
In the Matter of the Compensation of
ALAN W. MORLEY, Claimant
WCB Case No. 12-01047
ORDER ON REVIEW
Moore Jensen, Claimant Attorneys
Michael G Bostwick LLC, Defense Attorneys

Reviewing Panel: Members Lowell and Lanning.

Claimant requests review of those portions of Administrative Law Judge (ALJ) McWilliams's order that: (1) upheld the denial by Sedgwick Claim Management Service (Sedgwick), the statutory claim processing agent for the noncomplying employer, of claimant's new/omitted medical condition claims for L4-5 herniated disc, neurogenic claudication, L2-3 and L3-4 worsened stenosis, and combined low back condition; (2) upheld Sedgwick's denial of claimant's medical services claim for his low back condition; and (3) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. Sedgwick cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's new/omitted medical condition claim for arachnoiditis. On review, the issues are scope of acceptance, claim processing, medical services, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and the third, fourth, and fifth paragraphs of the ALJ's "Findings of Ultimate Fact." We do not adopt the other portions of the ALJ's "Findings of Ultimate Fact." We provide the following partial summary of relevant facts.

In 1976, claimant had a laminectomy to repair a herniated lumbar disc. In 1985, he began working for the employer as a choke setter. (Ex. 7A).

In October 1986, while at work, claimant injured his lower back. (Ex. 8). He filed an injury claim for a ruptured disc in the vicinity of his prior laminectomy. (*Id.*) In June 1987, the claim was accepted for "low back pain." (Exs. 11, 11A).

In August 1987, claimant underwent another back surgery to remove scar tissue and a herniated disc. (Ex. 17).

On November 6, 1987, a stipulation was approved by an ALJ (then-referee). (Ex. 17A). The stipulation stated that claimant had filed a claim alleging that he had sustained a low back strain, the claim had been accepted, and claimant had filed a request for hearing “raising issues including late payment of medical bills and other issues.” (Ex. 17A-1). The stipulation further recited that the parties “agree to settle all issue(s) raised or raisable at this time” by allowing claimant a penalty, awarding claimant’s attorney a fee, and dismissing claimant’s request for hearing with prejudice. (Ex. 17A-1-2).

In August 1988, claimant had a laminectomy on the left at L3-4, L4-5, L5-S1 and on the right at L4-5 and L5-S1 with discectomy bilaterally at L4-5. (Ex. 25).

On April 5, 1989, a second stipulation was approved by an ALJ (then-referee). (Ex. 29A). This stipulation stated that claimant had filed a claim for a back strain, the claim had been accepted, and claimant had filed a request for hearing raising “issues including penalties and attorney fees for late payment of temporary total disability.” (Ex. 29A-1). The stipulation recited that the parties “agree to settle all issues raised or raisable at this time” by allowing claimant a penalty, awarding claimant’s attorney a fee, and dismissing claimant’s request for hearing with prejudice. (Ex. 29A-2).

On April 7, 1994, a Disputed Claim Settlement (DCS) was approved by an ALJ (then-referee). (Ex. 96A). The DCS identified the accepted condition as a “low back strain” and stated that claimant’s cervical strain and psychiatric condition had been denied and claimant had requested a hearing “to appeal the denials and raise other issues.” (*Id.*) The terms of the DCS provided that the denial would be fully effective and claimant would withdraw his hearing request, which would be dismissed with prejudice, in consideration for payment “in full settlement of all issues raised or raisable.” (Ex. 96A-4).¹

On April 12, 1994, a Claim Disposition Agreement (CDA) received Board approval. (Ex. 96B). The CDA identified the accepted condition as a “low back strain.” (Ex. 96B-2). The CDA stated that, “the parties agreed to settle claimant’s claim for compensation and payments of any kind due or claimed for all past, present, and future conditions, except compensable medical services, for the payment of” a stated sum. (Ex. 96B-3).

¹ Sedgwick subsequently assumed the processing of this carrier’s claims.

In January 1999, Dr. Black began treating claimant. He diagnosed arachnoiditis, failed back syndrome and depression. (Ex. 105).

Claimant has had a total of six lumbar surgeries, five of which were processed as part of his October 1986 injury claim. Dr. Hutton believes a seventh surgery is appropriate, consisting of a decompression at L2-3 and L3-4. (Exs. 146-6, 148).

In February 2012, Sedgwick denied claimant's medical services claim for a lumbar surgical procedure and various narcotic medications. (Ex. 155). In its denial, Sedgwick recited that "[m]edical information in our file indicates that the requested surgery and the provision of narcotic medications are neither reasonable nor necessary and the surgery and narcotic medications are unrelated to your accepted claim of lumbar strain." (*Id.*)

In September 2012, claimant filed a new/omitted medical condition claim for arachnoiditis as a consequence of his accepted condition and resulting surgeries. (Ex. 158B). Sedgwick denied the claim, contending that the medical evidence was insufficient to establish that the accepted lumbar strain was the major cause of the arachnoiditis. (Ex. 159).

In January 2013, claimant filed new/omitted medical condition claims for L4-5 disc herniation, neurogenic claudication, and worsened stenosis at L2-3 and L3-4. (Exs. 165A, 165B). Sedgwick denied these claims on April 8, 2013. (Ex. 168).

Claimant requested the acceptance of a combined condition, asserting that the work injury combined with a preexisting low back condition resulting from an earlier L4-5 herniation and surgery, on April 16, 2013. (Ex. 169). Sedgwick denied this claim on July 10, 2013. (Ex. 170). Claimant requested a hearing, contesting these denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ reasoned that the 1987 stipulation established that the scope of the claim acceptance was limited to "low back strain." Because the compensability of the L4-5 herniation could have been raised at that time, the ALJ concluded that the L4-5 herniation and the combined condition including the L4-5 herniation were not included in the scope of acceptance and that claimant's new/omitted medical condition claims for those conditions were precluded. The ALJ further reasoned that the evidence supporting the compensability of claimant's L2-3 and L3-4 stenosis and neurogenic claudication was premised on the previous acceptance of

“low back pain,” instead of “low back strain.” Accordingly, the ALJ upheld the denials of those conditions. The ALJ also upheld the medical services denial, reasoning that the scope of acceptance was limited to “low back strain.”

Nevertheless, finding that the compensable injury, including treatment of the compensable injury, was the major contributing cause of claimant’s arachnoiditis, the ALJ set aside the denial of that condition. Additionally, the ALJ declined to award a penalty or penalty-related attorney fee.

On review, claimant contends that the denials should be set aside, and a penalty and penalty-related attorney fee should be awarded, because the accepted condition was, and remains, “low back pain.” In its cross-request, Sedgwick contends that claimant has not proven the existence of arachnoiditis or that it was caused by the “low back strain.” Based on the following reasoning, we agree with claimant’s contentions regarding the denials, but do not award a penalty or penalty-related attorney fee.

Scope of Acceptance

The scope of an acceptance is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992). When a carrier accepts a specific condition, it is not necessary to resort to contemporaneous medical records to determine what condition was accepted. *See Jerry W. Gabbard*, 54 Van Natta 1022 (2002); *Kim D. Wood*, 48 Van Natta 482, 484 (1996), *aff’d without opinion*, 144 Or App 496 (1996) (because there was a specific acceptance of a “left knee strain,” it was not necessary to examine the contemporaneous medical evidence to determine what condition was accepted). If the specific acceptance is ambiguous or vague, however, we examine the contemporaneous medical evidence to determine what was accepted. *Gilbert v. Cavenham Forest Indus. Div.*, 179 Or App 341, 344 (2002); *Jack L. Kruger*, 52 Van Natta 627, 628 (2000).

Here, claimant’s claim was accepted for “low back pain.” (Ex. 11, 11A). That acceptance is not ambiguous or vague.² Moreover, we conclude that acceptance of “low back pain” was an acceptance of a symptom of preexisting or underlying condition(s). Also, the prior claim acceptance was not modified by any of the parties’ subsequent agreements. We reason as follows.

² Noting that the words “low back pain” are “handwritten on the acceptance over an area that has obviously been altered, whited-out, or poorly copied,” Sedgwick asserts that it is “highly unlikely that ‘low back pain’ was the accurate acceptance.” Nevertheless, “low back pain” is legibly and unambiguously identified as the accepted condition in the Notice of Acceptance, and no evidence indicates that this was an erroneous later addition.

If a carrier accepts a *symptom* of an underlying condition, it is precluded from later denying the underlying condition, regardless of its cause. *Georgia-Pacific v. Piwowar*, 305 Or 494, 501-02 (1988). That is, a carrier may not deny the compensability of an underlying condition that is the medical cause of an accepted symptom, even if that underlying disease or condition is not itself compensable. *Id.* at 501. Thus, acceptance of a particular symptom automatically includes acceptance of the underlying condition causing that symptom. *Hill v. Qwest*, 178 Or App 137, 140 (2001).

However, if the evidence establishes that the accepted condition is separate from (*i.e.*, not caused by or a symptom of) the underlying condition, the rule of *Piwowar* does not apply, and the carrier may deny the claim for the underlying condition. *Boise Cascade Corp. v. Katzenbach*, 104 Or App 732, 735 (1990), *rev den*, 311 Or 261 (1991); *Quinna J. Nolan*, 53 Van Natta 226 (2001).

Applying these principles to the case at hand, we conclude that the initial acceptance of “low back pain” accepted the underlying cause of that pain. In this regard, Dr. Serbu, a neurosurgeon, diagnosed a lumbar disc condition, which was confirmed by later lumbar myelogram and operative findings. (Exs. 1-2, 2, 3). Based on this record, we conclude that the underlying cause of claimant’s low back pain included an L4-5 disc herniation. Accordingly, the initial acceptance of “low back pain” encompassed acceptance of the L4-5 disc herniation.

We further conclude that the stipulations, DCS, and CDA did not modify the scope of the acceptance to exclude claimant’s “low back pain” or underlying L4-5 disc herniation.

We first address the 1987 and 1989 stipulations. We note that although the stipulations stated that claimant’s initial claim had *alleged* low back strain, they noted only that the claim had been accepted without specifying the *accepted* condition. (Exs. 17A-1, 29A-1). Thus, while they do not indicate that “low back pain” had been accepted, the stipulations do not explicitly purport to define the scope of the acceptance or otherwise contradict the earlier, unambiguous Notice of Acceptance. Considering the unambiguous acceptance of “low back pain,” the stipulations are not probative of the scope of acceptance.

Additionally, even if the stipulations had specifically identified the accepted condition as limited to “low back strain,” we would not conclude that they settled the scope of acceptance. We reach this conclusion because, although the stipulations recited that they settled all issues “raised or raisable,” we do not find that the scope of acceptance was “raised or raisable.”

The stipulations themselves identified only the issues of penalties and fees for late payment of medical bills and temporary total disability. (Exs. 17A-1; 29A-1). Although the 1987 stipulation indicates that claimant's hearing request had also raised "other issues," the record does not indicate that the scope of acceptance had been "raised."

We also do not find that the scope of acceptance was "raisable." After "low back pain" was accepted, compensability of "low back pain" could not have been denied unless there was a showing of fraud, misrepresentation, or other illegal activity. *Piwowar*, 305 Or at 499; *Bauman v. SAIF*, 295 Or 788, 794 (1983). The record does not indicate that there was any allegation of fraud, misrepresentation, or other illegal activity to support a denial of the previously accepted "low back pain." Therefore, we do not conclude that the compensability of the previously accepted "low back pain" was "raisable."

Sedgwick cites *Joseph D. Hapka*, 59 Van Natta 213 (2007), in which we looked to a stipulation to determine the scope of acceptance. In *Hapka*, we noted that the scope of an acceptance is a question of fact and that an acceptance encompasses only those conditions specifically or officially accepted in writing. 59 Van Natta at 215 (citing *Tull* and *Johnson v. Spectra Physics*, 303 Or 49 (1987)). We reasoned that a stipulation expressly provided what psychological condition the carrier had accepted, and thereby limited the scope of acceptance to exclude other psychological conditions. *Id.*

Hapka does not suggest that the identification of an accepted condition in a stipulation revokes a prior acceptance. Our opinion in that case does not indicate that there was a Notice of Acceptance, or any other written evidence, indicating that the carrier had accepted any psychological condition other than that identified by the stipulation. Thus, the stipulation was the best evidence to answer the factual question of what condition was specifically or officially accepted in writing.

Here, by contrast, there is a Notice of Acceptance specifically identifying "low back pain" as the accepted condition. As in *Hapka*, we evaluate the record to determine what condition has been accepted. On this particular record, the question of the scope of acceptance is answered by the Notice of Acceptance's express reference to "low back pain."

Sedgwick also cites *Richard D. Chick*, 58 Van Natta 91 (2006), in which we concluded that a stipulation barred the claimant from litigating certain new/omitted medical condition claims. In that case, however, the stipulation addressed "all

issues pertaining to [the claimant's] * * * request for the acceptance of additional conditions.” 58 Van Natta at 98. We noted that the intent of a stipulation “is a question of fact that is specific to each case” and turned to extrinsic evidence to determine the parties’ intent. *Id.* at 98-99. We concluded that the stipulation addressed the conditions that were the subject of the later litigation, thus barring such litigation. 58 Van Natta at 102-03.

As in *Chick*, we evaluate the factual question of the intent of the stipulations. As discussed above, the record does not indicate that the stipulations addressed the scope of acceptance or otherwise purported to modify the earlier “low back pain” acceptance. We also conclude that the acceptance was not modified by the 1994 DCS or CDA.

A DCS resolves only issues related to denied claims. *Trevisan v. SAIF*, 146 Or App 358, 362 (1997). Although the DCS identified the accepted condition as “low back strain,” it identified only claimant’s “cervical strain” and “psychiatric condition” as denied conditions. (Ex. 96A-1). The DCS did not indicate that there had been a “back-up” denial of the previously-accepted “low back pain.” Accordingly, the DCS resolved only the denied claims involving “cervical strain” and “psychiatric condition,” and had no effect on the acceptance of claimant’s low back pain.

The parties’ CDA also did not modify the scope of the acceptance. A CDA is a release of benefits for an accepted claim. ORS 656.236(1); OAR 438-009-0001(1). It is not the function of a CDA to resolve any disputes regarding the processing of a claim. *See Simmons v. Lane Mass Transit Dist.*, 171 Or App 268, 272 (2000) (a CDA involves an accepted claim; it is not the function of a CDA to resolve issues that arise in the processing of a claim); *Felix R. Sanchez*, 59 Van Natta 524, 534 (2007) (recognizing same); *Jeffrey B. Trevitts*, 46 Van Natta 1767, 1775-76 (1994) (same); *Lynda J. Thomas*, 45 Van Natta 894, 895 (1993) (same). As such, the inclusion of “low back strain” as the accepted condition, does not alter the scope of the carrier’s prior and unequivocal acceptance of “low back pain.”

Accordingly, for the above reasons, we conclude that claimant’s injury claim was accepted for “low back pain” and, under the *Piowar* rule, that acceptance included the underlying L4-5 disc herniation. Accordingly, Sedgwick may not now deny the accepted “low back pain” or L4-5 disc herniation.

L2-3 and L3-4 Stenosis, Neurogenic Claudication and Combined Condition.

To establish the compensability of his new/omitted medical condition claims, claimant must prove that the conditions exist, and that the work injury was a material contributing cause of the disability/need for treatment for the conditions. *See* ORS 656.266(1); ORS 656.005(7)(a); *Betty J. King*, 58 Van Natta 977 (2006); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005). When reasonable and necessary treatment of a compensable condition is the major contributing cause of a new injury, the compensable injury is deemed the major contributing cause of the consequential condition. ORS 656.005(7)(A)(a); *Barrett Bus. Servs. v. Hames*, 130 Or App 190, 193, rev den, 310 Or 492.

Because of the disagreement between physicians regarding the existence and cause of the claimed conditions, resolution of this matter is a complex medical question that must be resolved on the basis of expert medical opinion. *Jackson County v. Wehren*, 186 Or App 555, 559 (2003) (citing *Uris v. State Comp Dep't*, 247 Or 420, 426 (1967)). When presented with disagreement between 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).

Claimant's new/omitted medical conditions have been diagnosed by Drs. Black, Hutton, and Kosek. (Exs. 142, 146, 148-3-4, 150-1). Moreover, Dr. Kosek, claimant's treating physician, attributed those conditions to claimant's compensable condition and the resulting surgeries. (Exs. 142, 146, 148-3, 160).

Sedgwick maintains that claimant's disability/need for treatment is not materially related to his new/omitted medical conditions, but is "driven" by his somatoform pain disorder diagnosed by several mental health physicians. We note, however, that these physicians' opinions were informed that claimant's accepted condition was a "low back strain." (Ex. 150A). Based on our conclusion that "low back pain" was accepted, including the L4-5 disc herniation and resulting surgeries, we further reason that these physicians' opinions were based on an inaccurate history. Consequently, we do not consider their opinion persuasive. *See Miller v. Granite Constr. Co.*, 28 Or App 473, 478 (1977) (medical opinion unpersuasive where it was based on inaccurate information); *see also Rosalinda M. Camacho*, 54 Van Natta 1591, 1595 (2002) (medical opinion based on inaccurate history unpersuasive)

In summary, based on the foregoing reasoning, the medical evidence persuasively establishes that claimant's disputed conditions are caused, in major part, by the compensable condition and its resultant surgeries. Therefore, we find the aforementioned claims to be compensable. Consequently, we reverse those portions of the ALJ's order that upheld denials of those conditions.

Compensability of Arachnoiditis

Sedgwick contends that claimant has not proven the existence of arachnoiditis and, even if the condition exists, it is not compensable as a consequential condition. In particular, again assuming the accepted condition is a lumbar strain, Sedgwick maintains that arachnoiditis is not a consequential condition of a lumbar strain. In concluding that claimant's arachnoiditis exists and that it was a consequential condition of his compensable injury, the ALJ relied on Dr. Kosek's opinion that claimant has arachnoiditis and it is "more likely a result of lumbar surgery for his work-related injury." (Ex. 164-2).

Under ORS 656.005(7)(a)(A), "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." However, "[w]here necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, a distinction between the compensable injury and its treatment is artificial. In such instances, the compensable injury itself is properly deemed 'the major contributing cause of the consequential condition.' ORS 656.005(7)(a)(A)." *Barrett Bus. Servs. v. Hames*, 130 Or App 190, 196-97, *rev den*, 320 Or 492 (1994).

In this case, Sedgwick's "arachnoiditis" denial is based on the assumption that the accepted "low back strain" had not contributed to the condition/need for treatment. Yet, as we concluded above, the acceptance is much broader than a low back strain, and includes all conditions that were causing the accepted "low back pain," including claimant's L4-5 herniated disc and the resulting surgeries for that accepted condition. Claimant's treating physician and pain management specialist, Drs. Black and Kosek, respectively, diagnosed arachnoiditis and opined that the major contributing cause was claimant's L4-5 herniated disc and resulting surgeries. (Exs. 105, 107, 148-3, 160, 164-2).

In response, Sedgwick relies on the opinion of Dr. Fuller, who examined claimant on its behalf, that claimant does not have arachnoiditis (or if he does it is asymptomatic) and that arachnoiditis is not caused by a lumbar strain or

treatment for a lumbar strain. (Ex. 167-45-46). Because we have determined that the accepted condition was “low back pain” and not a “low back strain,” we find the opinion of Dr. Fuller less persuasive. *See Rosalinda M. Camacho*, 54 Van Natta at 1595 (medical opinion based on inaccurate history unpersuasive). Further, we consider Drs. Kosek and Black to have been in a more advantageous position to offer opinions, based on their history of treating claimant, to evaluate the existence of arachnoiditis. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983).

Because the opinions of Drs. Kosek and Black are well reasoned and based on accurate information, we find them to persuasively establish the existence and cause of claimant’s arachnoiditis. *See Somers*, 77 Or App at 263. Accordingly, we affirm that portion of the ALJ’s order that set aside Sedgwick’s denial of claimant’s consequential condition claim for arachnoiditis.

Medical Services

Claimant challenges Sedgwick’s partial denial of medical services consisting of a surgical procedure for neurogenic claudication and narcotic medications. Sedgwick issued the denial, asserting that the procedure/medications were neither appropriate treatments, nor related to the accepted lumbar strain. (Ex. 155). The ALJ upheld Sedgwick’s denial concluding that the accepted lumbar strain was not a material cause of claimant’s need for treatment. As explained above, we have concluded that the accepted condition was “low back pain,” which included the L4-5 herniated disc and resulting surgeries and other underlying low back conditions. Accordingly, we now address claimant’s medical services claim with those considerations in mind.

Under ORS 656.245(1)(a), claimant must prove that the need for medical services was caused in material part by the compensable condition.³ *Luis Rodriguez*, 59 Van Natta 104, 105 (2007). The phrase “in material part” means a “fact of consequence.” *SAIF v. Swartz*, 247 Or App 515, 525 (2011); *Mize v. Comcast Corp.-AT&T Broadband*, 208 Or App 563, 569-70 (2006).

Claimant relies on the opinions of Drs. Hutton and Kosek that the proposed surgical procedure is necessitated, at least in material part, by claimant’s accepted “low back pain.” (Exs. 148-4, 160-1). Dr. Kosek also opined that claimant’s narcotic medications were necessitated by his accepted “low back pain.” (Ex. 160-1).

³ The parties agree that the medical services dispute is governed by the first sentence of ORS 656.245(1)(a).

In response, Sedgwick again maintains that the accepted condition is a lumbar strain that is not materially related to the need for the proposed surgical procedure or the narcotic medications. Sedgwick also relies on the opinions of several mental health physicians that claimant's disability/need for treatment is "driven" by his somatoform pain disorder, not the accepted "low back strain."

Because we have concluded that the accepted condition was "low back pain," we disagree with Sedgwick's contentions. We find the opinions of Drs. Hutton and Kosek well reasoned and based on accurate information and, thus, persuasive. *See Somers*, 77 Or App at 259. We also again conclude that the opinions of the mental health physicians are not persuasive because they were informed that the accepted condition was limited to a "low back strain."

Penalties/Attorney Fees

Claimant contends that Sedgwick engaged in unreasonable claim processing when it denied his claims for new/omitted medical conditions and medical services. According to claimant, Sedgwick's position that the accepted condition was a "low back strain" was unreasonable. Consequently, claimant seeks penalties and attorney fee under ORS 656.262(11)(a).

Under ORS 656.262(11)(a), if an insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amount "then due." The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *Int'l Paper Co. v. Huntley*, 106 Or App 107 (1991); *Katrina Miller*, 60 Van Natta 1307, 1309 (2008). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. *Brown v. Argonaut Ins.*, 93 Or App 588, 591 (1988).

Although we have eventually disagreed with Sedgwick's position regarding the effect of the stipulations, DCS, and CDA, we conclude that the existence of those agreements provided it with a legitimate doubt regarding its liability for the claimed conditions. Consequently, we do not consider its processing to have been unreasonable. Accordingly, penalties and attorney fees under ORS 656.262(11)(a) are not warranted.

Claimant's attorney is entitled to an assessed fee for services at the hearing level and on review regarding the new/omitted medical condition claims for L5 herniated disc, neurogenic claudication, L2--3 and L3-4 worsened stenosis, and combined low back condition, and for services on review regarding the new/omitted medical condition claim for arachnoiditis. ORS 656.382(2); 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find a reasonable fee for claimant's attorney's services at the hearing level and on review regarding these issues is \$13,000, payable by Sedgwick. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record, claimant's appellate briefs, and his counsel's uncontested fee submission), the complexity of the issues, the values of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the aforementioned denials, to be paid by Sedgwick. See ORS 656.386(2); OAR 438-015-0019; *Gary E. Gettman*, 60 Van Natta 2862 (2008).; *Nina Schmidt*, 60 Van Natta 169 (2008); *Barabara 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).

Regarding the medical services dispute, ORS 656.386(1) provides for an attorney fee if a claimant "finally prevails" against a denial. Where a medical services denial involves both matters concerning a claim and matters not concerning a claim, the claimant must prevail on both aspects of the medical services claim to prevail finally over the denial. *AIG Claim Servs. v. Cole*, 205 Or App 170, 179 (2006). Here, the record supports a conclusion that Sedgwick is also challenging the disputed medical services on grounds subject to WCD's jurisdiction; *i.e.* reasonable and necessary (propriety). Our practice in such cases is to award a "contingent" attorney fee, payable if claimant finally prevails against all aspects of the medical services dispute. See *Stephen H. Moore*, 66 Van Natta 812, 817 (2014);⁴ *Antonio L. Martinez*, 58 Van Natta 1814 (2006), *aff'd*, *SAIF v. Martinez*, 219 Or App 182 (2008).

⁴ The record is unclear regarding the status of any "propriety" dispute concerning the medical services. If a "propriety" dispute is currently pending before WCD, or if a request to resolve such a dispute is filed with WCD within 30 days of this order, our attorney fee award will remain contingent until WCD resolves the "propriety" dispute subject to its jurisdiction. However, if no such dispute is currently pending with WCD and no request to resolve such a dispute is filed with WCD within 30 days of this order, claimant will have finally prevailed against the denial, and our attorney fee award shall become payable. See *Moore*, 66 Van Natta at 817 n 7.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable “contingent” fee for claimant’s attorney’s services at the hearing level and on review regarding the medical services dispute is \$5,000, payable by Sedgwick. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, the appellate briefs, and claimant’s counsel’s uncontested fee submission), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, we make a similar contingent award of reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial of medical services, to be paid by Sedgwick in the event that claimant finally prevails against all aspects of the medical services dispute. *See* ORS 656.386(2); OAR 438-015-0019; *Moore*, 66 Van Natta at 817; *Schmidt*, 60 Van Natta at 170; *Lee*, 60 Van Natta at 140. The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

ORDER

The ALJ’s order dated October 28, 2013 is reversed in part and affirmed in part. Those portions of the ALJ’s order that upheld Sedgwick’s denials of claimant’s new/omitted medical condition claims for a L4-5 herniated disc, neurogenic claudification, L2-3 and L3-4 worsened stenosis, and combined low back condition are reversed. That portion of the ALJ’s order that upheld Sedgwick’s denial of claimant’s medical services claim is also reversed. The aforementioned denials and the claims are remanded to Sedgwick for processing according to law. The remainder of the ALJ’s order is affirmed. For services at hearing and on review regarding the aforementioned new/omitted medical conditions, and for services on review concerning the arachnoiditis issue, claimant’s attorney is awarded an assessed fee of \$13,000, payable by Sedgwick. For services at hearing and on review regarding the medical services dispute, claimant’s attorney is awarded an assessed attorney fee of \$5,000, payable by Sedgwick, contingent on claimant prevailing over all aspects of the medical services dispute as described in this order. Claimant is awarded reasonable expenses and costs for records, expert opinion, and witness fees, if any, incurred in finally prevailing over the new/omitted medical condition denials, to be paid by Sedgwick. Claimant is also awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the medical services denial, to be paid by Sedgwick, contingent on claimant prevailing over all aspects of the medical services dispute as described in this order.

Entered at Salem, Oregon on June 4, 2014