
In the Matter of the Compensation of
ESPRIT M. STEWARD, Claimant
WCB Case No. 14-06059
ORDER ON REVIEW
Michael N Warshafsky, Claimant Attorneys
SAIF Legal Salem, Defense Attorneys

Reviewing Panel: Members Johnson, Weddell, and Somers. Member Johnson dissents.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Donnelly's order that: (1) excluded a physician's report offered by SAIF; (2) set aside its denial of claimant's new/omitted medical condition claim for cervical myelopathy, C4-5 disc herniation, and C5-6 disc herniation; and (3) awarded a \$25,000 insurer-paid attorney fee. On review, the issues are evidence, compensability, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following summary and supplementation.

On February 22, 2014, claimant, a caregiver, sustained a compensable injury while assisting a disabled client. (Ex. 1). Claimant was seated by the client, when the client suddenly started to fall backward. (Tr. 7, 26). Claimant "lunged forward and caught her." (*Id.*) As she did so, claimant felt a "pop" and a burning sensation between her shoulder blades. (Tr. 8).

On February 23, 2014, claimant was seen by Dr. Dandy, a family medicine physician, who diagnosed a thoracic sprain. (Ex. 4-3).

On February 27, 2014, claimant followed-up with Dr. Hawes, an urgent care physician. Dr. Hawes documented paresthesias or numbness in the ulnar distribution of the forearms and upper back/thorax muscle spasm, tenderness, and decreased range of motion. (Ex. 7-1, -2). She referred claimant for chiropractic care. (Ex. 7-3).

On February 28, 2014, claimant began chiropractic treatment with Dr. Reneau. Claimant reported thoracocervical, mid-thoracic, and thoracolumbar discomfort, as well as bilateral numbness that extended into her hands. (Ex. 9-1). Dr. Reneau reported decreased sensation over the C4, C5, C6, C7, and T1 nerve

roots on the left and severe muscle spasm and tenderness in the thoracocervical, mid-thoracic and thoracolumbar areas. (Ex. 9-1, -2). His assessment included thoracic sprain/strain and thoracic, lumbar, and cervical segmental dysfunction. (*Id.*)

SAIF accepted a thoracic strain. (Ex. 27).

On April 21, 2014, claimant saw Dr. Burns, an urgent care physician. Claimant reported that she was unable to turn her head. (Ex. 35-1). Dr. Burns observed “very limited” cervical range of motion due to left trapezius and rhomboid muscle pain. (Ex. 35-2). Although claimant did not have neck pain, based on her limited range of motion, he suspected that she might need a cervical MRI to rule out a C5 lesion. (*Id.*)

On April 23, 2014, claimant returned to Dr. Burns. She reported no neck pain, but she had radicular pain down the outside of her left arm to the 4th and 5th fingers of her left hand. (Ex. 37-1). Dr. Burns opined that an April 23, 2014 cervical x-ray showed neuroforaminal narrowing in the lower cervical spine on the left and intense paracervical muscle spasm.¹ (*Id.*) He diagnosed thoracic sprain and neck muscle strain. (Ex. 37-2). Noting that claimant had practically no cervical range of motion due to muscle spasm, he surmised that the “problem is really a cervical disc disease impingement on the lower neuroforamina with intense spasm and radiculitis.” (*Id.*)

On April 24, 2014, claimant followed-up with Dr. Hawes, who noted neck and upper back tenderness, muscle spasm, and decreased range of motion. (Ex. 40-2). Dr. Hawes proposed that claimant’s neck spasm might “well be due to recruitment of those muscles to spasm by the involved mid-thoracic muscles which were initially involved.” (*Id.*)

An April 28, 2014 cervical MRI showed straightening of the cervical lordosis (attributed to positioning or muscle spasm), C4-5 disc bulge (minimally indenting the ventral thecal sac), and C5-6 disc bulge (minimally indenting the ventral thecal sac) with intervertebral disc space narrowing and desiccation. (Ex. 48-1). The central spinal canal was normal in caliber and intrinsic signal. (*Id.*) The central spinal canal and neural foramina “remained widely patent.” (*Id.*)

On May 6, 2014, Dr. Burns recommended an electrodiagnostic study to rule out cervical radiculitis and to identify any peripheral neuropathy. (Ex. 52-2).

¹ The April 23, 2014 cervical x-ray showed minimal degenerative change at the C5-6 disc space level with narrowing of the right uncovertebral joint, but no osteophytes or facet arthrosis. (Ex. 39).

On May 12, 2014, claimant saw Dr. Powell, an urgent care physician. Claimant reported persistent back pain, neck pain, and increased right hand numbness (involving the 4th and 5th fingers) and pain. (Ex. 56-1). Noting that claimant's neurological symptoms (right ring and little finger) were incongruent with her MRI findings, Dr. Powell recommended nerve conduction studies to clarify the discrepancy. (Ex. 56-3).

A June 2, 2014 electrodiagnostic study showed bilateral ulnar neuropathies at the elbow (cubital tunnel syndrome) and a right median sensory neuropathy (carpal tunnel syndrome). (Ex. 68-1). The study did not show any other mononeuropathy, plexopathy, or radiculopathy affecting the upper extremities. (*Id.*)

On June 6, 2014, Dr. Kuhn, an orthopedic surgeon, performed an examination at SAIF's request. Dr. Kuhn diagnosed preexisting cervical degenerative disc disease (which he identified as an "arthritic" condition²), thoracic strain, and left ulnar sensory neuropathy (not secondary to the work injury). (Ex. 70-10, -12). He also opined that the work injury was not a material contributing cause of the disability/need for treatment related to the cervical symptoms. (Ex. 70-12).

On June 10, 2014, claimant consulted Dr. Herring, a neurologist. Dr. Herring performed an examination and reviewed a "1.5 Tesla scan," plain films, and the electrodiagnostic study. (Ex. 71-4). He diagnosed a cervical myelopathy (related to the work injury), neck pain, thoracic pain (related to the cervical pathology), and gait imbalance consistent with a possible cervical myelopathy. (Ex. 71-4, -5). He requested a "repeat cervical MRI on a 3-tesla magnet and cervical flexion/extension views." (Ex. 71-5).

A September 8, 2014 cervical MRI showed a C4-5 disc extrusion producing mild canal stenosis and mild indentation of the cord surface and a C5-5 disc protrusion and associated annular fissure producing mild canal stenosis without significant mass effect on the spinal cord. (Ex. 79-1). Neural foramina were deemed "adequate" at both levels. (*Id.*)

² Dr. Kuhn opined that the preexisting cervical degenerative disc disease "involves the intervertebral discs of the cervical spine, particularly at C4-5 and C5-6 and is secondary to metabolic or constitutional causes and thereby meets the State of Oregon's definition of an arthritic condition." (Ex. 70-12).

On October 23, 2014, claimant initiated a new/omitted medical condition claim for cervical spine myelopathy, C4-5 disc herniation, C5-6 disc herniation, and “cervicogenic.” (Ex. 87).

On November 7, 2014, claimant consulted Dr. Hutton, a surgeon. Dr. Hutton did not find signs of myelopathy and did not recommend surgery. (Ex. 89-4).

On November 25, 2014, Dr. Rosenbaum, a neurosurgeon, performed an examination at SAIF’s request. Dr. Rosenbaum diagnosed preexisting cervical spondylosis (an “arthritic” condition), thoracic strain, and probable functional overlay.³ (Ex. 91-8, -11). He opined that claimant did not have a myelopathy or C4-5 and C5-6 disc herniations, “but rather spondylosis and arthritic changes with some degree of minor disc bulging.” (Ex. 91-9). He concluded that the work injury was not a cause of the treatment/disability. (Ex. 91-10).

On December 3, 2014, SAIF denied cervical spine myelopathy, C4-5 disc herniation, and C5-6 disc herniation. (Ex. 92). Claimant requested a hearing.

On February 24, 2015, Dr. Herring opined that the September 8, 2014 MRI showed a C4-5 disc extrusion that was superimposed on a broad-based bulge that effaced the ventral subarachnoid space with mild indentation of the ventral cord surface and a C5-6 disc extrusion with associated annular fissure superimposed on a broad-based disc bulge producing canal stenosis. (Ex. 106-1). He also stated that cervical myelopathy is a clinical diagnosis that was based on findings at the time of claimant’s initial and subsequent examinations. (*Id.*) Based on the history claimant presented, the mechanism of injury, and the immediate onset of severe upper thoracic pain, he concluded that the work incident was the major cause of these conditions. (*Id.*)

At the March 3, 2015 hearing, SAIF submitted a concurrence report, signed by Dr. Kuhn, that maintained that claimant did not have a cervical myelopathy or disc herniations, but rather, degenerative changes. (Ex. 109-1, -2). Dr. Kuhn also opined that the work incident was not a material contributing cause of the need for

³ Dr. Rosenbaum opined that cervical spondylosis is an arthritic condition. He stated that claimant’s C4-5 and C5-6 disc bulges “work in tandem with the posterior facets. When disc bulging is present, the posterior facts on a microscopic basis would have inflammatory cells present. They are undergoing a structural type degradation and it is a constitutional cause. It therefore fulfills the Oregon Guideline Rules of an arthritic-type condition.” (Ex. 91-11).

treatment of the C4-5 and C5-6 discs, but if it were, there would be a combined condition and the work incident would not be the major contributing cause of the disability/need for treatment of the combined condition. (Ex. 109-2)

At the hearing, SAIF also submitted a concurrence report, signed by Dr. Rosenbaum, which opined that claimant did not have a cervical myelopathy or disc herniations, but rather, degenerative changes or bulges. (Ex. 109A-1). Dr. Rosenbaum also concluded that the work incident was not a material contributing cause of the need for treatment of the C4-5 and C5-6 discs, but if it were, there would be a combined condition and the work incident would not be the major contributing cause of the disability/need for treatment of the combined condition. (*Id.*)

The ALJ allowed claimant's motion for a continuance to obtain rebuttal evidence regarding the recently submitted reports of Drs. Kuhn and Rosenbaum. (Tr. 1). SAIF also sought a continuance to obtain rebuttal reports from Drs. Kuhn and Rosenbaum on the "combined condition" defense. (Tr. 2). In granting SAIF's motion, the ALJ stated that she would consider the reports if she determined that there was a combined condition. (Tr. 3).

Claimant testified that, before the injury, she was not limited in performing work or off-work activities and she was not receiving medical treatment for neck or upper back symptoms. (Tr. 19, 20).

Dr. Herring provided two "post-hearing" rebuttal reports. He opined that claimant's cervical x-rays and MRIs did not support the existence of spondylosis. (Ex. 111-1). He also stated his opinion, as well as that of Drs. Wensel (who read the September 8, 2014 MRI) and Hutton, that claimant had two disc herniations. (Ex. 112-4). Considering the "post-injury" onset of symptoms, their progressive nature, and the absence of prior problems, he concluded that the disc annulus probably tore as a result of the work injury and the disc herniations were chemically irritating the nerve fibers. (Ex. 111-2, -3). He also concluded that the cervical myelopathy was due to the work injury. (Ex. 112-2).

SAIF submitted "post-hearing" rebuttal reports from Dr. Rosenbaum as proposed Exhibits 113 and 114.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that the work injury did not combine with a legally cognizable preexisting condition and declined to admit Dr. Rosenbaum's "post-hearing" reports. Relying on the opinion of Dr. Herring, the ALJ concluded that

the claimed C4-5 and C5-6 disc herniations and cervical myelopathy were compensable and set aside SAIF's denial. The ALJ awarded claimant's counsel a \$25,000 attorney fee under ORS 656.386(1) for prevailing over SAIF's denial.

On review, SAIF argues that it is entitled to the last presentation of evidence on its "combined condition" defense. SAIF also disputes the ALJ's evaluation of the medical evidence, contending that Dr. Herring's opinion is unpersuasive and therefore insufficient to satisfy claimant's burden of proof. Alternatively, SAIF relies on the opinion of Dr. Rosenbaum in contending that it met its burden to prove that the otherwise compensable injury was not the major contributing cause of the disability/need for treatment of a combined condition. Lastly, SAIF contends that the attorney fee award is excessive.

To begin, we need not resolve the ALJ's evidentiary ruling because, even if we considered the disputed physicians' reports, we would conclude that the claim is compensable. We reason as follows.

To prove compensability of her new/omitted medical condition claim, claimant must establish that the claimed C4-5 and C5-6 disc herniations and cervical myelopathy exist and that the work injury was a material contributing cause of the disability or need for treatment for those conditions. ORS 656.005(7)(a); ORS 656.266(1); *Betty J. King*, 58 Van Natta 977 (2006). If claimant establishes an "otherwise compensable injury," and a "combined condition" is present, SAIF 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 656.266(2)(a); *Jack G. Scoggins*, 56 Van Natta 2534, 2535 (2004). Where the carrier has the burden of proof under ORS 656.266(2)(a), the medical evidence supporting its position must be persuasive. *See Jason V. Skirving*, 58 Van Natta 323, 324 (2006), *aff'd without opinion*, 210 Or App 467 (2007).

Considering the disagreement between medical experts regarding the existence and cause of the need for treatment of the disputed conditions, these issues present complex medical questions that must be resolved by expert medical evidence. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993). When presented with disagreement among experts, we give more weight to those opinions that are both well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

In contending that claimant did not satisfy her initial burden of proof, SAIF argues that Dr. Herring's opinion is not persuasive. SAIF further contends that the opinions of Drs. Kuhn and Rosenbaum, as supported by the records and conclusions of Drs. Powell, Burns, and Hawes, are more persuasive than the opinion of Dr. Herring. For the following reasons, we disagree.

Dr. Herring opined that the September 8, 2014 cervical MRI showed "significant effacement at the C4-5 level" and that claimant had subtle findings of myelopathy.⁴ (Ex. 80-4). He also stated that the September 8, 2014 MRI showed a C4-5 disc extrusion that was superimposed on a broad-based bulge and a C5-6 disc extrusion with associated annular fissure superimposed on a broad-based disc bulge.⁵ (Ex. 106-1). Based on claimant's history, the mechanism of injury, and the immediate onset of severe upper thoracic pain, he concluded that the work incident was the major cause of these conditions. (*Id.*)

Dr. Herring explained that when claimant reached out to catch the client, her hands were out in front of her and there was flexion, compression, and torque that caused the herniated cervical discs and myelopathy. (Ex. 107-3). He opined that the temporal relationship between the injury and claimant's disability and need for

⁴ On June 10, 2014, Dr. Herring found a "positive Lhermitte's" and impaired tandem gait. (Ex. 71-3, -4). He diagnosed a gait imbalance consistent with a possible cervical myelopathy. (Ex. 71-5). On August 12, 2014, Dr. Herring reported neurologic findings "that would be consistent with a cervical myelopathy, including an up going toe on the left and brisk reflexes at the knees, although some findings such as impaired tandem gait and Lhermitte's have improved." (Ex. 75-4). On September 16, 2014, Dr. Herring reported that claimant's tandem gait was again impaired. (Ex. 80-4). On January 22, 2015, Dr. Herring reported that claimant no longer had myelopathic findings, which had improved from her initial visit in June 2014. (Ex. 98-1, -2). He also stated that these findings had resolved before claimant saw Dr. Hutton on November 7, 2014. (Ex. 106-1).

⁵ SAIF asserts that Dr. Herring's mistaken impression that the April 28, 2014 cervical MRI was performed without a 3-Tesla magnet is a basis to discount his opinion. On June 10, 2014, Dr. Herring described a "1.5 Tesla scan, which shows bulging indenting the ventral thecal sac at 4-5 and 5-6, with straightening of the cervical lordosis." (Ex. 71-4). He requested a "repeat cervical MRI on a 3-Tesla magnet and cervical flexion/extension views." (*Id.*) He stated that he was not "comfortable ordering more aggressive physical therapy without the ability to reimagine her cervical spine, which [was] still quite symptomatic." (Ex. 75-5). The September 8, 2014 MRI (done on a 3-tesla magnet) showed a C4-5 disc extrusion effacing the ventral subarachnoid space and causing mild canal stenosis and mild indentation of the cord surface and a C5-6 disc protrusion associated with an annular fissure causing mild canal stenosis without significant mass effect on the cord. (Exs. 79-1, 80-3). Dr. Rosenbaum reported that the MRIs were similar, but that the April 28, 2014 MRI was not as clear and the September 8, 2014 MRI showed the disc bulging at C4-5 and C5-6 "slightly better." (Exs. 91-8, 109A-1). Because the September 2014 MRI confirmed the C4-5 and C5-6 disc bulges, we do not find that Dr. Herring's mistaken impression regarding the "magnet strength" of the April 2014 MRI diminishes the persuasiveness of his opinion.

treatment is important, noting that claimant reported upper extremity paresthesias five days after the incident (which was evidence of her cervical conditions) and that, within a week of the injury, Dr. Reneau reported radiating upper extremity symptoms and diagnosed cervical segmental dysfunction.⁶ (Exs. 106-1, 107-2, -3). Further explaining that a cervical disc herniation often causes mid-thoracic pain, mid-scapular pain, and related symptoms, Dr. Herring opined that claimant probably herniated the discs at the same time that she strained her thoracic spine and, over a short period of time, the cervical symptoms became more prominent.⁷ (Ex. 107-4). He reasoned that claimant's cervical x-rays showed a healthy spine, with no significant or progressive degeneration, and that other levels of her cervical spine still appeared healthy on the September 8, 2014 MRI, which supports the conclusion that the C4-5 and C5-6 disc herniations were acute and caused by the injury. (Ex. 107-5, -6). He also noted that claimant had been asymptomatic before the acute onset of symptoms and that the first sign of disc herniations appeared after the work injury. (*Id.*)

After reviewing the record, we find Dr. Herring's opinion to be well reasoned and based on an accurate history.

In contrast, Dr. Rosenbaum opined that claimant did not have a cervical myelopathy because the MRIs did not show any cord compression and there were no clinical findings (*i.e.*, sensory loss that fits with cord compression, diminished reflexes or motor function, or hyperreflexia) that correlate with a myelopathy.

⁶ SAIF asserts that Dr. Herring did not explain the electrodiagnostic results. In fact, Dr. Herring stated that he reviewed the report and did not find it to be relevant to the disputed issues. (Ex. 108-1). Specifically, he opined that "the mild entrapment findings bear no clinical significance to the onset of the mid scapular and thoracic pain, myelopathy, cervical conditions and symptoms or disc herniations." (*Id.*) He also stated that the "mild entrapment findings do not change any of the objective findings or clinical findings relative to the disc herniations or myelopathy or the onset of symptoms or mechanics of injury." (*Id.*) Lastly, he concluded that his clinical findings were more relevant to a diagnosis than "an isolated EMG," explaining that "EMGs can have a significant rate of false-negatives[.]" (Ex. 112-3). For instance, he noted that four days after the electrodiagnostic report, Dr. Kuhn's findings were not consistent with a diagnosis of carpal tunnel syndrome. (*Id.*)

⁷ SAIF asserts that Dr. Herring's opinion that claimant's condition was initially misdiagnosed is contrary to "the law of the case" that claimant had a compensable thoracic strain. See *Kuhn v. SAIF*, 73 Or App 768, 772 (1985) (opinion that conflicts with the law of the case is wrong as a legal matter). In attributing claimant's cervical disc herniation to her work injury, Dr. Herring stated that the injury was "misdiagnosed as merely a cervical strain." (Ex. 84-3). In that same report, Dr. Herring diagnosed a thoracic strain. (Ex. 84-4). He subsequently opined that claimant probably herniated the discs at the same time she strained her thoracic spine. (Ex. 107-4). Therefore, we find that Dr. Herring's opinion is consistent with the initial thoracic strain diagnosis.

(Ex. 109A-1, -2). Yet, Dr. Rosenbaum did not specifically address Dr. Herring's findings (*i.e.*, positive Lhermitte's, tandem gait impairment, left up going toe, and brisk reflexes at the knees). Accordingly, we discount Dr. Rosenbaum's opinion.⁸ *See Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2009) (medical opinion unpersuasive when it did not address contrary opinion).

Dr. Rosenbaum also opined that claimant does not have disc herniations. (Exs. 91-9, 109A-2, -3). He acknowledged that the mechanism of injury could cause a herniated cervical disc, but stated that claimant does not have disc herniations because "these abnormalities are not producing radiculopathy [or] myelopathy." (Ex. 91-10). As previously discussed, Dr. Herring's opinion persuasively established that claimant had findings consistent with a cervical myelopathy.

Dr. Rosenbaum also reasoned that the work injury did not cause the need for treatment or disability because claimant initially presented with low thoracic, not cervical, region discomfort. (*Id.*) Yet, in reviewing claimant's records, Dr. Rosenbaum noted that on February 28, 2014 (which was six days after the injury), Dr. Reneau reported that claimant was complaining of cervical symptoms, with radiating upper extremity symptoms. (Ex. 91-2). In the absence of an explanation for this apparent internal inconsistency, we find Dr. Rosenbaum's opinion unpersuasive for this reason as well. *See Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained opinion); *Howard L. Allen*, 60 Van Natta 1423, 1424-25 (2008) (internally inconsistent medical opinion, without explanation for the inconsistencies, was unpersuasive).

Likewise, Dr. Kuhn concluded that claimant did not have C4-5 or C5-6 disc herniations or a cervical myelopathy, but rather, preexisting cervical degenerative disc disease. (Ex. 70-10). Dr. Kuhn reviewed claimant's 2006, 2009, 2010, and 2013 cervical radiology reports and concluded that claimant had a history of multiple neck injuries and serial radiographs over a several year period that showed progressive degenerative changes at the C4-5 and C5-6 levels. (Ex. 70-5, -9). Yet, in contrast to this conclusion, Dr. Kuhn's summary of the "pre-injury"

⁸ Dr. Rosenbaum also opined that the electrodiagnostic study explained claimant's bilateral upper extremity symptoms and supported the proposition that there was no cord compression. (Ex. 109A-2). However, as previously discussed, Dr. Herring persuasively explained why his clinical findings were more relevant to the diagnosis than the electrodiagnostic study. (Ex. 112-3).

radiology reports states that the disc spaces were well-maintained and does not describe degenerative disc disease at any cervical spine level.⁹ We are unable to reconcile this contradiction.

Moreover, Dr. Kuhn concluded that claimant's left hand symptoms were not documented until April 23, 2014, nearly two months after the work injury. (Ex. 70-10). Yet, on February 27, 2014, five days after the work incident, Dr. Hawes noted that claimant had paresthesias or numbness in the ulnar distribution of her forearms. (Ex. 7-1). Additionally, on February 28, 2014, Dr. Reneau documented claimant's description of bilateral numbness, which extended into her hands. (Ex. 9-1).

Under these circumstances, Dr. Kuhn's opinion that claimant's disability/need for treatment was due to preexisting spondylosis was based on an inaccurate history. Therefore, we find his opinion unpersuasive. *See Miller v. Granite Constr. Co.*, 28 Or App 473, 476 (1977) (opinion based on inaccurate history found unpersuasive).

In conclusion, after considering these physicians' opinions, we find the well-reasoned opinion of Dr. Herring to be more persuasive. Consequently, we conclude that claimant has established an "otherwise compensable injury" regarding the claimed C4-5 and C5-6 disc herniations and cervical myelopathy.

We turn to SAIF's burden to prove that the "otherwise compensable injury" (*i.e.*, the "work-related injury incident") was not the major contributing cause of the disability/need for treatment of the combined condition. *See* ORS 656.266(2)(a); *Brown v. SAIF*, 262 Or App 640, 652 (2014); *Jean M. Janvier*, 66 Van Natta 1827, 1832-33 (2014), *aff'd without opinion*, 278 Or App 447 (2016) (applying the *Brown* definition of an "otherwise compensable injury to initial and new/omitted medical condition claims). For the following reasons, we conclude that (even considering the disputed evidence excluded by the ALJ's ruling), SAIF has not met its statutory burden of proof.

⁹ Dr. Kuhn described a December 21, 2006 cervical x-ray report as following a motor vehicle accident and showing well-maintained disc spaces. (Ex. 70-5). He described a December 11, 2009 cervical x-ray report as "unremarkable cervical spine with the exception of her head was tilted to the right due to a cervical collar[.]" (*Id.*) He described a December 5, 2010 cervical x-ray report as showing normal alignment and well-maintained disc space. (*Id.*) Finally, he described a November 15, 2013 x-ray report as following possible foreign body ingestion and showing no evidence of airway compromise or foreign body. (*Id.*) The radiology reports are not included in the record.

Here, Drs. Kuhn and Rosenbaum signed concurrence statements that “if it were found that the work incident was a material contributing cause of the need for treatment/disability of the C4-5 or C5-6 disc, then this would be a combined condition situation.” (Exs. 109-2, 109A-3). Yet, Dr. Kuhn had previously opined that claimant had preexisting cervical degenerative disc disease and that the work injury was not a material contributing cause of the disability/need for treatment related to the cervical symptoms. (Ex. 70-10, -12). Likewise, Dr. Rosenbaum had opined that claimant did not have C4-5 and C5-6 disc herniations (but rather “spondylosis and arthritic changes with some degree of minor disc bulging”), and the work injury was not a cause of the treatment/disability. (Ex. 91-9, -10).

Thus, those physicians’ opinions asserted that claimant’s condition was entirely due to a degenerative/arthritic condition. Their subsequent concurrences (which retreat from their previous opinions) are conclusory and unexplained. In the absence of a persuasive analysis for these altered assessments, we discount the physicians’ opinions.¹⁰ See *Moe*, 44 Or App at 433; *Ronald E. Prebe*, 62 Van Natta 2763, 2766 (2010) (because a physician did not believe that the work injury was a material contributing cause of the claimant’s disability/need for treatment, the physician did not adequately weigh the relative contribution of the work injury when discussing an assumed combined condition). Consequently, we conclude that SAIF has not persuasively established that the “otherwise compensable injury” (*i.e.*, the work-related injury incident) was not the major contributing cause of claimant’s disability/need for treatment of the combined condition. ORS 656.266(2)(a); *Janvier*, 66 Van Natta at 1832-33; *Skirving*, 58 Van Natta at 324.

We turn to the ALJ’s attorney fee award under ORS 656.386(1). We review the ALJ’s attorney fee award *de novo*, based on the record as it was developed at the hearing level and considering the parties’ arguments regarding the application of the factors set forth in OAR 438-015-0010(4) to the particular circumstances of

¹⁰ Dr. Rosenbaum’s “post-hearing” reports maintain that claimant did not have myelopathy or C4-5/C5-6 disc herniations, but rather idiopathic cervical spondylosis. (Proposed Ex. 113-5). Dr. Rosenbaum also opined that the work incident was not a material contributing cause of any need for treatment of the C4-5 or C5-6 disc. (Proposed Ex. 113-6). Nevertheless, if it were determined that the work incident was a material contributing cause of any need for treatment of the C4-5 or C5-6 disc, Dr. Rosenbaum concluded that the work incident would have combined with the preexisting spondylosis, but the work incident would never have been the major contributing cause of the combined condition. (Ex. 113-6).

this case.¹¹ *See Schoch v. Leupold & Stevens*, 325 Or 112, 118-19 (1997). Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. Application of the rule-based factors does not involve a strict mathematical calculation. *Robert L. Lininger*, 67 Van Natta 1712, 1718 (2015). For the following reasons, we affirm the ALJ's attorney fee award.

At the hearing level, claimant's counsel requested an attorney fee award of \$25,000. (Hearing File). SAIF responded that, under the circumstances (a 90-minute hearing, at which claimant was the only witness, and a 115-exhibit record, which included five concurrence letters generated by claimant's counsel), a reasonable fee would be \$7,500. (*Id.*)

The ALJ applied the factors prescribed in OAR 438-015-0010(4) and concluded that \$25,000 was a reasonable attorney fee for claimant's counsel's efforts, which resulted in three separate cervical conditions being found compensable.

On review, SAIF argues that, compared to other disputes coming before the Hearings Division, there is less value and the legal issues are of average complexity. SAIF acknowledges that, compared to other compensability disputes, there were more exhibits and claimant's counsel generated more medical reports than is usual. SAIF argues, however, that the issues were not unusually complex and contends that a reasonable fee would be \$9,000.¹²

Here, at the hearing level, claimant's counsel requested a specific fee amount for his efforts in finally prevailing over SAIF's denial and specifically addressed the "rule-based" factors under OAR 438-015-0010(4) for determining a reasonable attorney fee. In estimating the time devoted to the denied claim at

¹¹ We do not consider claimant's "Statement of Services at Hearing," submitted for the first time on review. *Daniel L. Demarco*, 65 Van Natta 1837, 1847 (2013). (Board review of the ALJ's attorney fee award is based on the record as it was developed at the hearing, as supplemented by the parties' arguments regarding the application of the "rule-based" factors to the record developed at the hearing level).

¹² SAIF also argues that the fee should not "be triple what is usually awarded" simply because there are three conditions at issue.

approximately 90 hours, claimant's counsel explained that the file was large and required extensive, multiple reviews, to prepare Dr. Herring's concurrence reports and because of the lengthy delay between hearing preparation and written closing argument. He also reported that he performed extensive legal and medical research to prepare for the medical consultations/reports, the hearing, and written closing argument.

Based on our review of record and considering the parties' arguments, we consider claimant's counsel's estimation of the time devoted to the denied claim at the hearing level to represent a reasonable approximation.¹³ The hearing record, which is extensive and medically complex, reflects significant effort by claimant's counsel in challenging SAIF's denial.

The value of the interest involved and the benefit secured for claimant include two cervical disc herniations, resulting in a myelopathy condition. The record shows that claimant was not medically stationary and had been referred for additional medical treatment. (Ex. 98-4). This record suggests a possibility of additional temporary disability benefits, as well as eventual permanent impairment. Thus, the record supports a conclusion that the value of the interest involved and the benefit secured for claimant are significant.

The hearing lasted approximately one hour (the transcript consists of 39 pages), involved one witness (claimant), and included written closing arguments (which were presented some seven months after the hearing). There were 115 exhibits (five generated by claimant, two medical examinations arranged by SAIF, and four addendum reports generated by SAIF). Compared to cases generally litigated before this forum, the medical issues were of a higher complexity level.

Considering the medical evidence developed by the carrier in its vigorous defense of the claim, there was a substantial risk that claimant's counsel's efforts might go uncompensated. Counsels for both parties are experienced and presented their respective positions in a skillful and professional manner. There were no frivolous issues or defenses.

Accordingly, based on our review of the record and considering the parties' arguments regarding the application of the factors set forth in OAR 438-015-0010(4) to the particular circumstances of this case, we find that the \$25,000 attorney fee awarded by the ALJ's order is a reasonable fee for claimant's attorney's services at the hearing level regarding the compensability issue. In

¹³ SAIF does not challenge claimant's counsel's representation of the time devoted to the case.

reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing record, including claimant's counsel's representations, and SAIF's objection), the complexity of the medical issues (due to the physicians' opinions), the value of the interest involved and benefit obtained for claimant, the nature of the proceedings (including the written closing argument), and the risk that claimant's counsel's efforts in this particular case may have gone uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2), (3); OAR 438-015-0070(1), (2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding this case is \$9,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, his counsel's Statement of Services and fee requests for services rendered on review, and SAIF's response), the complexity of the issues, the values 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 of the cervical conditions, to be paid by SAIF. *See* ORS 656.386(2); OAR 438-015-0019; *Gary E. Gettman*, 60 Van Natta 2862 (2008). The procedure for recovering this award, if any, is prescribe in OAR 438-015-0019(3).

ORDER

The ALJ's order dated December 17, 2015 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$9,000, payable by SAIF. Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial of the cervical conditions, to be paid by SAIF.

Entered at Salem, Oregon on September 2, 2016

Member Johnson dissenting.

The majority relies on Dr. Herring's opinion in finding claimant's C4-5 and C5-6 disc herniations and myelopathy compensable. Because I find the opinion of Dr. Herring less persuasive than those of Drs. Rosenbaum and Kuhn, and insufficient to satisfy claimant's initial burden, I respectfully dissent.

There are three causation opinions. Dr. Herring, a neurologist, supports the existence of the claimed myelopathy and the C4-5 and C5-6 disc herniations and a causal relationship with claimant's work injury. In contrast, the opinions of Drs. Rosenbaum and Kuhn do not support the existence of the claimed conditions or their causal relationship to the work injury.

After claimant injured her back at work in February 2014, she was diagnosed with and treated for a thoracic strain/sprain. (Exs. 4, 7). Drs. Dandy and Hawes confined their examinations to her upper and lower back. (Exs. 4-2, 7-2). Claimant also received extensive chiropractic care. On March 4, 2014, Dr. Reneau documented limited normal cervical range of motion. (Ex. 12-1).

On April 21, 2014, claimant saw Dr. Burns and reported, for the first time, that she could not turn her head. (Ex. 35-1). Dr. Burns documented "very limited" neck range of motion, due to left trapezius and rhomboid pain. (Ex. 35-2). He also reported that claimant did not have neck pain. (Ex. 37-1).

On April 25, 2014, claimant told Dr. Reneau that she had burning discomfort in the back of her neck. (Ex. 43-1). Although she described the discomfort as "worse since her last visit," during her prior visit to Dr. Reneau (on March 21, 2014), she reported only upper and mid-back discomfort. (Ex. 31-1).

Dr. Herring opined that claimant's disc herniations caused thoracic and mid scapular symptoms, which progressed to a point where the cervical symptoms became more prominent. (Ex. 107-4). Yet, as discussed above, the record shows that claimant developed new neck discomfort and decreased range of motion rather abruptly, about two months after the injury. Dr. Herring does not acknowledge this delay or explain the apparent abrupt onset of neck discomfort and loss of range of motion.

Moreover, I am not persuaded by Dr. Herring's opinion that Dr. Hawes's reference to upper extremity paresthesias and Dr. Reneau's reference to radiating upper extremity symptoms was evidence of a cervical injury. (Ex. 107-3).

Dr. Hawes stated that claimant's "only paresthesias or numbness [wa]s in the ulnar distribution of both forearms." (Ex. 7-1). The June 2, 2014 electrodiagnostic study confirmed the presence of mild bilateral ulnar neuropathies. (Ex. 68-1). There was no evidence of any plexopathy or radiculopathy in the upper extremities. (*Id.*) Drs. Kuhn and Rosenbaum concluded that the peripheral neuropathies and carpal tunnel syndrome explained claimant's bilateral upper extremity symptoms, which were not due to any radiculopathy. (Exs. 109-2, 109A-2).

In contrast, Dr. Herring opined that his clinical findings were more relevant than the electrodiagnostic study in determining the etiology of claimant's symptoms. (Ex. 112-3). Yet, Dr. Herring's assessment of a cervical myelopathy that waxed and waned was not confirmed by any other physician.¹⁴ To the contrary, Drs. Kuhn, Rosenbaum, and Hutton concluded that there was no myelopathy. (Exs. 89-4, 91-9, 109). Dr. Rosenbaum reasoned that, if claimant had a myelopathy as a result of the work injury, findings would have appeared fairly soon after the incident and would have been persistent; it would be unlikely that findings would appear eight weeks after the incident, or would "come and go." (Ex. 109A-2). Additionally, Dr. Hutton reviewed claimant's cervical MRI and saw no change in cord signal or caliber. (Ex. 89-4). Drs. Kuhn and Rosenbaum also reviewed claimant's MRIs and reported that there was no compression of the cervical cord. (Exs. 109-1, 109A-1). After reviewing these thoughtful opinions, I do not find Dr. Herring's response (which merely states that his clinical examination of myelopathic findings confirmed that there was some cord irritation) persuasive. (Ex. 112-1).

Based on the foregoing, I would conclude that the medical evidence is insufficient to establish the existence of the claimed myelopathy or that the C4-5 and C5-6 disc herniations were due to the work injury. Accordingly, I would reinstate SAIF's denial.

¹⁴ On June 6, 2014, Dr. Kuhn documented a negative Lhermitte's sign. (Ex. 70-4). On June 10, 2014, four days later, Dr. Herring reported a positive Lhermitte's and "definite" tandem gait impairment. (Ex. 71-3). On August 12, 2014, Dr. Herring documented a negative Lhermitte's and normal gait. (Ex. 75-3, -4). On September 16, 2014, Dr. Herring reported "some" tandem gait impairment. (Ex. 80-3). On November 7, 2014, Dr. Hutton documented a normal gait. (Ex. 89-3). On November 25, 2014, Dr. Rosenbaum reported a normal gait. (Ex. 91-7). On January 22, 2015, Dr. Herring reported that "any prior findings consistent with a myelopathy are not a feature of today's exam." (Ex. 98-4).