deposition and Dr. Yodlowski's report that address the insurer's "combined condition" defense. (Exs. 60, 61). Claimant also argues that Dr. Yodlowski's report improperly addressed the material contributing cause of claimant's right foot conditions and need for treatment and was cumulative, not rebuttal evidence.

In allowing the insurer to amend its denial to raise the "combined condition" defense, the ALJ also allowed it to obtain evidence to satisfy its burden of proof under ORS 656.266(2)(a) by cross-examining Dr. Lin and obtaining Dr. Yodlowski's rebuttal report. (Tr. I-30, -33). In doing so, the ALJ reasoned that the insurer was entitled to the last presentation of evidence on its burden to prove that the otherwise compensable injury was not the major contributing cause of the need for treatment of the combined condition. *See SAIF v. Kollias*, 233 Or App 499, 505 (2010).

We find no abuse of discretion in the ALJ's rulings regarding those portions of Dr. Lin's cross-examination deposition and Dr. Yodlowski's report that addressed the "combined condition" defense. Further, in evaluating the medical evidence, as discussed below, we confirm claimant's right to the last presentation of evidence regarding his burden to prove an "otherwise compensable injury." OAR 438-007-0023. Accordingly, in conducting our review, we do not consider those portions of Dr. Yodlowski's rebuttal report that addressed material causation.

The insurer objects to the admission of the prescription drug card/letter. In admitting the document into the record, the ALJ reasoned that although claimant's submission was untimely, the insurer had not shown material prejudice. *See* OAR 438-007-0018(5). The insurer argues that the "material prejudice" requirement does not apply because the disputed document is not a "document pertaining to the claim." *See* OAR 438-007-0015(5). For the following reasons, we disagree with the insurer's contentions.

OAR 438-007-0015 pertains to disclosure requirements. Under OAR 438-007-0018(5), the ALJ has the discretion to allow the admission of “other documentary evidence not disclosed as required by OAR 438-007-0015” subject to a material prejudice determination.

Here, the ALJ allowed claimant to procure and submit the prescription card/letter in conjunction with the admission of the insurer’s “welcome letter.” The ALJ determined that the documents were relevant to the “alleged acceptance/back-up denial” issue. Under these circumstances, we find no abuse of discretion in the ALJ’s admission of the prescription card/letter.

Lastly, the insurer challenges the ALJ’s ruling concerning that portion of Dr. Lin’s report that referred to Ms. Versteeg’s statement. (Ex. 57A). Admitting Dr. Lin’s report over the insurer’s hearsay objection, the ALJ stated that Dr. Lin’s deposition and Ms. Versteeg’s testimony would be reviewed in determining how much weight to give Dr. Lin’s report. (Tr. I-17). In its closing argument, the insurer withdrew its hearsay objection, but maintained that Ms. Versteeg was not an agent of the insurer and, therefore, her statements were not a party admission. (Hearing File).

In discussing the admissibility of Exhibit 57A, the ALJ’s order found that Ms. Versteeg was not an agent of the insurer and, therefore, her statement as recalled by Dr. Lin was not a party admission. The ALJ’s order also reasoned that the insurer had cross-examined Dr. Lin on Exhibit 57A.

On review, asserting that it did not cross-examine Dr. Lin on Exhibit 57A, the insurer contends that the last paragraph of Exhibit 57A (which described Ms. Versteeg’s statements about workers’ compensation coverage for claimant’s fifth toe amputation) should not be admitted. We disagree with the insurer’s contention.

Under ORS 656.310(2), the disputed medical report “constitute[s] prima facie evidence as to the matter contained therein * * * provided that the doctor rendering [the] report consents to submit to cross-examination.” Here, Dr. Lin consented to cross-examination. Therefore, we find no abuse of discretion in the admission of Exhibit 57A in its entirety. *See Julie Gatlin*, 61 Van Natta 2766, 2768 (2009) (finding no abuse of discretion when the ALJ admitted medical report including hearsay where the physician writing the report consented to cross-examination).

Acceptance/Equitable Estoppel

We agree with the ALJ's reasoning and conclusion that neither the insurer's actions nor those of Ms. Versteeg constituted an acceptance of the claim or estopped the insurer from denying the claim. For equitable estoppel to apply, there must be (1) a false representation, (2) made with knowledge of the facts, (3) with the intent that the other party rely, (4) when the other party was ignorant of the truth, and (5) the other party must have been induced to rely upon the representation to his or her detriment. *Day v. Advanced M&D Sales, Inc.*, 184 Or App 260, 264-65 (2002). The law is well settled that merely paying or providing compensation does not constitute acceptance of a claim or a "false representation" of liability. See ORS 656.262(10); *Arthur D. Roppe*, 61 Van Natta 1391 (2009), *aff'd without opinion*, 241 Or App 352 (2011) (the carrier's payment of medical benefits, including a surgery and subsequent treatment, did not constitute an acceptance of the conditions involved in that surgery and treatment). Therefore, we adopt the ALJ's reasoning that the insurer did not accept the claim or issue a "back-up" denial and was not estopped from denying the claim.

Compensability

To establish the compensability of his injury claim, claimant has the initial burden to prove that his work injury was a material contributing cause of disability or need for treatment. ORS 656.005(7)(a); ORS 656.266(1); *Albany Gen. Hosp. v. Gasperino*, 113 Or App 411, 415 (1992). The need for treatment includes diagnostic or other medical services. *K-Mart v. Evenson*, 167 Or App 46, 51-52 (2000). Claimant must prove both legal and medical causation by a preponderance of the evidence. *Harris v. Farmer's Co-op Creamery*, 53 Or App 618, *rev den*, 291 Or 893 (1981); *Carolyn F. Weigel*, 53 Van Natta 1200 (2001), *aff'd without opinion*, 184 Or App 761 (2002). Legal causation is established by showing that claimant engaged in potentially causative work activities and hinges principally on his credibility/reliability; whether those work activities caused claimant's condition is a question of medical causation. *Darla Litten*, 55 Van Natta 925, 926 (2003).

If claimant carries his initial burden, and the "otherwise compensable injury" combined with a "preexisting condition" to cause or prolong disability or a need for treatment, the insurer must prove that the otherwise compensable injury was not the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); ORS 656.266(2)(a); *Kollias*, 233 Or App at 505; *Jack G. Scoggins*, 56 Van Natta 2534, 2535 (2004). For injury claims,

a “preexisting condition” is an injury, disease, or condition that contributes to disability or need for treatment, which has been diagnosed or treated before the injury or is arthritis or an arthritic condition. ORS 656.005(24)(a).

Considering the complicated nature of claimant’s right foot condition and the possible alternate causes, the claim presents a complex medical question that must be resolved by expert medical opinion. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993). We give more weight to those opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

We adopt the ALJ’s reasoning concerning claimant’s credibility/reliability and conclude that legal causation was established. As to medical causation, we conclude that even if the work event was a material contributing cause of claimant’s disability/need for treatment, the medical evidence persuasively establishes that the “otherwise compensable injury” combined with a “preexisting condition” to cause or prolong disability or a need for medical treatment and was not the major contributing cause of the disability/need for treatment of the combined condition. We reason as follows.

There are two medical opinions that address causation: that of Dr. Lin, claimant’s treating orthopedic surgeon, and Dr. Yodlowski, an orthopedic surgeon who performed an examination at the insurer’s request.

Dr. Lin opined that claimant’s diabetes, associated peripheral neuropathy, Charcot arthropathy, and rocker bottom deformity are preexisting conditions that combined with the work injury incident to cause or prolong claimant’s need for treatment/disability. (Ex. 60-86, -87, -88). In asking Dr. Lin whether claimant had “preexisting conditions,” the insurer’s counsel informed him that “preexisting condition” means an injury or a disease, a congenital abnormality, or a similar condition that contributes to the need for treatment or disability and was diagnosed or its symptoms were treated before the injury, or arthritis. (Ex. 60-78). Dr. Lin responded that claimant’s diabetes and diabetic neuropathy satisfied these criteria. (Ex. 60-78, 79). The record also shows that claimant was previously diagnosed with type 2 diabetes and neuropathy. (Ex. H-4).

Dr. Lin further explained that diabetes causes poor circulation, weakening the bone and resulting in disintegration of the bones and joints in the foot and ankle, Charcot arthropathy, and arthritis. (Exs. 57-2, 60-80). He stated that “there was definitely arthritis with destruction at the joint level” and inflammation in the joint. (Ex. 60-108, -109). Dr. Lin’s opinion is supported by that of Dr. Yodlowski

who, when provided with the definition of “arthritis,” stated that Charcot arthropathy “refers to a severe form of arthritis resulting in disintegration and destruction with breakdown of the joints in the foot.” (Ex. 56A-15).

We conclude that these un rebutted opinions are sufficient to establish that claimant’s Charcot arthropathy is “arthritis.” *See Schleiss v. SAIF*, 354 Or 637, 652-53 (2013) (defining “arthritis” to mean the “inflammation of one or more joints, due to infectious, metabolic, or constitutional causes, and resulting in breakdown, degeneration, or structural change”); *Hopkins v. SAIF*, 349 Or 348, 364 (2010) (same).

Dr. Lin’s opinion explained how claimant’s preexisting diabetes and Charcot arthropathy combined with the injury and contributed to the disability and need for treatment of the combined condition. He reasoned that stepping down from the truck would be unlikely to cause the severe deformity in claimant’s foot, but the injury could have caused soft tissue swelling and enlarged the foot, resulting in increased pressure and friction within claimant’s shoe and blistering. (Ex. 60-88, -97). He surmised that claimant’s diabetic neuropathy caused him to delay seeking treatment, which would have prevented the development of infection and need for surgery. (Ex. 60-88, -89).

Based on Dr. Lin’s persuasive explanation, we find that claimant’s preexisting diabetes and Charcot arthropathy were an active, rather than a passive, contributor to claimant’s disability/need for treatment and, as such, did not merely render claimant more susceptible to an injury. *See* ORS 656.005(24)(c); *Corkum v. Bi-Mart Corp.*, 271 Or App 411, 422 (2015) (“the text, context, and legislative history of ORS 656.005(24)(c) show that a condition merely renders a worker more susceptible to injury if the condition increases the likelihood that the affected body part will be injured by some other action or process and does not actively contribute to damaging the body part”); *Shelby J. Vantassel*, 66 Van Natta 559, 601-02 (2014) (a medical report explaining how the preexisting conditions contributed to the disability and need for treatment persuasively established more than a mere susceptibility); *cf. William J. Merrill*, 63 Van Natta 2498, 2502 (2011) (a medical opinion that the claimant’s artificial knee rendered him less able to resist a bacterial infection, established a “predisposition” as opposed to a statutory “preexisting condition”).

Lastly, Dr. Lin opined that the work injury was never the major cause of claimant’s disability/need for treatment of the combined condition. (Exs. 60-88). In drawing that conclusion, he considered the mechanism of injury and the severe

deformity in claimant's foot and weighed the contribution from preexisting conditions against the work injury. (Ex. 60-89). We find Dr. Lin's opinion to be well reasoned, based on complete information, and persuasive.

Dr. Lin's opinion is supported by that of Dr. Yodlowski. Although Dr. Yodlowski initially opined that the work event was neither a major contributing cause nor any cause of a combined condition, when she was asked to assume that there was an otherwise compensable injury, she agreed with Dr. Lin's opinion that the injury would have combined with claimant's preexisting conditions to cause the disability/need for treatment and was never the major cause of the disability/need for treatment of the combined condition. (Exs. 56A-16, 61-3).

Therefore, the opinion of Dr. Lin, supported by that of Dr. Yodlowski, satisfies the insurer's statutory burden. Accordingly, we affirm the ALJ's order upholding the insurer's denial.

Penalties/Attorney Fees

Finally, claimant seeks penalties and attorney fees for an unreasonable denial. The ALJ concluded that such an award was not warranted. For the following reasons, we adopt the ALJ's conclusion.

If a carrier unreasonably delays or refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, it shall be liable, under ORS 656.262(11)(a), for a penalty up to 25 percent of any amounts then due, plus an assessed attorney fee. Whether a denial was an unreasonable resistance to the payment of compensation depends on whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. *Int'l Paper Co. v. Huntley*, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988).

Here, we are persuaded that the insurer had a legitimate doubt when it issued its denial. The claim administrator interviewed claimant and his brother and reviewed claimant's medical records. (Tr. II-168; Exs. 1A, 20A). There were varying descriptions of the injury incident and treatment for nonwork-related conditions. (Tr. III-77). Dr. Lin's initial diagnoses and treatment referred to chronic conditions rather than an acute injury. (Exs. 8, 9A, 11). Therefore, we

conclude that when the denial issued, there was evidence that raised a legitimate doubt about the insurer's liability. Accordingly, we find no basis to award a penalty for an unreasonable resistance to the payment of compensation.

ORDER

The ALJ's order dated September 14, 2015 is affirmed.

Entered at Salem, Oregon on August 5, 2016