IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2002 MTWCC 18

WCC No. 2001-0400

JODY DIERKS BURTELL

Petitioner

vs.

STATE COMPENSATION INSURANCE FUND

Respondent/Insurer for

WEST MONT

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: Claimant's temporary total disability (TTD) benefits were terminated in 1994. For the next five years she did not seek medical care and worked part time only for a few weeks with little or no effort to seek other work. In May 2000 her low-back symptoms increased and she again sought medical care. Surgery on her back was thereafter performed. She now seeks TTD benefits retroactive to 1994.

Held: While surgery was appropriate in 2000, it was not appropriate in 1994. In 1994 there was no treatment prescribed for her that would have improved her condition or which she was willing to undertake, therefore she had reached maximum medical improvement (MMI) at that time. Since she had also been medically and vocationally approved for return to work in a number of jobs, she was no longer entitled to TTD benefits. She became re-entitled to TTD benefits in May 2000, when her condition worsened and she sought out medical care leading to surgery. She is therefore due TTD benefits only since May 2000.

Topics:

> **Maximum Medical Improvement: Failure to Follow Physician's Recommendations.** Where claimant fails to follow through with the only treatment which might materially improve her condition, she has reached MMI.
>
> **Maximum Medical Improvement: When Reached.** Maximum medical improvement is reached where further treatment would not materially improve

claimant's condition, or claimant refuses or fails to follow through with treatment which might improve her condition.

Maximum Medical Improvement: When Reached. The fact that claimant's condition may later deteriorate and require treatment which will improve her condition does not negate the fact that she was MMI prior to the deterioration of her condition. MMI means only that she would not benefit from further treatment at the time of the MMI determination.

Maximum Medical Improvement: When Reached. A claimant who has reached MMI may return to non-MMI status where her condition deteriorates to the point that further treatment would materially benefit her condition.

Benefits: Temporary Total Benefits. A claimant is no longer entitled to TTD benefits where she has reached MMI, has been medically and vocationally approved to return to several jobs, and her excuses for failing to return to work are unpersuasive.

¶1 The trial in this matter was held on February 20, 2002, in Helena, Montana. Petitioner, Jody Dierks Burtell, was present and represented by Mr. John C. Doubek. Respondent, State Compensation Insurance Fund was represented by Ms. Ann E. Clark.

¶2 Exhibits: Exhibits 1 through 21 were admitted without objection.

¶3 Witness and Depositions: Claimant was the only witness at trial. The depositions of claimant and Dr. M. Brooke Hunter were admitted and considered by the Court.

¶4 Issues Presented: The sole issue set forth in the Pretrial Order is:

> Whether the Insurer wrongfully denied payment of TTD benefits for the period of May 17, 1994 to September 15, 2000.

(Pretrial Order at 2.)

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

FINDINGS OF FACT

¶6 Claimant, Jody Dierks Burtell (claimant), is forty-five years old. She has a GED and two years of pre-nursing courses. Her work experience includes waitressing, day care, and nurse's aide. (Burtell Dep. at 5-6.)

¶7 On December 31, 1990, claimant was working for West Mont as a certified nurse's aide. (*Id*. at 7.) While transporting a patient to the bathroom, she fell and twisted her back. (*Id*.) She thereafter experienced low-back pain.

¶8 At the time of her accident, West Mont was insured by the State Fund, which accepted liability for her injury.

¶9 The State Fund paid medical and wage-loss benefits.

¶10 Claimant was initially treated by Dr. Earl E. Book, a family practitioner. (Ex. 20.) Dr. Book summarized her early treatment as follows:

> Initially, [her injury] was felt to be a strain-type injury to her low lumbar spine. However, x-rays showed a decreased disc space at L-5-S-1. Subsequent MRI scan of the lumbar spine performed 2/27/91, shows a protruding and possibly herniating disc at the L-5-S-1.

(*Id*. at 218.) In March 1991, he referred claimant to Dr. M. Brooke Hunter, an orthopedic surgeon, for evaluation for possible surgery. (*Id*. at 218.)

¶11 Claimant was first examined by Dr. Hunter on March 13, 1991. He noted x-rays showing "degenerative changes" and an MRI showing "a possible disc herniation at the 5,1 level." (Ex. 17 at 197.) He testified that claimant "certainly had a disc bulge at that lowest level in her spine, at the L5-S1 level, a possible small amount of herniation there," but he was **not** convinced it was the source of her pain. (*Id.*; Hunter Dep. at 7.) He also found claimant to be "quite deconditioned" and suffering from "multisystems disease from her smoking." (Hunter Dep. at 6.) He informed her she was not a surgical candidate, advised her to quit smoking, and recommended aerobic conditioning and spine stabilization programs. (Ex. 17 at 197; Hunter Dep. at 7-9.)

¶12 Claimant returned to Dr. Hunter on April 26, 1991. (Ex. 17 at 198.) His office note records that she was continuing to experience low-back pain but that she was still smoking and **"quit PT on her own feeling that she couldn't afford to get back and forth**." (*Id*., emphasis added.) He recommended against going back to work as a nurse's aide but "told her that I think she can be doing some type of light or moderate activities." (*Id*.)

¶13 On May 28, 1991, claimant returned to Dr. Hunter. At that time he gave "her a return to work date for one month to give her time to get a little bit more conditioned" and told her to return "in a month after that if she is still having problems." (*Id*. at 199.)

¶14 The State Fund referred claimant for a vocational assessment and on June 14, 1991, claimant met with Colleen M. Lordemann (Lordemann), who is a vocational counselor. Claimant had been initially scheduled to meet with Lordemann on May 31, 1991, but did not "show for that appointment." (Ex. 7 at 101.)

¶15 During her initial interview by Lordemann, claimant said she was relocating to Nebraska and would not participate in a rehabilitation program. (*Id*. at 103.) Because claimant was planning to relocate, Lordemann did not make any final determination regarding employability. (*Id*.)

¶16 Claimant returned to Dr. Hunter on July 16, 1991. He recorded that she was continuing to complain of "grumbly low back pain" and difficulty sitting, as well as pain radiating into her buttock or neck. (Ex. 17 at 200.) Dr. Hunter testified that claimant's complaints were of a myofascial nature, were not objectively related to the disk, and would not be improved by disk surgery. (Hunter Dep. at 11-12.) "She was complaining of pain, basically, between her shoulder blades, down to her back or pelvis, which is a much larger area than just the disc-pain would be responsible for." (*Id*. at 11.) He told claimant surgery would not benefit her, however, claimant informed him "that she has decided that she is going to have surgery and that she would rather have it out in Nebraska where her sick mother lives." (Ex. 17 at 200.) Dr. Hunter recalled his impression that claimant thought "surgery was going to be a quick fix. She'd be up and going and things would be wonderful." (Hunter Dep. at 12.) In his experience, the myofascial component of her pain indicated otherwise. He testified: the "myofascial part of things is not made better by surgery. For a lot of people, it actually sets them back quite a bit." (*Id*. at 12-13.) He also indicated that claimant's smoking reduced claimant's chances for a positive surgical outcome.

¶17 Dr. Hunter sent claimant to Helena Physical Therapy Associates for a program involving "stretching, strengthening and work hardening." (Ex. 11 at 161.) Claimant's first session was on August 2, 1991. (*Id*.) She cancelled her next scheduled session (August 5), stating she had "no car." (*Id*. at 165.) She reported for therapy on August 7, indicating "no change" in her condition. (*Id*.) On August 11, she called from Nebraska to cancel her appointment. (*Id*.)

¶18 On August 19, 1991, claimant returned to therapy but was unable to tolerate even the mildest massage. (*Id*.) On August 21, even with "treatment reduced to minimum," claimant would not tolerate therapy. The physical therapist wrote, "Will contact [doctor] seems to be unusually severe reaction to treatment done thus far." (*Id*. at 166.) Claimant returned to therapy on August 23, but was a "no show" on August 28 and August 30. (*Id*.) On September 4, 1991, the therapist informed Dr. Hunter's office that claimant had an extreme reaction "to treatment no matter how minimal or non-stressful." (*Id*.) Commenting on an upcoming functional capacity evaluation (FCE) which had been ordered, the therapist indicated that the FCE might not be useful given claimant's extreme reactions. (*Id*.)

¶19 Dr. Hunter testified claimant was not following his recommendations. She "hadn't followed up and had missed most of her appointments." (Hunter Dep. at 15.)

¶20 Claimant apparently went to Nebraska for a period of time, then returned to Helena and was again examined by Dr. Hunter on October 18, 1991. (Hunter Dep. at 16.) "She said that she was about the same, perhaps a little bit more pain on her right leg, in the front part of her leg." (*Id*.; Ex. 17 at 201.) Dr. Hunter believed this pain was "not neurologically likely to come at all from an L5, S1 disc, so it puts it back more into the myofascial type of thing rather than in the hard radicular part of things." (Hunter Dep. at 16.)

¶21 Dr. Hunter did not consider claimant at MMI at that point, primarily because she still had not been through an appropriate physical therapy program. (*Id.*) Nevertheless, he believed "she could do the light and sedentary type of work" and "thought that she could be returned to the type of work she was doing before if she could push through the therapy." (*Id*. at 17.) He referred claimant to Dr. Allen M. Weinert, Jr., a specialist in physical and rehabilitative medicine, for evaluation, nerve conduction studies, and "perhaps a functional capacity evaluation through therapy and getting her on line to get returned to work." (Ex. 17 at 201; Hunter Dep. at 17.)

¶22 Dr. Weinert thereafter examined and tested claimant. (Ex. 8 at 130-135.) Her EMG and nerve conduction tests were normal and he recommended that "she begin a supervised program for her low back through physical therapy," followed by a FCE. (*Id.* at 135.)

¶23 On March 12, 1992, claimant began a physical therapy program to instruct her in a home exercise and aerobic program, maintenance of a neutral spine position, and the use of passive lumbar extension exercises. (Ex. 10 at 155-57.) Claimant cancelled the next therapy session, scheduled for March 17, "secondary to her car not starting." (*Id.* at 159.) She "failed to show" for an appointment scheduled for March 19, 1992. (*Id.* at 160.) There is no record of any further therapy on this referral.

¶24 An FCE was performed on April 9, 1992, by Joseph Cullen, a Physical Therapist at St. Peter's Hospital. (Ex. 9 at 137-154.) Although he concluded the exam was valid, Cullen noted symptom exaggeration and observed that claimant seemed unable to distinguish between exertion and pain. (*Id.* at 137-38, 146.) He concluded claimant was able to work in sedentary or light occupations. (*Id.* at 150.)

¶25 On April 30, 1992, Dr. Weinert examined claimant and concluded that she

> has reached maximum medical improvement. I discussed with Jody consideration of further work conditioning or an organized program for the low back and at this point, she does not feel that she would benefit significantly from this. I concur with her.

(Ex. 8 at 133.) He rated her impairment at 8% of the whole person and approved claimant for sedentary to light-duty work. (*Id.* at 133-34.) He specifically approved job analyses for desk clerk (Ex. 7 at 119), casino cashier (*id.* at 122), house parent (*id.* at 124), and customer service representative (*id.* at 126). Lordemann found that claimant had the necessary skills and abilities to perform those jobs. (*Id.* at 114.)

¶26 The State Fund paid claimant for her impairment rating on June 5, 1992. (Ex. 4 at 45-47.)

¶27 On November 25, 1992, a Rehabilitation Panel of the Department of Labor and Industry entered a final determination finding that claimant could return to work in a related

occupation for which she was suited by education and marketable skills. This was "option (c)" under the rehabilitation options in effect at the time of claimant's injury, § 39-71-1012, MCA (1989). Alternative jobs noted by the Panel in its original report as available to the claimant were customer service representative, house parent, desk clerk, and casino cashier. (Ex. 3 at 13.)

¶28 Following the Panel determination, on December 12, 1992, the State Fund gave claimant a 14-day notice that it was terminating her TTD benefits. (Ex. 4 at 50.) Two weeks later, it in fact terminated the benefits. (Ex. 5 at 85.)

¶29 Following termination of her benefits, claimant returned to Dr. Book on March 17, 1993, for back pain. (Ex. 20 at 221.) Claimant told Dr. Book she mostly sat at home and had not been to physical therapy in two years. (*Id.*) She said she was depressed, attributing this to the recent death of her father and to feeling unproductive at home.

¶30 Thereafter, evidently on the recommendation of Dr. Book, claimant returned to Dr. Hunter on April 16, 1993, complaining of constant back pain and depression. Dr. Hunter noted:

> She came in today saying she wanted to set up surgery. I've explained to her that she meets none of the criteria, that she has no nerve root tension signs, no objective neurologic deficit. (She did have symmetric reflexes, no atrophy or fasiculations, etc. and no subjective weakness either). As risk factors is the extreme myofascial component of this. She does continue to smoke, although sounds like she is cutting back significantly. Talked about all of our options. She defers injections of any sort. I've explained that the only chance that she probably has is a functional restoration type program. **She won't hear of being involved or getting engaged in her own care with physical therapy or with Dr. Weinert**.

(Ex. 17 at 202, emphasis added.)

¶31 On May 10, 1993, claimant saw Robert J. Bateen, Ph.D., a psychologist. (Ex. 2.) She complained of pain on a 24-hour basis and said "that the pain is worst when she exerts herself." (*Id.* at 5.) Dr. Bateen noted signs of depression, and recommended therapy "directed toward helping Jody to accept limitations imposed by her physical problems and to establish realistic goals for the future within those limitations." (*Id.* at 6.)

¶32 Claimant returned to Dr. Book on May 12, 1993, and said she had seen Dr. Bateen for depression and was feeling better. (Ex. 20 at 222.) Dr. Book prescribed Prozac for depression. (*Id.* at 223.)

¶33 Claimant returned to Dr. Bateen on May 26, 1993. (Ex. 2 at 7.) They discussed her current situation. Dr. Bateen encouraged her to make an appointment for vocational

rehabilitation. (*Id*.) At deposition, claimant could not remember if she followed through on that recommendation. (Burtell Dep. at 14.)

¶34 Claimant returned to Dr. Book on July 23, 1993. (Ex. 20 at 224.) Claimant told him the Prozac seemed to help but caused her to have indigestion and heartburn. On her own initiative, she had stopped taking Prozac. She denied the possibility that other medications caused the heartburn. (*Id*.)

¶35 Claimant returned to Dr. Book on October 1, 1993. (*Id*. at 226.) She complained of a two-month history of "pins and needles like sensations in 3 separate areas of her body," including the thigh to knee on one leg, near the thumb, and in the thoracic area. (*Id*.) She told Dr. Book that when the numbness came on, it would arise simultaneously in all three areas. Dr. Book recorded:

> I told the patient I am not certain about the etiology of her rather unusual paresthesias. They don't follow any dermatomal distribution. Neurologically, she otherwise appears to be intact, although she is a little intoxicated. . . .

(*Id*. at 227.)

¶36 On October 14, 1993, counsel for State Fund wrote to Dr. Bateen, requesting information about any psychological treatment recommended or planned for claimant and whether such was related to the industrial accident and/or return to work. (Ex. 4 at 57.) The claim file and other exhibits do not include any response from Dr. Bateen.

¶37 Claimant returned to Dr. Bateen on March 14, 1994. (Ex. 2 at 8.) His office note for that day states:

> 3/14/94 Jody returns after long absence. I have agreed to see her and **have received a letter from her attorney indicating that Workers Comp will reimburse for this visit as well as past visits.** Jody complains of deepening depression. Most of this appears situational. Status has changed little since I last saw her. Wants to work on pain management and I feel this is a reasonable goal. Will see her next week.

(Ex. 2 at 8, emphasis added.) The claimant was scheduled for further sessions with Dr. Bateen.

¶38 Dr. Bateen's file contains the following letter, dated April 24, 1994, to the State Fund:

> Jody was initially seen in May, 1993 at which time I felt that she had depression secondary to her current life situation. Jody recently returned to the clinic at the request of her attorney and upon self referral. She continues to complain of depression and indicates that at times feels quite suicidal. In talking with Jody, it is apparent that she is reacting poorly to her pain complaints. It is my opinion that if she could learn to better manage her pain, she would be able to be more productive

> which in turn should reduce her depressive complaints. Treatment of choice would consist of cognitive restructuring with the goal of helping her to see herself as a [sic] disabled secondary to her pain complaints. I have also talked with Mrs. Dierks about the use of relaxation techniques and possibly hypnosis as a means of better controlling her pain. I would note that Mrs. Dierks denies any psychological difficulties prior to her industrial accident and again much of her depression appears to be related to the limitations imposed by her pain.
>
> In reference to the questions raised in the October 14, 1993 letter from Elizabeth Horsman-Wiitala, legal counsel, I have had one correspondence from Mrs. Dierks [sic] attorney requesting that I see Mrs. Dierks. Beyond this, I have had no contact with this individual. Mrs. Dierks was referred by her attorney.
>
> It is felt that therapy with Mrs. Dierks would be relatively short term. I feel that if she has not had a positive response within ten sessions that it is likely that she would benefit little from ongoing psychotherapy/pain management techniques.

(Ex. 2 at 9.)

¶39 The letter does not appear in the State Fund file and it appears the State Fund never received it. In a letter dated May 4, 1994, the claims examiner told claimant's counsel that two letters had been directed to Dr. Bateen without response. (Ex. 4 at 60.)

¶40 Claimant did not keep her next appointment with Dr. Bateen and never followed up with the agreed treatment. The only record of further sessions with Dr. Bateen is an office note of August 22, 1994, when she sought him out after "her dog died and she felt as though she was 'falling apart.'" (Ex. 2 at 10.) Dr. Bateen's office note states that claimant "[h]ad missed last several appt [appointments]." (*Id*.) On the other hand, he noted that she "[r]eported she had done well emotional up to this crises." (*Id*.) He scheduled a further "supportive" session for the next week (*id*.), but there is no record of claimant ever keeping that appointment.

¶41 As with other therapy offered claimant, I can only find and conclude that while Dr. Bateen offered claimant therapy to address her depression, she never followed up with the treatment proffered her.

¶42 Although the record is not fully fleshed out, a May 4, 1994 letter from Jacob Bristow, a claims adjuster for the State Fund to Mr. John C. Doubek, claimant's attorney, indicates that the claims adjuster and Mr. Doubek reached an agreement to retroactively reinstate claimant's TTD benefits and bring them up to date, at least as of the date of the letter. The letter, however, goes on to cite the April 30, 1992 MMI finding and notified Mr. Doubek that the reinstated benefits were being terminated in 14 days due to a lack of medical evidence of disability, the prior MMI finding, and approved jobs. (Ex. 4 at 60.)

¶43 A review of the State Fund's record of payments shows that in fact benefits were retroactively reinstated on March 8, 1994 and were then terminated in accordance with the May 4, 1994 letter. (Ex. 5.)

¶44 Claimant was examined by Dr. Hunter on January 24, 1995, "two years after last being seen." (Ex. 17 at 203; Hunter Dep. at 20.) She reported "continuous right buttock area pain, some pain down into her posterior thigh" and pain "up in her interscapular area and neck." (Ex. 17 at 203.) She was not taking any medication "other than over-the-counter narcotics from Canada." (*Id.*) Dr. Hunter's medical note reads:

> EXAM; Shows her to be moving around quite guardedly. Exquisitely responsive to light touch anywhere around low back or sacral area. Volition[al]ly poor motion. Straight leg raising negative although she is tight in her hamstrings. No obvious neurologic deficits. **Talked to her about the problems one visit like this engenders. I would not change the Functional Capacity Evaluation, work evaluation etc. done by Dr. Weinert in the past.**
>
> If there is any controversy about Functional Capacity and work capacity, I'd recommend repeat of the FCE etc. She continues to smoke, continues to be poorly involved with things. I am not sure that unless she wants to get engaged or has vocational goals that there is any sense in a Functional Restoration Program. See her PRN.

(*Id.*, emphasis added.)

¶45 In April of 1995, claimant returned to Dr. Hunter, with similar complaints. She also noted she had recently fallen "into a sharp edge of a counter top on her sacral area." (*Id.*; Hunter Dep. at 22.) Regarding her complaints, Dr. Hunter recorded:

> She is the same night and day with or without activity. She doesn't walk or do much exercise and doesn't think it helps when she does. She does continue to smoke and says she is smoking about two packs a day. She describes an area from the thoracic-lumbar junctional area clear down to the lower part of buttocks and full body as the area of pain. She says she has problems at night and day equally and that there is no difference with activity. She doesn't like to exercise and doesn't think it helps.
>
> EXAM: Shows her to be moving around quite guardedly. Straight leg raising is negative although she does have some tight hamstrings. Toggle of hip motion on either side causes her to complain of pain in essentially thoraco-lumbar to sacro-iliac area of spine. Reacts quite strongly to even light touch. No obvious spasm. Deep tendon reflexes are physiologic and symmetric. No obvious atrophy or fasciculations.

> **This all continues to appear to be myofascial.** I've talked to her about the work-up that has already been done. **I don't believe further evaluation is necessary. She says she wouldn't contemplate undergoing surgery even if this was a surgical problem which is certainly does not appear to be.** This leaves us with what we've already done and tried.
>
> **I don't see anything here today that would make me think that changing her work status etc. makes sense. I've explained that this has all been done well by Dr. Weinert.** She would like another opinion it sounds like on all this, and I've explained that this is between her and work comp. She has asked for recommendations, and I feel that if she does not wish to follow-up with Dr. Weinert that the physciatrist [sic] in Butte or Great Falls might become involved.

(Ex. 17 at 203-204, emphasis added.) In his deposition, Dr. Hunter recalled telling claimant surgery was not appropriate, to which she replied, "that's okay. I wouldn't do it anyway." (Hunter Dep. at 23.) While claimant denied the conversation, I did not find her denial credible.

¶46 Claimant thereafter did not seek medical treatment for five years. (Burtell Dep. at 11-12). According to claimant, she stopped treatment due to a "personality clash" with Dr. Hunter, stating she disagreed with his position on her smoking and surgery. She testified that she became depressed because Dr. Hunter did not offer surgery to her. (*Id*. at 27.) She acknowledged treating with Dr. Bateen for depression, but said she then threw up her hands and stayed out of sight for a few years. (*Id*. at 28.) When asked why she waited so long to obtain other medical treatment if her condition was as she described, claimant testified, "If he didn't care, I didn't care." (Trial Test.)

¶47 Claimant acknowledged she refused to go back and see Dr. Weinert. (Burtell Dep. at 25.) She testified she did not agree with Dr. Weinert or what he said to her. (*Id*. at 13.) She further acknowledged quitting physical therapy, testifying she could not afford to get there. (*Id*. at 16-17.) Claimant admitted refusing injections recommended by Dr. Hunter, stating she did not want needles in her back.

¶48 According to claimant, she "didn't do much of anything" between 1995 and 2000. She claims that she "just ate tons of Tylenol," taking Tylenol Codeine from Canada when she could obtain it. (*Id*. at 12.) At some point between 1997 and 1999, claimant worked briefly as a waitress, and in other capacities, at Rose's Cantina in Helena. (*Id*. at 10.) According to claimant, she worked there for approximately two months, but "maybe 10, 15 hours a week, tops." (*Id*.) "Then after that, I just got tired of it because I couldn't take the pain. . . ." (*Id*. at 11.)

¶49 Claimant testified that she also applied to work as a room maid at the Colonial, but "when they found out I had filed a workman's comp, they would not even hire me." (*Id*. at

11.) She did not try other jobs. When asked what she did over the years, she answered, "Pretty much, in all honesty, rotting at home." (*Id*. at 12.)

¶50 Claimant again sought medical care for her back in the spring of 2000, when she experienced an increase in her symptoms. (*Id*. at 21, 28.) She testified that "the outsides of my legs went numb, shooting pains down my legs, leg cramps during the night, couldn't stand to stand or work; like, even go shopping, I couldn't handle it, or hold my grandbaby." (*Id*. at 21.)

¶51 Claimant saw Dr. B. Max Iverson on May 3, 2000. (Ex. 16 at 187.) She described an increase in symptoms over time. (*Id*.) Dr. Iverson ordered "an updated MRI" (*id*. at 187), which was done on July 5, 2000. (Ex. 13 at 180.) The MRI showed a worsening of claimant's herniated disk:

> DIAGNOSIS: LARGE PROTRUDING LEFT SIDED DISC AT THE L5-S1 LEVEL **WHICH HAS PROGRESSED SINCE PREVIOUS STUDY OF JUNE 1994.**
>
> COMMENT: MRI evaluation of the lumbar spine was obtained in the sagittal and axial projections. These scans were compared with previous study of June 13, 1994.
>
> FINDINGS: There's dessication and degeneration of the intervertebral disc space at the L5-S1 level. No significant offset of the vertebral bodies. The remainder of the disc spaces are well preserved. At the L5-S1 level, there is a large central and left sided protruding disc without true disc herniation present. This does impinge however upon the thecal sac and compromises the spinal canal. **This certainly has progressed since the previous study of June 13, 1994.** The remainder of the disc spaces are well preserved. No additional abnormalities are evident.

(*Id*., emphasis added.) Dr. Iverson characterized the herniated disk as having "increased significantly since the last MRI Scan that was performed previously." (Ex. 16 at 189.)

¶52 On August 16, 2000, Dr. Iverson wrote to the insurer that claimant's "condition has progressively worsened since her MRI that was taken in February of 1991. She had a bulging disc at L5 S1 level with a possible disc herniation. It is relatively common for someone with a disc bulge to eventually progress to a disc herniation." (Ex. 21 at 230.) It was Dr. Iverson's "opinion the symptoms she has are a direct result of her December 31, 1990 injury . . . ." (*Id*. at 230.)

¶53 Dr. Iverson performed surgery on claimant on September 15, 2000.

¶54 Based upon the information supplied by Dr. Iverson, the State Fund reinstated claimant's TTD benefits as of September 15, 2000. (Ex. 6 at 95.) At the time of her deposition she was still receiving benefits.

Resolution

¶55 Claimant is now seeking TTD benefits retroactive to 1994. She claims she never reached MMI. I am unpersuaded. She was determined to be at MMI by Dr. Weinert in 1992. She was not a surgical candidate in 1994 and refused or failed to carry through with other forms of treatment (injections and physical therapy). As to her depression, while further treatment was authorized in April 1994, she failed to keep her appointments. An office note of Dr. Bateen in August 1994 indicates that she had been doing well without treatment, thus indicating that further treatment was unnecessary. She has failed to show that there was reasonable treatment offered or available to her in 1994, or at any time between 1994 and 2000, which would have materially improved her condition or which she was willing to pursue.

¶56 When her TTD benefits were finally terminated in 1994, jobs had been approved for her and the Rehabilitation Panel had issued a final determination that her return to work in a related occupation was appropriate. That determination was not appealed and was therefore conclusive. It cannot be collaterally attacked here. Moreover, jobs were approved both medically and vocationally prior to termination of TTD benefits. Those approvals were never revoked. Claimant has presented no evidence, other than her own testimony, that she was not medically or vocationally qualified for the identified jobs. In light of claimant's poor record with physical therapy and involvement in her own treatment, as well as my own assessment of her credibility, I am not persuaded that she was physically unable to perform sedentary to light work.

¶57 Finally, I did not find claimant's testimony, including her excuses for failing to follow recommended treatment and for not working, persuasive. Based on review of the entire record, and having observed claimant's testimony, I am persuaded that the medical and physical therapy records, and the testimony of Dr. Hunter, present an accurate portrayal of claimant's situation. The record is replete with evidence that claimant did not cooperate with recommended treatment. There are numerous references, in the records of Dr. Hunter, Dr. Weinert, and physical therapists, of symptom exaggeration, as well as a non-organic and/or non-dermatomal pain patterns. Claimant did not follow up with recommended psychological counseling. She impressed me as having little motivation to work. Although claimant's case is premised on the notion that she "should have" received surgery much earlier and therefore was not at MMI, I am persuaded surgery was not appropriate until May, 2000.

¶58 I am persuaded, however, that as of May 3, 2000, the date on which she first saw Dr. Iverson, she was no longer at MMI. At that point, her condition had deteriorated to the point that she again sought medical care. The subsequent MRI disclosed a significant worsening of her disk protrusion, making surgery appropriate. Based on these facts and the recommendation for and actual undertaking of surgery, I find that as of May 3, 2000, the claimant's condition had worsened to the point that further treatment, i.e., surgery, would materially improve her condition.

CONCLUSIONS OF LAW

¶59 This case is governed by the 1989 version of the Montana Workers' Compensation Act since it was the law in effect at the time of the claimant's industrial accident. *Buckman v. Montana Deaconess Hospital*, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶60 Claimant bears the burden of proving by a preponderance of the evidence that she is entitled to the benefits she seeks. *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).

¶61 Section 39-71-701(1) , MCA (1989), provides that "a worker is eligible for temporary total disability benefits when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing." Subsection (2) states that the "determination of temporary total disability must be supported by a preponderance of **medical** evidence." (Emphasis added.)

¶62 Maximum medical healing "means the status reached when a worker is as far restored medically as the permanent character of the workrelated injury will permit." § 39-71-116(10), MCA (1989). I am persuaded that when claimant's TTD benefits were finally terminated in 1994, she was as far restored medically as her injuries permitted at that time. The fact that her medical condition thereafter deteriorated such that she could again benefit from treatment six years later, does not change that conclusion. She merely reverted to non-MMI status at that time.

¶63 When benefits were terminated in 1994, claimant had been approved to return to work in jobs for which she was qualified both medically and vocationally. That approval was still in effect in 1994 and never revoked. Moreover, a medical panel had issued a final order finding she was capable of returning to work and that determination was never appealed and was final. § 39-71-1012, MCA (1989). I was unpersuaded by claimant's excuses for not returning to work.

¶64 It was only on May 3, 2000, that claimant's condition had deteriorated such that she needed additional medical treatment which would improve her condition. At that point she was no longer at MMI and requalified for TTD benefits. Since the State Fund did not commence those benefits until September 15, 2000, she is due benefits for the period of May 3 through September 14, 2000. Her request for retroactive benefits is otherwise **denied**.

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¶65 Claimant is entitled to additional TTD benefits for the period May 3, 2000 through September 14, 2000. Her request for retroactive TTD benefits is otherwise **denied with prejudice**.

¶66 Claimant is entitled to costs and shall file her memorandum of costs in accordance with the rules of this Court.

¶67 This JUDGMENT is certified as final for purposes of appeal.

¶68 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.

DATED in Helena, Montana, this 18th day of March, 2002.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. John C. Doubek
Ms. Ann E. Clark
Submitted: February 20, 2002