

In the Matter of the Compensation of  
**DOMINGO RIVAS, Claimant**

WCB Case No. 15-01256

ORDER ON REVIEW

Johnson Johnson & Schaller, Claimant Attorneys  
Michael G Bostwick LLC, Defense Attorneys

Reviewing Panel: Members Curey and Lanning.

Sedgwick Claims Management Services (Sedgwick), the assigned claims agent under ORS 656.054(1), requests review of Administrative Law Judge (ALJ) McWilliams's order that set aside its denial of claimant's new/omitted medical condition claim for a left shoulder labral tear. On review, the issue is compensability.

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

On April 10, 2013, claimant was involved in a work-related motor vehicle accident (MVA) when he lost control of his vehicle after a tire blew out. (Ex. 4). Later that same day, claimant sought emergency medical treatment. Pain in the left shoulder was noted and a shoulder immobilizer was provided. (Ex. 1).

On April 22, 2013, Dr. Ackerman, claimant's treating physician, reported tenderness in the left rhomboid area. (Ex. 3). He diagnosed a left rhomboid strain and bilateral small corneal abrasions. (Ex. 3-2).

Claimant filed an 801 form reporting injuries to his neck, back, shoulder, lower back, left knee, and both eyes as a result of the MVA. (Ex. 5).

On May 6, 2013, Dr. Ackerman documented "point tenderness" around the left medial scapular border. (Ex. 7-1). Claimant, who was referred for physical therapy, continued to report pain in his left shoulder. (Exs. 8, 11-2-3, 12).

On June 21, 2013, Dr. Ackerman noted "pain in the left rhomboid area along the medial scapular border" with occasional "radiating pain into the shoulder itself and partially down in the arm." (Ex. 14-1). Dr. Ackerman continued to diagnose a left rhomboid strain and a lumbar strain. (*Id.*)

On July 29, 2013, claimant's claim was accepted for a left rhomboid strain, lumbar and thoracic sprains, and bilateral corneal abrasions. (Ex. 18).

A December 2013 MRI showed “[l]inear signal irregularity involving the anterior and superior glenoid labrum.” (Ex. 34). If symptoms persisted, a shoulder arthrogram was recommended to exclude a labral tear. (*Id.*)

On December 24, 2013, Dr. Ackerman reported that claimant prioritized his pains as follows: (1) left scapular pain; (2) the left shoulder joint itself; (3) the left arm itself with tingling in the upper arm; and (4) pain in the lumbar region. (Ex. 35-1). Dr. Ackerman reviewed claimant’s MRI and noted that it showed “[i]rregularity of the glenoid labrum possibly indicating a tear.” (Ex. 35-1).

On January 17, 2014, Dr. Ackerman reported that claimant’s pain was primarily in the left shoulder. (Ex. 37-1). Dr. Ackerman referred claimant for an orthopedic evaluation due to the MRI findings and his relative lack of progress. (*Id.*)

In June 2014, at Sedgwick’s request, Dr. Strum, an orthopedic surgeon, and Dr. Green, a neurologist, examined claimant and reviewed his medical records. (Ex. 40). Acknowledging claimant’s accepted conditions, with regard to the left shoulder, they also diagnosed “preexisting moderate degree of degenerative joint disease of the acromioclavicular joint” and “preexisting mild degree of degenerative tendinopathy of the supraspinatus tendon portion of the rotator cuff.” (Ex. 40-16). Despite finding decreased range of motion in the left shoulder, they observed that claimant’s symptoms were not anatomically consistent with the degree and nature of the underlying preexisting pathology identified through the imaging studies. (Ex. 40-17). With respect to the left shoulder, they concluded that there were no true objective findings. (*Id.*) They agreed with Dr. Ackerman that claimant’s accepted conditions of left rhomboid strain, thoracic sprain, and lumbar sprain were medically stationary as of October 28, 2013. (Ex. 40-19).

Dr. Ackerman continued to treat claimant. (Exs. 47, 49). On November 24, 2014, Dr. Ackerman diagnosed left shoulder tendinosis, and indicated that claimant “may have a SLAP tear of the anterior and superior labrum,” which he did not think had been addressed at all, as well as the symptomatic left rhomboid strain. (Ex. 49-1).

A January 2015 arthrogram showed a “SLAP tear of the superior glenoid labrum with probable extension into the anterior and small portion of the posterior labrum.” (Ex. 53).

On January 16, 2015, at Sedgwick's request, Dr. DiPaola examined claimant and reviewed his medical records. (Ex. 56). Dr. DiPaola reported that claimant's "initial presentation and description of his symptoms were excessive and the pattern of pain and radiation was non-anatomic; this is evidence of symptom magnification." (Ex. 56-8). Dr. DiPaola opined that claimant's "symptomatic presentation and objective findings over the course of his treatment and including today's examination are not consistent with a SLAP tear of the labrum." (*Id.*) Dr. DiPaola, however, acknowledged that the "mechanics of the trauma involved in the April 10, 2013 crash could possibly cause a labrum tear[.]" (*Id.*)

In February 2015, claimant began treating with Dr. Lamoreaux, an orthopedic surgeon. (Ex. 58-1). She described an April 10, 2013 MVA accident on the interstate when a tire blew and claimant's vehicle jackknifed and "flipped and rolled twice." (Ex. 58-1). Dr. Lamoreaux concluded that claimant had a labral tear and that the mechanism of injury with a "rollover" is "a significant mechanism for labral tear, even though he is 54 [years old] and [it] could be degenerative." (Ex. 58-2). She opined that the labral tear was "consistent with the time of onset, the pain and symptoms." (*Id.*) She recommended an intraarticular injection and more physical therapy to address claimant's "very poor" motion, before recommending surgery. (*Id.*)

On March 5, 2015, claimant requested acceptance of a left labral tear as a new or omitted medical condition. (Ex. 62). Sedgwick denied that claim.<sup>1</sup> (Ex. 63).

Following Sedgwick's denial, claimant requested a hearing.

Relying on the medical opinion of Dr. Lamoreaux, claimant's treating surgeon, the ALJ found that claimant's work-related MVA was a material contributing cause of his disability/need for treatment of the claimed left labral tear. In doing so, the ALJ discounted the opinions of Drs. Ackerman, Green, Strum, DiPaola, and Morgan, who believed that claimant's left labral tear was degenerative and preexisted the work injury.

On review, Sedgwick contends that Dr. Lamoreaux's opinion is unpersuasive and, therefore, insufficient to establish that claimant's work injury was a material contributing cause of a need for treatment for a left labral tear.

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<sup>1</sup> In its denial, Sedgwick also indicated that the accepted conditions included a left shoulder strain. (Ex. 63-1). A March 10, 2015 Corrected Updated Notice of Acceptance also included a left shoulder strain. (Ex. 65).

Moreover, Sedgwick argues that the remaining opinions are persuasive and establish that the work-related MVA was not a material cause of a left labral tear. For the following reasons, we affirm the ALJ's decision to set aside Sedgwick's denial.

To prevail on his new/omitted medical condition claim, claimant must establish that the claimed left labral tear exists and that his work injury is at least a material contributing cause of his disability/need for treatment for that condition. ORS 656.005(7)(a); ORS 656.266(1); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005).<sup>2</sup>

Because of the varying medical opinions regarding the cause of claimant's left labral tear, the compensability issue presents a complex medical question that must be addressed by expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 283 (1993). We give more weight to those opinions that are well reasoned and based on the most complete relevant information. *Somers v. SAIF*, 77 Or App 259 (1986). Absent persuasive reasons to do otherwise, we give greater weight to the opinion of a claimant's treating physician, although we may give more or less weight to the treating physician's opinion, depending on the record in each case. *Dillon v. Whirlpool*, 172 Or App 484, 489 (2001); *Weiland v. SAIF*, 64 Or App 810, 814 (1983). An attending surgeon's opinion may be given deference where the surgeon's unique opportunity to view the claimant's condition firsthand forms the basis for a causation opinion. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988).

Here, Sedgwick contends that Dr. Lamoreaux's opinion is not entitled to deference as the treating surgeon because she did not observe anything that was not depicted in the "excellent" interoperative photographs that Drs. Ackerman, Strum, and DiPaola also reviewed, giving them the same "firsthand" observations. See *Emma I. Sims*, 63 Van Natta 1198, 1202 (2011) (declining to defer to treating surgeon's opinion in light of well reasoned contrary opinions). For the following reasons, we disagree.

Dr. Lamoreaux relied on her surgical observations (which she specifically indicated were not captured in the interoperative photographs)<sup>3</sup> in opining that

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<sup>2</sup> The parties do not dispute the existence of the left labral tear.

<sup>3</sup> Dr. Lamoreaux explained that "the best inter-operative photos of the tear are numbers eight and nine" and that she could have "used the retractor to lift the tissue and expose the tear more clearly to demonstrate that it was a type 2 tear, but [she is] not accustomed to taking inter-operative photos for purposes of litigation." (Ex. 75-2). She confirmed, however, that she had observed a type 2 tear during surgery. (*Id.*)

claimant's left labral tear was acute and resulted from trauma, as opposed to a degenerative process. (Exs. 67, 68-2, 75-2). In particular, based on her surgical observations of the left labral tear, she concluded that it was a type 2 tear going on a type 4 tear, and that "these types of displaced tears are almost always caused by traumatic forces because displaced tendon tears are very unlikely to result from normal wear and tear and degeneration." (Ex. 75-2).

Considering that Dr. Lamoreaux expressly drew on her surgical observations in reaching an opinion (as well as rebutting contrary theories), we find her opinion entitled to deference. *See Robert A. Burfitt*, 65 Van Natta 2106, 2111 (2013) (treating surgeon's opinion given greater weight where he relied on his surgical observations in forming his causation opinion); *cf. Sims*, 63 Van Natta at 1202 (where the treating surgeon did not persuasively address the severity of the claimant's condition or explain how examination findings were consistent with that condition, there were persuasive reasons not to defer to the treating surgeon's opinion).

Sedgwick next contends that Dr. Lamoreaux's opinion is unpersuasive because she did not know the mechanism of injury associated with the MVA and, thus, could only "speculate" that it could have caused a left labral tear. We disagree.

Dr. Lamoreaux reviewed claimant's records and went over the mechanism of injury "in detail." (Ex. 58-1). She reported that claimant was driving when "he blew a tire" and he "jackknifed the rig, and because of that, he flipped and rolled twice." (*Id.*) That description of claimant's MVA is consistent with other accounts in the record. (Exs. 3-1, 4, 40-2, 56-1). Accordingly, we find that Dr. Lamoreaux had an accurate understanding of claimant's mechanism of injury.

Moreover, Dr. Lamoreaux specifically rebutted the theory that the mechanism of injury was insufficient to cause a left labral tear. She explained her disagreement with the "assertion that traction forces on the bicep muscle tendon or translational movements of the humerus with respect to the glenoid are the only, or even the primary, mechanism that would cause a superior labral tear." (Ex. 75-2). In Dr. Lamoreaux's opinion, "the severity of [claimant's MVA] would have involved sufficient trauma to cause the onset of a superior labral tear and the symptoms that developed as a result, which were not present prior to this trauma." (*Id.*)

Sedgwick relies on the opinions of Drs. Ackerman, Strum, DiPaola, and Morgan that the left labral tear is degenerative and preexisted the work-related MVA. For the following reasons, however, we find that Dr. Lamoreaux persuasively rebutted those opinions. We reason as follows.

Based on a review of the surgery photographs, MRI, and arthrogram, Dr. Ackerman opined that claimant's left labral tear was a degenerative condition that preexisted the work-related MVA. He reasoned that the "fraying" of the labrum and the presence of the "paralabral cyst" were primary indicators that the left labral tear preexisted the MVA. (Ex. 74-2). Drs. Strum and DiPaola also opined that the left labral tear was degenerative and preexisted the work-related MVA. (Ex. 69-5-6, 70-1-2). Dr. Strum explained that the pathology noted on the surgery photographs were of a type 1 SLAP lesion which, in nearly all instances, is degenerative in etiology. (Ex. 69-5). He further explained that traumatic injuries generally produce type II or IV SLAP lesions. (*Id.*)

Following his review of the MRI and arthrogram, Dr. Morgan, a radiologist, also opined that the left labral tear preexisted the work-related MVA. (Ex. 71). He reasoned that the existence of a 10 mm paralabral cyst shown in the MRI (which remained unchanged in the later arthrogram) indicated that the labral tear predated the injury. (*Id.*)

In response to the above opinions, Dr. Lamoreaux explained that the size of the paralabral cyst does not indicate how long it took to develop and that claimant's labral tear was of sufficient size to have caused the cyst to develop, which could have happened instantaneously. (Ex. 75-1) She also disagreed with the assertion that claimant's left labral tear was a type I. (Ex. 75-2). She explained that the "presence of the paralabral cyst necessarily means that there was "displacement of the joint and tendon," which by definition is "a type 2 tear going on a type 4 tear," which are "almost always caused by traumatic forces." (*Id.*) Because Dr. Lamoreaux fully considered and responded to the contrary opinions of Drs. Ackerman, Strum, DiPaola, and Morgan, we consider that an additional reason to find her opinion persuasive. *See Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2009) (medical opinion less persuasive when it did not address contrary opinions).

In conclusion, based on the aforementioned reasoning, as well as the reasons expressed in the ALJ's order, we find that Dr. Lamoreaux's opinion persuasively established that claimant's work-related MVA was a material contributing cause of the left labral tear. Accordingly, we affirm.

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Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee award is \$4,000, to be paid by Sedgwick. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's uncontested submission), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Finally, claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by Sedgwick. *See* ORS 656.386(2); OAR 438-015-0019; *Gary Gettman*, 60 Van Natta 2862 (2008). The procedure for recovering this award, if any, is described in OAR 438-015-0019(3).

### ORDER

The ALJ's order dated January 20, 2016 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$4,000, payable by Sedgwick. Claimant is awarded reasonable expenses for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by Sedgwick.

Entered at Salem, Oregon on August 1, 2016