
In the Matter of the Compensation of
SHELENE PEDERSON, Claimant
WCB Case No. 14-06102
ORDER ON REVIEW
Scott M McNutt Sr, Claimant Attorneys
SAIF Legal Salem, Defense Attorneys

Reviewing Panel: Members Lanning, Johnson, and Somers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Poland's order that: (1) excluded a "post-hearing" physician's report offered by SAIF; and (2) set aside SAIF's denial of claimant's new/omitted medical condition claim for complex regional pain syndrome (CRPS). On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

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

On December 25, 2013, claimant, a nursing assistant, compensably injured her right shoulder while helping a patient. (Ex. 33). SAIF accepted a right shoulder strain, right trapezius muscle strain, and right rotator cuff tendonitis. (Ex. 55).

On February 27, 2014, claimant came under the care of Dr. Vallier, an orthopedic surgeon. (Ex. 45-2). On April 14, 2014, he performed a right shoulder debridement, distal clavicle excision, and acromioplasty.¹ (Ex. 51-1).

After the surgery, Dr. Vallier noted that claimant did well initially, but then had increasing right shoulder pain. (Ex. 57-1). On October 3, 2014, he opined that she had a right shoulder impingement syndrome, "now with what seems to be [an] onset of upper extremity [CRPS]." (Ex. 66-2).

On October 7, 2014, Dr. Kitchel, an orthopedic surgeon, performed an examination at SAIF's request. He concluded that the accepted conditions were medically stationary. (Ex. 67-10). He also opined that claimant's physical examination was not valid for measuring impairment (because it showed significant subjective responses out of proportion to the objective findings). (*Id.*)

¹ Dr. Vallier's post-operative diagnoses were right shoulder impingement with rotator cuff tendonitis and acromioclavicular arthritis. (Ex. 51-1).

On October 22, 2014, claimant initiated a new/omitted medical condition claim for CRPS. (Ex. 68). Dr. Vallier opined that claimant had developed CRPS “directly due to her injury and surgery.” (Ex. 70-1).

On November 21, 2014, Dr. Kitchel stated that he had not observed any objective findings that would support the CRPS diagnosis. (Ex. 74). He opined that claimant did not meet the qualifications for the diagnosis. (*Id.*)

On December 8, 2014, claimant consulted Dr. Croson, a pain management specialist. (Ex. 75-4). Dr. Croson diagnosed right shoulder pain, CRPS, and chronic pain syndrome. (*Id.*)

On December 9, 2014, SAIF denied the new/omitted medical condition claim for CRPS. (Ex. 76). Claimant requested a hearing.

On February 10, 2015, Dr. Bell, a neurologist, and Dr. Glass, a psychiatrist, performed an examination and record review at SAIF’s request. Relying on the AMA Guides 6th edition diagnostic criteria for CRPS, Dr. Bell opined that claimant did not have CRPS. (Ex. 79A-19). Dr. Glass diagnosed a pain disorder, which he concluded was probably an extension of a prior psychogenic/somatoform disorder. (Ex. 79B-10, -12).

On February 11, 2015, Dr. Brenneke, an orthopedic surgeon, performed an examination at SAIF’s request. (Ex. 79C-14). Dr. Brenneke concluded that claimant did not have CRPS. (Ex. 79C-15).

In response to these reports, Dr. Vallier opined that “claimant fits the criteria for a diagnosis of CRPS.” (Ex. 80-1). He also concluded that the work injury and related surgery were the major contributing cause of the condition. (Ex. 80-2).

At the hearing, claimant moved for a continuance to cross-examine Drs. Bell, Glass, and Brenneke and obtain rebuttal reports from Drs. Vallier and Croson, which the ALJ granted. (Tr. 3).

In his “post-hearing” rebuttal report, Dr. Vallier asserted that he had observed claimant’s CRPS “symptoms.” (Ex. 81-2). He argued that the AMA Guides 6th edition diagnostic criteria are “too tight” (*i.e.*, the criteria are for a “full blown” CRPS, which claimant did not have). (Ex. 81-1). He also opined that her findings were caused by “the damaged nerve as a result of her shoulder surgery.” (Ex. 81-2).

On July 2, 2015, claimant submitted Dr. Croson's "post-hearing" rebuttal report. (Proposed Exhibit 82, Hearing File). On November 9, 2015, claimant "withdrew" the proposed exhibit. (*Id.*)

Thereafter, SAIF offered Dr. Croson's report, to which claimant objected. The ALJ declined to admit the report.

CONCLUSIONS OF LAW AND OPINION

During written closing argument, SAIF sought reconsideration of the ALJ's evidentiary ruling regarding Dr. Croson's report and its admission. Reasoning that Dr. Croson's "post-hearing" report would not change the ultimate outcome of the case, the ALJ adhered to her earlier evidentiary ruling. Furthermore, deferring to Dr. Vallier's "attending physician" status and analysis, the ALJ set aside SAIF's denial.

On review, SAIF contends that the record was left open for reports from Drs. Croson and Vallier and substantial justice warrants Dr. Croson's report's inclusion in the evidentiary record. SAIF also asserts that Dr. Vallier's opinion is not sufficiently persuasive to carry claimant's burden of proof. For the following reasons, we reverse.²

Claimant's new/omitted medical condition claim for CRPS is based on a "consequential condition" theory. Therefore, claimant must prove that the CRPS condition exists and that her compensable injury and related treatment were the major contributing cause of the claimed condition. *See* ORS 656.005(7)(a)(A); ORS 656.266(1); *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211, 215 (2015) ("compensable injury" under ORS 656.005(7)(a)(A) means the "work-related injury incident"); *Barrett Bus. Servs. v. Hames*, 130 Or App 190, *rev den*, 320 Or 492 (1994) (when treatment for a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition); *Robert D. Hanington*, 68 Van Natta 496, 498 (2016) (applying *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005) to a consequential condition claim).

² We need not resolve the propriety of the ALJ's evidentiary ruling. We reach this conclusion because, even if we did not consider the proposed exhibit (which supports SAIF's position), we find that the claim is not compensable.

Whether claimant's CRPS condition exists is a complex medical question that must be resolved by expert medical evidence. See *Barnett v. SAIF*, 122 Or App 279, 283 (1993). We may give greater weight to the opinion of the treating physician depending on the record in each case. *Dillon v. Whirlpool*, 172 Or App 484, 489 (2001). In some situations, a treating physician's opinion is entitled to greater weight because of a better opportunity to observe and evaluate a claimant's condition over an extended period of time. *Weiland v. SAIF*, 64 Or App 810 (1983). Likewise, an attending surgeon's opinion may be given deference where the surgeon's unique opportunity to view the claimant's condition firsthand forms the basis for a causation opinion. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988). When there is a dispute between medical experts, 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); *Emma I. Sims*, 63 Van Natta 1198, 1202 (2011) (declining to defer to treating surgeon's opinion in light of well reasoned contrary opinions).

For the following reasons, we conclude that Dr. Vallier's opinion is insufficiently persuasive to establish that the claimed condition is compensable.

Drs. Kitchel, Bell, Glass, and Brenneke opined that claimant does not have CRPS. (Exs. 74, 79A, 79B, 79C). Dr. Bell provided the AMA Guides 6th edition diagnostic criteria for CRPS and explained in detail why claimant's condition did not satisfy those criteria.³ (Ex. 79A-20, -21). She also observed that Dr. Vallier diagnosed CRPS "in the absence of any truly objective findings to support CRPS/RSD." (Ex. 79A-14). She explained that occasional discoloration occurs for a variety of reasons (e.g., claimant's reported use of heat and ice on her upper extremity and her tendency to guard the extremity could lead to transient coloration changes in the skin) and the absence of objective evidence of any

³ Dr. Bell listed the four criteria that must be satisfied to diagnose CRPS under the AMA Guides 6th edition. (Ex. 79A-20, -21). She opined that claimant did not display any of the objective signs required under the third criterion (i.e., "sensory" hyperalgesia to pinprick and/or allodynia to light touch and/or deep pressure and/or joint movement, vasomotor evidence of temperature asymmetry and/or skin color changes and/or asymmetry, sudomotor/edema evidence of edema and/or sweating changes and/or asymmetry, and motor/trophic evidence of decreased range of motion and/or motor dysfunction and/or trophic changes). (Ex. 79A-21). She also opined that claimant did not meet the fourth criterion because claimant had another diagnosis (somatoform disorder) that explained her symptoms. (*Id.*) Dr. Bell's opinion was supported by that of Dr. Glass, who diagnosed a pain disorder and opined that, in view of claimant's extensive medical history before age 30 and prior to the work injury, a preexisting somatization disorder needed to be ruled out. (Ex. 79B-10, -12). Dr. Bell opined that a diagnosis of CRPS may be excluded in the presence of identified conditions that could account for the presentation, including somatoform disorder. (Ex. 79A-20).

persistent color abnormalities suggested that there was not “any true pathology of the sympathetic nerves.” (Ex. 79A-22). Drs. Glass and Bell further identified a potential somatoform disorder that potentially explained claimant’s symptoms. (Exs. 79-19, 80-10).

In his “post-hearing” rebuttal report (which was admitted into evidence by the ALJ without objection), Dr. Vallier conceded that claimant did not have all the diagnostic criteria for a “full blown” CRPS condition. (Ex. 81-1). Furthermore, he did not respond to Dr. Bell’s reasoning, which diminishes the persuasiveness of his opinion. *See Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff’d without opinion*, 227 Or App 289 (2009) (medical opinion less persuasive when it did not address contrary opinions).

In addition, Dr. Glass opined that, in view of claimant’s extensive medical history before age 30 (and before the work injury), a preexisting somatization disorder needed to be ruled out.⁴ (Ex. 79B-10, -12). Likewise, Dr. Bell concluded that claimant’s medical record was consistent with a somatoform disorder.⁵ She represented that the CRPS diagnostic criteria require that differential diagnoses, like somatoform disorders, be ruled out. (Ex. 79A-20).

In response to these opinions, Dr. Vallier stated that he had not “seen” a somatoform disorder in claimant. (Ex. 81-2). In the absence of a reasoned explanation, this conclusory response to the opinions of Drs. Glass and Bell is not persuasive. *See Moe v. Ceiling Sys. Inc.*, 44 Or App 429, 433 (1980) (rejecting unexplained or conclusory opinion); *Claudia J. Stacy*, 58 Van Natta 2998, 3000 (2006) (medical opinion supporting claim unpersuasive in light of contrary opinions).

Moreover, Dr. Vallier’s rebuttal statement did not indicate that he had reviewed claimant’s prior medical record or acknowledge the medical history described by Drs. Bell and Glass. Therefore, we discount his opinion for this reason as well. *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

⁴ Dr. Glass reviewed claimant’s prior medical records, including records from 2003 (describing a history of posttraumatic stress disorder, characterized by anxiety and depression) and 2005 (recording a history of panic attacks with anxiety and depression). (Ex. 79B-5, -6).

⁵ Dr. Bell’s summary of claimant’s prior medical records noted a history of chronic neck pain since 2003, anxiety, depression, and panic attacks. (Ex. 79A-6, -9).

physician's opinion and does not exclude information that would make the opinion less credible); *Miller v. Granite Constr. Co.*, 28 Or App 473, 476 (1997) (medical opinion that is based on incomplete or inaccurate history is not persuasive).

Claimant argues that we should defer to Dr. Vallier's expertise as her "attending physician." See *Mageske*, 93 Or App at 702; *Weiland*, 64 Or App at 814. We disagree. Because the "existence" dispute involves expert analysis, rather than expert external observation, we do not accord Dr. Vallier's opinion special deference based on his status as claimant's attending physician. See *Allie v. SAIF*, 79 Or App 284 (1986) (no special deference given to 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) (where the existence of the claimed condition was in dispute and the dispute concerned differing interpretation of the claimant's findings, the claim turned primarily on expert analysis, rather than expert external observation).

In sum, for the foregoing reasons, this record does not persuasively establish the existence of the claimed CRPS condition. Additionally, even if the existence of CRPS were established, the record does not persuasively establish that claimant's "work-related injury incident" was the major contributing cause of her claimed CRPS condition. We reason as follows.

At various times, Dr. Vallier attributed the CRPS to the injury and surgery, the underlying shoulder condition,⁶ claimant's rotator cuff syndrome, and a "hyper reaction by a nerve as a result of a traumatic injury or as a result of surgery." (Exs. 70-1, 78-2, 79-2, 80-1). Most recently, Dr. Vallier's "post-hearing" rebuttal report stated, for the first time, that claimant's "findings on examination are caused by the damaged nerve as a result of her shoulder surgery." (Ex. 81-2). He did not identify the nerve or explain how it had been damaged. In addition, his apparent change of opinion was not explained, nor does the record establish that he received "new information" that might otherwise explain the change. Under such circumstances, we consider Dr. Vallier's opinion unpersuasive. *Moe*, 44 Or App at 433 (conclusory medical opinion found unpersuasive); *Francisco R. Mejia*, 61 Van Natta 1265, 1268, *recons*, 61 Van Natta 2005 (2009) (no reasonable explanation for changed opinion where a physician did not explain the change and the record did not establish that the physician received new information that otherwise might explain the changed opinion).

⁶ Dr. Vallier did not identify the "underlying shoulder condition." His post-operative diagnoses were right shoulder impingement syndrome with rotator cuff tendonitis and acromioclavicular arthritis. (Ex. 51-1).

Finally, Vallier's "major contributing cause" opinion did not acknowledge claimant's medical history, as previously described, or persuasively weigh the relative contribution of the work incident and other potential causes identified by opposing opinions to determine whether the compensable injury was the primary of the claimed condition. *See Wehren*, 186 Or App at 559; *Andrew J. Winsor*, 64 Van Natta 892, 897 (2012) (medical opinion unpersuasive when it did not adequately address or rebut contrary evaluation of the relative contribution of the claimant's preexisting condition).

In conclusion, based on the aforementioned reasoning, the record does not persuasively establish the compensability of the claimed consequential CRPS condition. Therefore, we reverse.

ORDER

The ALJ's order dated January 27, 2016 is reversed. SAIF's denial is reinstated and upheld. The ALJ's \$9,000 attorney fee and cost awards are also reversed.

Entered at Salem, Oregon on September 7, 2016