IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2000 MTWCC 6

WCC No. 9910-8330

LOREN HAMS

Petitioner

vs.

LIBERTY NORTHWEST INSURANCE CORPORATION

Respondent/Insurer for

NUPAC/PACK AND COMPANY

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: 38-year-old claimant suffered injury to throat and neck, leading to neck pain, headaches, and right arm pain. Insurer terminated TTD benefits following IME report putting claimant at MMI. Claimant's doctor contended he had not reached MMI and recommended pain clinic and treatment for depression.

Held: Opinion of treating physician more persuasive in this case, particularly where (1) IME physician did not have pre-injury medical records, (2) treating physician was familiar with pre-injury medical condition and had assisted claimant in returning to work following earlier injury, (3) IME physician did not render opinion on causation involving earlier injury, and (4) even IME physician agreed claimant's condition should improve with further assistance with eliminating coffee and cigarettes and modifying medications. Insurer ordered to reinstate TTD benefits, retroactive to date of discontinuation.

Topics:

> **Maximum Medical Improvement (MMI).** WCC resolved conflict in opinions of two physicians to find claimant had not reached MMI because further medical treatment, on a more probable than not basis, would significantly improve claimant's depression and head, neck and myofascial pain. Significant to court's decision to credit one physician were facts that other doctor had not reviewed pre-injury medical records, was not the treating physician, did not address some causation issues, and agreed that a change in medications and elimination of

caffeine and tobacco should improve claimant's symptoms. Court ordered reinstatement of TTD benefits retroactive to date of discontinuation.

Maximum Medical Improvement (MMI): Failure to Follow Physician's Recommendations. Where treatment which might improve claimant's condition is available, it cannot be delayed or ignored so as to maintain claimant in a perpetual state of less than maximum healing, and where the treating physician recommends reasonable treatment, including elimination of particular vices such as caffeine or tobacco use, the claimant must follow the recommendations unless incapable of doing so or will be deemed to have reached MMI.

Medical Conditions: Depression. WCC resolved conflict in opinions of two physicians to find claimant had not reached MMI because further medical treatment, on a more probable than not basis, would significantly improve claimant's depression and head, neck and myofascial pain. Significant to court's decision to credit one physician were facts that other doctor had not reviewed pre-injury medical records, was not the treating physician, did not address some causation issues, and agreed that a change in medications and elimination of caffeine and tobacco should improve claimant's symptoms. Court ordered reinstatement of TTD benefits retroactive to date of discontinuation.

Proof: Conflicting Evidence: Medical. WCC resolved conflict in opinions of two physicians to find claimant had not reached MMI because further medical treatment, on a more probable than not basis, would significantly improve claimant's depression and head, neck and myofascial pain. Significant to court's decision to credit one physician were facts that other doctor had not reviewed pre-injury medical records, was not the treating physician, did not address some causation issues, and agreed that a change in medications and elimination of caffeine and tobacco should improve claimant's symptoms.

¶1 The trial in this matter was held on December 28, 1999, in Helena, Montana. Petitioner, Loren Hams (claimant), was represented by Mr. Kenneth S. Thomas. Respondent, Liberty Northwest Insurance Corporation (Liberty), was represented by Mr. Larry W. Jones. A trial transcript has not been prepared.

¶2 Exhibits: Exhibits 1through 5 were admitted without objection.

¶3 Witnesses and Depositions: Claimant and Sandy Scholl were sworn and testified. In addition, the parties submitted depositions of claimant, Dr. Michael Righetti, Dr. Dana Headapohl, and Sandy Scholl for the Court's consideration.

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

1. Whether claimant has reached maximum medical improvement.

2. Whether claimant is entitled to temporary total disability benefits retroactive to September 9, 1999, and continuing until he reaches maximum medical healing.

3. Whether respondent is liable for further medical expenses.

4. Whether respondent's termination of claimant's temporary total disability benefits and its failure to authorize a second opinion recommended by the treating physician were unreasonable, thereby entitling claimant to a penalty under section 39-71-2907, MCA, and to attorney fees and costs under section 39-71-611, MCA.

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

FINDINGS OF FACT

¶6 Claimant is presently 38 years old. He has a tenth grade education.

¶7 Claimant has worked as a heavy equipment mechanic all of his adult life. He repairs and maintains trucks, bulldozers, and other heavy equipment. His work as a mechanic is heavy work.

¶8 On March 5, 1993, claimant was injured in an industrial accident. He was lying under a truck using a cutting torch when a spark or molten metal from the solder rolled down his nose into his throat, causing him to flail about with his arms and body in a frantic attempt to get out from under the truck. In the process he struck and injured his neck, right shoulder and right arm, as well as his nose and throat. (Tr. Test. and *see* Ex. 1.)

¶9 Following his injury, claimant had multiple complaints involving neck pain, headaches, and right arm and hand pain and numbness. His primary diagnoses were right carpal tunnel syndrome, right cubital tunnel syndrome of the ulnar nerve at the elbow, and, ultimately, thoracic outlet syndrome. Over the next three years the claimant underwent three surgeries, specifically, a right carpal tunnel release, right ulnar nerve transposition, and thoracic outlet surgery involving a right 1st rib resection, scalenotomy, and dissection of a right posterior shoulder muscle. (Ex. 4 at 141; Ex. 5 at 69.)

¶10 As a consequence of his injuries, multiple surgeries and slow recovery, claimant became depressed. On October 3, 1995, Dr. Righetti, who performed the right ulnar nerve release in June 1995, recommended a psychological evaluation. (Ex. 4 at 98.)

¶11 Claimant was thereafter treated for his depression by Dr. Michael M. Newman, a psychiatrist. Dr. Newman wrote on October 5, 1995:

> Mr. Hams presented with severe depression associated with tearfulness, poor sleep, 30 pound weight loss and worthlessness. His depression was precipitated by

> an accident at his job work [sic] which has resulted in his not being able to currently work.

(Ex. 4 at 132.) Dr. Newman treated claimant with Klonopin (an anti-convulsant also used to treat panic disorder), Zoloft (an antidepressant) and Chloral Hydrate (a non-barbiturate sedative often used to treat sleep disturbances).[(1)] (*Id*. at 132-139.)

¶12 Following thoracic outlet syndrome surgery in 1996, claimant's condition stabilized. On October 1, 1996, Dr. Righetti rated him for impairment. (Ex. 4 at 104.) Sometime in 1996, claimant began working again, doing mobile heavy equipment repair, primarily of logging equipment. He worked as an independent contractor in that business for a year or more until logging decreased and business declined. In 1997 or 1998 he went to work for A-1 Paving, repairing heavy equipment. Then in July 1998 (*see* ex. 2) he went to work for NuPac as a heavy equipment mechanic, doing essentially the same work as in 1993 and prior years.

¶13 While able to work, claimant was not symptom free. He continued to suffer pain and depression. At the time of his March 15, 1999 injury he was still under Dr. Newman's care for depression and was being followed by a Dr. John V. Stephens, a physiatrist. At the time of his injury he was on multiple medications for depression and pain, including Klonopin, Zoloft, Ultram (a narcotic analgesic), and Ambien (a non-barbiturate sedative-hypnotic).[(2)] Dr. Stephens examined claimant on January 1, 1999, and noted his primary complaints as "[m]yofascial pain with muscle contraction headaches," sleep disruption and depression, which were being treated with the previously listed medications. (Ex. 3 at 2.) Regarding claimant's medical and work status in early 1999, Dr. Stephens wrote on April 23, 1999:

> I treated Mr. Hams as requested by Dr. Righetti and this gentleman, in fact, was able to continue working. The goal of my evaluation and treatment always is to keep the patient as functional as possible, and in this case that fortunately includes working as a mechanic. In this regards I have prescribed medications and recently have prescribed a time-limited course of physical therapy for what I believe is a flare-up of this gentleman's situation. Also, as part of continued treatment referable to the work injury, I order occasional laboratory data to be sure that we are not sustaining complications secondary to medication usage.

(Ex. 5 at 21.) Dr. Stephens' further commented:

I don't think his current employment is particularly aggravating the situation though certainly both vocational and avocational factors might lead to flare ups.

(*Id*. at 22.)

¶14 On March 15, 1999, while working for NUPAC, the claimant injured his head, neck, and left shoulder and arm. He was "pulling up on a long breaker bar, under a trailer fender . .

. when the socket slipped off the nut." When it slipped, he hit his "head, neck and upper shoulder on the fender and fender cross support or brace." (Ex. 2.)

¶15 Approximately one week after his injury, claimant sought care at an urgent care center and was taken off work for a day or two. He then returned to work and worked for approximately another week but continued to suffer pain. He then went to his family physician,[(3)] Dr. Charles L. Dixon. (Ex. 5 at 1 to 9.)

¶16 Dr. Dixon first saw claimant on March 31, 1999, at which time he noted that claimant was suffering intermittent numbness in his left arm and pain on the left side of his neck and left trapezius. (*Id.* at 1.) He took claimant off work for two or three days. The doctor saw claimant on two occasions in April, again noting left-sided neck, shoulder, and arm pain. (*Id.* at 3, 5.) Dr. Dixon took him off work in late April and renewed his off-work recommendation in mid-May. (*Id.* at 5, 6.) Claimant has not worked since then.

¶17 On May 6, 1999, claimant returned to Dr. Righetti, who had treated him for his 1993 injury. On that date Dr. Righetti recorded that claimant was suffering headaches and numbness in his left ulnar nerve distribution (left arm). He diagnosed a cervical contusion with soft-tissue symptoms, cubital tunnel symptoms, and occipital neuralgia, and ordered a cervical MRI to rule out a herniated disk. (*Id.* at 28-29.) Dr. Righetti has continued to treat claimant.

¶18 Electro-diagnostic studies conducted by Dr. Stephens on June 14, 1999, provided evidence of both left carpal tunnel syndrome and left cubital tunnel syndrome. (*Id.* at 24.)

¶ 19 In addition to his physical complaints, claimant experienced a relapse of severe depression following the second injury. On June 28, 1999, Dr. Dixon wrote that claimant was "appearing more and more depressed" and that he was "not responding to his current Zoloft 100 mg. a day." (*Id.* at 8.) Dr. Dixon attributed the increased depression to claimant's 1999 injury and sought permission to refer claimant to a psychiatrist. (*Id.*) Claimant was thereafter seen on August 19, 1999, by a clinical psychologist, Edward H. Trontel, Ph.D., who opined that claimant "was suffering from a serious distress syndrome (depression, anxiety, and tension) that was in need of intervention." (*Id.* at 75.) Dr. Trontel recommended that claimant return to his psychiatrist, Dr. Newman, for further assessment of his depression and medications, commenting, "Careful scrutiny of his medication use was believed to be the foremost matter." (*Id.*)

¶20 On September 10, 1999, Dr. Righetti provided claimant's attorney with an update concerning claimant's condition. (*Id.* at 34.) In that report he said the 1999 injury had "re-established a set of myofascial complaints that were under pretty good control" but noted that there were some differences between his pre-1999 and post-1999 injury complaints. (*Id.*) He noted that claimant "needs both physical and psychological support and is getting increasingly dependent on medication to help control his symptoms." He opined:

> [T]he majority of his symptoms are from his recent injury. He certainly had some mild symptoms previously, but he was back gainfully employed and now he is much worse and much more severe in all areas concerned above.

(*Id.* at 35.) As to maximum medical improvement, Dr. Righetti said, "I feel very clearly on a more probably than not basis that Loren has not achieved maximal medical improvement in regards to his March 15th industrial injury." (*Id.* at 34.) The doctor determined that claimant was unable "physically or emotionally" to return to his time-of-injury job. (*Id.*)

¶21 On October 4, 1999, Dr. Righetti examined claimant and noted that he was

> still having a lot of myofascial symptoms and pain in his neck and headaches. He is also having severe symptoms in his ulnar nerve on the left side.

(*Id.* at 36.) He recommended a further evaluation by a neurosurgeon for "symptoms of neck pain that may be coming from his cervical spondylosis." (*Id.*)

¶22 Earlier, on August 5, 1999, at the insurer's request, Dr. Dana Headapohl, who specializes in Occupational and Environmental Medicine, conducted an independent medical examination of claimant. She concluded that claimant's carpal and cubital tunnel syndromes of his left arm were "occupational diseases" and not attributable to his 1999 injury, and that he had reached MMI with respect to the 1999 injury. As did Dr. Righetti, she recommended referral to a psychiatrist for adjustment of medications to treat his depression, anxiety, and sleep disruption.

¶23 Based on Dr. Headapohl's evaluation, Liberty terminated claimant's temporary total disability benefits. His petition in this case followed.

¶24 The Court has the benefit of deposition testimony of both Drs. Righetti and Headapohl. Both adhered to the opinions they expressed in their written reports and records. The Court must determine whose opinion is the more persuasive.

¶25 Dr. Headapohl testified that the 1999 injury shifted "the focus from the right to the left temporally but it did not really increase the general pain picture." (Headapohl Dep. at 13.) With respect to the left carpal and cubital tunnel syndromes, she indicated that the conditions may be due to occupational factors but declined further comment, indicating that she had not been asked to address any causal relationship with respect to the conditions. (*Id.* at 35-36.) She also did not address the possibility of surgery for the conditions. Concerning claimant's depression, she noted that it was preexisting, that his post-1999 injury depression "was a continuation of the preexisting depression." (*Id.* at 10.) She did not address whether the 1999 injury worsened the depression or whether it had become totally disabling. (*Id.* at 37-41.)

¶26 Dr. Headapohl concluded that claimant had reached MMI with respect to his 1999 injury and that the injury did not cause any additional physical restrictions. Nonetheless,

she recommended additional treatment, specifically changing and simplifying claimant's medications and weaning the claimant from caffeine and nicotine. (*Id.* at 11, 39.) She testified that claimant's intake of caffeine (multiple cups of coffee daily) and nicotine (through cigarette smoking of many years duration) is worsening both claimant's pain and his depression. (*Id.* at 11-12, 39, 48.) With respect to his medications, she said that the combination of drugs prescribed for claimant "does not conform to current recommendations for treatment of chronic pain, whether the chronic pain comes from repetitive trauma problems, myofascial problems or other musculoskeletal problems." (*Id.* at 32.) She further commented that the Klonopin claimant was taking can "cause increased depression." (*Id.* at 47.) She recommended referral to a psychiatrist for management of his psychotropic medications. (*Id.* at 9-10.)

¶27 Of significance in resolving the conflicting medical testimony, Dr. Headapohl did not have claimant's pre-1999 medical records. While she said that the records were unlikely to change her opinions, she was asked whether there was "anything else that would make you feel more comfortable with your opinion that he's maximally improved from his 3/15 of '99 accident?" and replied:

> I would like to see [the] preexistent medical records. I would always like to see preexistent medical records. You know, patients present their recollection of things, sometimes discounting problems, sometimes magnifying, you know. Sometimes it's just totally accurate. But it's always helpful to see the past medical records to see what was the course from this injury. I mean, he had an incredible surgical history. I mean, that was an incredible surgical history. That was a very unusual surgical history. So I would imagine that there would be a number of -- I imagine that there would be a pile of medical records between '93 and '99. And I always like to have preinjury records. I think that it's helpful.

(*Id.* at 41-42.) Because she did not have the prior medical records, she did not know whether clamant had left-sided symptoms prior to 1999, the specific dosages of his medications, or the restrictions his physicians had placed upon him. (*Id.* at 41, 24-37.) With respect to his pre-1999 medications, she testified that "it would be important" to know the dosages and how he reacted to them. (*Id.* at 36.)

¶28 Dr. Righetti agreed with Dr. Headapohl concerning the need to adjust claimant's medications and wean him from coffee and cigarettes, however, he related claimant's carpel and cubital syndromes and increased depression to his 1999 injury and disagreed that claimant had reached MMI.

¶29 Dr. Righetti testified that the 1999 accident worsened claimant's underlying myofascial condition and extended it to his left side. (Righetti Dep. at 7, 17-18.) He did not feel, however, that the aggravation to claimant's preexisting right side myofascial pain and cubital and carpal tunnel syndromes was significant. (*Id.* at 17.) Therefore, the focus of the

Court's inquiry is what left-sided conditions are related to the 1999 injury and whether the claimant has reached MMI with respect to those conditions which are related.

¶30 Initially, Dr. Righetti's observation that the claimant's left-sided complaints arose only after his 1999 injury is supported by medical records which show that claimant's post-1993 complaints were right-sided. A mention of earlier left cubital symptoms contained in a couple of medical notes appear to be erroneous and intended to refer to the right, not the left, arm. (*See* Ex. 4 at 106.) In a hospital admission note of June 7, 1995, Dr. Righetti noted the history of claimant's 1993 injury and a prior right carpal tunnel release by Dr. Brown, and then said: "A certain amount of symptoms persisted, primarily ulnar distribution of his left hand . . . ." (*Id.*) The reference to the "left" is plainly in error as the hospital admission was for a transposition of the "right" ulnar nerve (*id.* at 108) and prior medical records reflect a persistence of symptoms in the right ulnar nerve. (*Id.* at 64, 69-70, 75-76.) There is also a reference in an October 28, 1993 report by Dr. Robert D. Schimpff, a neurologist who conducted electrical nerve studies on September 15, 1993, to "a mild conduction slowing across the left elbow and that may be in part contributing to his difficulty." (*Id.* at 19.) However, an earlier reference in the letter indicates that the slowing was across the right elbow: "He has previously had some electrical studies which did show evidence for slight decreased ulnar nerve conduction across the **right** elbow compared to the left." (*Id.* at 18; emphasis added.) A review of the September 15, 1993 study bears out the statement regarding the right elbow (*id.* at 15-16), and a review of records in 1993 and 1994 indicates that all of claimant's arm complaints in those years related to the right arm. After careful review of medical records and medical testimony, I find that claimant's 1993 complaints were limited to his right side and that his left-sided complaints and symptoms associated with left-arm cubital and carpal tunnel syndromes arose following his 1999 industrial accident.

¶31 With respect to the cubital and carpal tunnel syndromes, Dr. Righetti testified that the syndromes likely preexisted the 1999 injury and could be classified as occupational diseases, however, the conditions were asymptomatic. (Righetti Dep. at 27-28.) On a more likely than not basis, he testified that the 1999 injury "brought those [conditions] to clinical light" (*id*. at 28), i.e., the conditions became symptomatic as a result of the1999 injury. He described possible mechanisms to explain the contribution of the 1999 injury. Referring first to carpal tunnel syndrome, he said:

> [I]t's associated with something called a double crush syndrome. It can be part of a double crush syndrome. So if part of the brachial plexus or the nerves that go to the fingers are pinched somewhere besides the wrist, which is the primary pinch site in carpal tunnel. They will allow the carpal tunnel to be magnified.
>
> For instance, I use the example, if you take a hose and that's attached to the wall and you turn the hose on just a little bit and then you go to the other end and you try

> and pinch it off, it will be easy to do so. If you turn the hose on full at the spigot and then you try and pinch it off at the other end, you may not be able to do so; the water will still come out.
>
> So if you have obstruction in more than one place on the same nerve, you're going to get a pronounced expression or more clinical symptoms from a compression of a nerve down the hose a ways. So double crush syndrome and referred pain are particularly significant in this particular case.

(*Id*. at 8-9.) He then testified that cubital tunnel syndrome may be aggravated in the same way. In addition to muscle contraction of the neck and shoulder, brought on by the 1999 injury, triggering carpal and cubital tunnel symptomatology, he testified that claimant may also have struck his elbow in the accident and not noticed it because of the severity of blows to his head and neck. (*Id*. at 9-10.)

¶32 Dr. Righetti agreed with Dr. Headapohl that claimant's smoking and coffee drinking contribute to claimant's pain and with her recommendation that he be weaned from them. (*Id*. at 19-20.) But he also observed that even with claimant eliminating coffee and cigarettes it is unlikely that he will be able to return to his time-of-injury job. (*Id*. at 20-21.)

¶33 On MMI, the doctor strenuously disagreed with Dr. Headapohl, testifying that claimant is not at MMI and will benefit from further treatment. (*Id*. at 18, 25, 27.) In addition to recommending elimination of coffee and cigarettes by claimant, he recommends further psychological treatment to bring claimant's depression under better control. (*Id*. at 18, 32.) He urged a multi-disciplinary approach to pain management which addresses both physical and psychological elements, as well as medications. (*Id*. at 33.) He indicated that because of claimant's emotional state, he is not currently a candidate for ulnar nerve surgery, however, if his emotional state can be stabilized, then surgery -- certainly cubital and possibly carpal tunnel -- is a realistic prospect which may improve his left-arm condition. (*Id*. at 32-35.)

¶34 Dr. Righetti also disagreed with Dr. Headapohl's opinion that claimant's current restrictions are no greater now than prior to his 1999 injury. (*Id*. at 28.) He pointed out that prior to the 1999 injury claimant was able to work as a heavy equipment mechanic, now he is not. He said that claimant's depression prevents him from concentrating on work, claimant drops objects due to weakness in his left arm, and he cannot move freely or do repetitive work due to pain. (*Id*. at 28-29.)

¶35 Finally, Dr. Righetti recommended both a pain clinic, mentioning one in Seattle, and a consultation with a neurosurgeon. He did not, however, provide evidence demonstrating that claimant would not benefit from a multidisciplinary approach to treatment available in Montana and his recommendation of a neurosurgical consultation is to "add additional credence" to his own diagnosis and a second opinion on an ulnar nerve transfer. (*Id*. at 21.)

In light of Dr. Righetti's strong opinion that claimant is not now a surgical candidate and his unequivocal diagnoses, referral to a neurosurgeon for confirmation and a second opinion is premature.

¶36 Liberty has made much of the fact that claimant was taking numerous prescription medications prior to his 1999 injury and that he continued taking most of them following the injury. The number and amount of medication before and after, however, is not the benchmark for this Court's decision. Rather, the issue is whether, irrespective of his current medications, the claimant continues to be totally disabled and whether further medical treatment provides reasonable prospect of improving his condition.

¶37 After reviewing all of the evidence in this case, and giving careful consideration to the testimony of both Drs. Headapohl and Righetti, I find Dr. Righetti's opinions persuasive and that claimant is not at MMI. In reaching these findings, I am influenced among other things by the following:

- Dr. Headapohl did not have claimant's pre-1999 injury medical records. Notwithstanding her adherence to her opinions, she was clearly uncomfortable with rendering her opinions without those records and repeatedly indicated she would have preferred to have them.
- Dr. Righetti, on the other hand, has treated claimant with respect to both his 1993 and 1999 injuries and has performed surgery on claimant. He is familiar with claimant's medical history and the significance of his post-1999 complaints. He is also familiar with claimant's responsiveness to medical treatment, and with the help of Drs. Stephens and Newman, was able to return the claimant to work following his 1993 injury.
- Dr. Headapohl did not address causation of the left carpal and cubital tunnel syndromes and did not address or refute Dr. Righetti's opinion that the 1999 accident lit up those conditions and made them symptomatic.
- Dr. Headapohl testified that claimant's psychological and physical condition should improve with a change in his medications and his elimination of coffee and cigarettes. Dr. Righetti agreed. There is substantial evidence that further medical assistance in controlling his coffee drinking and cigarette smoking, and further evaluation and modification of his medication promises additional medical benefit to claimant.

¶38 While further treatment should benefit claimant, it does not appear that Dr. Righetti has taken concrete steps to secure or make that treatment available, at least based on the record presented. Dr. Newman has treated claimant for his depression and apparently is the physician prescribing psychotropic medications, however, there is no indication that the doctor has seen claimant since his 1999 injury or that Dr. Righetti has been in contact

with him to follow-up on Dr. Trontel's recommendations that claimant be seen by a psychiatrist. Additionally, while recommending a multidisciplinary approach for treatment of claimant's pain, there is no indication that Dr. Righetti has taken specific steps to secure such treatment, or of a request for authorization from the insurer to do so. The Court notes that, prior to the 1999 injury, Dr. Righetti referred claimant to Dr. Stephens for pain management, yet there has been no similar referral since the 1999 injury.

¶39 It also does not appear that claimant has fully committed to eliminating coffee drinking and smoking. He testified that he has cut his coffee intake from 5 pots to 1 pot a day and his smoking from 2 packs to 1 pack a day. However, he also said that he is addicted, and does not want to quit and that smoking helps him deal with his stress. The Court recognizes that smoking and coffee drinking are difficult habits to quit, and that outside medical assistance may be required. It was apparent to the Court that claimant did not appreciate the importance of giving up both coffee and cigarettes or his obligation to comply with medical recommendations that he do so.

¶40 The insurer's termination of temporary total disability benefits in this case was not unreasonable. It did so only after it obtained an IME that claimant had reached MMI. Moreover, Dr. Righetti's own records and correspondence failed to provide a specific treatment plan for the future, lending support to Dr. Headapohl's observation that claimant had not been offered additional treatment. (Headapohl Dep. at 18.)

CONCLUSIONS OF LAW

¶41 This case is governed by the 1997 version of the Workers' Compensation Act. *Buckman v. Montana Deaconess Hospital*, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶42 Temporary total disability benefits are governed by section 39-71-701, MCA (1997), which provides in relevant part:

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

The insurer terminated claimant's benefits based on Dr. Headapohl's determination that he had reached maximum healing. There is no suggestion that claimant is working or that he can return to his time-of-injury job, indeed Dr. Headapohl indicated that his job was probably medically inappropriate given his preexisting condition. (Headapohl Dep. at 26-27.) Therefore, the sole issue the Court must determine is whether claimant has reached maximum healing. If he has not, then he is entitled to reinstatement of temporary total disability benefits retroactive to the date they were terminated.

¶43 Maximum healing is defined in section 39-71-116(18), MCA, as follows:

> (18) "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.

"Material improvement" is not defined, but the dictionary definition of the "material" in the context it is used is "important, essential, or pertinent." "Primary medical services" is defined as "treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability." § 39-71-116(26), MCA (1997).

¶44 I have found as fact that claimant has not reached MMI because further medical treatment, on a more probable than not basis, will significantly improve both his depression and pain. The evidence persuaded me that further medical treatment, initially changing claimant's medication and treating his addictions to caffeine and nicotine, and then surgery on his ulnar nerve and possibly his medial nerve, will, on a more likely than not basis, relieve or at least reduce his depression, reduce his pain, and increase his ability to function. Claimant is therefore entitled to the retroactive reinstatement of temporary total disability benefits.

¶45 In addition to finding that claimant will benefit from further treatment, I have made two other findings of significance. First, I have found that claimant's treating physician, for whatever reasons, has not implemented a treatment plan: specifically, he has not followed up on obtaining psychiatric consultation and oversight for claimant's depression; he has not taken specific steps to implement a multidisciplinary plan for pain management; and, apparently, he has not provided medical assistance to assist claimant in curtailing his caffeine and nicotine addictions. Second, claimant has not complied with his treating physician's recommendation to cease drinking coffee and other caffeinated beverages and to stop smoking. These findings are important. Where treatment which might improve claimant's condition is available, it cannot be delayed or ignored so as to maintain claimant in a perpetual state of less than maximum healing, and where the treating physician recommends reasonable treatment, including elimination of particular vices, the claimant must follow the recommendations unless incapable of doing so. As applied to this case, those principles mean that prompt, reasonable steps must be taken to implement the claimant's treatment plan. The failure to do so may result in a future finding

that claimant has indeed reached MMI if it is not reasonable to expect that further medical treatment will be implemented.

¶46 The claimant's requests for attorney fees and a penalty are governed by sections 39-71-611 and -2907, MCA (1997). Those sections require a finding that the insurer has acted unreasonably before fees or penalty may be imposed. In this case, I have found that the insurer's termination of benefits was based on legitimate medical opinion, and therefore reasonable. Claimant is entitled to neither attorney fees nor a penalty. He is entitled to his costs.

JUDGMENT

¶47 1. Liberty shall reinstate claimant's temporary total disability benefits retroactive to the date it discontinued those benefits.

¶48 2. Claimant is entitled to costs pursuant to section 39-71-611, MCA. The parties shall follow the procedures set forth in ARM 24.5.342 and 24.5.343.

¶49 3. Claimant is not entitled to attorney fees or a penalty.

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

¶51 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 10th day of February, 2000.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Mr. Kenneth S. Thomas
Mr. Larry W. Jones

1. The information concerning class and usage of the three drugs was obtained from drug information furnished through www.medscape.com, an internet site for medical professionals.

2. See footnote 1.

3. See Ex. 5 at 8.