IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTA

2000 MTWCC 48

WCC No. 9907-8293

PHILLIP DAVIS

Petitioner

vs.

CREDIT GENERAL INSURANCE COMPANY

Respondent/Insurer for

UNITED STAFFING, INCORPORATED

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

AFFIRMED 1/29/02

Summary of Case: Claimant, who is a truck driver, suffered a right rotator cuff tear in 1995 and has undergone two surgeries on his right shoulder. While he cannot return to work as a truck driver, other jobs have been identified and approved. However, claimant alleges that his right shoulder condition is permanently totally disabling, claiming that shoulder pain precludes him from using his right arm and therefore from working.

Held: While claimant has limited motion and some pain in his right shoulder, his reports and testimony concerning his pain levels and inability to use his right arm are not credible. Medical testimony establishes that his reported pain far exceeds what is ordinarily expected; that his reported pain is inconsistent with his medical condition, objective medical evidence, and anatomical dermatomal patterns; that he has exaggerated his responses during medical examinations; and that his reported lack of use of his right arm is inconsistent with objective findings of muscle mass. Moreover, claimant denied engaging in activities he is shown doing during videotaped surveillance. He also denied engaging in activities which he reported doing to medical providers. He failed to persuade the Court that his pain levels are as great as he claims or that he is incapable of performing regular employment.

In the decision the Court condemns use of argumentative and slanted introductory letters to IME physicians. Such letters may undermine the credibility of the IME.

Topics:

Disability: Permanent Total. Claimant's testimony that right shoulder pain prevents him from using his right arm and therefore from working does not prove PTD status where medical testimony established that his reported pain is inconsistent with his medical condition, objective medical evidence, and anatomical dermatomal patterns; and that his reported lack of use of his right arm is inconsistent with objective findings of muscle mass. Moreover, claimant denied engaging in activities he is shown doing during videotaped surveillance.

Independent Medical Examination. WCC condemns use of argumentative and slanted introductory letters from attorneys to IME physicians. The more slanted the presentation of so-called "factual" materials, the less confidence the Court is likely to have in the expert's opinion. The hazard is greater if the facts are misstated or mischaracterized.

Medical Evidence: Dermatomal Patterns. Among the reasons WCC found claimant's report of disabling pain not credible was doctor's testimony that claimant's reported pattern of pain upon examination did not fit dermatomal patterns of pain distribution for his condition.

Witnesses: Credibility. While claimant has limited motion and some pain in his right shoulder, his reports and testimony concerning his pain levels and inability to use his right arm are not credible. Medical testimony established that his reported pain is inconsistent with his medical condition, objective medical evidence, and anatomical dermatomal patterns; and that his reported lack of use of his right arm is inconsistent with objective findings of muscle mass. Moreover, claimant denied engaging in activities he is shown doing during videotaped surveillance.

¶1 The trial in this matter was held on April 26, 2000, in Billings, Montana. Petitioner, Phillip Davis (claimant), was present and represented by Mr. Marvin L. Howe. Respondent, Credit General Insurance Company, was represented by Mr. Joe C. Maynard.

¶2 Exhibits: Exhibits 1 through 14 and 16 through 24 were admitted without objection. Exhibit 15 was admitted with the understanding that characterizations of claimant's behavior within the investigative report will not be considered by the Court. Exhibit 25 was withdrawn.

¶3 Witnesses and Depositions: The Court has received depositions of Howard T. Berglund, M.D., Gregory Scott Peterson, M.D., Lawrence J. Toder, M.D., Bob Zadow, and two depositions of claimant (September 25, 1998 and April 21, 2000). The parties agreed the Court may consider the transcript of proceedings conducted April 26 and 27, 1999, on a prior petition filed by claimant. Claimant and his wife, Shirley Davis, were sworn and testified at trial.

¶4 Issues Presented: The issues, as restated by the Court, are as follows:

1. Whether claimant is permanently totally disabled.

2. Whether claimant is entitled to attorney's fees and a penalty.

3. Whether claimant is entitled to treatment at a pain clinic.

4. Whether claimant has refused to cooperate with reasonable rehabilitation efforts.

Procedural History

¶5 This is the second of two proceedings commenced by claimant, who suffered a work-related rotator cuff tear in 1995. The first petition, filed July 13, 1998, requested permanent total disability benefits. That matter came to trial April 26, 1999, but was dismissed on the second day of trial when claimant indicated he wanted to give serious consideration to undergoing a second surgery recommended by several doctors. Dismissal was without prejudice.

¶6 Thereafter, claimant underwent the second surgery. He then brought the second, present petition, again seeking permanent total disability benefits. He asserts that the second surgery did not help and that he is worse now than before.

¶7 Having considered the Pre-trial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the depositions, exhibits, and transcript of prior proceeding, and the arguments of the parties, the Court makes the following:

FINDINGS OF FACT

¶8 Claimant is 58 years old. His education is through part of the tenth grade.

¶9 After farming several years with his father, claimant began working as a truck driver. Between 1965 and 1995, he drove for various companies in North Dakota, Montana, and Alaska.

¶10 Claimant and his wife now live in Jamestown, North Dakota, which is near the farm his family once worked.

1995 - 1996

¶11 On August 29, 1995, claimant was injured at work. The First Report states: "I was pulling on pull rope on tarp, when it broke and I fell into a rock pile, injuring my right shoulder." (Ex. 14 at 34.) At the time, claimant was working for United Staffing of America out of Missoula, Montana. (*Id*.) United Staffing was insured by Credit General Insurance Company, which accepted liability for the claim.

¶12 Claimant first sought medical treatment on September 22, 1995. (Ex. 7 at 1 and 2.) Medical records of Dr. Walter H. Peschel indicate claimant had a painful right shoulder. (Ex.

7 at 1.) On October 13, Dr. Peschel scheduled an MRI. The MRI indicated a "complete tear of rotator cuff." (*Id*.; Ex. 11 at 1.) Dr. Peschel referred claimant to an orthopedic surgeon. (Ex. 7 at 1.)

¶13 On November 10, 1995, Dr. Lawrence J. Toder, who is an orthopedic surgeon, operated on claimant, repairing the rotator cuff and removing two-thirds of an anterior acromion. (Ex. 12 at 1-3.)

¶14 Claimant's early post-operative course of recovery is reflected in Dr. Toder's medical records:

> 11/30/95
>
> The patient is now almost 3 weeks post rotator cuff repair. His incision is healing well. **He has minimal pain about the shoulder but does have some stiffness.** At the present time I would like to start him on passive range of motion exercises for 3 weeks. I would like to see him back at that time. If he is still continuing to do well, we will start him on more vigorous physical therapy program.
>
> 12/21/95
>
> He is now about 5 weeks post rotator cuff repair. He is doing somewhat better in physical therapy. We will start him on more vigorous physical therapy. Have him start increasing with weights and range of motion. I would like to see him in 6 weeks.
>
> 2/1/96
>
> The patient is now 2 ½ months post rotator cuff repair. He still has significant stiffness of the shoulder with range of motion barely to horizontal. **He has no pain.** I would like to continue his physical therapy for at least another 6 weeks. Hopefully he can gain greater range. We will see him at that time.

(Ex. 12 at 1 and 7, emphasis added.) At his deposition taken September 1998 (Davis Dep. I), claimant testified he had pain on February 1, 1996, despite what Dr. Toder recorded. (*Id*. at 52.)

¶15 Physical therapy records of Richard L. Smith (Smith), P.T., also describe claimant's progress. Initially, the goal of therapy was to prepare claimant for return to truck driving. According to Smith's records, in early December 1995, claimant "[appeared] to have moderate-severe pain and muscle guarding" and "very limited motion." (Ex. 5 at 2.) He encouraged home exercises. (*Id*.) By late December, claimant still appeared "tight" but was beginning to show "good ability to stretch himself." (*Id*. at 6.) In early January 1996, strengthening exercises were started, with Smith noting claimant was still weak, stiff, tight, and sore. (*Id*. at 15.) By the end of January, testing indicated approximately 50 percent deficit in flexion torque and work, and thirty percent deficit in rotation, but the therapist

recorded: "this is better than I expected, so this is good news." (*Id.* at 22.) On February 1, 1996, Smith wrote to Dr. Toder indicating claimant "has made excellent progress over the past month, yet still has a ways to go if he will be operating a truck gear shift." (*Id.* at 25.)

¶16 On February 15, 1996, Dr. Toder wrote to the insurer: "When last seen on 2/1/96 the patient was progressing slowly in physical therapy. At the present time the patient is still disabled and I expect him to continue his therapy." (Ex. 12 at 4.)

¶17 On February 16, 1996, Smith recorded that claimant "lifted 200 bales of hay yesterday and [right] arm is a little tired today." (Ex. 5 at 29.) The therapist observed: "Phil probably over did it yesterday, but he is obviously not hurt or injured - hard to understand how he did this with 1 ½ arms, but the guy is determined." (*Id*.) He also noted: "I still think he will get back to driving, but isn't ready yet." (*Id*.)

¶18 At his September 1998 deposition, claimant denied lifting bales of hay since his injury. (Davis Dep. I at 38-39.) He claimed to have tried three times to lift a couple bales of hay but "found out I couldn't." (*Id*. at 39.) Claimant acknowledged he grew an average of eight tons of grass hay in a year, which his neighbor baled in roughly hundred pound bales. (*Id*. at 55-56.) When asked if he stacked any of the bales since his injury, claimant testified: "No, no. Like I say, I tried those three and . . . . (*Id*. at 56.)

¶19 Claimant continued physical therapy during February and March 1996, working on strength and flexibility. (Ex. 5 at 29, 35.) On March 14, 1996, Dr. Toder noted:

> He is coming along slowly but surely. We will have him continue his physical therapy. I would like to see him in 6 weeks. We will allow him to go back to light duty and ride in the cab and work some of the cranks but not do some of the heavy driving.

(Ex. 12 at 7.)

¶20 Claimant contacted his employer regarding light-duty work, but was told none was available. Physical therapy notes on April 5, 1996, state claimant "evidently got into some heated discussion [with] his employer re: RTW light duty." (Ex. 5 at 48.) Claimant denied having an argument, testifying: "They just told me there was no light duty work, and that was the end of it." (Davis Dep. I at 59-60.)

¶21 Physical therapy continued. (Ex. 5 at 45-61.) On April 25, Dr. Toder recorded:

> He is now almost 6 months post rotator cuff repair. He has obtained almost 90 degrees of flexion and abduction but still lacks internal and external rotation. **He has less pain but has difficulty doing ordinary tasks, especially tasks necessary to do his former truck driving job.** We will have him continue his physical therapy. I would like to see him in one month.

(Ex. 12 at 7, emphasis added.)

¶22 Therapy resumed, focusing on building strength and simulation of driving. (Ex. 5 at 61.) On April 29 the therapist reported that claimant stated he "[d]oesn't know what he is going to do - job wise." (*Id*.) The therapist recorded, "Good session [with] strengthening right shoulder." (*Id*.) On May 1, 1996, claimant told the therapist, "He may go to North Dakota to farm this summer." (*Id*.) The therapist noted: "Good performance & isokinetics, steering wheel, mob. shoulder as tolerated. Ball toss." (*Id*.) On May 3, the notes indicated, "Phil is discussing possibility of driving a tractor for a job this summer," and "good effort [with] all work simulation, strengthening and ROM stretching." (*Id*.) Three days later, the therapist noted, "Phil may drive a tractor in N. Dakota. . . . He is able to use his [right] UE to reach to shoulder height, operate hand controls, etc. Yet Dr. Toder doesn't want him pulling, etc." (*Id*.) Smith noted that "[t]ruck driving . . . may be out" and "[h]e will contact claims examiner at GAB." (*Id*.)

¶23 On May 10, claimant reported that his employer had terminated his employment. (Ex. 5 at 68.)

¶24 On May 20, Smith recorded:

> He reports he strained his shoulder yesterday - 5/17 **when showing his neighbor how to use his rototiller**. It evidently jerked his arm pretty hard, causing increase pain for the rest of the day. It "swelled" and hurt a lot. Now, back to nearly baseline.

(Ex. 5 at 74, emphasis added.) Smith further noted: "Strain 5/17, but seems to have recovered." (*Id*.) On May 24, Smith noted that claimant reported that "shoul. ok after rototilling incident" and observed that "[l]ifting and carrying activities, tolerated well." (*Id*.)

¶25 At his September 1998 deposition, claimant said he did not remember using the rototiller with his neighbor. (Davis Dep. I at 63.) He testified he *was* able to run a rototiller with his *left* hand, but that if he put his right hand on the rototiller "the vibration, you know, it would - it would make it ache, it would make it hurt." (*Id*.) Claimant then changed his explanation, stating, "Most of the time when I got the roto - Like I say, my right arm was on there and, you know, you just hang it on there and you hold onto it with your left. I mean, it's - It don't, you know, it's - It's self-propelled. It does all the work itself, you know. You don't . . . ." (*Id*.)

¶26 Following testing conducted May 29, 1996, Smith wrote to Dr. Toder as follows:

> Phil Davis has continued to work on his right shoulder rehabilitation.
>
> **He has made some improvement in the past month in his shoulder flexion and rotation strength. He has approximately 20 percent strength deficit at this point, which is actually quite good.**

> He can safely lift and carry up to 45 pounds. Unfortunately, he still has a significant ROM deficit, and is unable to reach overhead for climbing or lifting.

(Ex. 5 at 70, emphasis added.)

¶27 Dr. Toder's May 30th entry states claimant "continues to have problems with elevation, forward flexion and internal rotation. His range is improving slowly in therapy and we will continue his therapy." (Ex. 12 at 7.) Claimant received an injection in his shoulder and was asked to return in six weeks. (*Id.*)

¶28 Physical therapy continued. On June 10, Smith recorded, **"Used his rototiller again last week and has significant in shoulder pain."** (Ex. 5 at 74, emphasis added.) That same day, Smith observed: "Today has ROM and strength status quo, i.e. no change." (*Id.*)

¶29 On July 15, Smith again tested claimant. (Ex. 5 at 76.) The following day, he wrote to Dr. Toder:

> Phil Davis has been seen once per week for the past six weeks for strengthening of his right shoulder, S/P rotator cuff repair 11/10/95.
>
> There has been very little change in his symptoms, range of motion or strength. In fact, isokinetic strength testing July 15, 1996 showed that he may have slipped back a little bit as compared to six weeks ago. His strength deficits are in the 25-30% range.
>
> He has probably plateaued in his progress. **Unfortunately, he does not have any specific vocational plans**, and I understand that his employer is not willing to take him back at this point.

(Ex. 5 at 79; emphasis added.)

¶30 On July 16, Dr. Toder recorded:

> He has not made much improvement. He still has about 90 of forward flexion and abduction. **He has no pain in his normal range but has pain and stiffness as he gets to the range that bothers him.**
>
> **I think at the present time he is close to reaching maximum medical improvement. He probably should be retrained in a job that doesn't require overhead work. He can certainly do work at bench level.**

(Ex. 12 at 7, emphasis added.)

¶31 Claimant was then referred to Dr. Stephen G. Powell, another orthopedic surgeon, for a second opinion. (Ex. 8 at 2.) Dr. Powell examined him on September 19, 1996. Dr. Powell's impression was: "Right shoulder pain status post rotator cuff repair with significant arthrofibrosis and with moderate persistent curvature of the acromion." (*Id.* at 1.) Dr. Powell

found claimant a bit tender anteriorly over his scar, noted limited range of movement in his right arm, and recommended manipulation of the shoulder. (*Id.*) Dr. Powell opined that claimant "certainly is not able to do **his work** at the present time.[(1)]" (*Id.*, emphasis added.)

¶32 On September 19, claimant also visited Dr. Toder, who concluded claimant "continues to do poorly with limitation of range of motion." (Ex. 12 at 8.) Dr. Toder interpreted Dr. Powell's suggestions as "congruent" with his own, though he noted: "I don't think manipulation of his shoulder can guarantee him a better result and he is reluctant to consider this." (*Id*.) Dr. Toder was concerned about an occult rotator cuff tear and ordered a new arthrogram of his shoulder. (*Id*.)

¶33 On October 3, Dr. Toder noted the arthrogram "shows a partial tear of the rotator cuff." (*Id*. at 8.) He recommended "an arthroscopy of the shoulder with debridement and a repair of his partial tear" to provide a "better range of motion." (*Id*.) **Claimant declined the surgery.** On October 24, Dr. Toder recorded:

> He continues in his present status. He is doing fairly well with his shoulder but cannot elevate or forward flex past 90. On internal rotation he can reach his iliac crest almost to the sacrum. **He is doing fairly well with the range of motion he has with minimal pain in that range of motion.**
>
> PLAN: At the present time his work status is in limbo and probably will remain so. We have offered him an arthroscopic exam and debridement of his shoulder as well as repair of his rotator cuff if indicated. The patient will continue to consider this. We will see him in 6 weeks and rediscuss it.

(*Id*., emphasis added.)

¶34 During October, Teri Bohnsack (Bohnsack), the claims adjuster, forwarded a copy of the arthrogram report to Dr. Powell and asked Dr. Powell for any new treatment recommendations. (Ex. 8 at 2.) Dr. Powell responded: "I would arthroscope his shoulder manipulate it, - fix his tendon if indicated." (*Id*.)

¶35 Meanwhile, Board Certified Rehabilitation Consultants of Montana (BCRC) was hired to assess claimant's "residual employability." (Ex. 1 at 6.) In a report dated October 18, 1996, Janet VanDyke (VanDyke), a certified rehabilitation counselor, recorded that claimant "had no ideas for vocational alternatives." (*Id*. at 7.) When VanDyke interviewed him, claimant described problems with his right arm and indicated physical therapy would be of no further use without additional surgery. (*Id*.) However, as VanDyke recorded, claimant was "reluctant to undergo another surgery unless Dr. Toder can guarantee he will be able to drive a truck again." (*Id*.) VanDyke delayed further assessment pending claimant's decision on surgery. (*Id*. at 8.)

¶36 Claimant returned to Dr. Toder on December 3, 1996. The doctor found his status "about the same" and noted:

> I think he would do best to have reexploration of his shoulder and arthroscopic debridement and exploration of his rotator cuff. At the present time he is reluctant to consider this possibility. We will continue to see him on a PRN basis and probably see him in 6-8 weeks. He is presently on a no work status.

(Ex. 12 at 11.)

¶37 Bohnsack wrote to Dr. Toder on December 3. Given claimant's refusal to proceed with surgery, Bohnsack asked whether claimant had reached MMI. (Ex. 12 at 9.) Dr. Toder answered that he had not, but wrote "unknown" in response to questions about when he might reach MMI and for treatment recommendations. Dr. Toder also did not know when claimant might be able to return to work and what physical restrictions he might have. (*Id*.)

¶38 On December 19, 1996, Bohnsack wrote to Dr. Powell, asking whether claimant had "reached maximum medical improvement based on the fact that he is unwilling to undergo another surgical procedure." (Ex. 8 at 4.) Dr. Powell responded that claimant had reached MMI under those circumstances. He also noted: "It appears he will [n]ot be able to return to work without further treatment." (*Id.* at 5.) Because Dr. Powell subsequently approved at least one job, he was evidently referring to claimant's ability to return to truck driving work. (*See Id*. at 7.) Dr. Powell assigned a permanent impairment rating of "21% of upper extremity = 13% of man as a whole." (*Id.* at 5.)

1997

¶39 During January 1997, Dr. Toder noted claimant may now be willing "to have something done." (Ex. 12 at 11.) He recorded that claimant was scheduled "to see Dr. Seim for a second opinion for the workers comp people and we will wait for Dr. Seim's opinion." (*Id*.)

¶40 On February 13, 1997, claimant was examined by Dr. Robert J. Seim. The examination was requested by a separate disability insurance provider which covered mortgage payments on claimant's real property. Dr. Seim interviewed claimant, reviewed medical records, and conducted his own examination. On February 20, Dr. Seim informed the insurer that claimant "has a continued and substantial residual problem secondary to rotator cuff tear" and did "need to have a re-exploration of his shoulder in attempt to improve on his function as [he] may well have further tears of the rotator cuff area." (Ex. 10 at 2.) Dr. Seim opined:

> He is in a situation where he will have a difficult time being employed at any job which requires use of his dominant right hand. The patient is in a situation where he has little to lose and a lot to gain by re-exploration of the area in an attempt to increase his function.

(*Id*. at 3.)

¶41 Surgery was scheduled, but on February 24, 1997, claimant cancelled. (Ex. 12 at 11.) Claimant then ceased treating with Dr. Toder until just before the first, 1999 hearing before this Court. (*Id*.)

¶42 During March 1997, claimant went through a comprehensive, five-day vocational evaluation at the WORCcenter of Community Medical Center in Missoula. (Ex. 6 at 1-10.) VanDyke arranged the evaluation, which was conducted by Barb Noggle (Noggle). Around the same time, VanDyke prepared a Vocational Diagnosis and Assessment of Residual Employability (VDARE). Both processes identified potential jobs that claimant might be able and qualified to perform. The jobs included escort driver, taxi driver, bus driver, forklift operator, and, with more accommodation, sporting goods stocker and fuel pump operator. Noggle expressed concern about whether claimant could work eight-hour shifts in light of his fatigued appearance near the end of a day of evaluation. VanDyke noted an FCE "could help discern Mr. Davis' true physical capacity to work since Ms. Noggle does not have expertise in evaluating physical capacities." (Ex. 1 at 14.)

¶43 VanDyke confirmed that claimant had sufficient work skills for positions of escort driver, bus driver, toll booth operator, and forklift operator. (*Id*. at 15.) She forwarded job analyses for these positions to Dr. Toder, Dr. Powell, and Smith. (*Id*. at 17-20.) Both doctors wanted to examine claimant before commenting.

¶44 On March 10, 1997, the Social Security Administration awarded claimant social security disability benefits as of April 1996. (Ex. 14 at 18.)

¶45 On June 19 and 20, 1997, Smith conducted a two-day functional capacity evaluation (FCE) of claimant. He found claimant's condition had deteriorated. (Ex. 5 at 85). Although Smith believed claimant "gave a good effort for all testing," he noted claimant had developed chronic pain behaviors involving his right shoulder and arm, as well as hand tremors. (*Id*. at 81, 83, and 85.) Smith found the following:

> **SIGNIFICANT ABILITIES.** The client demonstrated good physical abilities with the following:
>
> 1) Good ability to lift and carry light physical demands.
>
> 2) Good ability to carry medium demands in left hand.
>
> 3) Good ability to sit, stand, walk and climb stairs.
>
> 4) Good ability to bend and twist.
>
> 5) Satisfactory hand grip force bilaterally.
>
> 6) Good gross manual dexterity.

7) Good overall strength in uninjured left upper extremity and lower extremities.

SIGNIFICANT DEFICITS. The following limited client's functional capabilities:

1) Poor mobility right shoulder girdle.

2) Decreased strength right shoulder girdle.

3) Right shoulder pain, aggravated by more than light right upper extremity activity.

4) Slow fine manual dexterity both hands.

(Ex. 5 at 84.)

¶46 Smith reviewed three job descriptions: bus driver, forklift driver, and tollbooth operator. He believed claimant could drive a bus, noting he has excellent left upper extremity coordination, and could perform the tollbooth duties with some modifications. He did not believe claimant could operate a forklift, which requires continuous reaching with both hands. Smith concluded claimant could handle light physical work demands, although he recommended "a short term of work conditioning, focused on increasing his shoulder muscle endurance." (Ex. 5 at 85.) Claimant told Smith he operated a riding lawn mower and drove his own truck with standard transmission. (*Id*. at 82.)

¶47 Reviewing the same job descriptions as Smith, Dr. Powell refused to approve the bus driver job, but found claimant capable of handling the forklift driver and tollbooth operator jobs with modifications. (Ex. 8 at 6-8.)

¶48 Claimant moved to North Dakota during August 1997. (Ex. 1 at 24, 61.)

¶49 VanDyke drafted a rehabilitation plan during November 1997. (Ex. 1 at 60-61.) She obtained additional information clarifying the jobs Dr. Powell had conditionally approved. The new information indicated that the jobs met Dr. Powell's conditions. (*Id*.) VanDyke also identified another forklift operator position rated as light duty, which she believed claimant could perform. (*Id*. at 61.) She concluded claimant had been "medically approved for alternative occupations consistent with his age, education, existing skills, abilities, and physical capabilities." (*Id*.) She recommended job placement as "the most expedient means of returning Mr. Davis to the work force." (*Id*.)

¶50 Claimant testified at deposition that his pain prevented him from working eight hours in a tollbooth, but acknowledged that "if I can get rid of the pain, why, I suppose I could do it." (Davis Dep. l at 79). As for a forklift operator job, claimant testified "forklifts are too rough riding and your controls are all on the right side. And they'd require an eight-hour day. . . ." (*Id*. at 80).

¶51 On November 3, 1997, Bohnsack sent claimant a 14-day notice of termination of temporary total disability benefits. (Ex. 14 at 28; Davis Dep. I at 83, Ex. 11.) The letter relied

upon Dr. Powell's determination that claimant reached MMI on January 27, 1997, his assignment of a 13% whole person impairment, and the results of the recent FCE.

¶52 Between his move to North Dakota in August 1997 and his September 1998 deposition, claimant did not seek medical care for his shoulder. He testified:

> Well, I've just been waiting for - They wanted me to go through rehab and I was waiting for that, and Dr. Toder just never told me to come back, so I didn't go back.

(Davis Dep. I at 44.) Claimant said he considered seeing another doctor, but was "getting stonewalled" on obtaining an MRI. (*Id*. at 44-45.) I found no support in the medical records for his statement.

August 1998 Surveillance

¶53 On September 25, 1998, claimant was deposed. He testified that just about everything he does causes sharp shooting pain in his shoulder. (Davis Dep. I at 15-16.) He claimed lifting anything over ten pounds starts to "really hurt." (*Id*. at 17.) He acknowledged "piddling" in his garden, but maintained he did not use his right arm for anything more than balancing tools. (*Id*. at 29; Trial Test.) He admitted using a rototiller, but claimed to do so only for five minutes at a time. (*Id*. at 42.) He claimed to use the rototiller only with his left hand (*id*. at 42), then he said he rested his right hand on the rototiller. (*Id*. at 63.)

¶54 His testimony was contradicted by video surveillance conducted at his residence in North Dakota on August 13 through 15, 1998. (Ex. 15 at 1.) Portions of the surveillance videotape were played during trial and the claimant was questioned about them. His testimony was inconsistent with his videotaped activities, which showed him using his right arm and shoulder without apparent pain or limitation. His use was more than mere "balancing" or resting his hand on tools.

¶55 The video shows claimant gardening. Of significance, he carries a shovel with his right hand, digs with the shovel using both hands and arms, weeds with his right hand, carries a bucket with his right hand, tosses aside bushes with his right arm. Claimant then rototills using both arms and starts the rototiller by pulling the starter rope with his right arm. His gardening activities last approximately an hour.

¶56 The videotape continues on August 15, showing claimant's resumption of gardening activities around 11:09 a.m. He uses his right hand in planting bushes and carrying a bucket and shovel. A few minutes after starting this work, he stares toward the camera for several minutes; at one point he appears to be hiding behind a tree. He looks for several more minutes, moving closer, as if to investigate, then goes inside.

August 1998 FCE and IME

¶57 During August 1998, the insurer scheduled a second FCE and an independent medical examination (IME).

¶58 On August 19, Mr. Maynard wrote jointly to Todd Dundas, the exercise physiologist designated to perform the FCE, and Dr. Thomas L. Schumann, the IME physician. (Ex. 9 at 1-5.) Mr. Maynard's five page letter described the "facts" of the case and posed ten questions. Counsel for claimant has argued that Mr. Maynard's letter, as well as a subsequent similar letter to other experts, biased their opinions. I have reviewed both letters. The factual statements by Mr. Maynard are consistent with the facts as found herein. Both letters, however, are argumentative and slanted. Some "facts" are only marginally relevant to the expert's opinion while painting claimant in a negative light. For instance, Mr. Maynard states that claimant hired one attorney, fired him, hired another attorney, and then fired him. (Ex. 9 at 5.)

¶59 Given the whole record, I do not find Mr. Maynard's August 19 letter sufficiently misleading to cause me to ignore the opinions of Mr. Dundas and Dr. Schumann. Moreover, in large part my decision rests upon my finding that claimant is not credible and has exaggerated his shoulder pain and limitations. Nevertheless, the argumentative aspects of Mr. Maynard's letters highlight the hazard of arguing facts to experts before they render their opinions. The more slanted the presentation of so-called "factual" material, the less confidence the Court is likely to have in the expert's opinion. The hazard is greater where the facts are misstated or mischaracterized.

¶60 Dundas conducted the FCE on August 26, 1998. (Ex. 3 at 2-3.) In addition to observing claimant during testing, he watched the surveillance video. (Ex. 3 at 2.) Dundas concluded claimant "is not totally disabled and is functionally capable of returning to work outside of the home in the light to medium duty work capacity." (*Id*. at 2.)

¶61 During the examination, Dundas observed symptom magnification and inconsistent pain reports, noting as follows:

> The Functional Capacity Evaluation results were conditionally valid where the patient perceives himself to be at full capacity, but his capacity is actually greater. Mr. Davis, at the time of the evaluation, came in with his right hand tucked in his shirt as a sling due that he was unable to move his right shoulder. Howver [sic], during this evaluation, he was able to lift and carry up to 50# with reports of up to unbearable pain (10/10). During the evaluation, Mr. Davis's facial pain behaviors stayed the same throughout the entire evaluation whether he was lifting 2# or 50#. There also appears to be inconsistent pain reports in his lifting capacities and self-limiting his range of motion in his right shoulder. Also with the unbearable pain reports, there appeared to be symptom magnification throughout this entire evaluation. During the evaluation, Mr. Davis was able to perform all of the activities with minimal postural limitations.

(*Id*. at 2.)

¶62 Dr. Schumann conducted the IME on August 26. He was provided with medical records, Mr. Maynard's letter, the surveillance video, and Dundas' FCE report. After taking a history from claimant, Dr. Schumann examined claimant, which revealed "decreased range of motion of the right shoulder limiting forward flexion and abduction to about 90 degrees," along with "decreased strength with testing of all rotator cuff muscle groups on the right compared to the left." (Ex. 9 at 8.) From his review of the video, Dr. Schumann noted claimant was "weeding, shoveling, dumping a dirt like substance out of a wheelbarrow and operating a rototiller, also carrying a bucket of water, at times with the right arm." (*Id*.) Dr. Schumann opined these abilities "exceed[ed] what would be expected given the patient's history and physical presentation and would [sic] he was willing to demonstrate in the office." (*Id*.)

¶63 Dr. Schumann formed the following impressions:

> 1) History of rotator cuff tear with suspicion of recurrent rotator cuff tear based on most recent arthrogram dated 9/23/96; suggesting at least an inner substance tear and possibly a full thickness tear.
>
> 2) Evidence of symptom magnification based on inconsistent results reported from today's functional capacity evaluation and demonstrated activities on surveillance exceeding reported abilities in the exam room today.

(Ex. 9 at 8-9.)

¶64 Dr. Schumann placed claimant at MMI absent additional surgery. (Ex. 9 at 9.) He observed that the surgery proposed by Drs. Toder, Powell, and Seim would be reasonable and safe, "although in the presence of symptom magnification behavior, potential for a favorable outcome becomes more guarded." (*Id*.)

¶65 Addressing whether claimant could work on a full-time basis, Dr. Schumann commented this was "not objectively determined" absent a period of industrial rehabilitation, but noted rehabilitation "assumes willingness on the part of Mr. Davis to participate. . . ." (*Id*.) The doctor opined claimant was *currently* capable of gainful employment on at least a part-time basis with restrictions in the light to medium capacity, with limited lifting above the shoulder level. (*Id*. at 9-10.) He said that he "would not consider Mr. Davis necessarily permanently totally disabled." (*Id*. at 10.)

1998 - 1999 Rehab Reports

¶66 During August 1998, Brenda Williams (Williams), another BCRC consultant, interviewed claimant. She reported as follows:

> Mr. Davis stated that his last appointment with a physician was with Dr. Powell in June 1997. He has no treating physician in North Dakota and has received no medical treatment since June of 1997. He stated that he has been reluctant to undergo the recommended surgery because the doctors cannot give him any guarantees regarding the outcome. **He noted difficulties with lifting, carrying, pushing, pulling, driving, climbing, writing, gripping, and activities involving vibration.** He stated that he has had left hand tremors all his life, and the cause of this condition is unknown. **He utilizes over-the-counter medications**, home exercises, and a heating pad to alleviate his symptoms.
>
> Mr. Davis stated that he began receiving Social Security Disability benefits in 1996. He indicated that he does not feel he is capable of any type of employment at this time. He stated that he has talked to farmers in the Jamestown, North Dakota, area to see if he could try operating a tractor, but no one is interested in hiring him. He stated that he has also talked to a trucking firm regarding dispatcher work, but they were not interested in him due to his lack of computer skills. He stated that he engages in some yard work and spends time with his grandchildren to keep himself busy.

(Ex. 1 at 75.)

¶67 Williams forwarded nine job analyses to Dr. Schumann. (Ex. 1 at 65.) The doctor approved floral delivery driver, total direct delivery merchandiser, auto detailer, and forklift operator with conditions. Williams investigated the conditions mentioned for the forklift job (no lifting over twenty pounds and no driving on rough surfaces) and determined the job did not include those requirements. (*Id.* at 69.)

¶68 Williams then conducted labor market research on the positions approved by Dr. Schumann. She found that the jobs exist in both statewide and local labor markets. She concluded claimant was currently employable "with a wage range of $6.10 to $9.60 per hour, with an average wage of $7.85 per hour." (*Id*. at 75).

¶69 In March 1999 Williams prepared another Rehabilitation Plan which set a goal of obtaining "employment in an alternative occupation with medical capabilities, not limited to approved jobs." (*Id.* at 129.) The plan called for Williams to assist claimant by giving weekly job leads, following up with some employer contacts, and teaching job-seeking and resume skills. (*Id*.) Claimant did not sign the plan and did not pursue rehabilitation services. (Ex. 14 at 5.)

Dr. Toder's Testimony

¶70 Dr. Toder testified by deposition on April 13, 1999, shortly before the first trial. He reaffirmed his recommendation for further surgery: "I'm sure you understand and that Mr. Davis understands that no surgery is 100 percent guaranteed. But in my opinion I think we

could improve the situation. And I don't think we could make it much worse." (Toder Dep. at 27.)

¶71 Dr. Toder disagreed with the findings of symptom magnification made by Todd Dundas and Dr. Schumann. He testified: "My notes do not indicate any lack of credibility on the part of the patient, and I don't recall any lack of credibility." (*Id*. at 28.) He found no indication of malingering. (*Id*. at 29.) He did *not* doubt claimant's complaints of pain and attributed claimant's pain to the "residual stiffness of his right shoulder. Loss of range of motion." (*Id*. at 29.)

¶72 Dr. Toder reviewed the August 1998 videotape. He did *not* find claimant's work inconsistent with his presentations during exam, explaining:

> I looked at the tape fairly closely with regards [sic] to his shoulder motion. And nowhere in that tape, as far as I could see, did he elevate his shoulder 45 degrees - his right shoulder, that is. And nowhere did he extend or flex it more than 70 degrees. And so his range of motion in that tape - and I should parenthetically say it's a pretty poor tape - never exceeded the range we show in the charts here.

(*Id*. at 37.) His comments, however, concerned limitations of claimant's range of motion, not claimant's assertions that he did virtually nothing with his right arm.

¶73 Dr. Toder was asked if there was anything in the tape that was inconsistent with claimant's presentation in his office. Dr. Toder testified: "No. That tape is pretty poor quality, in my view." (*Id*.) When asked whether he observed any indication of pain on claimant's face on the videotape, the doctor testified: "The tape - At least the tape I got, is fairly poor quality, and I really could not see facial features on the tape. To the extent that I couldn't even tell that it was Mr. Davis on the tape." (*Id*. at 39.) While Mr. Davis did not always face the camera on the videotape, the Court had no difficulty recognizing claimant or observing his facial features on numerous instances. It is possible that the quality of the tape supplied Dr. Toder was inferior to that of the tape supplied to the Court.

¶74 Dr. Toder *did* testify that most people with rotator cuff tears have difficulty if the arm is elevated or flexed, as well as internal rotation problems, but "they do <u>not</u> often have difficulty with or pain with their arm at their side or keeping their shoulder level." (*Id*. at 35, emphasis added.)

¶75 Dr. Toder opined that claimant could perform sedentary work. (*Id*. at 24.)

<u>Treatment by Dr. Berglund</u>

¶76 In November 1998, claimant saw Dr. Howard T. Berglund, an orthopedic surgeon, in Fargo, North Dakota. (Ex. 2 at 1-2.) The history given by claimant to Dr. Berglund included the following:

> The patient states that he has continued with both pain as well as weakness of the right shoulder. He has not been able to return to work. He states he has been on a good exercise and physical therapy program. He complains of pain as well as significant weakness and also some episodes of numbness about the fingers.

(*Id*. at 2.)

¶77 On examination, Dr. Berglund noted tenderness and some limitation in range of motion. He found atrophy in the musculature about the right shoulder, but none in the right arm. At deposition, the doctor testified that he would expect significant atrophy of the arm if claimant had not used it for a period of two to three years. (Berglund Dep. at 27.)

¶78 Dr. Berglund discussed the possibility of additional surgery with claimant, but told him that he could not guarantee improvement. (Ex. 2 at 1.)

¶79 On the second day of the first trial in this Court, counsel for claimant informed the Court that claimant wanted to consider additional surgery with Dr. Berglund. (Tr. 116.) He moved to dismiss the first petition without prejudice. The motion was **granted**. (*Id*.)

¶80 Thereafter, on June 8, 1999, Dr. Bergland performed arthroscopic surgery on claimant's right shoulder. His records describe "arthroscopic debridement with revision acromioplasty and debridement of subacromial space." (Ex. 2 at 5.) In his deposition, the doctor reviewed his surgical findings and opinions:

> Q. And you examined the shoulder joint internally quite extensively?
>
> A. Correct.
>
> Q. And the glenohumeral articulation was normal?
>
> A. Correct.
>
> Q. And the labrum was largely normal except for some slight fraying on the superior labrum; is that correct?
>
> A. That is correct.
>
> Q. And would that slight fraying be adequate to explain Mr. Davis's reports of pain, weakness and disability?
>
> A. It's not - fraying of the labrum is not an uncommon finding, and I would not believe that that would cause significant pain or discomfort in my experience.
>
> Q. The rotator cuff was healed and intact, I believe?
>
> A. That is correct.

Q. Some scarring in the biceps tendon which I would not think would be at all unusual given Mr. Davis's history?

A. That is consistent with prior shoulder surgery so, yes, that would be something that would not be unusual in this case.

Q. Would the scarring of a biceps tendon adequately explain Mr. Davis's reports of pain, weakness and disability?

A. In my - in my experience I wouldn't believe that that amount of scarring would cause significant disability.

Q. I believe there's also some - you noted some scarring of the bursa which you appropriately decompressed. Would that scarring of the bursa be expected to cause all of his complaints of pain and weakness, radicular pain, disability and the inability to use his right arm?

A. I believe it could play a role in a painful shoulder, but again in my experience probably not to the degree that Mr. Davis complains.

Q. And there was no significant tearing or injury of the bursa; is that correct?

A. That is correct.

Q. So basically overall is it fair to say that your interoperative surgical findings did not explain Mr. Davis's reports of chronic, constant pain, the weakness, the disability, et cetera?

A. That is correct.

(Berglund Dep. at 28-29.)

¶81 On June 17, 1999, almost two weeks after the operation, Dr. Berglund recorded that claimant was doing "fairly well," but still complained of pain. (Ex. 2 at 9.) He noted that "[h]is rotator cuff did appear healed and intact, which is a good sign, but again I did not find any other reason except for subacromial scarring to explain his significant weakness." (*Id.*) Dr. Berglund explained during his deposition that while claimant complained of weakness, "his rotator cuff appeared sufficiently healed, and so that made that difficult to explain from that particular perspective." (Berglund Dep. at 30.)

¶82 Dr. Berglund ordered physical therapy. On June 28, 1999, claimant reported to the Rehabilitation Department of Jamestown Hospital. He claimed "pain rating 8 out of 10 on pain scale (0 = no pain and 10 = worse imaginable pain)." (Ex. 23 at 1.) He said neither surgery nor physical therapy had changed his pain, which he said averaged "8 to 9 out of 10" on the same scale. (*Id*.) Physical therapy records note: "Patient states that pain is constant and only decreases approximately 2 hours after taking pain medication." (*Id*.)

¶83 When claimant returned to physical therapy on June 30, he "stated that pain has been continues [sic] since previous treatment and rates a 9 out of 10 level." (*Id*. at 2.) On July 1, 1999, claimant reported his pain had "increased since the previous treatment and rates it at a 10/10 level." (*Id*.) He reported being ill the previous evening, with vomiting, which he attributed to physical therapy. (*Id*.) On July 2, the physical therapist spoke with Dr. Berglund's office and physical therapy was terminated. (*Id*. at 3.)

¶84 Claimant returned to Dr. Berglund on July 13, 1999. The doctor recorded:

> Phillip is not significantly improved following his right shoulder debridement. He notes pain and weakness in the shoulder. They have been working with him in physical therapy and this only made it worse he states.

(Ex. 2 at 10.) He further noted "the probability that [claimant] will continue with a certain amount of pain in the shoulder for an unbeknownst period of time." (*Id*.; Berglund Dep. at 31.) At deposition, he was asked what he meant by the term "unbeknownst." (Berglund Dep. at 31.) The doctor responded: "That's exactly what I meant. I had no idea . . . why his shoulder still hurt." (*Id*.) Dr. Berglund explained that "following his arthroscopy I could not complain - or could not explain why he complained of the significant amount of pain and the weakness in his shoulder so that's why I said that again he may well have pain for an unknown period of time." (*Id*.) He also stated: "**what I can tell you is that with what I found arthroscopically did not correlate with what I was seeing when I would examine Mr. Davis in the office; namely, the amount of pain and specifically the weakness that he was demonstrating**." (*Id*. at 35, emphasis added.)

¶85 Dr. Berglund testified that claimant reached MMI "in the fall, let's say September, of 1999." (*Id*. at 9.)

¶86 During November 1999, Dr. Berglund referred claimant to Dr. Michael Webster, a physician in Jamestown. (Ex. 2 at 15.) Dr. Berglund wrote a referral letter "for insurance purposes," concurring "with Dr. Webster that a Pain Clinic evaluation may very well be reasonable for Mr. Davis." (*Id*.) At deposition, Dr. Berglund testified that after the arthroscopy, he felt there was nothing more he could do for claimant surgically. However, because claimant "continued to complain of pain and discomfort... I felt that perhaps a Pain Clinic referral would be in his best interest in the hopes of helping to manage his pain on a long-term basis." (Berglund Dep. at 16.) At his April 10, 2000 deposition, the doctor still believed a Pain Clinic was "a reasonable option for him." (*Id*.)

Treatment with Dr. Webster

¶87 Claimant first saw Dr. Michael Webster on October 19, 1999, and again on November 3, 1999. (Ex. 24 at 1-2.) Dr. Webster assessed "[c]hronic pain syndrome" and recommended a pain clinic. (*Id*. at 2.)

Year 2000 Medical Examinations and FCE

¶88 The insurer set up another IME with Dr. Gregory Peterson, who is a physiatrist. (Ex. 20 at 1.) On January 24, 2000, Joe Maynard, the insurer's attorney, wrote to Dr. Peterson. He enclosed medical and vocational records, as well as the surveillance tape. Mr. Maynard again summarized the "facts" of the case, using virtually identical language as in his earlier IME letters, but bringing the case up to date.

¶89 Given the facts I find in this case, Mr. Maynard's January 2000 letter does not warrant my ignoring Dr. Peterson's opinions. However, I note and condemn the sort of characterizations set out in the letter; they are obviously intended to influence the opinion of the IME physician and have the potential of doing so.

¶90 Mr. Maynard stated that videotaped activities "grossly exceeded the restrictions [claimant] testified to in his deposition and his reports during the first IME." (Ex. 20 at 4.) He also characterized claimant's presentation to Dr. Seim as with "the usual self-imposed limitations." (*Id*. at 5.) Most problematically, he described claimant's decision to discontinue the prior trial as follows: "When it became clear claimant was not going to be successful, he dismissed the case in mid-trial. He then returned to Dr. Berglund for surgery. I suspect he underwent the surgery to strengthen his permanent total disability case." (*Id*.) The comments are inappropriate and require me to consider whether Dr. Peterson's opinions were influenced by them, thus detracting from his opinions.

¶91 After listening to Dr. Peterson's deposition, I am satisfied his opinions stand on their own. His testimony was cogent and credible. His opinions were supported by reference to credible, medical evidence. The doctor testified that when he reads such argumentative statements of the sort set out in Mr. Maynard's letter, he simply thinks "that the attorney has an opinion about the person's motivation." (Peterson Dep. at 43.) He testified that his own opinions were "based completely on my physical examination and my interview." (*Id*. at 27).

¶92 When viewed in light of all the evidence before the Court, I find the discussion section of Dr. Peterson's March 1, 2000, report particularly authoritative and persuasive. That section states:

> **Mr. Davis has complaints of pain and disability markedly out of proportion to objective findings.** Physical examination shows no significant objective abnormalities. Notably, despite reported restricted arm use for over four years, Mr. Davis shows no asymmetry of upper extremity circumference and no difference in his hands regarding callous formation. Mr. Davis' examination is impaired significantly by his abnormal pain behaviors. **Certainly, it is likely that some part of Mr. Davis' pain is referable to his right shoulder joint.** The arthroscopic studies have shown scarring in the subacromial space. **However, the MRI and**

> **interoperative findings have been mild in comparison with Mr. Davis' complaints of disability. The same findings in an average patient would result in only mildly decreased shoulder range of motion and only mildly decreased right arm use. Evaluation reveals no indication of a significant superimposed medical problem such as radiculopathy, brachial plexopathy, thoracic outlet syndrome, chronic region pain syndrome, or peripheral nerve injury.** Mr. Davis has had extensive conservative treatment trials without reported benefit. At this time there appears to be no indication that Mr. Davis would benefit from further evaluation, surgical treatment, or conservative treatment. **His demonstrations of exaggerated disability would likely significantly limit his potential for benefit from a comprehensive pain program or further rehabilitation.**

(Ex. 20 at 11, emphasis added.)

¶93 At deposition, Dr. Peterson explained his findings in more detail. Several points are worth noting. First, claimant's pain complaints did not follow a dermatomal pattern, which has the following significance:

> If the patient describes symptoms that correspond to a nerve distribution or to a typical distribution of pain, then you can feel more comfortable that there may be an underlying cause that would be identifiable. In a situation where it's non-dermatomal or diffuse or involves several different nerves, then, one, you doubt that you'll be able to find a specific underlying cause, and, two, you begin to question whether or not there may be some exaggeration going on.

(Peterson Dep. at 11.)

¶94 Second, Dr. Peterson observed "significant functional behaviors" in claimant's gross motor function. (*Id*. at 12.) He watched claimant walking in his normal fashion, toe walking, heel walking, and squatting. Claimants movements and pain behaviors were not consistent with an objective medical condition. The doctor stated: "And what I mean by functional behaviors is cannot be explained on a physical basis, but, rather, they're abnormal demonstrations of activities that perhaps are psychologically motivated or for reasons that aren't explainable physically." (*Id*.)

¶95 Third, Dr. Peterson's "manual muscle testing" of claimant indicated claimant was not giving full effort in the exam:

> [T]hat is I tested Mr. Davis' muscles by resisting his movement. And when I performed that, I noticed that he had inconsistency in his effort with all the muscles in his right arm, including the muscles that would not be affected by his shoulder. And I also noted what doctors describe as give-way, which is inconsistent effort. The patient contracts the muscle for a while, and then they let go. Those types of

> demonstrations are typically felt to demonstrate subconscious or conscious lack of effort rather than a physical underlying cause.

(*Id*. at 12-13.)

¶96 Fourth, Dr. Peterson noted that claimant's right arm in fact appeared slightly bigger than the left. (*Id*. at 13.) In the case of someone not using his right arm, he "would expect significant atrophy, or loss of circumference." (*Id*.)

¶97 Fifth, Dr. Peterson noted that when he gently touched the skin overlying claimant's shoulder, upper back, the front of his chest, and his upper arms, claimant complained of significant pain with very light palpation in all of these areas, which the doctor testified:

[J]ust speaks to the fact that it appears that Mr. Davis is significantly exaggerating his problem. In people that have obvious or well-demonstrated physical problems, you nearly never will see those types of complaints, that exaggerated tenderness diffusely over a wide area.

(*Id*. at 14.)

¶98 Dr. Peterson opined that further evaluation or treatment of claimant would result in no significant improvement. (*Id*. at 17.) He considered claimant at maximum medical improvement and capable of full-time employment. (*Id*. at 17, 19.)

¶99 With regard to restrictions, Dr. Peterson found it difficult to determine reasonable restrictions without the benefit of the patient's full effort. He testified that "[w]ith Mr. Davis' marked exaggeration, I used the other information and made my best guess and then used a very conservative estimate of his ability." (*Id*. at 18.) The doctor's restrictions were as follows:

> Mr. Davis is fully capable of performing work in the light duty range. I would recommend lifting with his left arm and no more than 10 pounds maximum. I recommend that he has no work which requires that he work with his elbow above the level of his shoulder (overhead work). Mr. Davis is physically capable of driving.

(Ex. 20 at 12.)

¶100 Based on his review of several job descriptions, Dr. Peterson testified claimant is capable of performing the jobs of floral delivery driver, front-end loader operator, and forklift operator. (*Id*. at 20.) He disapproved positions of total direct delivery merchandiser, backhoe operator, lubrication servicer, bus driver, or auto detailer. (*Id*. at 21.)

¶101 Dr. Peterson's recommendations and restrictions were seconded by Dr. Berglund. (Berglund Dep. at 35.)

¶102 Dr. Peterson found claimant a poor candidate for a pain clinic "because of his apparent lack of motivation to obtain improvement." (Ex. 20 at 14.) He explained:

> [Mr. Davis] reports that none of the surgical or conservative treatments to date have resulted in any benefit whatsoever. That history combined with his significant abnormal pain behaviors makes him a poor candidate for consideration of a pain clinic. If Mr. Davis is demonstrating less than a complete effort on initial testing it would be very difficult to gauge any objective evidence of improvement following a pain clinic approach. I think that a pain clinic would only further reinforce his resolve to continue to be a disabled person.

(*Id*.)

¶103 On March 8, 2000, an FCE was conducted at Medcenter One, Incorporated, in Bismarck, North Dakota. (Ex. 21.) Kim Stewart (Stewart), the evaluator, was unable to determine claimant's overall level of work "due to limited testing areas performed." (*Id*. at 1.) Steward noted claimant was "unable to do entire test due to right upper extremity being placed in a sling per physician orders." (*Id*. at 3.) The record contains no indication claimant was ever ordered by a physician to keep his right arm in a sling.

¶104 Based upon tasks claimant did perform, Stewart judged him able to carry 25 pounds with his left hand and to engage in frequent (but not constant) prolonged sitting, standing, kneeling, walking, and repetitive trunk rotation. (*Id*. at 2.) The following activities were found appropriate for claimant occasionally: working bent over from a standing or sitting position for prolonged periods, prolonged squatting, climbing stairs, or repetitive squatting. (*Id*. at 2.)

¶105 On March 27, 2000, claimant was evaluated by Dr. Steven D. Berndt at the Pain Management Outpatient Program of MeritCare Hospital in North Dakota. (Ex. 22.) Dr. Berndt found "some atrophy of the deltoid muscle[(2)] on the right as compared to the left," but otherwise no distinctions of the right upper extremity. His findings are basically consistent with those of Dr. Peterson:

> There are no definite trigger points but more just a diffuse tenderness. The patient is very jumpy with any examination of this area. On passive movement he has a very limited range of motion of the right shoulder and withdraws or pulls away with attempts to go past what he perceived as his end points. Extension is limited to about 15 degrees, flexion to about 30 degrees, abduction to about less than 30 degrees. He also gets pain on external rotation of the shoulder. **Overall his symptoms seem to be somewhat exaggerated on exam. Motor function in the right upper extremity is good with grip strength. He is very limited on other testing secondary to not wanting to cause pain. There are no signs of autonomic instability.**

(*Id*., emphasis added.)

Further Vocational Evidence

¶106 During April 2000, Williams prepared a "Revised Final Employability Assessment Report." (Ex. 1 at 132-138). She noted Dr. Peterson's approval of floral delivery driver, front-end loader operator, forklift operator, and escort vehicle driver (pilot car). Her labor market research showed that the positions exist both statewide in Montana and locally in Missoula. (*Id*. at 138.) Although noting these jobs are "less available" in the smaller rural labor market of Jamestown, North Dakota, Williams concluded:

> Based on actual employer contacts in both the Missoula, Montana, and Jamestown, North Dakota, labor markets, it appears that Mr. Davis is currently employable in these alternative occupations with a wage range of $5.15 to $15.38 per hour, with an average wage of $10.27 per hour.

(*Id*.)

¶107 Bob Zadow (Zadow) is a certified rehabilitation counselor hired by claimant to review the case. He testified by deposition taken March 19, 1999, before claimant's second surgery and the 1999-2000 medical evaluations. Zadow's testimony provides no support for claimant's assertion of permanent total disability. While he met with claimant for 90 minutes and reviewed various medical, physical therapy, and vocational assessment reports (Zadow Dep. at 7-8), he did not review the August 1998 videotape or conduct independent job market or placement research regarding claimant's employability. (*Id*. at 7-8, 10-11.) Moreover, he "deferred an opinion [on claimant's vocational status] until some of the medical issues are resolved." (*Id*. at 12-13.) He believed the question of claimant's ability to work was "unsettled." (*Id*. at 13.)

Testimony of Claimant

¶108 Claimant testified on April 26, 1999, that the pain in his right shoulder never goes away and becomes "sharp" if he tries to do something such as "go out and pick up in the yard, stuff like that." (Tr. at 84.) When asked if he does yard work, claimant testified: "Just picking up a little bit. I pick up after the dogs." (*Id*. at 85.) Claimant was asked whether he frequently does the type of work depicted in the August 1998 videotape. He testified: "No, I done it - I do it just maybe hour a year probably is all. In fact, I won't even do it this year." (*Id*. at 85-86.) When asked about rototiller use, claimant testified: "Just that one time is all I use it." (*Id*. at 87.) He claimed that after that incident, he "sat with the heating pad for the next two days pretty much solid." (*Id*. at 91.)

¶109 Claimant testified that after his physical therapy with Richard Smith, he looked for work in the trucking industry, but "I couldn't work full time so they didn't want me." (*Id*. at 69.) He then testified that he could not even work part time as a trucker "because my

shoulder, I couldn't shift." (*Id*.) He maintained that his right arm is sore all the time and moving his arm in any way causes pain.

¶110 Claimant also testified by deposition on April 21, 2000, a few days before trial on the present petition. He claimed the second surgery made his overall condition worse, stating "I've got about 60% less rotation than I had before, and the pain is a little worse than before." (Davis Dep. II at 4.) He acknowledged no one has explained why he has less rotation. (*Id*. at 4.) He claimed the pain is "there all the time," stating it "starts about my neck" and "goes clear down to my elbow." (*Id*. at 4-5.) He testified he cannot lift anything anymore with his right arm. (*Id*. at 5.) He claimed his arm has been in a sling constantly since the second surgery. (*Id*. at 6.)

¶111 At trial, claimant maintained he has sharp pain from his neck down to his shoulder, and from his shoulder down to his elbow, and that even light therapy or lifting makes the pain worse. He testified he always uses a sling except when sitting in his chair with an arm rest. He gave reasons why he could not perform each job suggested by vocational experts. For instance, he said he could not perform dispatch work because he would be in too much pain, would need both arms, and would need time out to use a heating pad.

Resolution

¶112 I find that claimant is not credible and that he has exaggerated his pain and physical limitations in his reports to medical providers and in his testimony before this Court. He has failed to persuade me that he is unable to work at the jobs identified by Brenda Williams or that he does not have a reasonable prospect of physically performing regular employment. I base my findings upon my observation of the claimant's demeanor and my assessment of his credibility, and upon the following evidence:

- Physical therapy reports show that claimant reported lifting bales of hay during February 1996, and showing a neighbor how to use his rototiller in May of that year. His denials of these activities only detracts from his credibility.
- The physicians who have examined claimant have found no credible, objective medical basis for the level of pain he reports. Dr. Toder appears to be alone in his belief that claimant is accurately reporting his pain level, however, his opinion appears to be do more due to his trust in his patient than to any objective findings. Moreover, Dr. Toder did not examine claimant following the second surgery.
- During a number of his medical examinations, claimant identified pain which is non-anatomical or not explained by any known physical condition.
- During cross-examination of claimant, claimant was shown portions of the August 1998 videotape. When asked questions about his activities, claimant sought to minimize his use of his right arm. I was not persuaded by his explanations. In several

instances claimant denied using his arm in a certain way, then was shown using his arm in that way on videotape. For instance, claimant testified at his first deposition that he uses his right hand only to balance tools, lifting the shovel with his left hand, "and the right hand I just keep there for kind of just balance." (Davis Dep. I at 29.) However, claimant is shown on the August 14 videotape using a shovel with both arms.

- Perhaps the most glaring inconsistency was claimant's testimony that he pull-started the rototiller only with his left arm. Contrary to his testimony, the video shows him pulling the rototiller start cord with his **right** arm. (Ex. 15, at 2:26:38 p.m.)
- Overall, the videotape surveillance shows claimant engaging in activities inconsistent with his reports of pain and limitations at that time.
- During cross-examination, Mr. Maynard asked claimant to explain how he picks up after his dogs in his yard. Claimant testified he uses a dust pan and a trowel and, with his right arm in his sling, kneels down and scrapes. Mr. Maynard asked him to demonstrate this maneuver in court. When he did so, with his arm was in his sling, he had difficulty keeping his balance. As he righted himself, he grabbed hold of the bar on the jury box to maintain balance. The demonstration showed the physical difficulty of doing the task in the manner he claimed.
- Finally, claimant's courtroom appearance and behavior did not indicate to me he was in significant pain.

¶113 Lack of motivation may explain claimant's exaggeration and failure to return to employment. His recovery halted when vocational experts began to talk about employment outside truck driving. Though offered job seeking assistance from Williams, he chose to rest on his claims of total disability. After he received social security benefits, he seems to have ruled out the possibility of returning to work in any capacity.

¶114 Claimant's range of motion is certainly restricted to some extent, and he may well have some degree of pain, but his exaggerated claims make it impossible for me to determine what his real limitations are. Relying on the opinions of Dr. Peterson, and the concurrence of Dr. Berglund, I find he is at least capable of performing work in the light - duty range, with lifting restrictions as noted by the doctors. I credit Williams' report that positions in that range are available. Claimant is not permanently totally disabled.

¶115 Relying on the opinions of Dr. Powell, the 1997 FCE, and the job study, I find that the insurer properly terminated claimant's temporary total disability benefits in November, 1997. Lacking further surgery, there was nothing further to be done medically for claimant at that time. Temporary total disability benefits resumed following the second surgery (*see* August 20, 1999 Order Dismissing Ptd Claim as Premature), but were again properly terminated.

¶116 I am persuaded by Dr. Peterson's opinion that claimant is **not** likely to benefit from treatment at a pain clinic. While Drs. Webster and Berglund recommended a pain clinic, their recommendation was as a last resort for handling claimant's inexplicable reports of pain. Their opinions did not consider motivation, which, as articulated by Dr. Peterson, is necessary for benefit from a pain clinic. Since claimant's symptoms are exaggerated and he is unmotivated, it is unlikely he would benefit from a pain clinic.

¶117 I also find that claimant has failed to cooperate with reasonable rehabilitation efforts. He did nothing in response to Williams' preparation of the 1999 rehabilitation plan. He has excuses for refusing to consider any of the jobs identified by the vocational providers.

CONCLUSIONS OF LAW

¶118 The 1995 version of the Workers' Compensation Act applies in this case since it was the law in effect at the time of claimant's August 29, 1995 industrial injury. *Buckman v. Montana Deaconess Hospital,* 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶119 Claimant has the burden of persuading me, by a preponderance of the evidence, that he is entitled to benefits. *See 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).

¶120 Section 39-71-701, MCA (1995) governs temporary total disability benefits, providing 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; or
>
> (b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.
>
> (2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.
>
> (3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in 39-71-702(5).

(4) If the treating physician releases a worker to return to the same, a modified, or an alternative position that the individual is able and qualified to perform with the same employer at an equivalent or higher wage than the individual received at the time of injury, the worker is no longer eligible for temporary total disability benefits even though the worker has not reached maximum healing. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available for any reason to the worker and the worker continues to be temporarily totally disabled, as defined in 39-71-116.

(5) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.

(6) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

(7) A worker may not receive both wages and temporary total disability benefits without the written consent of the insurer. A worker who receives both wages and temporary total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.

¶121 Section 39-71-702, MCA (1995), governs permanent total disability benefits, providing in relevant part:

39-71-702. Compensation for permanent total disability. (1) If a worker is no longer temporarily totally disabled and is permanently totally disabled, as defined in 39-71-116, the worker is eligible for permanent total disability benefits. Permanent total disability benefits must be paid for the duration of the worker's permanent total disability, subject to 39-71-710.

(2) The determination of permanent total disability must be supported by a preponderance of objective medical findings.

(3) Weekly compensation benefits for an injury resulting in permanent total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury.

(4) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.

(5) A worker's benefit amount must be adjusted for a cost-of-living increase on the next July 1 after 104 weeks of permanent total disability benefits have been paid and on each succeeding July 1. A worker may not receive more than 10 adjustments. The adjustment must be the percentage increase, if any, in the state's average weekly wage as adopted by the department over the state's average weekly wage adopted for the previous year or 3%, whichever is less.

(6) A worker may not receive both wages and permanent total disability benefits without the written consent of the insurer. A worker who receives both wages and permanent total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.

(7) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

¶122 Section 39-71-116(23), MCA (1995), defines permanent total disability as follows:

"Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

¶123 Section 39-71-116(17), MCA (1995) defines MMI as follows:

(17) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

¶124 Claimant has failed to persuade me he is incapable of performing regular work, or has no reasonable prospect of finding regular work within his physical capability. Therefore, he is not permanently totally disabled. He has also failed to persuade me his temporary total disability benefits were improperly terminated. When they were terminated, he was

refusing further surgery and other medical treatment was not benefitting him. He was therefore at MMI, § 39-71-116(17), MCA (1995), Finally, he has not shown that he would benefit from a pain clinic or that he would benefit from further rehabilitation benefits.

JUDGMENT

¶125 1. Claimant is not entitled to benefits for permanent total disability.

¶126 2. Claimant is not entitled to further temporary total disability benefits.

¶127 3. Claimant is not entitled to treatment at a pain clinic or to further rehabilitation benefits.

¶128 4. This JUDGMENT is certified as final for purposes of appeal pursuant to ARM 24.5.348.

¶129 5. 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 9th day of August 2000.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Mr. Marvin L. Howe
Mr. Joe C. Maynard
Date submitted: April 26, 2000

1. In referring to "his work", Dr. Powell was apparently referring to claimant's truck driving job.

2. The deltoid muscle is a posterior shoulder muscle.