
In the Matter of the Compensation of
RACHEL L. MELVIN, Claimant
WCB Case No. 14-05586
ORDER ON REVIEW
Dylan Hydes PC, Claimant Attorneys
SAIF Legal, Salem, Defense Attorneys

Reviewing Panel: Members Weddell and Curey.

Claimant requests review of Administrative Law Judge (ALJ) Pardington's order that upheld the SAIF Corporation's denial of claimant's new/omitted medical condition claim for complex regional pain syndrome (CRPS). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."¹

CONCLUSIONS OF LAW AND OPINION

On June 5, 2013, claimant was injured in a work-related motor vehicle accident (MVA). SAIF accepted a cervical strain, left ankle sprain, left lower leg contusion, chest wall contusion, right calf contusion, left clavicle abrasion, left ankle abrasion, left shin subcutaneous hematoma, right shin subcutaneous hematoma, and a left medial ankle full thickness wound. (Exs. 13, 50).

On September 23, 2014, SAIF denied claimant's new/omitted medical condition claim for CRPS. (Ex. 49). Claimant requested a hearing.

In upholding SAIF's denial, the ALJ found the opinions of Drs. Davis and Sdrulla insufficient to support the existence of CRPS. In doing so, the ALJ reasoned that claimant's treating physician, Dr. Davis, changed his opinion without adequate explanation. The ALJ discounted the opinion of Dr. Sdrulla because of an inability to determine the basis of his opinion. The ALJ also reasoned that the opinions of Drs. Bell, Dewing, Lorber, and Tilson persuasively established that claimant did not have CRPS.

¹ We do not adopt the second sentence of the second full paragraph on page 9.

On review, claimant disagrees with the ALJ's analysis of the medical opinions. For the following reasons, based on the persuasive opinions of Drs. Bell, Dewing, Lorber, and Tilson, we conclude that claimant has not established the existence of her CRPS condition.

To prevail on her new/omitted medical condition claim, claimant must prove that the condition exists. *See Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005). In addition, if it exists, and because she contends that her CRPS condition is a consequence of her 2013 work-related MVA, claimant must prove that her compensable injury (*i.e.*, the work-related injury incident) is the major contributing cause of the CRPS condition. ORS 656.266(1); ORS 656.005(7)(a)(A); *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211, 215 (2015); *Albany Gen Hosp. v. Gasperino*, 113 Or App 411, 415 (1992).

Whether claimant's CRPS exists is a complex medical question that must be resolved by expert medical evidence. *See Uris v. Comp. Dep't*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

For the following reasons, we conclude that the opinions of Drs. Bell, Dewing, Lorber, and Tilson are more persuasive than the opinions of Drs. Davis and Sdrulla.

On January 20, 2015, at SAIF's request, Dr. Bell, a neurologist, examined claimant and reviewed her medical history. (Ex. 57). Dr. Bell found that claimant had no objective findings to support CRPS. (Ex. 57-12). Dr. Bell noted that claimant's lower extremities were normal in appearance with "no trophic changes of nails or skin texture, no significant difference in coloration or temperature of the skin, and minimal swelling in the symptomatic region on the left." (Ex. 57-11).

According to Dr. Bell, claimant's persistent symptoms and findings could be explained by an injury to the saphenous nerve and/or vein. She explained that claimant had "sustained a deep penetrating wound to the medial aspect of the left ankle, which was slow to heal." (Ex. 57-12). Dr. Bell concluded that: "I do not see objective findings to support a diagnosis of [CRPS], and I believe that her persistent complaints (symptoms) and objective findings (signs) can be explained on the basis of her known mechanical injuries to nerve and blood vessels[.]"² (*Id.*)

² In her report, Dr. Bell referred to the difficulties associated with making a CRPS diagnosis (as stated in the "AMA Guides 6th edition chapter on CRPS"):

Dr. Bell emphasized that claimant's nerve conduction studies had not ruled out an injury to her saphenous nerve because of the location of her puncture wound and the test's lack of sensitivity, such that an "injury in the distal portion of the saphenous nerve would not necessarily produce an abnormal response on conventional nerve conduction studies." (Ex. 63-1). Moreover, Dr. Bell explained that "the swelling present in [claimant's] lower extremity * * * attributed to a saphenous vein injury can also cause an abnormal nerve conduction study because the swelling interferes with accurate NCV measurement." (*Id.*) Thus, she concluded that the "lack of sensitivity" in claimant's nerve conduction studies meant that a "'normal' result does not rule out [a saphenous] nerve injury." (Ex. 63-2).

Dr. Dewing, an orthopedic surgeon who also examined claimant, concurred with Dr. Bell's opinion. (Ex. 58-1). He agreed with Dr. Bell's conclusion that claimant's on-going pain, swelling, and tenderness in her left medial ankle was consistent with an injury to the saphenous vein and/or saphenous nerve. (Ex. 58-1-2). Dr. Dewing reasoned that, if claimant had CRPS, she would have had more widespread symptoms, *i.e.*, symptoms that were not localized to the area around her left ankle wound. (Ex. 58-2). Finally, Dr. Dewing agreed that "there were not consistent exam findings to support a diagnosis of CRPS." (*Id.*)

Dr. Lorber, a psychiatrist who examined claimant, also agreed with Dr. Bell's opinion that claimant did not meet the diagnostic criteria for CRPS. (Ex. 59-1). According to Dr. Lorber, claimant had focal pain around the area of her left ankle wound, whereas if she had CRPS, he would have expected her pain to have been more widespread. (Ex. 59-1-2).

"Since a subjective complaint of pain is the hallmark of this diagnosis, and since all of the associated physical signs and radiological findings can be the results of disuse, an extensive differential diagnostic approach is necessary. Differential diagnoses, which must be ruled out, include disuse atrophy, unrecognized general medical problems, somatoform disorders, factitious disorder, and malingering."

"A diagnosis of CRPS may be excluded in the presence of any of these conditions, which could account for the presentation. This exclusion is necessary due to the general lack of scientific validity for the concept of CRPS, and due to the reported extreme rarity of CRPS (any differentials would be far more probable). This is the rational[e] behind the 4th criterion * * *: 'There is no other diagnosis that better explains the signs and symptoms.'" (Ex. 57-15).

Dr. Tilson, an orthopedist who performed an extensive examination of claimant and made impairment findings, concluded that claimant's left ankle condition did not reveal any "unequivocal" evidence of CRPS. (Ex. 48-10).

Moreover, Drs. Bell and Dewing explained that CRPS is a diagnosis of exclusion, which means that if another diagnosis explains claimant's symptoms, a diagnosis of CRPS is not supported. (Exs. 57-16, 58-1). Because claimant's ongoing symptoms were explained by an injury to the saphenous nerve and/or vein, they concluded that claimant did not have CRPS. (*Id.*)

Claimant relies on the opinions of Drs. Davis and Sdrulla to establish the existence of her claimed CRPS condition. For the following reasons, when compared with the previously summarized opinions, we do not find their opinions persuasive.

In his June 30, 2015 report, Dr. Davis explained that his opinion that claimant had CRPS was based on his review of the reports from Drs. Sdrulla, Young, and Bell, his last examination findings of a "clammy and sweaty" left lower leg, which were consistent with CRPS (and inconsistent with damage to the saphenous nerve), and learning that the three-phase bone scan (TPBS) may not be reliable in diagnosing CRPS (particularly if more than six months had passed since the alleged trauma). (Ex. 65-1-3). For the following reasons, we do not find Dr. Davis's opinion persuasive.

Although Dr. Davis stated that his more recent exam findings of a "clammy and sweaty" left lower leg supported the existence of CRPS, the significance of those findings are subject to question in light of his prior chart notes that did not document a "clammy and sweaty" lower left leg.³ (Exs. 41, 42). Dr. Davis also conceded that he had not tested for temperature differences within claimant's lower legs and that he had not formally measured her range of motion in her left lower leg. (Ex. 65-1-2). Moreover, Dr. Davis did not adequately rebut Dr. Bell's opinion that claimant's nerve conduction study results did not rule out an injury to the saphenous nerve, and that such an injury would explain claimant's ongoing pain symptoms. Therefore, we are not persuaded by Dr. Davis's opinion because it lacks adequate explanation.

³ To the contrary, Dr. Davis's prior chart notes reported "No skin changes particularly consistent with a [CRPS]," (Ex. 41-2), and "[s]kin has norma[l] color, normal texture[.]" (Ex. 42-2).

Claimant asserts that we should defer to Dr. Davis's June 30, 2015 opinion that she has CRPS because of his status as the treating physician. *Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001) (we properly may or may not give greater weight to the opinion of the treating physician, depending on the record in each case). However, given the deficiencies in Dr. Davis's opinion, and in light of the more persuasive opinions of Drs. Bell, Dewing, Lorber, and Tilson, we decline to defer to Dr. Davis.

Finally, claimant contends that Dr. Sdrulla's opinion persuasively establishes the existence of her CRPS condition because he has greater expertise in treating and diagnosing CRPS. However, we find Dr. Sdrulla's opinion to be conclusory, particularly in comparison to Dr. Bell's detailed and well-explained opinion. In light of the conclusory nature of Dr. Sdrulla's opinion, we do not consider Dr. Sdrulla's expertise to be determinative in gauging the persuasiveness of his opinion in relation to the countervailing opinions. *See Miller v. Granite Constr. Co.*, 128 Or App 473, 478 (1977) (medical evidence that was based on inaccurate or incomplete information was not persuasive); *Joseph M. Themins*, 59 Van Natta 1902, 1904 (2007) (orthopedic surgeon's expertise did not make opinion more persuasive than the attending physician's); *Grace A. Oman*, 56 Van Natta 3044, 3047 (2004) (no deference to neurosurgeon's opinion over neurologist's opinion regarding lumbar pain and degenerative disc disease).

In sum, weighing Dr. Davis's and Dr. Sdrulla's opinions against the opinions of Drs. Bell, Dewing, Lorber, and Tilson, we find the latter opinions more persuasive because they are more thoroughly explained and reasoned. *See Somers*, 77 Or App at 263. Because the persuasive evidence does not establish that claimant's work activities were the major contributing cause of her CRPS condition, we conclude that the claim is not compensable. Accordingly, we affirm.

ORDER

The ALJ's order dated December 15, 2015 is affirmed.

Entered at Salem, Oregon on July 11, 2016