
In the Matter of the Compensation of
MARK R. NATIONS, Claimant
WCB Case Nos. 14-02242 & 13-06318
ORDER ON REVIEW
Alvey Law Group, Claimant Attorneys
SAIF Legal, Defense Attorneys

Reviewing Panel: Members Curey and Lanning.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial of his new/omitted medical condition claim for bilateral lower extremity chronic regional pain syndrome (CRPS);¹ and (2) found no causal relationship between claimant's disputed medical service claim for a spinal cord stimulator (SCS) and his compensable injury. On review, the issues are compensability and medical services.

We adopt and affirm the ALJ's order with the following supplementation.

On December 7, 1995, claimant sustained a compensable right ankle injury, for which SAIF accepted a right ankle sprain, and medial talocalcaneal coalition of the right hindfoot. (Exs. 11, 22). In June 1996, claimant underwent a surgical excision of the right hindfoot medial talocalcaneal coalition with release/decompression of the posterior tibialis nerve at the tarsal tunnel and fat graft from the right iliac crest. (Exs. 15, 17). In June 1997, he underwent a right foot subtalar fusion with internal fixation and bone graft from the right iliac crest. (Ex. 44).

A February 24, 1998 Notice of Closure awarded 10 percent scheduled permanent partial disability (PPD) for the right ankle. (Ex. 64). A May 19, 1998 Order on Reconsideration increased the total award to 48 percent scheduled PPD. (Ex. 67).

In June 2012, claimant treated with podiatrist Dr. Gentile. (Ex. 88). On September 24, 2012, Dr. Gentile performed a right ankle arthroscopy with synovectomy, removal of right talus hardware, lateral displacement wedge calcaneal osteotomy, talonavicular and calcaneocuboid joint fusions with bone graft, and a first metatarsal osteotomy. (Exs. 93, 94).

¹ The parties do not dispute that the terms "chronic regional pain syndrome" and "complex regional pain syndrome" are used interchangeably in this case to refer to the same condition. (Tr. 2).

A January 2013 right foot CT scan was interpreted as showing extensive postsurgical changes, which included an incompletely healed first metatarsal osteotomy, an incomplete fusion across the talonavicular and calcaneocuboid joints, and marked disuse osteopenia throughout the foot with possible insufficiency fracture at the base of the fifth metatarsal. (Ex. 103). Noting that the CT scan showed spotty fusion/healing at all bone sites, Dr. Gentile recommended that claimant remain in a boot. (Ex. 105).

On March 12, 2013, at Dr. Gentile's referral, claimant began treating with Dr. Balog, a pain management specialist, for complaints of right lower extremity pain. (Ex. 106). Dr. Balog noted that claimant continued to experience "touch sensitivity to the point of nausea, vasomotor instability with frequent skin color changes, swelling and sweating, bone thinning with a diagnosis of disuse osteoporosis, and muscle atrophy of the gastrocnemius." (Ex. 106-1).

Dr. Balog diagnosed "RSD LOWER LIMB"² and stated that claimant's symptoms were consistent with CRPS. (Ex. 106-4). His treatment plan included medication simplification, a diagnostic right-sided lumbar sympathetic blockade, physical therapy, bisphosphonate therapy and bone growth stimulation to be performed in stages. (Ex. 106-5). Dr. Balog also stated that, "[i]n the future," a SCS may provide better relief if claimant failed to respond to conservative measures. (*Id.*) On March 27, Dr. Balog provided claimant with literature on CRPS and stated that, "after reviewing it [claimant] endorse[d] all the symptoms." (Ex. 107-1).

Thereafter, claimant filed a new/omitted medical condition claim for right and left lower extremity CRPS, which SAIF *de facto* and expressly denied. (Exs. 117, 133). SAIF also denied the compensability of the proposed SCS. (Ex. 132). Claimant requested a hearing contesting those denials.³

In upholding SAIF's denial of claimant's new/omitted medical condition claim, the ALJ found that claimant did not persuasively establish the existence of bilateral lower extremity CRPS. In doing so, the ALJ reasoned that the opinion

² Dr. Balog did not indicate whether the "limb" was left and/or right. (Ex. 106-4).

³ The Medical Resolution Team of the Workers' Compensation Division (WCD) also referred a disputed medical service claim to the Hearings Division to determine whether a sufficient causal relationship exists between the medical service and the accepted claim. (Ex. 134). At hearing, SAIF preserved its rights before the WCD to determine whether the disputed medical service was reasonable and necessary treatment. (Tr. 3).

of Dr. Balog, with whom Dr. Gentile concurred, did not persuasively rebut the contrary opinions from Dr. DeBolt, Dr. Bell, and Dr. Lorber, who identified other diagnoses to explain claimant's symptoms (such as post-operative changes and disuse).⁴ Concluding that the condition for which the SCS was prescribed was not an accepted condition under claimant's claim or a proposed diagnostic service, the ALJ found that there was no causal relationship between the disputed medical service and claimant's accepted injury.

On review, claimant contests the ALJ's evaluation of the medical evidence. For the following reasons, we conclude that Dr. Balog's opinion, with whom Dr. Gentile concurred, does not persuasively establish the compensability of the claimed conditions and disputed medical service.

To prevail on his new/omitted medical condition claim for bilateral lower extremity CRPS, claimant must prove that the claimed conditions exist, and that his 1995 work injury was a material contributing cause of the disability or need for treatment of those conditions. ORS 656.005(7)(a); ORS 656.266(1); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005). Based on the time that elapsed between claimant's 1995 work injury and the March 2013 diagnoses of the disputed conditions, as well as disagreement between medical experts, whether claimant's CRPS conditions exist is a complex medical question that must be addressed by expert medical evidence. *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Shelene Pederson*, 68 Van Natta 1431, 1434 (2016).

Claimant contends that the opinion of his treating physicians, Drs. Gentile and Balog, are entitled to deference and establish the existence of his claimed right and left lower extremity CRPS. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983) (a treating physician's opinion may be entitled to greater weight because of a better opportunity to observe and evaluate a claimant's condition over an extended period of time). However, given the dispute between the medical experts, more weight is given to those opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 OR App 259, 263 (1986).

We are not persuaded that the opinions of Drs. Gentile and Balog are entitled to deference because this record does not support a finding that their abilities to observe claimant over time put them in an advantageous position to

⁴ On October 15, 2013, Dr. DeBolt, neurologist, (with Dr. Bald, orthopedist), examined claimant at SAIF's request. (Ex. 119). On April 1, 2014, Dr. Bell, neurologist, examined claimant at SAIF's request. (Ex. 128). On April 16, 2014, Dr. Lorber examined claimant at the request of the managed care organization (MCO) medical director to evaluate treatment options for his lower extremity symptoms. (Ex. 129). These opinions are discussed in more detail below.

evaluate the existence of the disputed conditions. Rather, we conclude that this claim turns on expert analysis, rather than expert external observation. *See Allie v. SAIF*, 79 Or App 284 (1986) (no special deference given to the opinion of the treating physician where the case turned on expert analysis rather than expert external observation); *Margaret J. Steinkamp*, 67 Van Natta 1644, 1645 (2015) (record established that the resolution of a diagnostic issue concerning a disputed medical service claim involved expert analysis rather than expert external observations).

Here, all of the medical experts agree that the “AMA Guides” 6th edition provides the diagnostic criteria for CRPS. (Exs. 106, 119, 128, 129, 136).⁵ Dr. Balog, with whom Dr. Gentile concurred, opined that claimant satisfied all four criteria for the diagnosis of CRPS. (Exs. 106, 135, 136, 138, 142). However, Drs. DeBolt,⁶ Bell, and Lorber did not diagnose bilateral lower extremity CRPS. (Exs. 119, 128, 129, 140, 141). For the following reasons, we find the opinions of Drs. Bell, DeBolt, and Lorber to be more persuasive than the opinions of Drs. Balog and Gentile.

Dr. Bell noted claimant’s report that, after the 2012 right ankle surgery, he had persistent pain at the surgical site, worsened foot and ankle pain into the metatarsal area, and continued to use an “AFO brace” and some assistive device.

⁵ Specifically, under the AMA Guides 6th edition, four criteria must all be met to diagnose CRPS:

- (1) Continuing pain disproportionate to any inciting event.
- (2) Must report at least one symptom in three out of four of the following categories:
 - (a) Sensory: Reports of hyperesthesia and/or allodynia.
 - (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry.
 - (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry.
 - (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).
- (3) Must display at least one sign at the time of evaluation in two or more of the following categories:
 - (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement).
 - (b) Vasomotor: Evidence of temperature asymmetry (>1 degree Centigrade) and/or skin color changes and/or asymmetry.
 - (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry.
 - (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).
- (4) There is no other diagnosis that better explains the signs and symptoms.

⁶ Although Dr. DeBolt and Dr. Bald examined claimant in October 2013, Dr. DeBolt dictated the October 2013 report and provided a supplemental opinion. (Exs. 119-16, 140).

(Ex. 128-3).⁷ Dr. Bell further observed that claimant had sustained a recent left foot injury, and that a February 2014 left ankle MRI showed a peroneus longus tendon tear. (Ex. 128-3, -19).

Dr. Bell considered the fourth “AMA Guides” diagnostic criteria (*i.e.*, that findings are not explained by an alternative diagnosis) to be “the most important,” explaining that “if there is a medical condition (such as post-operative changes in the foot/ankle) that explains all the objective findings and/or if such post-operative changes together with DISUSE changes can better explain the signs and symptoms, then a diagnosis of CRPS cannot be made.” (Ex. 128-24-25).⁸ According to Dr. Bell, the only area of truly abnormal sensation was in the dorsum of the right toe, which demonstrated some hyperalgesia corresponding to a scar at one of claimant’s surgical sites. (Ex. 128-21). Additionally, claimant’s loss of right ankle motion was consistent with his post-operative status, and his right calf atrophy was consistent with use of the “AFO brace.” (Ex. 128-25).

Dr. Bell opined that claimant did not have classic symptoms or objective findings associated with the diagnosis of CRPS (*i.e.*, abnormal hair growth, abnormal nail growth, and hypersensitivity), and that all of his symptoms and objective findings could be explained by post-operative changes and disuse changes and non-weight bearing, which had not been ruled out as causes/differential diagnoses. (Exs. 128-24-26, 141-1-2). Finally, Dr. Bell stated that claimant did not have left lower extremity CRPS because he did not sustain an

⁷ Dr. Bell recommended further evaluation by a trained ankle and foot orthopedic surgeon to determine the extent to which claimant’s ongoing complaints were explained by his accepted conditions versus any possible non-injury related degenerative conditions, versus outcome from the recent surgery by Dr. Gentile. (Ex. 128-22-27).

⁸ Dr. Bell referred to the difficulties associated with making a CRPS diagnosis (as stated in the “AMA Guides”):

““Since a subjective complaint of pain is the hallmark of this diagnosis, and since all of the associated physical signs and radiological findings can be the results of disuse, an extensive differential diagnostic approach [is] necessary. Differential diagnoses which must be ruled out include disuse atrophy, unrecognized general medical problems, somatoform disorders, factitious disorder, and malingering. A diagnosis of CRPS may be excluded in the presence of any of these conditions which could account for the presentation. This exclusion is necessary due to the general lack of scientific validity for the concept of CRPS, and due to the reported extreme rarity of CRPS (any differentials would be far more probable).” (Ex. 128-23).

injury to his left lower extremity as a result of his 1995 work injury, that his left ankle symptoms were attributable to a more recent injurious event, and there was no evidence on examination or in the record of left lower extremity CRPS findings. (Ex. 141-2-3).⁹

Dr. DeBolt noted claimant's reports that he had some degree of back pain, numbness and tingling in his legs, right leg cramping since his 1995 work injury, and that "some time in the past, the left leg became involved with a similar situation." (Ex. 119-2). On examination, Dr. DeBolt found obvious wasting in the right leg and foot with discolored zones over both medial and lateral ankle scars, "appreciably cooler" temperature in the right lower extremity compared to the left, and decreased right ankle ranges of motion. (Ex. 119-6, -8-10). He further observed that claimant had no right foot/ankle hyperesthesia or allodynia on examination, and noted that the motor examination was complicated by claimant's joint arthrodesis and multiple surgeries with resultant edema. (Ex. 119-9-10).

According to Dr. DeBolt, the basic symptoms and signs of CRPS include sweating, redness, pallor, swelling, and protection of the limb from light touch or use. (Ex. 119-10). He explained that, with chronicity, osteoporosis, proximal muscle atrophy, or wasting from disuse would be expected. (*Id.*) However, Dr. DeBolt also stated that osteoporosis, which is a late developing feature of CRPS, may also develop because of claimant's multiple right foot surgeries. (Ex. 119-12).

Considering the four "AMA Guides" diagnostic criteria, Dr. DeBolt initially concluded that it was probable that claimant had right lower extremity CRPS. (Ex. 119-11). Nevertheless, he explained that claimant's right knee reflex, right leg cramping, hip pain, and involvement of the left leg were "unusual" features and complaints for a diagnosis of CRPS. (Ex. 119-11-12). Dr. DeBolt explained that two "compounding issues" that were probably not related to a CRPS diagnosis was the fact that claimant had reported the presence of back pain and lower extremity symptoms since his 1995 injury (rather than slowly and sequentially as with CRPS), and that his chronic right hip pain was possibly related to the graft donor site from his prior surgeries. (Ex. 119-9-11). He further opined that claimant's low back examination findings were consistent with lumbar spondylosis or degenerative disc disease, unrelated to claimant's work injury. (Ex. 119-14-16). Given those concerns, Dr. DeBolt recommended a lumbar spine MRI, x-rays of the right hip, and an EMG nerve conduction study of both lower extremities to further assess claimant's conditions. (Ex. 119-9-10, -15-16).

⁹ Dr. Bell did not test claimant's left ankle motion because of his recent injury. (Ex. 128-22).

Dr. DeBolt subsequently reviewed the March 2014 EMG nerve conduction study and Dr. Bell's April 2014 report. (Ex. 140). According to Dr. DeBolt, the EMG revealed no evidence of nerve injury or any sign of lumbosacral radiculopathy. (*Id.*) He also concurred with Dr. Bell's diagnoses and conclusions that claimant did not meet all four "AMA Guides" diagnostic criteria for CRPS, and specifically noted that claimant did not have allodynia or hyperpathia. (*Id.*)

Dr. Lorber stated that claimant had decreased right ankle motion compared to the left, "which is not surprising given the fusion," and that his legs were "cool to the touch but not substantially." (Ex. 129-6). However, claimant did not have significant hypersensitivity on examination. (Ex. 129-7). Dr. Lorber agreed with Dr. DeBolt's report that claimant had equivocal or unusual findings to support a diagnosis of CRPS. (*Id.*) Dr. Lorber opined that there was "no other obvious sequela of a [CRPS] other than postoperative changes for the foot[,]" with the most significant finding of marked right calf atrophy. (*Id.*) He recommended a bone scan to evaluate claimant's diffuse symptoms. (*Id.*) Further noting claimant's particular pain complaints in the area of his first metatarsal where the hardware plate was not flush against the bone, Dr. Lorber explained that hardware removal, which had previously been considered, was reasonable. (Ex. 129-8-9).

In sum, Drs. Bell and DeBolt explained that CRPS is a diagnosis of exclusion, which means that if another medical condition explains claimant's symptoms, a diagnosis of CRPS is not supported. (Exs. 128-24-26, 140, 141). Furthermore, Drs. Bell, DeBolt, and Lorber opined that claimant's symptoms and findings were explained by post-operative changes. (Exs. 119, 128, 129, 140, 141). Drs. Bell and DeBolt concluded that claimant did not have CRPS, and Dr. Lorber stated that a diagnosis of CRPS was equivocal. (*Id.*)

Claimant relies on the opinion of Dr. Balog, with whom Dr. Gentile concurred, to establish the existence of his bilateral lower extremity CRPS condition. For the following reasons, when compared with the previously summarized opinions, we do not find the opinions of Drs. Balog and Gentile to be persuasive.

Dr. Balog opined that claimant met all four "AMA Guide" diagnostic criteria for CRPS, with the exception of vasomotor findings on evaluation, and that he had no plausible alternative diagnoses. (Ex. 136-2-3). He referred to his March 12, 2013 and June 27, 2014 chart notes. (Ex. 136-2; *see* Exs. 106, 135).

Dr. Balog disagreed with Dr. Bell's opinion, and concluded that claimant had a diagnosis of left and right lower extremity CRPS. (Ex. 136-3). Dr. Gentile concurred with Dr. Balog's report. (Ex. 138).

After reviewing the supplemental reports from Drs. DeBolt and Bell, Dr. Balog continued to opine that claimant had met all four "AMA Guides" diagnostic criteria for CRPS. (Ex. 142-1-2). He also disagreed with Dr. Bell's opinion that post-operative changes and disuse of the right foot and ankle were reasonable explanations for claimant's symptoms because those conditions would have responded to the conservative measures used. (Ex. 142-2). For the following reasons, we do not consider the opinions of Drs. Balog and Gentile to be persuasive.

Although Drs. Balog and Gentile stated that claimant had no other plausible alternative diagnoses to explain his signs and symptoms, their chart notes indicate otherwise. For example, Dr. Balog previously noted that claimant had bone thinning with a diagnosis of disuse osteoporosis and muscle atrophy, and that the 2013 right foot CT scan showed extensive postsurgical changes and confirmed a fracture for which claimant had been wearing a boot and using a cane. (Exs. 106, 107, 120, 135). Similarly, Dr. Gentile identified spotty fusion and healing at all bone sites, and considered removal of the first metatarsal plate hardware reasonable to address some of claimant's right foot symptoms. (Exs. 105, 118, 122). Therefore, Dr. Balog and Dr. Gentile identified other diagnoses that would explain claimant's signs and symptoms, including post-operative changes and disuse changes (which were noted by Drs. Bell, DeBolt and Lorber).

Moreover, in concluding that "post-operative changes" and "disuse of the right foot and ankle" were not reasonable explanations for claimant's symptoms because those conditions would have responded to the conservative care measures utilized if they had been the source of claimant's complaints, Dr. Balog did not explain what "conservative care measures" he had utilized. (Ex. 142-2). Also, in June 2014, Dr. Balog noted that the recommended interventional treatments that "would have been proven helpful in the diagnostic" issue had been denied. (Ex. 135-5).¹⁰

¹⁰ Dr. Balog also stated that a nonresponse to an L4-5 injection would support a diagnosis of CRPS. (See Ex. 124B). However, there is no indication in the record that an L4-5 injection was performed.

In light of those medical records, and considering the alternative explanations and diagnoses identified by Drs. Bell, DeBolt, and Lorber, we do not find Drs. Balog's and Gentile's opinions that no other diagnoses explained claimant's signs and symptoms to be persuasive. *Somers*, 77 Or App at 263; *Pederson*, 68 Van Natta at 1435.

We acknowledge claimant's argument that Dr. Bell's opinion is unpersuasive because she did not follow the "sequential criteria" to diagnose CRPS and, instead, focused on the fourth criteria. However, Dr. Balog (who supported the diagnosis of CRPS) stated that "lack of an explainable diagnosis is the first requirement for [CRPS]." (Ex. 135-5). In any event, all of the medical experts agree that *all four* "AMA Guides" criteria must be met for a diagnosis of CRPS, and they do not suggest a "sequential" process in the consideration of the criteria.

Furthermore, neither Dr. Balog nor Dr. Gentile addressed the contrary medical opinions from Drs. Bell and DeBolt that claimant could not be diagnosed with CRPS because he did not have the classic and necessary symptoms of hypersensitivity, or abnormal hair or nail growth. (Exs. 140, 141). Dr. Balog also did not provide any explanation for his disagreement with Dr. Bell's opinion that claimant did not have *left* lower extremity CRPS. (Exs. 141-2-3, 142-2). Under such circumstances, we discount the opinions of Drs. Balog and Gentile. *See Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained or conclusory opinion); *see also Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2010) (medical opinion unpersuasive when it did not address contrary opinions).

In sum, weighing Dr. Balog's and Dr. Gentile's opinions against those of Drs. Bell, DeBolt, and Lorber, we find the latter opinions (particularly Dr. Bell's opinion) to be more persuasive because they are more thoroughly explained and reasoned. Accordingly, claimant did not persuasively establish the existence of his new/omitted medical condition claim for right and left lower extremity CRPS. *Graves*, 57 Van Natta at 2381.

We turn to the medical services dispute. No party disputes that the proposed SCS was for the claimed CRPS conditions and that the compensability of that medical service is governed by the first sentence of ORS 656.245(1)(a).¹¹

¹¹ ORS 656.245(1)(a) provides:

Thus, the record must persuasively establish that the disputed medical service is for a condition caused in material part by the compensable injury. The phrase “in material part” refers to a “fact of consequence.” *Mize v. Comcast Corp.-AT&T Broadband*, 208 Or App 563, 569-70 (2006). The “compensable injury” is not limited to the accepted condition, but is defined by the work-related injury incident. *See SAIF v. Carlos-Macias*, 262 Or App 629, 637 (2014); *see also Brown v. SAIF*, 262 Or App 640, 652 (2014) (the “compensable injury” is the “work-related injury incident”); *Barbara A. Easton*, 67 Van Natta 526 (2015) (on remand) (medical services under ORS 656.245(1) must be related to the work-related injury incident, rather than to an accepted condition); *Roberta S. Curley-Richmond*, 66 Van Natta 1670 (2014) (same).

Furthermore, if diagnostic services are necessary to determine the cause or extent of a compensable injury, those services are compensable whether or not the condition that is discovered as a result of them is compensable. *Counts v. Int’l Paper Co.*, 146 Or App 768, 771 (1997). Therefore, diagnostic services undertaken as a result of a work-related injury incident, to discover a work-related injury or disease, are sufficiently causally related to the compensable injury. *Carlos-Macias*, 262 Or App at 636.

Here, Dr. Balog opined that the proposed SCS would treat both claimant’s foot conditions and the denied CRPS condition, and would help establish the diagnosis of CRPS. (Ex. 142-2-3). In contrast, Dr. Bell opined that an SCS would be used to treat chronic neuropathic pain, not pain due to arthritis, and that claimant did not have evidence of a nerve or nerve root injury underlying his pain. (Exs. 128-27, 141-3). She also stated that an SCS is not a diagnostic procedure because it may improve pain due to a placebo effect, regardless of the source of the pain, and could lead to an incorrect diagnosis. (Ex. 141-4). Similarly, Dr. DeBolt opined that claimant’s accepted right foot/ankle conditions were not materially related to the proposed SCS, and would not be a diagnostic procedure

“For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.”

to determine the cause or extent of claimant's work injury, because it would treat any neuropathic pain either from CRPS or disc disease and inflamed nerve roots. (Ex. 140-2).

Absent further explanation in response to the contrary assessments expressed by Drs. Bell and DeBolt, we find Dr. Balog's opinion that the proposed SCS would treat claimant's foot conditions from his 1995 work injury to be conclusory and unpersuasive. *Moe*, 44 Or App at 433; *Benedict*, 59 Van Natta at 2409. As such, the record does not persuasively establish that the disputed medical service was for a condition caused in material part by the compensable injury, or that an SCS would be a diagnostic service to determine the cause or extent of claimant's compensable injury. ORS 656.245(1)(a); *Carlos-Macias*, 262 Or App at 636; *Counts*, 146 Or App at 771. Consequently, we affirm.

ORDER

The ALJ's order dated December 11, 2015 is affirmed.

Entered at Salem, Oregon on October 20, 2016