

In the Matter of the Compensation of
ROBERT MCCUTCHEN, Claimant

WCB Case No. 15-00960

ORDER ON REVIEW

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Reviewing Panel: Members Weddell, Johnson, and Somers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brown's order that upheld the self-insured employer's denial of claimant's medical services claim for a spinal cord stimulator. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following summary and supplementation.

In June 2007, claimant sustained a compensable back injury, and had intense low back and left leg pain. (Exs. 1, 6). He initially treated with Dr. Cummings. (Ex. 2).

In July 2007, the employer accepted a low back strain. (Ex. 4).

Although claimant returned to work in July 2007, he subsequently fell and reported constant, severe, and mechanical back pain. (Ex. 6). A lumbar MRI showed an L4-5 herniated disc. (Ex. 5).

In September 2007, Dr. O'Neill, a neurosurgeon, assessed lumbar radiculopathy and recommended an L4-5 and L5-S1 surgery if conservative treatment was not successful. (Ex. 6-2, -3).

Subsequently, Dr. Fiks, a pain management physician, performed epidural steroid injections. (Exs. 7A, 7B).

In December 2007, Dr. O'Neill noted that claimant's leg pain was now bilateral. (Ex. 7C).

In January 2008, claimant had a second lumbar MRI, which did not show an L4-5 disc herniation. (Ex. 8).

In February 2008, Dr. Rosenbaum, a neurosurgeon, examined claimant at the employer's request. (Ex. 9). He diagnosed lumbar spondylosis and a resolved left L4-5 herniated disc. (Ex. 9-4). He reported that the June 2007 work injury was the major contributing cause of the disc herniation, but that the condition had resolved. (Ex. 9-5, -6).

A lumbar CT scan showed multilevel degenerative changes most significant at L5-S1 with severe bilateral foraminal stenosis affecting the exiting L5 nerve roots. (Ex. 10-2).

After reviewing additional treatment records, Dr. Rosenbaum reported that there was no evidence of nerve root compression. (Ex. 12). He opined that claimant's primary symptoms were due to the degenerative process and a functional component (90 percent) and that 10 percent of his symptoms were due to the L4-5 herniated disc. (*Id.*) Drs. O'Neill and Cummings noted disagreement with Dr. Rosenbaum's opinion that claimant had a functional component. (Exs. 13B, 13C).

In October 2008, Dr. Sandell, an orthopedic surgeon, examined claimant at the employer's request. (Ex. 14). He reported that claimant was medically stationary for his June 2007 work injury and did not recommend any further treatment. (Ex. 14-12). He noted that claimant had a chronic L5-S1 condition related to preexisting degenerative disc disease. (Ex. 14-14). Dr. Sandell related 10 percent of claimant's current pain complaints to the L4-5 disc herniation and 90 percent to his preexisting condition. (*Id.*) Dr. O'Neill disagreed with Dr. Sandell's opinion. (Ex. 16).

In December 2008, Dr. Yoo, an orthopedic surgeon, opined that claimant had trauma to the L5 nerve causing symptoms. (Ex. 17). He recommended a spinal cord stimulator rather than decompression surgery. (Ex. 17-2).

In January 2009, Dr. Fiks diagnosed a lumbar sprain/strain and noted chronic lumbosacral radiculitis with lower extremity pain. (Ex. 18-4). He recommended a spinal cord stimulation trial subject to a pretrial psychological evaluation. (*Id.*) Subsequently, Dr. Cummings requested a spinal cord stimulator trial. (Ex. 19).

In February 2009, Dr. Lorber, a physiatrist, examined claimant at the employer's request. (Ex. 20). He determined that claimant's bilateral radiculitis was multifactorial, but that the June 2007 work injury was a material contributing cause of his symptoms. (Ex. 20-11). He opined that claimant was a reasonable

candidate for a spinal cord stimulator, but only if psychological testing was also supportive. (Ex. 20-16). He explained that there were psychological contraindications, including claimant's chronic depression. (Ex. 20-18). He opined that the relationship between the treatment and the work injury was "nebulous." (Ex. 20-17).

In January 2012, Dr. Fiks declined to offer neurostimulation until claimant obtained a psychological opinion to stabilize his situational depression. (Ex. 22).

In September 2013, Dr. Wong, a physiatrist, examined claimant at the employer's request. (Ex. 25). He opined that claimant had a lumbar strain and L4-5 herniated disc related to the June 2007 work injury. (Ex. 25-13). On examination, he found no evidence of radiculopathy or a myelopathy, but instead found functional responses inconsistent with objective findings. (Ex. 25-14). He determined that claimant had a significant psychological component to his clinical presentation and did not recommend additional treatment. (*Id.*) Dr. Fiks disagreed with Dr. Wong's opinion. (Ex. 26).

In December 2014, Dr. Fiks noted that claimant was seeing a therapist regularly, and that he felt antidepressant treatment and counseling were helpful. (Ex. 29-1). In January 2015, Dr. Fiks requested the spinal cord stimulator trial, which was denied. (Ex. 30).

In February 2015, the employer notified the Medical Resolution Team (MRT) of the Workers' Compensation Division (WCD) that there was a causation issue regarding the spinal cord stimulator trial. (Exs. 32, 33). Subsequently, MRT issued a Defer and Transfer Order, acknowledging the employer's assertions that the proposed trial was not causally related to the accepted conditions, was for new/omitted conditions for which the worker had not yet made a claim, and was not appropriate. (Ex. 35).

In May 2015, Dr. Fiks indicated that claimant was scheduled to see a psychiatrist the following week. (Ex. 39-4).

Dr. Rosenbaum examined claimant for a second time, reporting that claimant's pain generator source was his lumbar spondylosis with potential psychosocial issues. (Ex. 40-9). He concluded that the spinal cord stimulator would not be a reasonable recommendation for claimant, because he did not have classic radicular symptoms. (Ex. 40-11). Dr. Rosenbaum subsequently reaffirmed this opinion after reviewing additional records. (Ex. 45).

Dr. Fiks noted that claimant was treating at a county mental health facility. (Ex. 41-3). He also disagreed with Dr. Rosenbaum's opinion, and he explained that all of claimant's previous treatment options had failed. (Ex. 43).

In January 2016, Dr. Fiks opined that claimant's June and July 2007 injury events in combination constituted the major contributing cause, and separately were each at least a material contributing cause, of claimant's chronic bilateral radiculitis/radiculopathy conditions and his current need for treatment, including the spinal cord stimulator trial. (Ex. 51-3, -4). He disagreed with Dr. Rosenbaum's opinion that functional overlay was the sole or primary cause of claimant's low back and bilateral lower extremity symptoms. (Ex. 51-5-6).

CONCLUSIONS OF LAW AND OPINION

In upholding the medical services denial, the ALJ found that Dr. Fiks's opinion, as supported by Dr. Lorber, was insufficient to sustain claimant's burden of proof.

On review, claimant contests the ALJ's analysis of his medical services claim. For the following reasons, we find the claim compensable.

A carrier must generally cause to be provided medical services for conditions "caused in material part" by a compensable injury. ORS 656.245(1)(a). 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, 569-71 (2006). However, for combined or consequential conditions, the carrier is responsible for only those medical services that are "directed to medical conditions caused in major part by the injury." ORS 656.245(1)(a); *SAIF v. Sprague*, 346 Or 661, 673 (2009).

The "compensable injury" is the "work-related injury incident," not the accepted condition. *See Brown v. SAIF*, 262 Or App 640, 652 (2014); *SAIF v. Carlos-Macias*, 262 Or App 629, 637 (2014). Thus, the medical services need not relate to an accepted condition, but the requisite causal relationship must be shown between the work-related injury incident and the condition that the disputed medical service is "for" or "directed to." *Fernando Javier-Flores*, 67 Van Natta 2245, 2248 (2015); *Barbara A. Easton*, 67 Van Natta 526, 529 (2015).

Here, claimant contends that the disputed medical service (a spinal cord stimulator) is “for” his radiculitis/radiculopathy condition. Accordingly, we analyze what condition the disputed medical service was “for” or “directed to.”

In January 2009, Dr. Fiks diagnosed radiculitis with lower extremity pain and recommended a spinal cord stimulator subject to a psychological evaluation. (Ex. 18-4). In January 2012, he declined to offer neurostimulation until claimant obtained a “psychological opinion” to see if his situational depression could be stabilized. (Ex. 22). At that time, Dr. Fiks “ultimately believe[d]” that neurostimulation had merit in claimant’s care. (*Id.*)

By December 2014, after noting that claimant’s treatment with a mental health specialist was going well, Dr. Fiks no longer mentioned a need for a psychological evaluation before claimant obtained the spinal cord stimulator/neurostimulation treatment. (Exs. 29, 30, 39, 41). He explained that a spinal cord stimulator treats neuropathic pain, and that he proposed the treatment for claimant’s “radiculitis/radiculopathy” condition. (Ex. 51-5).

Dr. Yoo recommended a spinal cord stimulator, which he attributed to L5 nerve root trauma. (Ex. 17).

Dr. Lorber opined that claimant was a reasonable candidate for a spinal cord stimulator for neuropathic symptoms, but only if psychological testing was supportive.¹ (Ex. 20-16, -18). However, Dr. Lorber explained that claimant’s depression, in and of itself, was not a contraindication for the treatment. (Ex. 20-18). Dr. Lorber did not relate claimant’s need for the spinal cord stimulator to his psychological condition. (Ex. 20-16-18). Rather, he explained that spinal cord stimulators are used to treat neuropathic symptoms. (Ex. 20-18).

In contrast, Dr. Rosenbaum originally attributed most of claimant’s complaints to the degenerative process and a “functional” component. (Ex. 12). However, he subsequently clarified that claimant’s presentation was atypical for the degenerative process. (Ex. 40-9). Rather, Dr. Rosenbaum considered it likely that significant psychosocial issues were contributing to claimant’s status, and he did not believe that claimant had a classic radiculopathy. (Exs. 40-9-10, 45). He reasoned that there was no evidence of ongoing L4-5 nerve root compression because the disc herniation had resolved, and claimant’s symptoms were inconsistent with the L5-S1 level where there were findings of spondylosis and narrowing. (Ex. 40-10). Nevertheless, Dr. Rosenbaum indicated that spinal cord stimulators are used to treat neuropathic pathology. (Ex. 45-3).

¹ Dr. Lorber examined claimant before Dr. Fiks indicated that he was undergoing therapy.

Dr. Wong also opined that claimant did not have a radiculopathy at the time of his evaluation and had a functional component to his presentation. (Ex. 25-14).

After considering this record (including the aforementioned physicians' opinions), we find that the spinal cord stimulator is "for" or "directed to" a radiculitis/radiculopathy condition. While Dr. Fiks originally had recommended a psychological evaluation before authorizing the spinal cord stimulator, there was no indication that Dr. Fiks attributed the need for the medical service to any condition other than the radiculopathy/radiculitis condition. In fact, Drs. Fiks, Lorber and Rosenbaum explained that spinal cord stimulators are used to treat neurological conditions. Moreover, Dr. Fiks no longer mentioned the psychological evaluation after his notations that claimant was undergoing therapy.

We recognize that Drs. Rosenbaum and Wong opined that claimant did not have a true radiculopathy/radiculitis condition and, as a result, they attributed the medical service to psychosocial, functional or preexisting conditions. However, Dr. Fiks, Lorber, Yoo, and O'Neill diagnosed a neurological condition based on their examinations. In addition, Drs. O'Neill, Cummings, and Fiks, all treating physicians, specifically disagreed with Dr. Rosenbaum's assessment that claimant's presentation was due to a "functional" or "psychological" component. (Exs. 13B, 13C, 51-5-6). Under such circumstances, based on Dr. Fiks's persuasive opinion, as supported by Drs. Lorber and Yoo, we find that the requested medical service is "for" or "directed to" the radiculitis/radiculopathy condition.

The employer contends that the radiculopathy/radiculitis condition is better analyzed under a "consequential condition" analysis rather than a direct causation theory, and that claimant has not established that his condition was caused in major part by the compensable injury.² As explained below, considering the causal relationship between claimant's work injury and the radiculopathy/radiculitis to which his medical services claim is "for," we disagree with the employer's contention.

² We decline to consider the employer's contention on review that this case is better analyzed as a "combined condition." See *Stevenson v. Blue Cross*, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing). In any event, even if we were to consider the employer's contention, the medical evidence does not support the existence of a combined condition and that a statutory preexisting condition was the major contributing cause of the need for treatment. Consequently, we focus on whether the medical service is related directly or indirectly to the work-related injury incident.

The distinguishing feature of a “consequential condition” is that it is not directly caused by the “work-related injury incident,” but instead is a separate condition that arises as a consequence of an injury or condition caused directly by the “work-related injury incident.” *Allen v. SAIF*, 279 Or App 135, 138 (2016); *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211, 215 (2015). An illustrative example would be a back strain caused by an altered gait resulting from a compensable foot injury. *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997); *Albany Gen. Hosp. v. Gasperino*, 113 Or App 411, 415 n 2 (1992). In the alternative, if the proposed spinal cord stimulator is “for” an “ordinary condition,” medical services “for” that condition would be compensable if the condition were caused in material part by the compensable injury. ORS 656.245(1)(a).

Here, claimant had a June 2007 work injury, which resulted in lower extremity symptoms. (Exs. 1, 6). According to Dr. Fiks, claimant sustained an L4-5 disc herniation at the time of his June 2007 work injury, which simultaneously caused compression of, and injury to, his left L5 nerve root, resulting in radiculitis/radiculopathy. (Ex. 51-2, -4). Dr. Fiks explained that the disc herniation eventually reabsorbed, but the injury to the L5 nerve roots persisted and resulted in chronic bilateral radiculopathy/radiculitis. (Ex. 51-3). Dr. Fiks concluded that claimant had a radiculitis/radiculopathy condition, and that his June 2007 work injury was, at least, a material contributing cause of his condition and need for the spinal cord stimulator. (Ex. 51-4).

Dr. Lorber also concluded that claimant had a radicular condition, and that the June 2007 work injury was a material contributing cause of his lower extremity symptoms, which the record reflects are indicative of the radiculitis/radiculopathy condition. (Ex. 20-11).

As previously mentioned, Drs. Rosenbaum and Wong disagreed that claimant had a true radiculopathy. They attributed claimant’s presentation to functional issues or preexisting conditions.

After reviewing the medical opinions, we rely on the well-reasoned and thorough opinion of Dr. Fiks. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). We conclude that he was in the best position to assess the contribution from claimant’s work injury and his need for the spinal cord stimulator. He had an opportunity to treat claimant on numerous occasions since 2007. *See Kevin G. Gagnon*, 64 Van Natta 1498, 1500 (2012) (physician’s longitudinal history with the claimant rendered his opinion persuasive). He was also aware of claimant’s psychological testing, unlike the other physicians, and specifically disagreed that

claimant had a “functional” component to his presentation. *See Jackson County v. Wehren*, 186 Or App 555, 561 (2003) (a history is complete if it includes sufficient information on which to base the physician’s opinion and does not exclude information that would make the opinion less credible); *cf. Miller v. Granite Constr. Co.*, 28 Or App 473, 476 (1997) (medical opinion that is based on incomplete or inaccurate history is not persuasive). Thus, we conclude that claimant has persuasively established a direct relationship between the June 2007 work injury and his radiculitis/radiculopathy condition, which was caused in material part by the work-related injury incident.

In sum, based on the foregoing reasons, we find that the disputed medical service is “for” a condition caused in material part by the work-related injury incident. ORS 656.245(1)(a). Consequently, we reverse.

Because this proceeding pertains only to the causal relationship under ORS 656.704(3)(b)(C), claimant has not yet “prevailed” on the medical services claim and, therefore, he is not entitled to an attorney fee under ORS 656.386(1) at this time. *Antonio L. Martinez*, 58 Van Natta 1814, 1822 (2006), *aff’d*, 219 Or App 182 (2008). Furthermore, we do not have jurisdiction to award an assessed attorney fee under ORS 656.385, because that statute refers to attorney fees awarded by the Director, not the Board. *Id.*

Although claimant has not yet “finally prevailed” within the meaning of ORS 656.386(1), in the event that he ultimately prevails, *i.e.*, if both aspects of the challenge to the medical services claim are decided in favor of claimant, we conclude that he is entitled to a reasonable assessed attorney fee of \$6,500 for services at hearing and on review, payable by the employer. ORS 656.386(1). In making this “contingent” award, we have considered the factors set forth in OAR 438-015-0010(4), giving particular consideration to the time devoted to the issue (as represented by the record and claimant’s appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant’s counsel might 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 medical services denial, to be paid by the employer in the event that claimant finally prevails over the medical services denial. *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).

ORDER

The ALJ's order dated February 12, 2015, as amended on February 22, 2016, is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed attorney fee of \$6,500, payable by the employer, contingent on claimant prevailing over the other aspects of the medical services denial. 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 the employer, contingent on claimant prevailing over all aspects of the medical services dispute as described in this order.

Entered at Salem, Oregon on October 6, 2016