In the Matter of the Compensation of
SHARON R. ANDREASON, Claimant
WCB Case No. 12-01052
ORDER ON REVIEW
Brian L. Pocock, Claimant Attorneys
Reinisch Wilson Weier, Defense Attorneys

Reviewing Panel: Members Curey and Lanning.

Claimant requests review of Administrative Law Judge (ALJ) Crummé's order that: (1) admitted a "post-hearing" report from Dr. Green, submitted by the insurer; and (2) upheld the insurer's denial of claimant's new/omitted medical condition claims for left pectoralis minor syndrome and left rotator cuff tendinitis/ tendinosis. In its respondent's brief, the insurer contests that portion of the ALJ's order that admitted a "post-hearing" report from claimant's attending physician. On review, the issues are evidence and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and provide the following summary.

Since 1988, claimant has received medical treatment for chest and shoulder complaints. In 1988, she had anterior right shoulder and pectoralis muscle pain. (Exs. 6, 8). In 1989, she underwent a right brachial plexus decompression surgery for thoracic outlet syndrome. (Ex. 14). In 1997, she experienced recurrent right-sided symptoms. (Ex. 19). In 1998, she developed bilateral arm pain and was diagnosed with fibromyalgia. (Exs. 39, 46, 47).

In 2005, Dr. Morris, a specialist in family medicine and pain management, assumed care of claimant's "chronic global musculoskeletal pain of 6 years duration." (Ex. 63-1). Noting "tender" points in her chest, shoulders, back, and lower extremities, he diagnosed fibromyalgia syndrome. (Ex. 63-4, -5).

Dr. Silver, a family medicine practitioner, who assumed claimant's care in 2006, prescribed pain medication for fibromyalgia. (Exs. 103-3, 104, 106, 108, 109, 110, 111, 112). On April 1, 2008, claimant told Dr. Silver that she "hurts so bad" and was taking over-the-counter pain medicine in addition to prescription medication. (Ex. 113).

On June 1, 2008, claimant, a grocery checker, lifted a 30-can case of beer and placed it in a customer's cart. In doing so, she felt pain in her left shoulder and arm. (Tr. 8-9). On June 17, 2008, she consulted Dr. Silver, who assessed a left shoulder strain and rotator cuff tendinitis/bursitis. (Exs. 117, 118). The claim was accepted for a left shoulder strain. (Exs. 119, 125).

In March 2009, Dr. Whitney performed left shoulder surgery. His post-operative diagnosis was rotator cuff tendinosis with impingement. (Ex. 134). On April 28, 2010, noting that claimant had chronic left shoulder pain, Dr. Silver opined that her condition was medically stationary. (Ex. 144).

In August 2010, Dr. Parvin, an orthopedic surgeon, performed an examination at the insurer's request. Dr. Parvin opined that the "diagnoses relating to the [2008] incident include [left shoulder] rotator cuff inflammation such as tendinitis, caused in combination by the work-related activity and preexisting superimposed degenerative change." (Ex. 148-6). He attributed the major contributing cause of her current condition to preexisting conditions. (Ex. 148-7). Dr. Whitney concurred with Dr. Parvin's report. (Ex. 155).

In January 2011, claimant consulted Dr. Butters, an orthopedist, for left shoulder complaints. Dr. Butters diagnosed left rotator cuff tendinitis. (Ex. 157-3).

A July 22, 2011 Notice of Closure awarded no permanent disability. (Ex. 180). Claimant requested reconsideration. (Ex. 188-1).

In November 2011, a medical arbiter panel performed an examination. Drs. Dordevich, Tiley, and Williams opined that, at the time of their evaluation, claimant had degenerative arthritic changes of the left acromioclavicular joint and evidence of chronic rotator cuff tendinopathy that represented degenerative changes related to age and anatomy (*i.e.*, claimant's condition was not causally related to the 2008 work injury). (Ex. 186-7).

On January 11, 2012, Dr. Silver examined claimant and elicited discomfort in the area of her left pectoralis minor muscle. (Ex. 160-1). On June 19, 2012, Dr. Machanic, a neurologist, performed an EMG/nerve conduction study and recommended clinical correlation for pectoralis minor syndrome or thoracic outlet syndrome. (Ex. 206-2). On June 20, 2012, Dr. Sanders, a vascular surgeon, performed an examination and concluded that claimant's primary problem was left pectoralis minor syndrome. (Ex. 194-1). He attributed the condition to the 2008 work injury. (Ex. 194-4).

On August 8, 2012, claimant initiated new/omitted medical condition claims for "left pectoralis minor syndrome" and "left rotator cuff tendinitis/tendinosis." (Ex. 196).[1] On September 19, 2012, Dr. Moneta, a vascular surgeon, and Dr. Green, a neurologist, performed separate examinations at the insurer's request. (Exs. 198, 199). Dr. Moneta opined that claimant did not have pectoralis minor syndrome. (Ex. 198-5, -6, -7, -8). Dr. Green opined that pectoralis minor syndrome did not exist. (Ex. 199-24). On October 15, 2012, the insurer denied that the claimed conditions existed or, alternatively, that they were "compensably related" to the 2008 work injury. (Ex. 201). Claimant requested a hearing.

The parties agreed to continue the hearing for the purpose of submitting post-hearing "rebuttal" reports. (Tr. 3). Thereafter, claimant submitted a report from Dr. Silver opining, in part, that she has rotator cuff tendinitis/tendinosis due to the work injury. (Ex. 207-4). Contending that the report went beyond the scope of rebuttal, the insurer objected to its admission. The insurer also submitted a report from Dr. Green. (Ex. 208). Claimant objected to its admission, arguing that the insurer did not have the right to the last presentation of evidence.

CONCLUSIONS OF LAW AND OPINION

Evidence

The ALJ overruled the insurer's objection to Dr. Silver's report. (Ex. 207). In doing so, the ALJ reasoned that Dr. Green's "pre-hearing" reports addressed the rotator cuff condition claim and, therefore, those portions of Dr. Silver's report that addressed the rotator cuff condition were appropriate for rebuttal purposes.

The ALJ also overruled claimant's objection to Dr. Green's report. (Ex. 208). Applying a "combined condition" analysis to the new/omitted medical condition claims, the ALJ determined that the insurer had the right to the last presentation of evidence on the "major cause" issue.

On review, asserting that Dr. Green only "recited" a review of the medical record and did not provide his opinion regarding claimant's rotator cuff conditions, the insurer contends that Dr. Silver's "post-hearing" report should be excluded as

[1] Claimant also initiated new/omitted medical condition claims for a "left shoulder strain combined with preexisting left AC joint arthritis," "left shoulder strain combined with preexisting fibromyalgia, thoracic outlet syndrome, and anxiety," and "left thoracic outlet syndrome," which the insurer denied. (Exs. 190, 196, 201). Claimant withdrew her requests for hearing pertaining to those denials.

exceeding the scope of rebuttal. Claimant argues that her new/omitted medical conditions were not claimed as "combined conditions" and, therefore, she has the right to the last presentation of evidence under a "material contributing cause" analysis. For the following reasons, we affirm the ALJ's evidentiary rulings.

The ALJ may conduct a hearing in any manner that will achieve substantial justice and has broad discretion regarding the admissibility of evidence. *See* ORS 656.283(6); *Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *SAIF v. Kurcin*, 334 Or 399 (2002).

Based on our review, portions of Dr. Silver's "post-hearing" report responded to Dr. Green's "pre-hearing" reports concerning the existence and cause of claimant's left shoulder symptoms. (Ex. 207-4). Under such circumstances, we find no abuse of discretion in the ALJ's admission of Dr. Silver's "post-hearing" report for rebuttal purposes. *See* OAR 438-007-0023 (the party bearing the burden of proof on an issue has the right of first and last presentation of evidence); *Kimberly A. Summerhays-Morgan*, 65 Van Natta 223, 224 (2013) (finding no abuse of discretion in the ALJ's admission of the claimant's rebuttal report).

We turn to claimant's objection to Dr. Green's "post-hearing" report, which addressed the major contributing cause of claimant's disability/need for treatment. Where, as here, the burden of proof could shift to the carrier to prove that an "otherwise compensable injury" was not the major contributing cause of the disability/need for treatment for any combined condition, the carrier would be entitled to the last presentation of evidence regarding that issue. *See* OAR 438-007-0023; *SAIF v. Kollias*, 233 Or App 499, 505 (2010); *Michael D. Fuller*, 64 Van Natta 627, 629 (2012). Considering such circumstances, we find no abuse of discretion in the ALJ's admission of Dr. Green's "post-hearing" report for that rebuttal purpose.

Compensability

To prevail on her new/omitted medical condition claims, claimant must prove that the conditions exist and that the work injury was a material contributing cause of her disability/need for treatment of those conditions. *See* ORS 656.005(7)(a); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005). If claimant satisfies her burden and the medical evidence establishes that the "otherwise compensable injury" combined at any time with a preexisting condition to cause or prolong disability or a need for treatment of the "combined condition," the burden shifts to the carrier to prove that the "otherwise compensable injury" is

not the major contributing cause of claimant's disability/need for treatment of the combined condition. *See* ORS 656.005(7)(a)(B); ORS 656.266(2)(a); *Kollias*, 233 Or App at 505; *Jack G. Scoggins*, 56 Van Natta 2534, 2535 (2004). The "otherwise compensable injury" means the "work-related injury incident." *See Brown v. SAIF*, 262 Or App 640, 652 (2014); *Jean M. Janvier*, 66 Van Natta 1827, 1832-33 (2014) (applying the *Brown* definition of an "otherwise compensable injury" to claims under ORS 656.266(2)(a)).

These issues present complex medical questions that must be resolved by expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 283 (1993). When presented with disagreement among medical experts, we give more weight to those opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Left Pectoralis Minor Syndrome

Relying on Dr. Green's opinion, the ALJ reasoned that the insurer met its burden to prove that the pectoralis minor syndrome condition was not compensable. Accordingly, the ALJ upheld the insurer's denial of that condition.

On review, arguing that there was no preexisting condition, claimant contends that Dr. Sanders's opinion was sufficient to meet her burden to prove that the injury was a material contributing cause of her need for treatment. In response, the insurer asserts that claimant did not establish the existence of her claimed pectoralis minor syndrome or that the 2008 work injury was a material contributing cause of her need for treatment of that condition. Relying on Dr. Green's opinion, the insurer also argues that claimant's preexisting condition was the major contributing cause of her need for treatment of the combined condition. For the following reasons, we conclude that claimant met her burden to prove an "otherwise compensable injury," but that the record does not establish a statutory "preexisting condition" or a "combined condition."

The physicians disagree regarding the existence of the condition. Dr. Sanders diagnosed left pectoralis minor syndrome based on specific examination findings, including "severe tenderness over the left pectoralis minor," claimant's response to a left pectoralis minor muscle block, and Dr. Machanic's abnormal EMG and nerve conduction study. (Ex. 194-3, -4, -41, -42, -48).

Dr. Moneta did not believe that there is any "credible objective evidence that [claimant] has * * * left pectoralis minor syndrome." (Ex. 198-5). Yet, he did not describe specifically examining claimant's left pectoralis, stating only that the left side of her chest was "diffusely tender below the clavicle, most tender laterally." (Ex. 198-2). He also disputed Dr. Sanders's use of the left pectoralis minor muscle block to diagnose the condition, stating that the condition "has no objective form of diagnosis," "no support in the medical literature," and that the post-injection "diffuse relief of symptoms in a non-dermatomal pattern" made "no anatomic sense." (Ex. 198-5). Yet, he did not address claimant's "post-injection" ability to perform left arm maneuvers that she had not been able to perform before the injection. Finally, he did not discuss the results of Dr. Machanic's EMG/nerve conduction study.

Dr. Green opined that left pectoralis minor syndrome "does not exist," in that the diagnosis has no "specific medical meaning," "generally accepted" criteria, or "demonstrable underlying pathophysiology." (Ex. 199-24). He also considered claimant's "subjective" relief after the injection to demonstrate "absolutely nothing" because her "subjective symptoms (such as tenderness, pain, or volitional reduction in range of motion or strength) were not plausible or verifiable from the beginning." (*Id.*) Yet, although he noted that various left arm and shoulder movement caused claimant pectoral discomfort, he did not describe specifically examining claimant's left pectoralis area. (Exs. 199-5, -6, 208-5). He considered Dr. Machanic's "diagnostic technique" as having been "completely discredited and abandoned," but was mistaken about the test that Dr. Machanic performed.[2] (Exs. 204-19, -20, 206-64, -65). Dr. Green ultimately attributed claimant's symptoms to "malingering; *e.g.*, conscious deception for personal gain." (Ex. 199-22).

In response, Dr. Sanders did not find any evidence of malingering when he examined claimant. Instead, claimant's responses to his examination were "exactly" what he would expect from a pectoralis minor compression syndrome. (Ex. 206-55).

[2] Dr. Green understood that Dr. Machanic had performed a diagnostic procedure that had been discredited and abandoned. (Ex. 204-19, -20). Describing Dr. Machanic's diagnostic technique as "absolutely different" than the discredited procedure, Dr. Sanders said that Dr. Green had misunderstood the procedure performed by Dr. Machanic. (Ex. 206-64, -65). Dr. Green later reviewed Dr. Machanic's study. Acknowledging that the data might show an abnormality, Dr. Green criticized the study's reliability and concluded that a "technical artifact" was more likely. (Ex. 208-13, -14).

We consider Dr. Sanders's diagnostic opinion to be well-reasoned and more persuasive than the opinions of Drs. Green and Moneta. *Somers*, 77 Or App at 263. In diagnosing (*i.e.*, establishing the existence of) the condition, Dr. Sanders explained that the pectoralis minor muscle and tendon, the biceps tendon, and the armpit must be specifically palpated. (Ex. 206-40). Neither Dr. Moneta nor Dr. Green described specifically palpating these areas.[3] Instead, Dr. Moneta opined that there was no objective method for diagnosing pectoralis minor syndrome. (Ex. 198-4). Similarly, Dr. Green did not "put undue emphasis on nonphysiologic subjective complaints[.]" (Ex. 208-5).

Dr. Sanders further explained that the most important diagnostic criteria was claimant's response to the pectoralis minor muscle block, which not only resulted in the disappearance of symptoms but also allowed her to perform maneuvers that she had been unable to perform before the injection. (Ex. 206-41, -42, -43, -44, -45). Dr. Moneta opined that "[i]t makes no anatomic sense that injection of the local anesthetic in one location would result in diffuse relief of symptoms in a non-dermatomal pattern." (Ex. 198-5). Dr. Green opined that diagnostic blocks that rely entirely on "subjective response" are invalid. (Ex. 208-8). However, neither Dr. Moneta nor Dr. Green addressed claimant's "post-injection" ability to maneuver her left arm, which Dr. Sanders had relied on in reaching his opinion. In the absence of such a discussion, we find the opinions from Drs. Moneta and Green less 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)

Based on the aforementioned reasoning, we consider Dr. Sanders's opinion to persuasively support the existence of the claimed pectoralis minor syndrome.

Turning to the causation issue, Dr. Sanders concluded that claimant's left pectoralis minor syndrome was not a preexisting condition and that the 2008 work injury caused her symptoms. (Ex. 194-4). He opined that the mechanism of injury (*i.e.*, lifting a 30-can case of beer and placing it in a grocery cart) would injure the pectoralis minor muscle, explaining that in the course of lifting and moving a heavy object, the shoulder and shoulder blade are moved backward (into abduction), stretching the pectoralis muscle. (Ex. 206-36, -37). He also understood that claimant developed left anterior shoulder and chest pain shortly after the June 2008 injury. (Ex. 206-26).

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[3] Dr. Whitney also reported that claimant did not present any signs or symptoms of left pectoralis minor syndrome during the time he treated her, but did not describe examining claimant's left pectoralis muscle area. (Ex. 202).

Dr. Sanders acknowledged that claimant told him that she had not had similar symptoms before the 2008 work injury. (Ex. 206-6). He subsequently reviewed "pre-2008 work injury" medical records that reported ongoing "generalized symptoms" in multiple body areas, including bilateral chest pain. (Ex. 206-6, -7). He maintained, however, that claimant's "pre-2008 work injury" symptoms were quite different than the left chest and arm pain she described after the 2008 injury.[4] (Ex. 206-7).

Dr. Sanders also acknowledged that claimant's pectoralis pain was not documented until January 2011, but opined that this did not establish the onset of her symptoms.[5] (Ex. 206-26, -27, -28). Instead, he considered claimant's report of gradually intensifying and more frequent left upper extremity and chest pain after the 2009 surgery, to suggest that her left shoulder pain "well could have been accompanied by pain in the left chest * * * but no one asked about it." (Exs. 194-2, 206-29). He explained that patients commonly report shoulder pain without including the chest, and the chest wall is not routinely examined for tenderness around the pectoralis minor areas. (Ex. 206-30, -33, -34).

We find Dr. Sanders's opinion persuasive because it is thoroughly explained, well reasoned, and based on complete and accurate information, taking into account claimant's prior history, mechanism of injury, and "post-injury" symptom development. *Somers*, 77 Or App at 263.

In contrast, Dr. Green summarily stated that "lifting and putting down a case of beer * * * would not be expected to cause any injury to the pectoralis minor[.]" (Ex. 199-28). Lacking adequate explanation, we consider his opinion to be unpersuasive. *See Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained or conclusory opinion).

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[4] After considering claimant's "pre-2008 work injury symptoms," Dr. Sanders did not expressly conclude that the 2008 work injury was a material contributing cause of her disability/treatment. Nonetheless, he did not retract his prior opinion that the 2008 work injury caused her symptoms and need for treatment. (Ex. 194-4). His later statements/testimony support a correlation between claimant's symptoms, disability/treatment, and the 2008 work injury. *See SAIF v. Strubel*, 161 Or App 516, 521-22 (1999) (medical records are evaluated in context and based on the record as a whole to determine sufficiency).

[5] Dr. Silver disagreed with a statement that he did not know whether claimant complained of pain in the pectoralis area since June 2008 or whether she developed this pain at a later date. (Ex. 200-2). He stated that claimant had "[left] anterior shoulder pain since the beginning but the pectoralis muscles are a *large* area in [the] anterior chest." (*Id.*)

Dr. Moneta concluded that the injury could not have caused left pectoralis minor syndrome because he did not believe that claimant had the condition. (Ex. 198-5). Because we have found that the condition exists, we do not find his opinion to be persuasive. *See Jessica M. Taylor*, 62 Van Natta 3034 (2010) (opinion of physician who did not believe that the disputed condition existed was unpersuasive when the medical evidence established the existence of that condition).

For the foregoing reasons, we find that Dr. Sanders's opinion persuasively establishes the existence of pectoralis minor syndrome and that the 2008 work injury was a material contributing cause of the disability or need for treatment of the condition. Accordingly, claimant has established an "otherwise compensable injury."

Therefore, the burden of proof shifts to the insurer to establish that the "otherwise compensable injury" was not the major contributing cause of disability/need for treatment of the combined condition. ORS 656.266(2)(a). The insurer's burden includes proof of a "preexisting condition" under ORS 656.005(24)[6] and a "combined condition." *Kollias*, 233 Or App at 505.

Here, the record does not establish that claimant was diagnosed with, or treated for the symptoms of, pectoralis minor syndrome, regardless of the diagnosis, before the 2008 injury, or that she had "arthritis" or an "arthritic condition." *See Schleiss v. SAIF*, 354 Or 637, 652-53 (2013) (defining "arthritis" for purposes of determining a preexisting condition under ORS 656.005(24)(a)(A) to mean the "inflammation of one or more joints, due to infectious, metabolic, or constitutional causes, and resulting in breakdown, degeneration, or structural change"); *Hopkins v. SAIF*, 349 Or 348, 364 (2010) (same). For the following reasons, we are not persuaded that the insurer established a "preexisting condition" or a "combined condition."

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[6] ORS 656.005(24)(a) provides in part:

> "Preexisting condition" means, for all industrial injury claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment, provided that:
>
> (A) Except for claims for which a preexisting condition is arthritis or an arthritic condition, the worker has been diagnosed with such condition, or has obtained medical services for the symptoms of the condition regardless of diagnosis;"

Dr. Green opined that claimant's "pre-2008 work injury" medical records showed "diffuse and migratory pain symptoms that were medically unexplained, involving the anterior chest bilaterally, upper thoracic levels bilaterally, shoulders, and left arm," and that these historical symptoms were "reminiscent of her current symptoms – which also are medically unexplained." (Ex. 204-16). Nevertheless, he did not opine that claimant obtained medical services for symptoms of what has now been diagnosed as pectoralis minor syndrome. Instead, he concluded that "similar treatment – for similar symptoms – seems reasonable support for considering [this] condition to be preexisting, if [it exists] at all." (*Id.*)

Under such circumstances, we do not consider Dr. Green's opinion sufficient to establish a preexisting condition under ORS 656.005(24). *See White v. Boldt Co.*, 212 Or App 59, 64 (2007) (a "preexisting" condition is not dependent on a pre-injury history of symptoms, but on whether the claimant has been diagnosed with, or received medical services for symptoms of, the condition before the date of the injury); *Bradford White*, 59 Van Natta 2483, 2487 (2007) (on remand) (a "preexisting" condition was not established where the claimant had a C6-7 surgery and sought medical advice for neck symptoms, but was not diagnosed with or treated for symptoms of a C6-7 degenerative condition before the injury). In any event, Dr. Green did not conclude that claimant suffered from a "combined condition," explaining that he did not find claimant's 2008 work injury to be "plausible." (Ex. 204-17).

Therefore, based on the foregoing reasoning, we are not persuaded that the insurer has established the existence of either a "preexisting condition" or a "combined condition." Consequently, we set aside the insurer's denial of claimant's new/omitted medical condition claim for left pectoralis minor syndrome. Accordingly, we reverse this portion of the ALJ's order.

Left Rotator Cuff Tendinitis/Tendinosis

The ALJ determined that the existence of left rotator cuff tendinitis/ tendinosis had been established. Applying the major contributing cause standard for a combined condition, the ALJ concluded that the insurer proved that the condition was not compensable. ORS 656.005(7)(a)(B); ORS 656.266(2)(a).

On review, claimant contests the ALJ's evaluation of the medical evidence. Specifically, she contends that the medical evidence establishes that the 2008 work injury was a material contributing cause of her disability/need for treatment of left rotator cuff tendinitis/tendinosis. She also asserts that the medical evidence does not establish a "preexisting condition" or a "combined condition." For the following reasons, we agree with claimant's contentions.

In May 2013, Dr. Silver, claimant's attending physician, opined that claimant had rotator cuff tendinitis/tendinosis due to the 2008 work injury. (Ex. 207-4). The insurer asserts that this statement represents an unexplained change of opinion from his previous observations and is conclusory. *See Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained or conclusory opinion); *Kenneth L. Edwards*, 58 Van Natta 487, 488 (2006) (unexplained change of opinion rendered physician's opinion unpersuasive). We disagree, based on the following reasoning.

On June 17, 2008, shortly after claimant's work injury, Dr. Silver diagnosed left rotator cuff tendinitis. (Ex. 118). In March 2011, he disagreed with Dr. Parvin's opinion that "preexisting or other degenerative processes [were] to blame for [claimant's] ongoing [left] shoulder pain." (Ex. 163). Reasoning that the absence of preexisting left shoulder complaints and subsequent development of chronic pain suggested that claimant had more than a left shoulder strain, Dr. Silver acknowledged that the exact cause of her symptoms was not clear. (*Id.*) He "supposed" that she "could" have a chronic impingement syndrome, but noted that she had no problems before the 2008 work injury. (*Id.*)

In July 2011, when presented with opinions from Drs. Whitney, Parvin, and Butters,[7] Dr. Silver acknowledged that a strain or sprain should have long since resolved. (Ex. 175). Unable to identify a better diagnosis, he proposed "chronic myofascial pain or regional pain syndrome related to the left shoulder injury." (Ex. 175).

In August 2012, Dr. Silver opined that claimant suffered an injury to her rotator cuff muscles as a result of the June 2008 work incident. (Ex. 197). In September 2012, he did not consider either arthritis or fibromyalgia to be contributing to her left shoulder pain and need for treatment. (Ex. 200-1). Nevertheless, he disagreed that her condition "never included any pathology involving her rotator cuff," stating that he was "not so certain" and "would not want to commit to this." (Ex. 200-2).

Based on our review of the foregoing records, we do not consider Dr. Silver's current opinion to constitute a change of opinion concerning the cause of claimant's left shoulder symptoms. Although he expressed uncertainty about

[7] Dr. Whitney opined that claimant's left shoulder strain had resolved without impairment. (Ex. 170-1). He did not know the cause of her ongoing left shoulder pain. (Ex. 170-2). The record does not include the described opinion letters from Dr. Parvin or Dr. Butters.

the diagnosis,[8] his opinion that claimant's left shoulder pain was caused by the 2008 work injury did not waiver. *See SAIF v. Strubel*, 161 Or App 516, 521-22 (1999) (medical opinions are evaluated in context and based on the record as a whole to determine sufficiency); *James A. Powell*, 66 Van Natta 209, 213 (2014) (physician's opinions regarding the claimant's diagnosis represented a reasonable evolution of opinion based on treatment rather than an unexplained change of opinion); *Robert A. Hagar*, 65 Van Natta 551, 558 n 4 (2013) (physician's opinion about the etiology of the claimant's condition did not change over time when his opinions were evaluated in context and based on the record as a whole).

The insurer asserts that Dr. Silver did not consider the contribution of alternate, or preexisting, factors. Yet, Dr. Silver acknowledged pre-injury references to left shoulder symptoms. (Ex. 207-4). He opined that those symptoms were "totally different" from the symptoms that followed the 2008 injury. (*Id.*) Moreover, he considered that claimant might have left AC joint arthrosis, but, explaining that she never presented with symptoms suggestive of that condition, he concluded that the condition did not contribute to her need for treatment. (Ex. 200-1). He also opined that fibromyalgia, which causes generalized pain, was not contributing to the need for treatment for left shoulder pain. (*Id.*)

Dr. Silver's opinion is also supported by that of Dr. Parvin, who found that the "diagnoses relating to the [2008 work] incident include the left * * * rotator cuff inflammation such as tendinitis, caused in combination by the work-related activity and preexisting superimposed degenerative changes." (Ex. 148-6). Dr. Whitney concurred with Dr. Parvin's findings.[9] (Ex. 155).

For the foregoing reasons, we find that the medical evidence supports a conclusion that claimant's 2008 work injury was a material contributing cause of the disability/need for treatment of left rotator cuff tendinitis. *See* ORS 656.005(7)(a); ORS 656.266(1); *Van Blokland v. Oregon Health Sciences Univ.*,

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[8] The record persuasively establishes the existence of the claimed rotator cuff tendonitis/ tendinosis. In March 2009, Dr. Whitney diagnosed rotator cuff tendinosis post-operatively. (Exs. 134, 202-1). In August 2010, Dr. Parvin diagnosed rotator cuff inflammation, "such as tendinitis." (Ex. 148-6). In January 2011, Dr. Butters diagnosed rotator cuff tendinitis. (Ex. 157-3). In November 2011, Drs. Dordevich, Tiley, and Williams diagnosed rotator cuff tendinitis. (Ex. 186-6). In April 2012, claimant's left shoulder MRI showed rotator cuff tendinitis. (Ex. 192-2). Dr. Silver ultimately opined that claimant had acute rotator cuff tendinitis and chronic rotator cuff tendinosis. (Ex. 207-4).

[9] Dr. Whitney later was unable to determine whether claimant's tendinopathy contributed to her need for treatment in light of her lack of improvement post-operatively. (Ex. 202-1).

87 Or App 694, 698 (1987) (a "material contributing cause" is a substantial cause, but not necessarily the sole cause or even the most significant cause); *Summit v. Weyerhaeuser Co.*, 25 Or App 851, 856 (1976) ("material contributing cause means something more than a minimal cause; it need not be the sole or primary cause, but only the precipitating factor); *Donna Lenocker*, 66 Van Natta 628, 632 (2014) (same).

Consequently, the burden shifts to the insurer to prove a "preexisting condition," a "combined condition," and that the "otherwise compensable injury" was not the major contributing cause of the disability/need for treatment of a combined rotator cuff tendinitis condition. Based on the following reasoning, we are not persuaded that the insurer met its burden.

The record does not establish that claimant was diagnosed with, or treated for symptoms of, a condition, or was experiencing "arthritis" or an "arthritic condition," that contributed to disability or the need for treatment of the left rotator cuff tendinitis condition. *See* ORS 656.005(24); *Schleiss*, 354 Or at 652-53. Dr. Parvin opined that claimant's "work related activity" combined with "preexisting superimposed degenerative changes." (Ex. 148-7). However, he did not conclude that the so-called "preexisting" condition was diagnosed or treated before the 2008 injury or was "arthritis" or an "arthritic condition." Similarly, Drs. Dordevich, Tiley, and Williams related claimant's rotator cuff tendinitis to "degenerative arthritic changes of the left acromioclavicular joint," but did not establish that claimant was diagnosed with or treated for that condition before the 2008 injury or had "arthritis" under ORS 656.005(24). (Ex. 186-7, -8). *See Staffing Services, Inc. v. Kalaveras*, 241 Or App 130, 139 (2011) (no "arthritis" or "arthritic condition" without evidence of joint inflammation); *Paul D. Beer*, 63 Van Natta 975, 978 n 1 (2011) (no preexisting condition without pre-injury diagnosis or treatment or joint inflammation due to infectious, metabolic, or constitutional causes).

In contrast, Dr. Silver opined that radiological findings that "may" show arthrosis had never contributed to claimant's need for treatment. (Ex. 200-1). Moreover, Dr. Butters, an orthopedist who previously examined claimant in 2011, agreed. (Ex. 203). Likewise, Dr. Whitney observed a bone spur resulting in rotator cuff tendinopathy, but did not opine that claimant was diagnosed with, or treated for, the bone spur before the 2008 injury or that claimant had "arthritis" or an "arthritic condition." (Ex. 202).

In the absence of a "preexisting condition" that contributes to disability/need for treatment, the insurer has not met its burden. ORS 656.005(24); ORS 656.266(2)(a); *Kollias*, 233 Or App at 505 (the carrier's burden of proof under ORS 656.266(2)(a) encompasses establishing that the claimant has a "preexisting condition" and a "combined condition).[10] Consequently, we set aside the insurer's denial of left rotator cuff tendinitis/tendinosis. Accordingly, we reverse that portion of the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the insurer's denials. ORS 656.386(1). 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 at hearing and on review regarding these denials is $8,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's appellate briefs), the complexity of the issues, the values of the interest involved, and the risk that counsel may 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 left pectoralis minor syndrome and left rotator cuff tendinitis/tendinosis denials, to be paid by the insurer. *See* ORS 656.386(2); OAR 438-015-0019; *Nina Schmidt*, 60 Van Natta 169 (2008); *Barbara Lee*, 60 Van Natta 1, *recons*, 60 Van Natta 139 (2008). The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

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[10] In any event, the evidence does not establish that the "otherwise compensable injury" was not the major contributing cause of claimant's disability/need for treatment of a combined condition. ORS 656.005(7)(a)(B) specifies that a "combined condition" is compensable "if an otherwise compensable injury combines *at any time* with a preexisting condition to cause or prolong disability or a need for treatment * * *." Here, Dr. Parvin and Drs. Dordevich, Tiley, and Williams attributed the major contributing cause of claimant's "current" condition to preexisting conditions. (Exs. 148-7, 186-7, -8). However, these physicians did not address the cause of claimant's condition "at any time." Therefore, their opinions do not satisfy the insurer's burden of proof. *See Rodney R. Erickson*, 66 Or App 989, 992 (2014) (physician's opinion addressing the major contributing cause of the claimant's *current* condition did not satisfy the carrier's burden to prove that the "otherwise compensable injury" was not the major contributing cause of the disability/need for treatment of the combined condition "at any time").

ORDER

The ALJ's order dated March 10, 2014 is reversed in part and affirmed in part. The insurer's denials of left pectoralis minor syndrome and left rotator cuff tendinitis/tendinosis are set aside and the claims are remanded to the insurer for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review regarding the aforementioned denials, claimant's attorney is awarded an assessed fee of $8,500, to be paid by the insurer. Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over these denials, to be paid by the insurer.

Entered at Salem, Oregon on December 26, 2014