
In the Matter of the Compensation of
MICHAEL SHERMAN, Claimant
WCB Case Nos. 14-02071 & 15-00499
ORDER ON REVIEW
Alvey Law Group, Claimant Attorneys
Elkins Zipse & Mitchell, Defense Attorneys

Reviewing Panel: Members Lanning and Curey.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of his new/omitted medical condition claim for right L1-2 facet arthropathy. The insurer cross-requests review of those portions of the ALJ's order that awarded penalties and attorney fees for unreasonable claim processing. On review, the issues are compensability, penalties, and attorney fees.¹ We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," which we summarize and supplement below.

On October 4, 2011, claimant sustained a compensable low back injury when he slipped from an extension ladder, fell 15 feet, and landed on his right buttock. (Tr. II 8-9).

The insurer accepted right transverse process fractures at L1, L2, and L3. (Ex. 2).

Following treatment, in January 2012, claimant was released to return to his regular job. (Exs. 9, 13-1).

An April 2012 Notice of Closure granted a 15 percent permanent impairment award for the low back. (Ex. 11).

¹ Based on the insurer's agreement with claimant's motion to strike, its counsel's affidavit has not been considered. Furthermore, because the insurer's counsel's letterhead is already present in the record, consideration of the copy of the letterhead included in claimant's reply brief would not change the outcome of this case.

On February 21, 2014, claimant filed an aggravation claim. (Ex. 20A).

A February 2014 lumbar MRI revealed advanced degenerative disc disease L1-2, with mild retrolisthesis. (Ex. 21-1). The MRI reflected that the “[r]ight L1-2 facet joint is asymmetrically widened likely due to the retrolisthesis with prominent joint effusion but no signs of degenerative facet arthropathy.” (Ex. 21-1-2).

In March 2014, claimant was examined by Dr. Kinder, a pain specialist. (Ex. 22-1). Dr. Kinder interpreted claimant’s MRI as significant for “L1-2 mild retrolisthesis with facet arthropathy/effusion[.]” (*Id.*) He diagnosed thoracic/lumbosacral neuritis and lumbago, and recommended epidural steroid injections. (Ex. 22-3)

In April 2014, at the insurer’s request, Dr. Woodward, an orthopedic surgeon, and Dr. Weinstein, a neurosurgeon, examined claimant. (Ex. 23). They concluded that claimant’s accepted transverse process fractures had healed and that his low back pain was unrelated to the fractures. (Ex. 23-8). They opined that claimant had “common idiopathic mechanical low back pain, which was not related to the healed fractures.” (*Id.*)

The insurer denied claimant’s aggravation claim. (Ex. 24-1). In April 2014, claimant requested a hearing regarding the denial of his aggravation claim.

In May 2014, Dr. Stapleton, a pain specialist, examined claimant. (Ex. 27-1). He diagnosed a lumbar sprain, a “closed FX lumb vert w/o cord injury,” thoracic/lumbosacral neuritis, and lumbosacral spondylosis. (Ex. 27-2). He explained that claimant “continues to have pain primarily in the low back that I think is related to the right transverse process fractures that he sustained in October of 2011 and I would like to see if we could treat this with Facet injections at L1-2 and 2-3.” (*Id.*) He also noted that, if the injections were not effective, “then there are other treatment options but I don’t think they would be related to his accepted condition from his work injury.” (*Id.*)

On June 11, 2014, in response to claimant’s then-pending hearing request regarding the insurer’s aggravation denial, the insurer’s counsel filed a Notice of Appearance with the Hearings Division (with a copy to claimant’s counsel) announcing that: “All correspondence and communications in this case should be directed to the undersigned [counsel].” (Hearing File).

On July 16, 2014, claimant's counsel sent a certified letter to the insurer's attorney requesting acceptance of L1-2 right facet arthropathy. (Ex. 30). The insurer's attorney received the letter on July 17, 2014. (Ex. 31).

In October 2014, claimant filed a supplemental request for hearing alleging a *de facto* denial of his new/omitted medical condition claim. Claimant requested consolidation with the pending case involving the insurer's aggravation denial.

On October 23, 2014, claimant informed the assigned ALJ that he would not be contesting the aggravation denial, but would be proceeding with regard to the *de facto* denial of his new/omitted medical condition claim.

On November 3, 2014, claimant's attorney sent a certified letter to the insurer requesting acceptance of the L1-2 right facet arthropathy as a new/omitted medical condition. (Ex. 32-A).

On December 3, 2014, the insurer denied claimant's claim for L1-2 right facet arthropathy. (Ex. 33-1). The insurer asserted that there was no objective medical evidence of such a condition and, even if that condition existed, the work-related injury incident was not the major contributing cause of the condition. (*Id.*) Claimant requested a hearing.

On July 22, 2015, the insurer issued an amended denial that also denied responsibility for claimant's current medical treatment based on his subsequent employment exposure.² (Ex. 35).

At the hearing, claimant acknowledged that he was pursuing the compensability of the L1-2 right facet arthropathy as a consequential condition. (Tr. II 1, 16, 20).

CONCLUSIONS OF LAW AND OPINION

In upholding the insurer's denial, the ALJ found that Dr. Stapleton's opinion did not persuasively establish that the claimed L1-2 right facet arthropathy existed or that the October 2011 work-related injury incident was the major contributing cause of any such condition. The ALJ also concluded that the

² The parties confirmed at hearing that the partial denial was intended to deny both compensability and responsibility for the L1-2 arthropathy as a consequential condition. (Tr. II 1-4).

insurer's compensability denial was untimely because it issued more than 60 days after claimant's initial request for acceptance of the L1-2 right facet arthropathy condition. Consequently, the ALJ assessed a 25 percent penalty and a penalty-related fee for unreasonable claim processing. Finally, the ALJ also determined that the insurer's responsibility denial was untimely and assessed a separate penalty-related fee.

On review, claimant contends that Dr. Stapleton's opinion establishes the existence and compensability of his L1-2 right facet arthropathy condition. Concerning the ALJ's penalty/attorney fee assessments, the insurer asserts that it did not engage in any unreasonable claim processing. According to the insurer, its December 3, 2014 denial of compensability of the L1-2 right facet arthropathy condition was timely because it issued within 60 days of its receipt of claimant's November 3, 2014 request for acceptance. Furthermore, asserting that it is entitled to amend its denial, the insurer argues that its responsibility contention was not untimely. Alternatively, the insurer maintains that the ALJ's assessment of separate penalty-related attorney fees for the same unreasonable act was not statutorily authorized.

We affirm the ALJ's compensability decision, as well as the assessment of a penalty and penalty-related fee for an untimely compensability denial. However, we reverse the ALJ's award of a separate "penalty-related" attorney fee award. Our reasoning follows.

To establish the compensability of his L1-2 right facet arthropathy, claimant must prove that the condition exists and that it is compensably related to the work injury. *See Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005) (proof of the existence of the condition is a fact necessary to establish compensability of a new/omitted medical condition). For a condition arising directly from the work-related injury incident, he must prove that the injury was a material contributing cause of his disability or need for treatment for the condition. ORS 656.005(7)(a); *Albany Gen. Hosp. v. Gasperino*, 113 Or App 411, 415 (1992). On the other hand, for a condition arising as a consequence of a compensable injury, he must prove that the compensable injury was the major contributing cause of the consequential condition *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997); *Rex M. Butler*, 67 Van Natta 216, 217 (2015). "Compensable injury, under ORS 656.005(7)(a)(A), means the 'work-related injury incident.'" *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211, 215 (2015); *Denise Petersen*, 67 Van Natta 1023, 1025 (2015) (same).

The determination of major contributing cause involves the evaluation of the relative contribution of the different causes of claimant's condition and a decision as to which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed*, 321 Or 416 (1995); *Linda E. Patton*, 60 Van Natta 579, 581 (2008).

Because of the disagreement between medical experts, this claim presents complex medical questions that must be resolved by expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Matthew C. Aufmuth*, 62 Van Natta 1823, 1825 (2010). More weight is given to those medical opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986); *Patton*, 60 Van Natta at 581. We properly may or may not give greater weight to the opinion of the treating physician, depending on the record in each case. *See Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001); *Darwin B. Lederer*, 53 Van Natta 974, 974 n 2 (2001) (absent persuasive reasons to the contrary, the Board generally gives greater weight to the opinion of the claimant's attending physician).

Here, Dr. Stapleton, claimant's treating physician, opined that the 2014 MRI established the existence of the claimed L1-2 right facet arthropathy condition. (Ex. 29-1). He further determined that the 2011 work-related injury incident caused direct trauma to the L1-2 facet joint, resulting in progressive widening of the facet joint, and that the work injury was the major contributing cause of the L1-2 right facet arthropathy condition. (Ex. 29-2). Dr. Stapleton concluded that the results of the epidural steroid injections in the L1-2 and L3-4 facet joints, which were followed by claimant's marked pain relief, supported his opinion. (*Id.*)

In contrast, Drs. Woodward and Weinstein opined that claimant was experiencing idiopathic mechanical low back pain, which was unrelated to his 2011 work-related injury incident. (Ex. 23-8). Based on their review of the 2014 MRI, they concluded that it showed marked degenerative disc disease at L1-2, which they associated with age and genetics. (Ex. 23-8). They did not diagnose an L1-2 right facet arthropathy condition. (Ex. 23-7-8).

In a subsequent concurrence letter, Dr. Stapleton diagnosed L1-2 facet joint arthropathy. (Ex. 29-1). Referring to the 2014 MRI, Dr. Stapleton reasoned that the 2011 work-related injury incident caused direct trauma to the L1-2 facet joint, which resulted in progressive widening of the right facet joint. (Ex. 29-2). He opined that "the damage to the L1-2 facet is a direct consequence of the work injury, with the work injury constituting the major contributing cause of the progressive changes at L1-2." (*Id.*)

In an addendum report, Dr. Woodward explained that claimant's 2011 work-related injury incident resulted in transverse process fractures, but that no other known injury or damage to the spine occurred. (Ex. 32-4). He also determined that the transverse process fractures had healed and would not have affected the remainder of claimant's spine. (*Id.*) He referenced three medical articles regarding the effects of transverse process fractures, which showed that "there is no evidence that the transverse process fractures were associated with other disease of the spine." (Ex. 32-5). Dr. Woodward attributed claimant's low back pain to degenerative disc disease, which he explained tends naturally to worsen over time. (Ex. 32-4). He also opined that the CT scan on the date of the work-related injury incident was the best evidence that there was no damage to the facet joint as a result of the injury. (Ex. 32-5).

Dr. Stapleton did not respond to Dr. Woodward's explanation regarding the L1-2 right facet arthropathy. Moreover, Dr. Stapleton did not address Dr. Woodward's reasoning concerning the CT scan results, which did not support any damage to claimant's L1-2 facet joints. In the absence of such responses, we do not consider Dr. Stapleton's opinion to be persuasive. *See Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2009) (medical opinion unpersuasive when it did not address contrary opinion).

Based on the foregoing reasoning, as well as the reasons expressed in the ALJ's order, we are not persuaded that the claimed L1-2 right facet arthropathy exists or that claimant's work injury was either a material contributing cause of the need for treatment/disability for the claimed condition or the major contributing cause of the claimed condition. Consequently, we affirm the ALJ's decision to uphold the insurer's denial.

We turn to the penalties and penalty-related attorney fee issues.

For the following reasons, we affirm the ALJ's determination that the insurer's compensability denial was untimely and the ALJ's award of a penalty and penalty-related attorney fee for an untimely denial. However, we reverse the ALJ's additional penalty-related attorney fee concerning the insurer's amended denial.

In a June 11, 2014 letter to the ALJ concerning claimant's hearing request regarding the insurer's denial of claimant's aggravation claim (which was copied to claimant's counsel), the insurer's counsel enclosed a copy of its Notice of Appearance, directing that: "All correspondence and communications in this case

should be directed to” insurer’s counsel. This “Notice” was submitted under the insurer’s counsel’s letterhead, which describes the counsel as an employee of the insurer.

Under these particular circumstances, we conclude that claimant’s July 16, 2014 request for acceptance of the L1-2 right facet arthropathy as a new/omitted medical condition, which was received by the insurer’s counsel on July 17, 2014, provided sufficient notice to the insurer to trigger its claim processing obligations. *See Dep’t of Consumer & Bus. Servs. v. Muliro*, 359 Or 736, 752 (2016) (under the common law of agency, it is presumed that an agent always communicates to the principal all information that it should communicate within the scope of the agency, and, thus, notice to an agent is notice to the principal); *see also Int’l Paper Co. v. Huntley*, 107 Or App 107, 110 (1991) (the employer’s attorney was its agent, and the employer, as principal, could not hide behind the incorrect advice of its agent).

Here, on July 16, 2014, claimant requested acceptance of a new/omitted medical condition claim for L1-2 right facet arthropathy. (Ex. 30). The insurer’s counsel received that request on July 17, 2014. Nevertheless, the insurer did not issue its denial of that claim until December 3, 2014. (Ex. 33). We have previously concluded that the insurer’s counsel identified himself as an employee of the insurer and notified claimant of his representation for the purposes of the claim. Under such circumstances, notice of the claim to the insurer’s counsel constituted notice to the insurer. Because the insurer issued its denial more than 60 days after receiving claimant’s request for acceptance of the L1-2 right facet arthropathy condition, we consider the insurer’s delay in issuing its denial to have been unreasonable.

Accordingly, we conclude that the insurer’s claim processing was unreasonable. Thus, we affirm the ALJ’s penalty assessment, as well as the \$2,000 attorney fee award for unreasonable claim processing.

However, we disagree with the ALJ’s assessment of a separate “penalty related” attorney fee award regarding the insurer’s amended denial.

Under ORS 656.308(2)(a), a carrier who disputes responsibility “shall so indicate in *or as part of* a denial otherwise meeting the requirements of ORS 656.262 issued in the 60 days allowed for processing of the claim.” (Emphasis added). Here, the insurer amended its previously issued denial under ORS 656.262 to include a denial of responsibility. (Ex. 35). Thus, the “amended” denial is a part of the initial denial under ORS 656.262.

For the reasons expressed above, we have already concluded that the insurer's denial was unreasonably delayed. Because a penalty and attorney fee award have already been assessed for the insurer's unreasonable claim processing, we decline to assess penalties and related fees for the insurer's amendment of an already unreasonably delayed denial.³ See *Eliseo Sales-Parra*, 68 Van Natta 679, 683-84 (2016) (where carrier issued an unreasonable denial, the carrier's unreasonable claim investigation was encompassed within that unreasonable denial and separate penalty/attorney fee award for the same unreasonable conduct was not warranted).

Therefore, in this particular situation, we do not consider an amendment to an otherwise untimely denial to constitute a separate act of misconduct. Consequently, we reverse the ALJ's award of a separate penalty-related \$1,000 attorney fee.

Claimant's attorney is entitled to an assessed fee for services on review regarding the ALJ's penalty and penalty-related attorney fee awards that we have affirmed. See ORS 656.382(3). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the aforementioned issues is \$1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, the values of the interests involved, and the risks that counsel may go uncompensated.

ORDER

The ALJ's order dated November 12, 2015 is affirmed in part and reversed in part. That portion of the ALJ's order that awarded a \$1,000 penalty-related attorney fee is reversed. The remainder of the ALJ's order is affirmed. For services on review regarding the penalty and penalty-related attorney fee awards that have been affirmed, claimant's attorney is awarded an assessed fee of \$1,000, payable by the insurer.

Entered at Salem, Oregon on October 11, 2016

³ In this case, there is no contention that the responsibility denial itself was unreasonable. Rather, claimant contends that it also was untimely issued. We note that, if the responsibility denial was unreasonable (*i.e.*, no legitimate basis for the responsibility denial), a separate penalty and penalty-related fee for that separate unreasonable act might be justified. Here, however, the alleged unreasonable conduct is essentially the same act, *i.e.*, an unreasonably delayed denial. Under such circumstances, one penalty and attorney fee award for that unreasonable action is warranted.