

In the Matter of the Compensation of
JOHN W. WANTOWSKI, Claimant
WCB Case No. 98-08420, 98-07743
ORDER ON REMAND
Nicholas M Sencer, Claimant Attorneys
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Reviewing Panel: Members Biehl and Lowell.

This matter is before the Board on remand from the Court of Appeals. *Wantowski v. Crown Cork & Seal*, 175 Or App 609 (2001). The court reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's aggravation claim for a low back condition. In reaching our conclusion, we adopted the ALJ's reasoning that there were no objective findings to support an actual worsening of claimant's condition even if his symptoms had worsened sufficiently to conclude that his condition had worsened. Citing *SAIF v. January*, 166 Or App 620 (2000), the court reiterated its understanding of *SAIF v. Walker*, 330 Or 102, 118 (2000), that a symptomatic worsening may meet the proof standard for an actual worsening if a medical expert concludes that the symptoms demonstrate the existence of a worsened condition. Reasoning that our approach was inconsistent with *Walker* and *January* (decisions that issued after our order), the court remanded for reconsideration. Having received supplemental briefs from the parties, we proceed with our review.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We summarize the facts from the Court of Appeals' opinion.

Claimant worked for employer for over 30 years. Between 1976 and 1996, he filed a series of workers' compensation claims, each accepted by the insurer. As a consequence of claimant's compensable workplace injuries, he underwent six separate lumbar spinal surgeries. The last sequence of claims included a February 1993 L4-5 disc herniation claim. Following surgery to remove extruded disc material, the claim was closed in July 1994 with an award of 12 percent unscheduled permanent partial disability (PPD) for claimant's low back injury and 5 percent scheduled PPD for loss of use or function in his right foot. (Ex. 65).

In March 1996, claimant filed, and the employer accepted, an aggravation claim for a recurrent L4-5 disc herniation that resulted in further surgery to repair the injury. (Exs. 77, 79, 80). The aggravation claim was closed in April 1997 and, in September 1997, an Order on Reconsideration awarded claimant 12 percent unscheduled PPD for his low back injury. (Exs. 84, 87).

In April 1998, claimant experienced an acute back strain and returned to his attending physician, Dr. Schmidt. Claimant's strain improved slightly after that visit. However, claimant returned to Schmidt in June 1998 complaining of increased pain in his low back, pain in his right leg and calf, and numbness in his right big toe. (Ex. 101). Schmidt's file notes from that appointment reveal that claimant's right knee jerk was diminished and that both ankle jerks were absent. (*Id.*) Schmidt also noted that claimant developed radicular pain at 45 degrees of straight-leg raising on the right. (*Id.*) Schmidt ordered diagnostic testing that included an MRI, a CT scan, myelogram and x-rays. (Exs. 102, 104, 105A, 105B).

On September 15, 1998, claimant was examined by Drs. Gambee and Gripekoven on behalf of the insurer. They reported a waxing of claimant's symptoms, but concluded that no objective evidence existed of an actual worsening of claimant's condition. (Ex. 106-6).

After examining claimant's test results, Schmidt referred claimant to Dr. Waldram, another surgeon, to explore the possibility of lumbar fusion surgery. Waldram's physical exam revealed that claimant had a limited back range of motion, as well as some dysesthesias¹ and decreased sensation in his right foot. (Ex. 109A). Waldram also noted that claimant's diagnostic imaging studies indicated that he suffered from severe degenerative changes at L4-5 and L5-S1 with laminectomy defects at both levels. (*Id.*) Waldram concluded that claimant's only reasonable chance of improvement would come through a fusion. (*Id.*)

The insurer denied claimant's aggravation claim in September 1998. The ALJ upheld the denial on the basis that there were no objective findings to support an actual worsening of claimant's condition, even if his symptoms had worsened sufficiently to conclude that his condition had worsened. We affirmed the ALJ's order.

¹ *Stedman's Electronic Medical Dictionary*, v.4.0 (1998), defines "dysesthesia" as:
"1. Impairment of sensation short of anesthesia. 2. A condition in which a disagreeable sensation is produced by ordinary stimuli; caused by lesions of the sensory pathways, peripheral or central. 3. Abnormal sensations experienced in the absence of stimulation."

After we issued our order, the Supreme Court decided *SAIF v. Walker*, which held that evidence of a symptomatic worsening may prove an aggravation claim if, but only if, a physician concludes, based on objective findings (which may incorporate claimant's symptoms), that the underlying condition has worsened. 330 Or at 118-119.

Here, claimant appealed our order, arguing that *Walker* established a different test for aggravation claims. He asserted that there were sufficient objective findings in the record to support his physicians' conclusions that his condition had actually worsened. Relying on *Walker* and *SAIF v. January*, 166 Or App at 620, the Court of Appeals found that we had not considered the medical opinions of Schmidt and Waldram that the increase in claimant's symptoms indicated an actual worsening of his condition. The court explained that we had relied solely on objective findings in the record, and it determined that approach was inconsistent with its opinion in *January* and the Supreme Court's opinion in *Walker*. The court reversed and remanded for us to apply the proper test to determine whether claimant has proven a compensable aggravation claim under ORS 656.273(1).

Claimant argues on remand that there are many objective findings that support Dr. Schmidt's opinion that his back condition has actually worsened and he asserts that the fact that Schmidt based his opinion on subjective reports of increased pain does not undermine compensability. Alternatively, claimant contends that objective evidence establishes an actual worsening.

The insurer argues that Dr. Schmidt's deposition testimony does not support a compensable aggravation because his opinion of a worsening was based solely upon the subjective history provided by claimant. The insurer also contends that Dr. Waldram's opinion is not sufficient to establish compensability.

For the following reasons, we conclude that claimant has sustained his burden of establishing medical evidence of an actual worsening of the compensable condition supported by objective findings. In *SAIF v. Walker*, the Court held that evidence of a symptomatic worsening that exceeds the amount of waxing anticipated by an original permanent disability award may prove an aggravation claim "if, but only if, a physician concludes, based upon objective findings (which may incorporate the particular symptoms), that the underlying condition itself has worsened." 330 Or at 118-19. In *SAIF v. January*, 166 Or App at 624, the court explained that "if *medical* evidence--*i.e.*, a physician's expert opinion--establishes that the symptomatic worsening represents an actual

worsening of the underlying condition, then such evidence may carry the worker's burden.” (Emphasis in original).

We agree with claimant that Dr. Schmidt’s opinion is sufficient to establish a compensable aggravation. Dr. Schmidt, neurosurgeon, performed claimant’s most recent back surgery in August 1996 for a recurrent extruded disc. (Ex. 80). Claimant returned to work in December 1996 and was performing regular work about 6 weeks later. (Tr. 16, 17). Dr. Schmidt found claimant medically stationary in March 1997. (Ex. 83).

Claimant did not have any back or leg problems in early 1998. (Tr. 41). However, his back started bothering him in April 1998 and he sought treatment from Dr. Schmidt. (Tr. 41-42; Ex. 101). In June 1998, Dr. Schmidt said claimant had symptoms of an acute strain in April 1998 followed by a gradual increase in pain in his low back and right lower extremity. (Ex. 101). He explained:

“He has developed numbness into his great toe. His motor examination was difficult in the sense that he demonstrated weakness fairly diffusely in that extremity related to pain. His deep tendon reflexes revealed the right knee jerk to be diminished compared to the left, his ankle jerks both being absent. At 45 degrees of straight leg raising on the right he developed radicular pain. It was my impression that he has a recrudescence of his previous radiculopathy.” (*Id.*)

Dr. Schmidt referred claimant for a lumbar spine MRI, x-rays, a CT scan and a myelogram. (Exs. 102, 104, 105A, 105B). On August 14, 1998, claimant told Dr. Schmidt he had been unable to work because of increased pain. (Ex. 105C). Schmidt noted that claimant’s “[n]umbness which has had in past ? lat foot now entire top of foot.” (Ex. 105C-1). He said claimant could not work out because of increasing pain. (*Id.*) He referred claimant to Dr. Waldram, who recommended a fusion. (Ex. 109A).

Claimant returned to Schmidt on November 3, 1998. (Ex. 110A). He had increased pain in any position. Schmidt noted that claimant had radiation in his right buttock and thigh, and some numbness in his right foot when driving. (*Id.*)

In a later concurrence letter from claimant’s attorney, Dr. Schmidt agreed that claimant was currently unable to perform his regular work and his inability to

work was due to progressive post-surgical degenerative changes at L4-5. (Ex. 112-2). He agreed with the following:

“The x-rays and MRI constitute objective findings that support [claimant’s] subjective report of a worsened condition manifested by increased symptoms of pain. Other objective findings are positive straight leg raising test on the right and difficulty walking on [right] heel.” (Ex. 112-2).

In a deposition, Dr. Schmidt changed part of his opinion. He explained that, because no scans were taken after claimant’s August 1996 surgery, there was no baseline from which he could objectively determine that there was a change or worsening in claimant’s disc. (Ex. 113-7, -8). He was unable to determine from claimant’s x-rays and MRI scan whether the findings were recent because there was no baseline after surgery. (Ex. 113-23). He explained that the scans did not provide conclusive information that there had been a change. (*Id.*)

On the other hand, Dr. Schmidt found that claimant’s condition in June 1998 had progressed beyond where it was in March 1997, and was beyond the waxing of his condition that had been anticipated when claimant was medically stationary in March 1997. (Ex. 113-16, -17). In discussing the differences in claimant’s condition between March 1997 and April 1998, he said that in March 1997, claimant was working out three days a week and did not have any leg pain. (Ex. 113-14). Although claimant had back pain, it seemed to be decreasing. In April 1998, claimant had lifted some heavier boxes at work, which caused more back pain, as well as pain in his right buttocks and upper thigh. (*Id.*) Two months later, claimant had gradually increasing pain in his back and right leg. The exercise program was no longer helping him. In July 1998, claimant was not working. In August, claimant was having more pain and more trouble with numbness, and he was unable to workout because it made his pain worse, which was different than before. (Ex. 113-15, -16).

Dr. Schmidt explained the physiologic basis for claimant’s increased symptoms beginning in April 1998:

“He has obviously a lot of fibrous tissue where he had the disk. He has a fibrous tissue adherence of the covering of the nerve, to the adjacent bony structures, to the ligaments where the disk normally was, and so he has a restricted travel of the nerve root. So that if there’s a force, or movement I

should say, of the structures, and that's going to tug on the covering of the nerve, where it wouldn't in somebody who has never been operated on. Then, combined with the fact that he's had all those surgeries, that he probably has more movement at that level than somebody who has not been operated on. So I think those interactions probably has resulted in his flare-ups of pain, and the fact that this last flare has not ceased.” (Ex. 113-19, -20).

Dr. Schmidt had no reason to doubt claimant's subjective reports of pain. (Ex. 113-18). He never suspected that claimant was exaggerating. (Ex. 113-19). Dr. Schmidt agreed that, based on claimant's history, the nerve root movement and instability was pathologically worse. (Ex. 113-20). Despite the fact that the x-rays and scans did not provide conclusive information of a change, Dr. Schmidt had no reason to doubt that claimant had actually experienced a pathological worsening since 1997. (Ex. 113-23).

The insurer contends that Dr. Schmidt's opinion does not establish an aggravation claim because he agreed with Drs. Gambee and Gripekoven that there was a lack of “objective findings” that claimant's back condition had actually worsened since 1997. (Ex. 113-9).

In *SAIF v. Lewis*, 170 Or App 201, 212 (2000), *rev allowed* 331 Or 692 (2001), the court discussed the definition of “objective findings” in ORS 656.005(19), explaining that “[t]he statutory emphasis is on findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing that produces results -- either physical or subjective responses -- that are witnessed, measured, or can be reproduced.”

In his December 1998 concurrence letter, Dr. Schmidt agreed that claimant had objective findings of positive straight leg raising on the right and difficulty walking on his right heel. (Ex. 112-2). In his deposition, he explained:

“Those are sort of objective, and sort of not, in the sense that if somebody has pain, then they are not going to walk on their heels as well. So that can kind of fluctuate. Straight-leg raising also is a self-reported – the patient is reporting what they are feeling.” (Ex. 113-24).

We have previously held that “objective findings” is a legal term, not a medical term, and a physician's opinion that examination findings do not constitute objective findings is irrelevant if those findings otherwise satisfy ORS 656.005(19). *See, e.g., Linda M. Hansen, 51 Van Natta 1253 (1999), on recon 51 Van Natta 1747 (1999)*. Although Dr. Schmidt said that the findings of positive straight leg raising on the right and difficulty walking on the right heel were based on claimant’s self-reporting, he also testified that he had no reason to doubt claimant’s subjective reports of pain and he did not suspect that claimant was exaggerating. (Ex. 113-18, -19). Similarly, Dr. Waldram found that claimant was “very straightforward” and did not demonstrate any significant pain behavior. (Ex. 109A).

We find that the findings of positive straight leg raising on the right and difficulty walking on the right heel, as well as claimant’s subjective responses to Dr. Schmidt’s exams, were subject to a verification process by Dr. Schmidt (who witnessed and measured the responses), which was based on his trained observation and examinations and his ability to compare claimant’s condition based on his previous exams and treatment. Under these circumstances, we conclude that Dr. Schmidt’s findings constitute “objective findings” of an actual worsening of his back condition.² The insurer relies on Dr. Schmidt’s statement that “it was difficult to know whether the pain was increasing, or just that he couldn’t – he wasn’t able to deal with it as well” (Ex. 113-15), to argue that his opinion was based on an unverifiable history and was therefore not based on objective findings. When we consider Dr. Schmidt’s opinion as a whole, however, we are satisfied that he engaged in an adequate verification process that produced physical or subjective responses that were witnessed and measured.

In evaluating the medical evidence, we may give greater weight to the opinion of the treating physician, depending on the record in each case. *See Dillon v. Whirlpool Corp., 172 Or App 484, 489 (2001)*. Here, we are persuaded by the opinion of Dr. Schmidt, claimant’s treating physician, because of his opportunity to observe the claimant over an extended period of time, and because

² We note that the court said that our previous order failed to explain why the results of the x-ray and CT scan, straight leg test, knee-jerk test and claimant’s documented numbness in his right toe and foot did not constitute “objective findings” under ORS 656.005(19). 175 Or App at 616. In response, we offer the following explanation. There is no expert medical evidence in the record explaining whether or not those tests demonstrate an “actual worsening” since the last award of compensation and we do not have the necessary medical expertise to make that determination. We are not an agency with specialized medical expertise. *Benz v. SAIF, 170 Or App 22, 26 (2000); SAIF v. Calder, 157 Or App 224, 227-28 (1998)*.

he performed his most recent surgery. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 701 (1988); *Weiland v. SAIF*, 64 Or App 810 (1983). Dr. Schmidt persuasively explained that claimant's symptomatic worsening represented an actual worsening of the underlying condition, which was beyond the waxing of his condition that had been anticipated when claimant was medically stationary in March 1997. (Ex. 113-16, -17). Dr. Schmidt agreed that claimant's back condition, including nerve root movement and instability, was pathologically worse. (Ex. 113-20, -23).

Dr. Schmidt's opinion was supported by that of Dr. Waldram, who examined claimant in October 1998 and found limited motion, some dysesthesias and decreased sensation in his right foot over the top of his foot. (Ex. 109A). He said claimant was "very straightforward" and did not demonstrate any significant pain behavior. (*Id.*) In a concurrence letter from claimant's attorney, Dr. Waldram agreed that claimant needed a fusion at L4-5 and L5-S1 and was currently unable to perform his regular work. (Ex. 111). He attributed claimant's inability to work to progressive post-surgical degenerative changes at L4-5. (Ex. 111-2). Dr. Waldram agreed that x-rays and the MRI constituted objective findings that supported claimant's subjective reports of a worsened condition manifested by increased symptoms of pain. (*Id.*)

The only other opinion is from Drs. Gambee and Gripekoven, who examined claimant on behalf of the insurer. They found that claimant had an increase of subjective complaints, but no objective evidence of worsening. (Ex. 106-6, -7). Although they found reduced lumbar range of motion, they said it may be due to guarding secondary to pain. (Ex. 106-6). In contrast to claimant's treating physicians, Drs. Gambee and Gripekoven found that claimant had some functional behavior. (Ex. 106-7). We rely instead on the opinion of Dr. Schmidt, who had an opportunity to examine claimant on several occasions, and found no reason to doubt claimant's reports of pain.

Based on the opinion of Dr. Schmidt, as supported by Dr. Waldram, we conclude that claimant has met his burden of proving that he has a worsened condition resulting from the original injury "established by medical evidence of an actual worsening of the compensable condition supported by objective findings[.]" pursuant to ORS 656.273(1).³

³ The ALJ's order also addressed the extent of claimant's disability related to his hernia claim, but because that issue has not been contested, we do not address it.

Where a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). Claimant requests a total of \$16,600 for his counsel's services at hearing and before the Board and the Court of Appeals. Claimant's attorney submitted a petition for attorney fees for his services at judicial review, based on 45.5 hours at \$200 per hour. The insurer objected to the petition.

On remand, the insurer reiterates that claimant's fee request is unreasonably high. The insurer contends that the time claimant's attorney spent preparing for and attending oral argument (12 hours) was unreasonable. Further, the insurer asserts that the hourly rate of \$200 per hour is unreasonable for this case. The insurer asserts that a fee between \$150 and \$160 per hour should be applied instead.

In deciding whether the requested fee is appropriate, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of each case. *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 issue(s) 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 any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

There were two issues at hearing: extent of claimant's permanent disability related to his hernia claim (which was unsuccessful) and aggravation of his low back condition. The hearing lasted over two hours (61 page transcript). Claimant and his wife testified. The record contains 123 exhibits, including 12 exhibits submitted by claimant's counsel. There was one deposition with a 23-page transcript. Closing arguments consisted of a 27-page transcript. After the ALJ issued the initial order, claimant requested reconsideration and submitted a 4-page opening brief and a 5-page reply brief.

On Board review, claimant's counsel submitted a 15-page appellant's brief and a 5-page reply brief.⁴ On judicial review, claimant's counsel submitted an 11-page petitioner's brief, with appendices, and presented oral argument. On

⁴ We note that, on previous Board review, claimant requested a \$7,500 fee if he prevailed on review. The insurer did not object to his fee request at that time.

remand, claimant's counsel submitted a 5-page opening brief and a 6-page reply brief.

The insurer argues on remand that the legal issue in this case was not complex and instead presents as a “mirror image” of *Walker*. The insurer’s attorney fee argument about complexity appears to be inconsistent with the rest of its brief, which disagrees with claimant’s interpretation of the *Walker* case and its application to these facts. In any event, contrary to the insurer’s assertion, we find that the legal and factual issues presented on remand are of above-average complexity, as compared to those normally presented to this forum for resolution.

Furthermore, we are not persuaded by the insurer’s argument that the 12 hours claimant’s attorney spent in preparing for and attending oral argument was unreasonable. In claimant’s reply to the insurer’s objections, claimant’s attorney explained that, on the day of oral argument, this case was one of the last to be heard. In addition to two hours driving, he devoted seven hours to this case on the day of oral argument. He also devoted five hours to preparing for argument. We find that the 12 hours claimant devoted to preparing for and attending oral argument was entirely reasonable.

We also disagree with the insurer’s contention regarding claimant’s requested fee, particularly in light of the above-average complexity of this case. In addition, the claim’s value and the benefits secured are significant, especially considering that surgery is recommended and claimant may be entitled to an additional permanent disability award. Claimant asserts that, given the scope of his impairment, he may be eligible for permanent total disability benefits. The parties’ respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant’s counsel’s efforts might have gone uncompensated, particularly considering the insurer’s vigorous challenge.

Based upon our application of each of the previously enumerated factors and considering the parties’ arguments, we award \$16,600 for services at hearing, before the Board, and before the Court of Appeals, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issue (as represented by the record, and claimant’s counsel’s fee petition and the insurer’s objections), the above-average complexity of the aggravation issue, the value of the interest involved, and the risk that claimant’s counsel might go uncompensated. Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee issue. *See Dotson v.*

Bohemia, Inc., 80 Or App 233, *rev den* 302 Or 461 (1986); *Amador Mendez*, 44 Van Natta 736 (1992).

Accordingly, the ALJ's order dated April 1, 1999, as reconsidered June 10, 1999, is reversed in part. The insurer's denial of claimant's aggravation claim is set aside and the claim is remanded to the insurer for further processing according to law. For services performed before the Hearings Division, Board, and court, claimant's counsel is awarded \$16,600, to be paid by the insurer.

IT IS SO ORDERED.

Entered at Salem, Oregon on May 15, 2002