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In the Matter of the Compensation of  
**ALONZO H. HERRERA, Claimant**  
WCB Case No. 16-01540  
ORDER ON REVIEW  
Miller Law, Claimant Attorneys  
Sather Byerly & Holloway, Defense Attorneys

Reviewing Panel: Members Johnson, Lanning, and Somers. Member Johnson dissents.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Fisher's order that set aside its denial of claimant's new/omitted medical condition claim for left shoulder impingement syndrome. On review, the issue is compensability.

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

When claimant first sought treatment for bilateral shoulder symptoms in June 2014, Dr. Ware, his attending physician, noted positive impingement signs and listed impingement as a "differential diagnosis." (Ex. 4-2). Dr. Ware continued to opine that claimant had impingement syndrome subsequent to a left shoulder sprain and referred claimant to Dr. Young, an orthopedist, for consultation regarding the etiology of claimant's condition. (Ex. 11-2). Based on his August 2014 examination, Dr. Young diagnosed left shoulder tendinitis/impingement. (Ex. 13-4). Dr. Bald, who examined claimant at the employer's request, also diagnosed impingement secondary to claimant's left shoulder strain. (Ex. 15-2).

The employer accepted bilateral shoulder strains, a left shoulder SLAP tear, and a left bicep tear. In February 2016, claimant filed a new/omitted medical condition claim for left shoulder impingement syndrome, which the employer denied. Claimant requested a hearing.

Based on the opinions of Drs. Bald, Ware, and Young, the ALJ concluded that the claimed left shoulder impingement syndrome existed and was caused, in major part, by the compensable injury. Accordingly, the ALJ set aside the employer's denial.

On review, citing the opinions of Dr. Jones, who examined claimant at the employer's request, and Dr. Chang, who became claimant's attending physician in February 2016, the employer disputes the existence of the claimed impingement

syndrome. Alternatively, the employer disputes that the compensable injury was the major contributing cause of the impingement syndrome. We disagree with the employer's contentions.

To establish the compensability of his new/omitted medical condition claim, claimant must establish the existence of the claimed impingement syndrome. ORS 656.266(1); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005). Further, because the impingement syndrome is alleged to be a consequence of the compensable injury, claimant must prove that the compensable injury was the major contributing cause of the impingement syndrome. ORS 656.005(7)(a)(A); ORS 656.266(1); *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997); *Albany Gen. Hosp. v. Gasperino*, 113 Or App 411, 415 (1992). The major contributing cause is the cause, or combination of causes, that contributed more than all other causes combined. *Schuler v. Beaverton Sch. Dist. No. 48J*, 334 Or 290, 296 (2002).

The existence and causation of claimant's impingement syndrome present complex medical questions that must be resolved by expert medical evidence. *See Uris v. State Comp. Dep't*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). When presented with disagreement among 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). An expert's failure to address contrary medical opinions or information that would be inconsistent with the expert's opinion may reduce the weight we give that opinion. *See Janet Benedict*, 59 Van Natta 2406 (2007), *aff'd without opinion*, 227 Or App 289 (2009). However, a medical opinion may be persuasive, based on its own reasoning, even if it does not specifically discuss a contrary, less persuasive, opinion. *See Brian Mobley*, 63 Van Natta 1424 (2011). An opinion is based on a complete history if the history includes sufficient information on which to base an opinion and does not exclude information that would make the opinion less credible. *Jackson County v. Wehren*, 186 Or App 555, 560-61 (2003).

Here, Dr. Bald opined that the objective physical findings from his August 2014 and January 2015 examinations of claimant supported the diagnosis of impingement syndrome. (Ex. 89-1). He described the impingement findings as consistent and reproducible, and noted that claimant's subjective complaints were consistent with impingement syndrome. (*Id.*) He also reviewed other providers' medical records that were available at the time of his examinations. (*Id.*) He interpreted those records as corroborating his own impingement diagnosis.<sup>1</sup> (*Id.*)

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<sup>1</sup> Dr. Bald stated, based on his review of the records of other providers at the times of his examinations, that Dr. Ware and Dr. Jones had diagnosed impingement. (Ex. 89-1). As the employer notes, Dr. Jones did not diagnose impingement and, in fact, had not examined claimant before Dr. Bald's

Dr. Bald explained that an impingement can result from anything that reduces the space between upper surface of the humeral head and the undersurface of the protective cover provided by the shoulder blade and collar bone. (Ex. 89-1-2). After identifying the accepted conditions, he concluded that claimant's impingement was "a consequential condition that [was] an inflammatory reaction caused by the underlying swelling and edema from those conditions," *i.e.*, the accepted bilateral shoulder strains, left shoulder SLAP tear, and left bicep tear. (Ex. 89-1).

The employer contends that Dr. Bald's impingement diagnosis is unpersuasive because his opinion was not based on complete information. Particularly, the employer identifies medical evidence developed after Dr. Bald examined claimant and reviewed medical records in January 2015, such as opinions of Dr. Jones (who examined claimant in November 2015 and May 2016), records related to the March 2015 surgery, and Dr. Chang's opinion. The employer further notes that Dr. Bald had, in January 2015, not diagnosed a SLAP tear or bicep tear, and had opined that impingement was a more likely cause of claimant's symptoms than an abnormality to the bicep or glenoid labrum. (Ex. 39-1). Thus, the employer further reasons that the subsequent diagnosis of SLAP tear and bicep tear undermines the persuasiveness of the impingement diagnosis.

Although Dr. Bald did not diagnose a SLAP tear or bicep tear in January 2015, he specifically discussed those conditions when he offered his ultimate opinion. (Ex. 89-1). He explained how those conditions, along with the initially-accepted strain, contributed to the swelling and inflammation, resulting in pain and a catching sensation with certain movements. (Ex. 89-1-2).

Additionally, Dr. Bald's diagnosis of impingement is not contradicted by the fact that Dr. Ware did not diagnose impingement after claimant's shoulder surgeries.<sup>2</sup> To begin, we note that Dr. Ware discussed claimant's impingement syndrome even in chart notes that did not list impingement syndrome in the "diagnosis" section. (Ex. 18A-1). Thus, we do not interpret her diagnosis of certain conditions to indicate that she did not believe that other conditions also

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January 2015 examination and medical records review. Although we are unsure of the basis for Dr. Bald's reference to Dr. Jones, after our review of the record, we conclude that it supports Dr. Bald's conclusion that, at the time of his review, the findings of other medical providers supported the impingement diagnosis.

<sup>2</sup> Claimant underwent left shoulder surgery in March 2015. (Ex. 46). A SLAP tear was confirmed at that time. (Exs. 46-1, 47). Claimant subsequently developed a bicep abnormality and, in April 2015, underwent a second surgery. (Ex. 51).

existed. Further, although Dr. Ware did not diagnose impingement after claimant's surgeries, she also did not diagnose the SLAP tear in ten subsequent chart notes, despite the confirmation and acceptance of that condition. (Exs. 56-1, 58-1, 60-1, 62-1, 64-1, 66-1, 68-1, 69-1, 71-1, 73-1). Assuming that Dr. Ware did not identify impingement syndrome after the surgery, we merely conclude that her post-surgical diagnoses pertained to claimant's then-current problems. Accordingly, we do not find that Dr. Ware implicitly disagreed with her previously-identified, but currently unlisted, diagnosis of impingement syndrome. Under such circumstances, we conclude that Dr. Bald had a sufficiently complete understanding of claimant's medical history. *See Wehren*, 186 Or App at 560-61.

We also do not find the persuasiveness of Dr. Bald's opinion to be undermined by his lack of specific discussion of the opinions of Drs. Jones and Chang. First, just as Dr. Bald did not specifically discuss the opinions of Drs. Jones and Chang, likewise, Drs. Jones and Chang did not specifically discuss Dr. Bald's opinion. Further, we do not find the opinions of Drs. Jones and Chang persuasive.

Dr. Jones considered the "impingement syndrome" diagnosis to have been a "working diagnosis or differential diagnosis." (Ex. 85-1). He opined that claimant did not have left shoulder impingement syndrome. (*Id.*) However, he did not explain why the clinical findings on which Drs. Bald, Ware, and Young relied in diagnosing impingement did not support that diagnosis. Moreover, he did not examine claimant until November 2015, over 16 months after the date of injury.

Whereas Dr. Bald continued to support the impingement diagnosis after considering claimant's bicep tear and SLAP tear, Dr. Jones did not diagnose the bicep tear and opined that claimant did not actually have a work-related left shoulder SLAP tear. (Ex. 74-5, -7). Further, the fact that Dr. Jones did not examine claimant until over 16 months after the date of injury and the diagnosis of impingement syndrome leads us to discount the importance of his examination findings to evaluating the existence of the impingement syndrome at an earlier date. *See Linda J. Starkey*, 62 Van Natta 721 (2010) (physician who examined the claimant closer in time to the date of injury was in a better position to evaluate the claimant's condition). Therefore, after reviewing the record, we find Dr. Bald's ultimate opinion better reasoned, and based on more accurate information, than Dr. Jones's.

Dr. Chang concurred with Dr. Jones's opinion that claimant's impingement syndrome "was a working diagnosis or a differential diagnosis" and that claimant did not have left shoulder impingement syndrome. (Ex. 86-1). She also noted that her physical examination findings did not support an impingement syndrome

diagnosis. (*Id.*) However, like Dr. Jones, Dr. Chang did not explain why the clinical findings of Drs. Bald, Ware, and Young did not support the impingement diagnosis. Moreover, Dr. Chang did not examine claimant until February 2016, over 19 months after the date of injury. We find Dr. Bald's opinion more persuasive than Dr. Chang's for the same reasons we find Dr. Bald's opinion more persuasive than Dr. Jones's.

Accordingly, we conclude that claimant has established the existence of the claimed impingement syndrome condition.

Moreover, Dr. Bald persuasively explained how the accepted conditions caused the impingement syndrome, and no expert has persuasively attributed major causation of claimant's impingement syndrome to other causes. Accordingly, we conclude that the compensable injury was the major contributing cause of claimant's impingement syndrome. Therefore, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). 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 is \$4,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, the risk of going uncompensated, and the contingent nature of the practice of workers' compensation law.

Finally, claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by the employer. *See* ORS 656.386(2); OAR 438-015-0019; *Gary E. Gettman*, 60 Van Natta 2862 (2008). The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

### ORDER

The ALJ's order dated December 2, 2016 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$4,000, payable by the employer. Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by the employer.

Entered at Salem, Oregon on April 19, 2017

Member Johnson dissenting.

The majority concludes that the claimed impingement syndrome condition exists and was caused, in major part, by the compensable injury. Because I do not conclude that claimant had impingement syndrome, I respectfully dissent.

To establish the compensability of his new/omitted medical condition claim, claimant must establish the existence of the claimed impingement syndrome. ORS 656.266(1); *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005). If the claimed consequential condition exists, it is only compensable if it was caused, in major part, by the compensable injury. ORS 656.005(7)(a)(A); ORS 656.266(1); *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997); *Albany Gen. Hosp. v. Gasperino*, 113 Or App 411, 415 (1992).

Here, the assessment and diagnosis of claimant's left shoulder condition evolved over time. Dr. Ware initially noted examination findings consistent with bilateral impingement and concluded, "Differential diagnosis includes tendinitis, bursitis, and impingement in the setting where [claimant] may have had a strain injury about 10 days ago." (Ex. 4-2). Dr. Young's impression in August 2014 was of left shoulder tendinitis/impingement. (Ex. 13-3). In November 2014, after claimant's left shoulder symptoms failed to resolve, Dr. Young recommended further evaluation of the labrum with an MRI arthrogram and an orthopedic opinion. (Exs. 24-1, 26).

It was not until December 29, 2014 that claimant underwent an MRI arthrogram of the left shoulder, which was read to show an extensive labral tear/avulsion. (Ex. 30-1). Dr. Sohn, an orthopedic surgeon, noted the MRI finding and diagnosed left acromioclavicular joint arthrosis and a labral tear. (Ex. 31-4). He recommended surgery. (*Id.*)

Following the MRI and Dr. Sohn's evaluation, Dr. Ware's assessment was "[l]eft shoulder strain and left labral tear in the setting of pre-existing acromioclavicular arthritis." (Ex. 34-1). She did not mention impingement.

When Dr. Bald examined claimant in January 2015, he recorded that a July 2014 MRI had been interpreted as "effectively normal." (Ex. 37-2). He reviewed the December 2014 MRI, and did not "see any evidence of a clinically significant SLAP tear." (Ex. 37-6). After reviewing additional medical records, Dr. Bald acknowledged the possibility of a labral tear, but opined that such a condition probably did not exist. (Ex. 39-3). He reasoned that claimant's symptoms were "consistent with an impingement syndrome and not consistent with a symptomatic labral tear." (*Id.*)

Dr. Ware continued to diagnose a labral tear, without mentioning impingement. (Exs. 40-1, 43-1).

When Dr. Sohn subsequently performed shoulder surgery, he confirmed a SLAP tear. (Ex. 46-1). When Dr. Ware was asked to concur with Dr. Bald's reports, she declined, noting that a "SLAP type 2 lesion" had been seen at surgery. (Ex. 47).

A second surgery addressed a biceps rupture. (Exs. 51-2, 52-1). Dr. Ware continued to treat claimant without again diagnosing impingement. (Exs. 52-156-1, 58-1, 60-1, 62-1, 64-1, 66-1, 68-1, 69-1, 71-1, 73-1, 75-1, 79-1).

After Dr. Chang became claimant's attending physician in February 2016, she did not diagnose impingement. (Exs. 83). On March 28, 2016, Dr. Chang agreed that, based on her review of the medical records and her physical examination of claimant, he "did not have and does not currently have left shoulder impingement syndrome." (Ex. 86-1). Dr. Chang described the impingement syndrome diagnosis as a "working diagnosis or differential diagnosis." (Ex. 86-1).

Dr. Jones, who examined claimant at the employer's request, also described the impingement syndrome diagnosis as "a working diagnosis or differential diagnosis." (Ex. 85-1). Based on his review of the medical records and physical examination of claimant, he also opined that claimant "did not have and does not currently have left shoulder impingement syndrome." (*Id.*)

This medical record is consistent with the description of impingement as a "working diagnosis" or a "differential diagnosis." Dr. Ware diagnosed impingement only prior to the confirmation of the SLAP tear. Dr. Bald's January 29, 2015 opinion suggested that he considered a SLAP tear diagnosis to be a less-likely alternative to an impingement diagnosis.

Considering the confirmation of the SLAP tear, the lack of an impingement diagnosis after the confirmation of the SLAP tear, and the explanation provided by Drs. Chang and Jones, I am persuaded that claimant did not have left shoulder impingement syndrome.

I do not find Dr. Bald's ultimate opinion persuasive. First, Dr. Bald based his opinion, in part, on the understanding that Dr. Jones's "final impression was left shoulder tendinitis/impingement." (Ex. 89-1). Dr. Jones actually diagnosed osteoarthritis, bilateral shoulder strain, and left shoulder SLAP tear, not impingement. (Ex. 74-5). As noted above, Dr. Jones specifically concluded that claimant never had impingement syndrome. (Ex. 85-1).

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Further, although Dr. Bald noted the existence of the SLAP tear and biceps tear, he did not discuss his prior reasoning that based his impingement diagnosis, in large part, on the reasoning that claimant's symptoms were more consistent with impingement than with a labral tear and that the December 2014 MRI did not show a SLAP tear. He also failed to discuss the effect that the confirmation of the SLAP tear and biceps tear had on the likelihood that claimant *also* had an impingement syndrome (a condition that was never otherwise diagnosed by a physician who understood that claimant had a SLAP tear).

In this context, I conclude that Drs. Chang and Jones offered the best-reasoned opinions regarding the existence of the claimed impingement syndrome. Therefore, I conclude that claimant has not carried his burden to establish the existence of the claimed impingement syndrome. Accordingly, I would reinstate the employer's denial. Because the majority does otherwise, I respectfully dissent.