IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2000 MTWCC 23

WCC No. 9911-8347

JODY BLOCK

Petitioner

vs.

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

Respondent/Insurer for

MOODY'S MARKETS, INCORPORATED
d/b/a HARVEST FOODS

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: 38 year-old former delicatessen worker sought additional temporary total disability benefits, claiming she had not reached MMI following back injury. IME physician, an orthopedic surgeon, examined claimant and also reviewed records of claimant's extensive medical history, concluding she had a long history of back pain and finding she had returned to her pre-injury baseline. Claimant's physician gave a later MMI date based on his general experience with back injuries. He did not review medical records until the day before trial. Insurer demonstrated through detailed review of medical records that claimant had history of seeking drugs and was not a credible witness.

Held: Where records from numerous medical providers documented claimant's drug seeking behavior, and claimant was not a credible witness, WCC rejected her testimony about continued disability and that of physician who had not reviewed complete medical records before rendering opinion. Claimant not entitled to continued TTD.

Topics:

> **Benefits: Temporary Total Benefits.** Where records from numerous medical providers documented claimant's drug seeking behavior, and claimant was not credible witness, Court rejected her testimony about continued disability and that of physician who opined claimant had not reached MMI but had not reviewed complete set of medical records.

Evidence: Expert Testimony: Physicians. Where records from numerous medical providers documented claimant's drug seeking behavior, Court rejected testimony of physician who opined claimant had not reached MMI but had not reviewed complete set of medical records.

Maximum Medical Improvement. Where records from numerous medical providers documented claimant's drug seeking behavior, and claimant was not credible witness, Court rejected her testimony about continued disability and that of physician who opined claimant had not reached MMI but had not reviewed complete set of medical records.

Witnesses: Credibility: Drug Abuse. Where records from numerous medical providers documented claimant's drug seeking behavior, and claimant was not credible witness, Court rejected her testimony about continued disability and that of physician who opined claimant had not reached MMI but had not reviewed complete set of medical records.

¶1 This trial in this matter was held on January 18, 2000, in Missoula, Montana. The petitioner, Jody Block (claimant), was present and represented by Mr. Rex Palmer. Respondent, Indemnity Insurance Company (Indemnity), was represented by Mr. Leo S. Ward.

¶2 Exhibits: Exhibits 1 through 17 and 19 through 21 were admitted without objection. Exhibit 18 was withdrawn. Exhibit 22 was consolidated with Exhibit 21.

¶3 Witnesses and Deposition: Claimant, Dr. Gary Cooney, and Michelle Fairclough testified at trial. The deposition of claimant was also submitted for the Court's consideration.

¶4 Issues: As rephrased by the Court, the following issues are presented:

1. Whether claimant is entitled to additional temporary total disability benefits.

2. Whether claimant is entitled to attorney fees and a penalty with respect to any additional temporary total disability benefits which may be awarded by the Court.

¶5 Having considered the Pretrial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the deposition and exhibits, and the arguments of the parties, the Court makes the following:

Findings of Fact

¶6 Claimant is 38 years old. She dropped out of school in the 10th grade and does not have a GED.

¶7 Claimant's testimony concerning her work history was inconsistent in places and contradicted by medical records in others. She testified in her deposition that after moving

to Montana in 1986, she worked a short time for West Mont as a home care provider, quit that job, then worked caring for an elderly woman for approximately five years. (Block Dep. at 10-12.) She then testified that she couldn't work for several years because her boy friend harassed and stalked her. Her testimony indicates this went on for eight years. (*Id*. at 12-13.) Later in her deposition she indicated she was unemployed only two years. (*Id*. at 21.) Her trial testimony was that she was unemployed for four or five years. Medical records indicate that she was working as a home care provider in early 1996, (ex. 21 at 16, 20-21), but she denied working at that time.

¶8 In late 1996 claimant was hired by Moody's Markets (Moody's) in Lolo, Montana, to work in its delicatessen.

¶9 On March 24, 1998, the claimant hurt her back at work while lifting a 50 pound bag of flour. She filed a claim for compensation.

¶10 At the time of her injury, Moody's was insured by Indemnity, which accepted liability for her claim.

¶11 On the same day as her injury, claimant sought care at the emergency room of Community Medical Center in Missoula. (Ex. 21 at 159-165.) At that time she was complaining of "thoracic spine pain radiating down to her lower back," along with "radiation of the pain down her right buttock." (*Id*. at 161.) Upon examination, the only noteworthy finding was "tenderness" in the right back and buttock. (*Id*.) The ER physician diagnosed "[b]ack strain," prescribed Ibuprofen, Lortab (a narcotic analgesic with acetaminophen) and Valium; discharged her to home; and instructed her to follow-up with Dr. Ned F. Vasquez, who is claimant's family physician. (*Id*.)

¶12 Three days later, on March 27, 1998, claimant returned to the Community Medical Center ER and advised the ER physician that she had an appointment with Dr. Vasquez for the next Monday but was nearly out of pain medication and "would be out of pain medication over the weekend." (*Id*. at 157.) The doctor wrote prescriptions for refills of Lortab and Valium.

¶13 Dr. Vasquez saw claimant on March 30, 1998. (Ex. 8 at 4-5.) On his examination he noted tenderness involving virtually her entire back from the neck down. (*Id*.) In his assessment, he wrote:

> A: Original injury probably involved lumbar strain. He [sic] has persisting Sx [symptoms] in that area but also has multiple other Sx suggesting bilateral trapezius strain and thoracic strain. . . .

(*Id*. at 5.) He prescribed various medications, including Lortab, and physical therapy. (*Id*.)

¶14 Following three physical therapy sessions (*id*. at 5-15), claimant returned to Dr. Vasquez on April 10, 1998. At that time she reported "she is ‘miserable' and proceeds in

describing numerous Sx [symptoms]." (*Id.* at 16, quotation marks in original.) Dr. Vasquez commented:

> Jody now has even more widespread Sx than she did at initial visit. Her Sx can certainly not be organized under one diagnosis. Most of her Sx are probably muscular in nature.

(*Id*.) He recommended a neurosurgical consultation. (*Id*.)

¶15 Dr. Richard C. Dewey, a neurosurgeon, examined claimant on April 21, 1998. She reported pain in different spots of her back, "first in one spot, then the other." (Ex. 13 at 1.) Upon examination, Dr. Dewey found "[m]arked spasm in the trapezii and the rhomboids bilateral and tenderness on all of the erector muscles of the spine." (*Id*.) He diagnosed a "typical case of fibromyalgia or migratory muscle spasms," recommended a good stretching program, and indicated she could return to work "when she is more comfortable." (*Id.* at 2.) He did not restrict her from heavy lifting but recommended she prepare herself before lifting and that she stretch hourly. (*Id*. at 2.)

¶16 Dr. Dewey saw claimant again on May 26, 1998, in follow-up. At that time he noted she was "much better than she was a month ago." (Ex. 8 at 25.) He noted, however, that she was not doing her stretching exercise effectively and reinstructed her on stretching. He released her to return to work without restriction. (*Id*.)

¶17 Meanwhile, on April 30, 1998, claimant went to Dr. Gary D. Cooney, a neurologist for evaluation. In her history to Dr. Cooney, claimant reported she had "intermittent problems with pain in various areas of her back for a number of years," which had generally responded to non-steroidal anti-inflammatory drugs. (Ex. 7 at 1.) She reported her pain following her March 24th injury as predominantly in the T7-T10 area on the right side with achy discomfort in the right lumbar and cervical-trapezius regions. She told Dr. Cooney that she had experienced no substantial improvement in her back pain since the injury. (*Id*.)

¶18 Dr. Cooney reported that claimant had some tenderness of her back upon examination and some degree of kyphoscoliosis, but the exam was otherwise unremarkable. (*Id*.) He diagnosed "[t]horacolumbar strain/sprain injury" and prescribed various medications. (*Id*. at 3.)

¶19 Dr. Cooney saw claimant again on June 1, 1998, six days after she had last been seen by Dr. Dewey. As did Dr. Dewey, he noted improvement in claimant's complaints. He released her to return to work as of June 4, 1998, however, he restricted her to lifting 50 pounds or less. (*Id*. at 6.)

¶20 Claimant then went back to work at Moody's sometime in June. (See Ex. 20 at 16-17.) On June 19, 1998, she went to Community Medical Center complaining that she had been lifting heavy objects at work and reinjured her back. (Ex. 21 at 85.) She reported low-back

pain and pain shooting down both legs. (*Id*.) The physician examining her diagnosed low-back sprain. (*Id*.) He instructed her to return to Dr. Vasquez.

¶21 On July 13, 1998, claimant returned to Dr. Cooney complaining of increased mid-thoracic pain due to work, which she reported was more physically demanding than her preinjury work. (Ex. 7 at 8.) Dr. Cooney took her off work for a month. (*Id*.) On August 10, 1998, claimant reported no significant improvement to Dr. Cooney and he extended her off-work status another six weeks.

¶22 Following the July 13th visit to Dr. Cooney, claimant never returned to work at Moody's.

¶23 At the request of the insurer, Dr. Catherine C. Capps, an orthopedic surgeon, did an independent medical examination of claimant on September 15, 1998. Dr. Capps also reviewed claimant's medical records dating back to at least as early as 1994. Her report is found at Exhibit 9. In it she points out that claimant has a long history of back pain dating back to age 15. Her back complaints led to multiple x-rays of all portions of her spine in 1994 and 1995. In 1996 she tested positive for HLA-B27, an antigen associated with ankylosing spondylitis, and was diagnosed by a rheumatologist as suffering from ankylosing spondylitis (rheumatoid arthritis of the spine). Dr. Capps' diagnosis was "[p]robable lumbar strain superimposed on underlying ankylosing spondylitis." (Ex. 9 at 6.) She found that claimant had returned to her preinjury baseline and was at maximum medical improvement (MMI).

¶24 Based on Dr. Capps' MMI finding, the insurer gave claimant a 14-day notice of its intent to terminate her TTD benefits. The notice was given December 14, 1999, (ex. 20 at 221), and benefits terminated on December 28, 1999.

¶25 In this proceeding, claimant seeks reinstatement of her TTD benefits through at least the date of hearing.

¶26 In support of her request, claimant presented the testimony of Dr. Cooney. He testified that claimant reached MMI on March 24, 1999. Claimant presented no evidence of a later MMI date. Further, she was employed as a home care provider for Olive Jacobs, an elderly lady, from December 31, 1998, until March 15, 1999. (Exs. 4 and 19 at 9.) At best, she would be entitled to 11 additional days of benefits for December 29 and 30 and March 15 through 23.

¶27 Moreover, Dr. Cooney's testimony regarding MMI was unpersuasive. His testimony as to the March 24, 1999 MMI date, was based on his experience that patients with back sprains or strains improve little if at all after one year. He testified that his date of MMI was therefore somewhat arbitrary. Until the day before trial, Dr. Cooney did not have claimant's medical records. More importantly, his disagreement with Dr. Capps' opinion that claimant suffered a temporary aggravation was based on what he viewed as claimant's lack of prior

history of significant pain prior to her injury and claimant's self-report that she had not returned to her preinjury condition. His view of claimant's prior back history is not supported by the medical records. As Dr. Capps' indicates, claimant had a long, significant history of preinjury back pain.

¶28 A review of medical records furnished the Court shows claimant had chronic back pain prior to her 1998 injury. Among other treatments, she had been treated with physical therapy, a TENS unit, and narcotic analgesics. The following is a brief synopsis of that history:

> 9/21/91 St. Patrick ER visit for sharp pain in upper back.
> (Ex. 21 at 306-309.)
>
> 8/11/93 Lumbar back strain. (*Id.* at 3.)
>
> 8/25 & 9/7/93 Continued lumbar pain. (*Id*. at 4-5.)
>
> 9/14/93 Back pain persists. (*Id.* at 6.)
>
> 2/25/94 Slip and fall, hurt back and neck. Lortab prescribed for severe pain. (*Id*. at 8-9.)
>
> 3/08/94 Continued treatment. (*Id.* at 9-10.)
>
> 1/15/95 ER. Low back strain chopping wood. Lortab prescribed. (*Id*. at 68.)
>
> 9/12/95 Upper neck and headache complaints. (*Id.* at 58.)
>
> 10/20/95 Chronic back pain. Physical therapy (PT) being done. (*Id*. at 11-12) More PT prescribed. (*Id*. at 14, 59.)
>
> 10/23/95 Car accident – rear ended. Neck and back pain. (*Id.* at 270-71.)
>
> 11/02/95 Follow up for car accident — back pain. (*Id*. at 13.) Lortab prescribed.
>
> 11/30/95 Mid-thoracic and mid-to-lower lumbar pain. "Recent acute symptoms are subsiding. Chronic symptoms will probably take considerably longer to improve." Lortab prescribed. (*Id.* at 15.)
>
> 12/28/95 Worsening back symptoms. (*Id*. at 16.)
>
> 1/05/96 Chronic back pain "suggestive of the possibility of fibromyalgia." Lortab prescribed. (*Id*. at 17.)
>
> 1/19/96 Slip and fall. Hurt back. (*Id*. at 18.)
>
> 2/20/96 Better but still has daily back pain, with "bad days" twice a week. (*Id.* at 20-22.)

2/29/96 TENS unit prescribed for chronic back pain. (*Id*. at 60.)

3/26/96 "Chronic back pain which is multifocal and without clear etiology." (*Id*. at 22.)

4/17/96 Dr. H.W. Busey, a rheumatologist, examined claimant. HLA-B27 positive. That and claimant's symptoms suggest ankylosing spondylitis. (*Id*. at 23-24.)

4/20/96 ER at Community. "Low back pain and possible drug-seeking behavior." (*Id*. at 168.)

5/22/96 Back pain. Bad days 50% of time. (*Id*. at 21.)

9/10/96 Back pain "at a significant level with increased activities." (*Id*. at 25.)

6/16/97 Back pain, significant by end of day. (*Id*. at 26.)

8/97 - 9/97 Prescription notes indicate Ultram and Lortab prescribed for severe pain. (*Id*. at 27-28.)

11/13/97 Three days of severe back pain. (*Id*. at 29.)

12/30/97 Back pain. (*Id*. at 31.)

¶29 A review of medical records shows that claimant was at best a poor historian after her injury, failing in many instances to mention her prior history of back pain. In point of fact, during her initial March 24, 1998 medical examination immediately following her accident, she denied any prior back injuries. (Ex. 21 at 5, 83, and 161.) At trial she agreed her statement was untrue but could not explain why she made it.

¶30 The medical records are replete with evidence of drug abuse, showing that claimant was obtaining narcotic drugs from different sources and not disclosing the prescription of one provider to another. She probably suffered drug overdoses on two occasions.

¶31 During cross-examination, claimant was taken through medical records indicating multiple instances of back pain and narcotic prescriptions prior to her March 1998 injury. Indeed, on December 30, 1997, claimant reported back and neck pain; she requested and obtained a prescription for Lortab, a narcotic analgesic. (*Id*. 21 at 31.)

¶32 The following post-injury history of claimant's inappropriate seeking of narcotic drugs was adduced in cross-examination:

> On April 30, 1998, Dr. Cooney prescribed 30 Darvocet N 100, a narcotic analgesic, to be taken 4 times a day as needed. (Ex. 7 at 3.) This represented a 1-week supply if taken as prescribed (4x7=28). Dr. Cooney authorized 5 refills, thus giving her a 6-week supply that should have lasted until June 11, 1998.

On June 1, 1998, Dr. Cooney prescribed 30 Lortab with 5 refills on the same, 4 times daily as needed basis. This represented another 6-week supply. Tacked on to the April 30th prescription, claimant's supply of Lortab should have lasted until July 22nd or 23rd.

On June 19, 1998, claimant went to Community Medical Center for back pain. Dr. G.J. Moore examined her. In his history he noted: "[T]his patient has been seen innumerable times for back pain, toothaches, and headaches and certainly is suspect for drug seeking behavior." (Ex. 21 at 85.) Obviously unaware that Dr. Cooney had prescribed a 6-week supply of Lortab less than 3 weeks previous, and that claimant should have had an additional week and a half supply of Darvocet left over from Dr. Cooney's earlier prescription, Dr. Moore prescribed 14 Lortab. (*Id*.) Claimant testified that she told Dr. Moore that she already had Lortab. I did not find her testimony believable.

On July 5, 1998, claimant went to the ER at St. Patrick Hospital for abdominal pain. She reported that she was "on no meds" and had "no other chronic medical problems." She was given Demoral in the ER. (*Id.* at 231.)

On July 13, 1998, Dr. Cooney prescribed a 6-week supply of Darvocet. (Ex. 7 at 3.) This should have lasted claimant until August 23rd.

On July 24, 1998, a physician at the Western Montana Clinic (perhaps Dr. Vasquez) called in a prescription for 20 Ultram to be taken 4 times a day for abdominal pain. (Ex. 8 at 24, 26-28 and Ex. 21 at 38.) Ultram is an opiate agonist.

On July 30, 1998, claimant was examined by Dr. Vasquez with respect to her abdominal pain. He prescribed 30 Ultram to be taken as needed 4 times a day with 1 refill. (Ex. 8 at 26, 28.) There is no indication he was aware of Dr. Cooney's prescription.

On August 10, 1998, Dr. Cooney told claimant to continue her Lortab, however, his medical note does not indicate he wrote an additional prescription. (Ex. 7 at 8.)

On August 26, 1998, claimant was examined at the Western Montana Clinic for right leg pain and was prescribed 15 Lortab.

On September 1, 1998, claimant presented at the ER of St. Patrick Hospital complaining of upper dental pain. She was given 10 Darvocet-N 100, which contains a "centrally acting narcotic analgesic agent." Physicians Desk Reference, 2000 Ed., at 1574. At trial claimant testified she does not like Darvocet and did not believe she had the prescription filled, however, I did not find her testimony credible, especially in light of the other evidence.

On September 9, 1998, she was evaluated by Dr. E. Morris with respect to her 12-week complaints of abdominal pain. He was unable to find a specific medical explanation for her pain and did not write any prescriptions. (Ex. 8 at 29-30.)

On September 17, 1998, claimant went to the Western Montana Clinic seeking pain medication for her back and said she "has been out of her Lortab now for some time." (*Id*. at 30.) A nurse practitioner wrote her a prescription for another 30 Lortab, as well as for Voltaren. (*Id*.)

On September 24, 1998, Dr. Vasquez wrote another prescription for 20 Lortab for her back pain. (*Id*. at 31.) His office note indicates claimant advised him that she had been prescribed Voltaren on September 17th but does not mention the Lortab prescription written on that date. The September 17th office note was not transcribed until September 22, 1998, and it is unknown whether that note was available to Dr. Vasquez on September 24th.

On September 29, 1998, Dr. Cooney provided claimant with another prescription for 30 Lortab with 5 refills. (Ex. 7 at 12.) There is no indication that she told Dr. Cooney about the recent Lortab prescriptions written by the nurse practitioner and Dr. Vasquez. Dr. Cooney's prescription on this date should have lasted until November 9th.

On October 5, 1998, just 6 days after Dr. Cooney's latest prescription, Dr. Vasquez called in another prescription for 15 Lortab "for severe pain." (Ex. 21 at 41.) The Court infers that claimant called to request the medication.

On October 29, 1998, Dr. Cooney prescribed a continuation for the Lortab, however, his medical note does not indicate an additional prescription was provided. (Ex. 7 at 14.)

Six days later, on November 5, 1998, claimant obtained a prescription for 15 Lortab from Dr. Vasquez for severe pain. (Ex. 21 at 43.)

On November 8, 1998, claimant went to Community Medical Center complaining of "progressive low back pain over the past 24-48 hours." She received an injection of Toradol, which is a non-asteroidal, non-narcotic analgesic, and yet another prescription for 20 more Lortab. (*Id*. at 143.)

On November 9, 1998, Dr. Cooney phoned in a prescription for 30 Lortab with 2 refills. (Ex. 7 at 15.)

On November 30, 1998, Dr. Cooney phoned in a prescription for 30 Hydrocodone with 2 refills. (Id.) Lortab is brand name hydrocodone. Physicians' Desk Reference, 2000 Ed., at 3120.

One day later, on December 1, 1998, Dr. Vasquez phoned in a prescription for 15 Lortab "for severe pain." (Ex. 21 at 44.)

On December 9, 1998, Dr. Cooney wrote another prescription for 60 Lortab with 2 refills, limiting the refills to "1 refill per 2 weeks. (Ex. 7 at 16.) This represented a 6-week's supply.

On December 22, 1998, long before the 6-week supply prescribed by Dr. Cooney should have been used up, Dr. Vasquez phoned in a prescription for 15 Lortab. (Ex. 21 at 44.) As with previous prescriptions, the Court must infer that the prescription was requested by claimant.

On January 21, 1999, Dr. Vasquez prescribed 30 Lortab for "occasional use for severe pain." (*Id.* at 44.)

On February 2, 1999, Dr. Cooney directed claimant to continue Lortab for pain but his note does not indicate whether a new prescription was written. (Ex. 7 at 20.)

On February 13, 1999, claimant was taken to Community Medical Center by her 20-year-old daughter for an apparent drug overdose. A history was taken from both claimant and her daughter. According to claimant, she had taken 2 Darvocet, 1 Valium and 2 Soma tablets. The history provided the daughter was more extensive:

> The daughter states, however, that she noticed that her mother was shaky and had slurred speech so she called Ask-A-Nurse and was told that the mother should be evaluated in the ED. [Sic.] The daughter also gives a history that mother frequently takes a lot of medication throughout the day and commonly at night has slurred speech and seems to be somewhat lethargic. Daughter is worried about the mother's use of the narcotic medications.

(Ex. 21 at 137.)

On April 7, 1999, Dr. Cooney prescribed 60 Lortab with 3 refills -- an 8-week supply. (Ex. 7 at 21.)

Nine days later, on April 16, 1999, claimant sought ER care at St. Patrick Hospital for neck and back pain following some sort of incident, apparently after being thrown into a pickup multiple times. Fourteen Tylenol #3 were prescribed. (Ex. 21 at 211-215.) The next day, April 17, 1999, claimant called the ER to report that the Tylenol #3 were "not helping ‘even doubling up & it ain't cutting it.'" A prescription for 12 Darvocet N100 was then provided. (*Id*. at 216.) There is no indication that claimant reported her access to the Lortab recently prescribed by Dr. Cooney.

> Another 10 days later, Dr. Cooney prescribed 10 tablets of additional, higher strength Lortab, "[a]dmonished [claimant] very strongly to avoid taking more narcotic analgesics than prescribed." (Ex. 7 at 22.)
>
> On April 29, 1999, claimant again presented at the St. Patrick ER complaining of pain in her right leg. The Aftercare Instruction Sheet indicates she should take "Lortab for Pain", but does not indicate that additional medication was prescribed. (Ex. 21 at 207.)
>
> On May 15, 1999, claimant was again in the St. Patrick ER for falling down steps and twisting her leg. Twelve Lortab were prescribed. (*Id*. at 199-204.) The next day, she telephoned to report that her pain medication was "not cutting it" and a prescription for 10 Darvocet N 100 was provided. (*Id*. at 205.)
>
> On May 22, 1999, claimant was again at the St. Patrick ER, this time for a drug overdose. The ER record indicates that family members called 911 "due to [claimant's] sluggish behavior" and reported claimant had been taking Soma and Lortab. (*Id*. at 192.) Paramedics reported that her "speech is slow but clear and [she] answers all question of orientation accurately (second try for month is accurate)." (*Id.*, parentheses in original.) Nursing observations indicate that upon admission, claimant "forgets information or directions given to her so needs repeated instructions . . . ." (*Id*. at 193.)

The Court stops its review here.

¶33 Claimant's explanations at trial were not credible and her drug seeking behavior lead me to conclude that she exaggerated her pain and condition to obtain narcotics.

¶34 At trial, Dr. Cooney disagreed with Dr. Capps' MMI finding. His diagnosis was based on claimant not having any history of significant pain prior to her injury and claimant's report that she had not returned to preinjury status. His opinion is only as good as his understanding of claimant's history. A review of claimant's preinjury medical records shows that she had a significant history of back pain preinjury, and had taken narcotic analgesics for it. Dr. Cooney was unaware that claimant had been prescribed narcotic drugs and a TENS unit for back pain prior to the 1998 injury, and agreed that the history was significant. As to claimant's report that she had not returned to preinjury status, the Court simply does not believe her pain reports. As the narcotics history above demonstrates, claimant was abusing narcotic drugs, seeking narcotic drugs from multiple sources and not reporting prescriptions written by one physician to other physicians treating her. When cut off benefits she went to work but did not report that fact to Dr. Cooney.

CONCLUSIONS OF LAW

¶35 Claimant's entitlement to benefits is governed by the 1997 version of the Workers' Compensation Act since that version was in effect at the time of her injury. Buckman v. Montana Deaconess Hospital, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶36 The claimant has the burden of proving by a preponderance of the evidence that she is entitled to compensation. Ricks v. Teslow Consolidated, 162 Mont. 469, 512 P.2d 1304 (1973); Dumont v. Wicken Bros. Construction Co., 183 Mont. 190, 598 P.2d 1099 (1979).

¶37 Claimant is seeking reinstatement of temporary total disability benefits. Her request is governed by sections 39-71-701 and -116(34), MCA (1997). Section 39-71-701, MCA, provides in relevant part:

> 39-71-701. Compensation for temporary total disability -- exception. (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:
> (a) when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing . . . .

Section 39-71-116(34) provides:

> (34) "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

As the Court has found, claimant reached MMI prior to the termination of her benefits. She is therefore not entitled to further TTD benefits.

¶38 Claimant argued at trial that the notice of termination of benefits was ineffective, however, her argument was premised upon the Court finding that she had not reached MMI at the time the notice issued. The argument was addressed at hearing and rejected by bench ruling. Since the Court has found that claimant reached MMI prior to the cutoff of her benefits, the argument need not be further addressed here.

¶39 Since claimant is not entitled to further TTD benefits, she is not entitled to either an attorney fee or a penalty since both require that she prevail on the merits. §§ 39-71-612 and -2907, MCA (1997).

¶40 Claimant is not entitled to her costs since she has not prevailed.

JUDGMENT

¶41 1. Claimant is not entitled to further temporary total disability benefits, attorney fees, a penalty, or costs. Her petition is dismissed with prejudice.

¶42 2. Any party to this dispute may have 20 days in which to request a rehearing from these Findings of Fact, Conclusions of Law and Judgment.

¶43 3. This Judgment is certified as final for purposes of appeal.

DATED in Helena, Montana, this 18th day of April, 2000.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Mr. Rex Palmer
Mr. Leo S. Ward
Date Submitted: January 18, 2000