IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

1999 MT WCC 38

WCC No. 9812-8116

EUGENE HARNED

Petitioner

vs.

STATE COMPENSATION INSURANCE FUND

Respondent/insurer for

S.J. PERRY

Employer.

DECISION AND JUDGMENT

Summary: Claimant suffered a right-sided disk herniation as the result of a compensable work injury. Following a microscopic laminotomy and disk excision, he continued to complain of low-back and right leg pain. A neurosurgeon recommended additional surgery. Other physicians recommended against surgery. Based on those recommendations, the insurer refused to authorize the additional surgery. Having reviewed the evidence pretrial, the Court noted during trial that it would order surgery on the condition the physician recommending surgery review the opinions of doctors recommending against surgery and continue his recommendation for surgery. Evidence of the surgeon's review was submitted to the Court.

Held: Surgery is ordered as a primary medical benefit to which claimant is entitled. Factors considered by the Court included: the doctor recommending surgery made the most recent examinations and evaluations of claimant, including examination following an incident claimant alleged exacerbated his pain; the persuasive evidence indicated that while the surgery may not cure claimant from all pain, it may alleviate some of his pain; where claimant has not worked since his accident, even a 50% prospect of success may be reasonable if success will increase his functioning and return him to work, whereas that prospect may not be reasonable if he were employed and reasonably functioning; claimant saw the surgeon recommending surgery as part of an independent medical examination.

Topics:

Constitutions, Statutes, Regulations and Rules: Montana Code: section 39-71-704(1)(a), MCA, 1995. Treating physician's opposition to surgery recommended by independent medical examiner to which claimant was referred as part of managed care organization handling of case was not fatal to demand for surgery based on recommendation of IME physician/surgeon.

Constitutions, Statutes, Regulations and Rules: Montana Code: section 39-71-116(25), MCA, 1995. Treating physician's opposition to surgery recommended by independent medical examiner to which claimant was referred as part of managed care organization handling of case was not fatal to demand for surgery based on recommendation of IME physician/surgeon.

Benefits: Medical Benefits: Surgery. Claimant suffered a right-sided disk herniation as the result of a compensable work injury. Following a microscopic laminotomy and disk excision, he continued to complain of low-back and right leg pain. A neurosurgeon recommended additional surgery. Other physicians recommended against surgery. Having reviewed the evidence pretrial, the Court noted during trial that it would order surgery on the condition the physician recommending surgery review the opinions of doctors recommending against surgery and continue his recommendation for surgery. Evidence of the surgeon's review was submitted to the Court. Surgery was ordered as a primary medical benefit to which claimant was entitled. Factors considered by the Court included: the doctor recommending surgery made the most recent examinations and evaluations of claimant, including examination following an incident claimant alleged exacerbated his pain; the persuasive evidence indicated that while the surgery may not cure claimant from all pain, it may alleviate some of his pain; where claimant has not worked since his accident, even a 50% prospect of success may be reasonable if success will increase his functioning and return him to work, whereas that prospect may not be reasonable if he were employed and reasonably functioning; claimant saw the surgeon recommending surgery as part of an independent medical examination.

¶1 This trial in this matter was held on February 26, 1999, in Butte, Montana. Petitioner, Eugene Harned (claimant), was present and represented by Mr. Bernard J. Everett. Respondent, State Compensation Insurance Fund (State Fund), was represented by Mr. David A. Hawkins.

¶2 Exhibits: Exhibits 1 through 17 were admitted without objection. Following the trial, an April 8th, 1999 letter from Dr. Chriss A. Mack's business manager and a January 11, 1999 office note were received by the Court and admitted as Exhibit 18.

¶3 Depositions: The parties agreed that the depositions of claimant, James Porta, Dr. Michael Lahey, and Dr. Allen M. Weinert can be considered part of the record.

¶4 Claimant was injured at work on June 7, 1996. He suffered a right-sided herniated disk at the L5-S1 level. (Ex. 11 at 1.) His claim for compensation is not disputed.

¶5 On December 19, 1996, claimant underwent a "[m]icroscopic laminotomy and disk excision removing herniated disk and disk from L-5/S-1." (Ex. 11 at 12.) Despite surgery claimant has continued to complain of low-back and right leg pain. Dr. Chriss A. Mack, a neurosurgeon, has recommended additional surgery. Other physicians have recommended against additional Surgery. Based on their recommendations, the State Fund refused to authorize the additional surgery, arguing that it is not reasonable.

¶6 In this action, claimant asks the Court to order the State Fund to authorize and pay for the surgery recommended by Dr. Mack. In conjunction with that request, he also seeks

> temporary total disability (TTD) benefits until the surgery is performed and he fully recovers. If the Court denies those requests, claimant asks the Court to determine that he is permanently totally disabled (PTD) and entitled to PTD benefits. Claimant also seeks attorney fees and a penalty.

¶7 The need for surgery is a medical issue. At the commencement of trial, I ascertained that the medical evidence the parties intended to offer was through depositions of Drs. Michael Lahey and Allen M. Weinert and the medical records admitted as exhibits. Having reviewed the depositions and exhibits in advance of trial, I advised the parties that I intended to order the surgery recommended by Dr. Mack on the condition that Dr. Mack reviews the opinions of Drs. Weinert and Lahey and, after considering their opinions, still recommends surgery. Pending Dr. Mack's review, I ordered that claimant be placed on TTD benefits.

¶8 In conjunction with my order, I provided counsel with the options of deposing Dr. Mack or obtaining his further opinion on a more informal basis. Counsel have proceeded in an informal fashion. Mr. Hawkins wrote to Dr. Mack asking him to Undertake the review requested by the Court. On April 8, 1999, the business manager of Dr. Mack's office replied to that request by forwarding an office note of January 11, 1999. The note reflected a January 11, 1999 conversation between Dr. Mack and Dr. Weinert. In her letter, the business manager wrote:

> Per Dr. Mack's request, I am forwarding the last visit (phone call) with Mr. Harned in response to the question you posed in you[r] letter of March 4, 1 999.

The letter and Dr. Mack's office note have been marked and admitted as Exhibit 18.

¶9 In his January 11, 1999 office note, Dr. Mack reiterates his recommendation of surgery notwithstanding Dr. Weinert's opinions. The note reads in relevant part:

> 1-11-99 PHONE CALL: I am [in] receipt of a letter from Dr. Weinert who aptly suggested that a repeat microdiscectomy is not likely to resolve Mr. Harned's back

> pain. I agree with this completely. He clearly has radicular pain. He clearly has residual or recurrent disc herniation on the right-hand side at L-5S 1. I have advised him that he undergo a microdiscectomy to resolve the leg pain. However, he has a significant amount of back pain. To that end, I suggested that the patient have facet blocks after a bone scan. His bone scan was negative which is commonly the case, but does not preclude the necessity to proceed with facet blocks. If the fact [sic] block is injected into the 5-S 1 facet joint and it substantially improves symptoms of his back pain, though I do not expect it to resolve the leg pain, then he would be a candidate for a repeat microdiscectomy and a lumbar threaded bone dowel fusion which I expect would have a 70% chance of resolving his back pain. The microdiscectomy and the decompression, which would be thorough, would resolve his leg pain with 90% likelihood despite being repeat surgery.

(Ex. 18 at 2.) It is clear from his note that Dr. Mack agrees that the microdiscectomy he recommends will not relieve all of claimant's back pain. On the other hand he believes to a 90% probability that the surgery will relieve claimant's radicular leg pain.

¶10 Dr. Mack's office note is not exactly what the Court contemplated at the time of trial. However, in a telephone conference on April 30, 1999, counsel and the Court agreed that it sufficiently addresses the Court's concerns regarding the surgery. Accordingly, at that time, I ordered that the surgery proceed. I advised counsel that I would issue a written decision more fully explaining my reasons for authorizing the surgery.

¶11 Because of the unique manner in which this case has unfolded, my decision is in narrative form.

Discussion

¶12 At the time of his industrial accident, claimant was employed by S.J. Perry Company, as a warehouse foreman. (Harned Dep. at 3.) He supervised and assisted loading and unloading hot tubs and plumbing supplies. *(Id.* at 4.)

¶13 On June 7, 1996, claimant was loading PVC pipe into a truck. *(Id.* at 8.) He bent over to pick up PVC pipe, twisted his body, and felt a sharp, stabbing and burning pain in his lower back. *(Id.* at 8-9.) At the time of his industrial accident, the State Fund insured S.J. Perry. It accepted his claim for compensation.

¶14 Claimant thereafter experienced both low-back and bilateral leg pain. (Ex. 3 at 1.) On October 2, 1996, an MRI disclosed a "[I]arge central and slightly right lateralizing HNP [herniated nucleus pulposus] with inferior extension of disc material." *(Id.)* On December 19, 1996, Dr. B. Max Iverson, an orthopedic surgeon practicing in Helena, performed surgery.

¶15 Since his surgery, claimant has reported continuing low-back and leg pain. He has sought treatment for his pain on numerous occasions and has been evaluated by several physicians.

¶16 Claimant's treating physician following his surgery has been Dr. Weinert, a physiatrist specializing in physical medicine and rehabilitation. (Weinert Dep. at 4.) Dr. Weinert initially saw claimant on June 20, 1997. At that time the claimant was complaining of

> central low back pain which is constant in nature. He gets intermittent numbness and tingling down both legs from the waist distally, right side greater than left. His back symptoms are worse with sitting, standing, bending or twisting....

(Ex. 10 at 1.) Waddell's tests for "nonorganic behavior" were 2 of 5, which Dr. Weinert characterized as inconclusive but sufficient to raise concern about psychogenic pain behavior. *(Id.* at 2; Weinert Dep. at 10.)

¶17 Dr. Weinert saw claimant again on July 18, 1997. Claimant reported that physical therapy, which he had been undergoing, was "not helping him at all and aggravates his pain." (Ex. 10 at 5.) Claimant complained of "intermittent radiating pain into the right leg." *(Id.)* After examining claimant, Dr. Weinert recommended further evaluation by Dr. Lahey, an orthopedic surgeon practicing in Missoula.

¶18 Dr. Lahey examined claimant on September 24, 1997. (Ex. 14.) Four of five Waddell's signs were positive and commented that claimant suffered from "probable behavioral pain disorder." *(Id.* at 2-3.) On the other hand, he noted that the most recent post-surgical MRI showed a "persistent annular defect at that the L5-S1] level with potential impingement of the S1 nerve root." *(Id.* at 3.) In his recommendation, Dr. Lahey wrote:

> RECOMMENDATION: I think at this time, it would be reasonable to have him seen for Behavioral Pain Program and psychological evaluation. If his functional level can be improved, anger, frustration and depression can be improved on as well as sleep disorder and his symptoms seem to localize more to an S1 distribution then repeat decompression of the S1 nerve root could be discussed. However, given his overall presentation, positive nonorganic physical findings, anger, frustration and willingness to blame a number of different issues for his continued symptoms, I don't think further aggressive treatment such as consideration of spinal arthrodesis is warranted. The patient became somewhat argumentative here in the office and despite my attempts to deal with those, kept coming up with more and more concerns and frustrations. I will make my suggestions known to Dr. Weinert. It is my impression that he will be sending his films off for interpretation somewhere else.

(Ex. 14 at 3.)

¶19 Following the evaluation by Dr. Lahey, Dr. Weinert continued to see claimant for ongoing pain complaints in his low back and legs. Dr. Weinert's reports acknowledge that claimant has "scarring and recurrent disc material at the L5-S1 level" but unaccompanied by "evidence of radiculopathy." (Ex. 10 at 8, 11, 13, 15, 16.) He prescribed various medications and epidural steroid injections. *(Id.* at 8-19.) He also determined, as did Dr. Lahey, that further surgery was not indicated. In an office note of June 22,1998, he wrote, "I do not see that there are any further invasive intervention treatments." *(Id.* at 16.) On June 22nd, he referred claimant to St. Patrick Hospital Center for Behavioral Medicine in Missoula.

¶20 Dr. Martin D. Cheatle, a psychologist who is the director of the Center for Behavioral Medicine, evaluated claimant in August and September 1998. (Ex. 9.) He also referred claimant for further evaluation to Dr. Mack.

¶21 Dr. Mack examined claimant on September 24, 1998. Reviewing a 1997 postsurgery MRI scan, Dr. Mack said:

> He has a residual or a frank recurrent right-sided 5-S 1 disc herniation which is completely evident on a 1997 MRI scan after the lumber surgical procedure.

(Lahey Dep. Ex. 2 at 1.) Dr. Mack also noted that some of claimant's low-back pain was "mechanical" in nature and not due to a herniated disk. *(Id.)* His impression was "[r]esidual right 5-S1 disc herniation with probable mechanical back pain." *(Id.* at 2.) Dr. Mack recommended a bone scan to determine the need for further surgery. (Id.)

¶22 On October 22,1998, following a bone scan, Dr. Mack recommended that claimant undergo a microdiscectomy at the L5-S1 level. *(Id.* Ex. 3.) Dr. Mack's office note reflects his opinion that to a 90% probability the surgery will relieve claimant's leg pain but is unlikely to relieve his low-back pain. (*Id.*)

¶23 Notwithstanding Dr. Mack's recommendation, both Drs. Weinert and Lahey still recommend against surgery.

¶24 Dr. Weinert testified that the surgery proposed by Dr. Mack does not promise "substantial benefit given the medical evidence that we have." (Weinert Dep. at 35.) He elaborated, as follows:

> Q. What would be the benefit of doing the surgery suggested by Dr. Mack?
>
> A. I think there's a limited expectation for benefit in Mr. Harned's case for a microdiskectomy, the reasons for which - The reasons are exactly as Dr. Mack has stated, although I come to a different conclusion than Dr. Mack. Number one, as Dr. Mack notes and as is my opinion, I do not, I would not anticipate that a procedure as suggested would relieve Mr. Harned's back pain. So both he and I and multiple other

> physicians who have seen Mr. Harned would conclude that that would not be an appropriate indication for surgery.
>
> Number two, Mr. Harned has had extremely variable and inconsistent lower-extremity symptoms, sometimes experienced on the left, sometimes on the right, flip-flopping back and forth. A microdiscectomy, again, on the right side would not be expected to relieve his left-leg pain, which actually seems to be more consistent recently than the right-sided pain, or at least as consistent. Therefore, one would not expect that this procedure would provide Mr. Harned with substantial benefit given the medical evidence that we have.

(Weinert Dep. at 35-36.) Dr. Weinert further commented on the inconsistency of claimant's complaints:

> Well, I don't feel that that's my opinion. I think he's employable in the light physical demand classification, as already stated; and, you know, one thing that's very clear throughout the multiple notes and documentation here is Mr. Harned's symptoms appear to be very inconsistent. They flip-flop from side to side, the severity changes, his range of motion changes, and so I'm having a great deal of difficulty putting too much credence on any one particular note because its pertinence several days later may be very lacking.

(Id. at 49.)

¶25 Dr. Lahey testified that given the facts of a failed first surgery, claimant's global complaints, and smoking, claimant is a poor candidate for a second surgery and he WO not operate on him. (Lahey Dep. at 13-15.) Dr. Lahey also noted claimant complained of left-sided numbness whereas his disk herniation was on the right side. *(Id*. at 11.)

¶26 In late 1997, as Dr. Lahey had predicted (1l18), claimant sought a further opinion regarding a possible second surgery from another orthopedic surgeon. He saw Dr. Thomas J. Mango, who practices in Utah, on November 11, 1997. (Ex. 15.) At that time, Dr. Mango also counseled against surgery, finding no hard evidence of a recurrent disk herniation. *(Id*. at 2.) He recommended epidural injections. *(Id.)* As a last resort, he suggested consideration of "the possibility of further decompression and perhaps a fusion. " (Id.)

¶27 At the commencement of trial, I indicated that I found Dr. Mack's recommendation of a further microdiscectomy reasonable and would require the State Fund to pay for the surgery if Dr. Mack was made aware of the contrary opinions of Drs. Lahey and Weinert and stuck by his recommendation. In finding Dr. Mack's recommendation the persuasive, I was influenced by a number of factors, as follows:

- Dr. Mack's examination and evaluation of claimant's condition was the latest evaluation by a surgeon, occurring a year or more after the evaluations by Drs. Lahey

and Mango. Moreover, Dr. Mack's evaluation followed an "acute exacerbation of [claimant's] low back and lower extremity pain" on August 16, 1998, after claimant sneezed. (Ex. 10 at 18.)

- Claimant's pain may be multifactoral. While surgery may not relieve all of his pain, Dr. Mack's surgery was directed at relieving only leg pain. The fact that the surgery will only partially relieve claimant's pain is not a reason to reject it.
- Claimant has not worked since his accident and claims that his pain is too severe for him to hold regular employment. While the medical records suggest the possibility of a significant psychogenic basis for his pain, and even a lack of motivation to work (see Dr. Cheatle's comments, ex. 9 at 5, 7), neither the State Fund nor any of the doctors who have examined the claimant have accused him of deliberate malingering. Moreover, there are physical abnormalities which may explain at least some of his pain. Whether claimant's reduced level of function is real or merely perceived, the threshold for risking surgery is reduced, i.e., a 50°/0 prospect of success may be reasonable if success will increase his functioning and return him to work, whereas that prospect may not be reasonable if he were employed and reasonably functioning.
- Even Dr. Lahey's testimony indicates that a second surgery for disk herniation has a 50°/0 chance of success despite a failed first surgery.

(Lahey Dep. at 14.)

- Dr. Lahey acknowledged that Dr. Mack is a respected neurosurgeon. (Lahey Dep. at 19.) He also acknowledged that he and Dr. Mack may reasonably differ in their recommendations and that there is no way (short of surgery) to determine which of their recommendations is correct. Stated simply, the evidence shows that reasonable physicians, including surgeons, can disagree on the need for surgery. That one physician recommends surgery while others do not does not make the surgical recommendation medically unreasonable. The fact that Dr. Lahey would not perform the surgery is not conclusive as to whether the surgery recommended by Dr. Mack is reasonable.
- Dr. Mack's evaluation of claimant was part of an independent medical evaluation of claimant's pain. Claimant was referred to him as a part of a pain clinic evaluation.
- More conservative treatments have not been successful.

¶28 Nonetheless, as noted earlier, I was reluctant to authorize the surgery unless Dr. Mack was aware of the contrary opinions of Drs. Lahey and Weinert and still recommended surgery. Dr. Mack's office note of January 11, 1999, which was subsequently submitted to the Court and which has been marked and admitted as Exhibit 18, shows that Dr. Mack is

fully aware of contrary opinions and nonetheless continues to recommend a second surgery. His office note reads, in full:

> 1-11-99 PHONE CALL: I am [in] receipt of a letter from Dr. Weinert who aptly suggested that a repeat microdiscectomy is not likely to resolve Mr. Harned's back pain. I agree with this completely. He clearly has radicular pain. He clearly has residual or recurrent disc herniation on the right-hand side at L-5S1. I have advised him that he undergo a microdiscectomy to resolve the leg pain. However, he has a significant amount of back pain. To that end, I suggested that the patient have facet blocks after a bone scan. His bone scan was negative which is commonly the case, but does not preclude the necessity to proceed with facet blocks. If the fact [sic] block is injected into the 5-S1 facet joint and it substantially improves symptoms of his back pain, though I do not expect it to resolve the leg pain, then he would be a candidate for a repeat microdiscectomy and a lumbar threaded bone dowel fusion which I expect would have a 70% chance of resolving his back pain. The microdiscectomy and the decompression, which would be thorough, would resolve his leg pain with 90% likelihood despite being repeat surgery.
>
> Mr. Harned tells me that he has been to the ER several times and each time he gets injections. He has had multiple epidural steroid injections which I do not believe have the capacity of making him better at this point in time and do not have the capacity of making degenerative disc disease better. That is why I suggested that after a bone scan he be set up with facet injections. I think that we still need to proceed with those as he is quite uncomfortable and certainly is getting nowhere with frequent trips to the ER.
>
> To that end, I have taken the liberty of scheduling him for a facet injection.

(Ex. 18. at 2.)

¶29 In light of Dr. Mack's note, I find that his recommendation for a second microdiscectomy with decompression is reasonable primary medical services. I note that Dr. Mack is also considering a "lumbar threaded bone dowel fusion" to address claimant's back pain. *(Id.)* This recommendation was not on the table at the time of trial and I make no determination as to whether or such a procedure is a reasonable one for which the State Fund should pay.

¶30 My finding that the State Fund should pay for the microdiscectomy recommended by Dr. Mack is made pursuant to the medical services statutes in effect at the time of claimant's industrial accident. Those statutes require further explication.

¶31 Medical benefits are governed by section 39-71-704(1)(a), MCA (1995), which provides:

> (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:
>
> (a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

Primary care is defined in section 39-71-116(25), MCA (1995):

> (25) "Primary medical services" means treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability.

Medical stability, in turn, is defined in section 39-71 -116(17), MCA (1995):

> (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.

The definitional language in subsections (25) and (17) is circular, but the intent is plain: if the medical services will materially improve claimant's condition, then they are primary medical services for which the insurer must pay. And, if the services will improve claimant's condition, he has not reached maximum medical improvement (MMI).

¶32 On its face, the language of section 39-71-704(1)(a), MCA, raises an additional issue not addressed by either of the parties. To wit, whether Dr. Weinert's opposition to the proposed surgery is fatal to the request. Section 39-71-704, MCA, as quoted above, is specific in defining primary treatment as treatment prescribed by a "treating physician." In this case, Dr. Weinert is, and for some time has been, claimant's treating physician. If his approval is required for surgery, and the Court cannot look to Dr. Mack's recommendation, then the Court's hands are tied and it must deny the petition.

¶33 However, the section in question cannot be read in isolation from other medical provisions of the Workers' Compensation Act, or the facts. As shown by the medical records in this case, Dr. Weinert is a member physician of a managed care organization (MCO) with which the State Fund has contracted to provide medical care to claimants under its insurance policies, see § 39-71-1103, MCA (1995) (authorizing insurers to contract with MCO's to provide medical services to injured workers). The MCO provisions expresslycontemplated the possibility that a treating physician will need to refer a claimant to a specialist for further consultation or treatment. Section, 39-71-1101, MCA (1995), expressly provides that a claimant must select an MCO physician as his or her treating physician whenever referral to a specialist is necessary, providing in relevant part:

> **39-71-1101. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) **Subject to subsection (3),** a worker may choose the initial treating physician within the state of Montana.
>
> (3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:
>
> (c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(Emphasis added.) In this case, Dr. Weinert found it prudent to refer claimant to the Missoula pain clinic for further evaluation and treatment. Dr. Mack provided part of that evaluation and proposed treatment, thus becoming an extension of the treating physician. Reasonably construed, the medical care provisions allow for consideration of medical recommendations by specialists, such as Dr. Mack, who evaluate claimant at the request of a treating physician. Indeed, Dr. Weinert was not claimant's initial treating physician; he assumed that role after Dr. Iverson's surgery on claimant and upon referral from Dr. Iverson. Moreover, if the medical services provisions are interpreted as giving the treating physician, who is part of an MCO, with which an insurer contracts unreviewable and absolute discretion to determine appropriate care, serious constitutional issues may arise.

See Leastman v. Liberty Mutual Fire Ins. Co., 1999 MTWCC 2 at 17-18 (applying *Ingraham v. Champion International,* 243 Mont. 42, 793 P.2d 764 (1990)).

¶34 In light of my finding that claimant is entitled to additional surgery, I *also* find that claimant has not reached MMI since the surgery has a reasonable prospect of materially improving his condition. He is therefore entitled to TTD benefits retroactive to their cut off. I leave it to the parties to determine the amount due, which may be offset for the time-being by any permanent partial disability payments. The Court retains continuing jurisdiction to determine the amount in the event the parties are unable to agree.

¶35 Finally, l find that claimant is not entitled to attorney fees or a penalty since the State Fund did not act unreasonably in refusing to approve the surgery recommended by Dr. Mack and in terminating temporary total disability benefits. The reasonableness of Dr. Mack's proposed surgery is reasonably debatable. The State Fund reasonably relied on opinions opposing further surgery. The opinions were by qualified physicians. Indeed, if the Court were required to abide by the majority opinion, it would have to reject claimant's petition.

JUDGMENT

¶ 36 1. Pursuant to section 39-71-2905, MCA, the Court has jurisdiction over this matter.

¶37 2. The microdiscectomy proposed by Dr. Mack is reasonable primary medical treatment and the State Fund shall pay for it.

¶38 3. The "lumbar threaded bone dowel fusion" mentioned by Dr. Mack in his January 11, 1999 office note is not at issue in the present case. The Court makes no determination as to the reasonableness of that procedure or the State Fund's potential liability for it. However, since such surgery might be done in conjunction with the microdisectomy, if a dispute arises concerning the procedure the parties may further petition the Court under the auspices of the present action and the matter will be heard on an emergency basis so as not to further delay surgery.

¶39 4. Provided the claimant elects to undergo the microdiscectomy, the State Fund shall pay TTD benefits retroactive to the date those benefits were cut off. The Court retains continuing jurisdiction to determine claimant's entitlement to TTD benefits should he refuse or unreasonably delay the surgery.

¶40 5. The claimant is entitled to his costs in this action.

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

¶42. 7. Any party to this dispute may have 20 days in which to request a rehearing from this Decision And Judgment.

DATED in Helena, Montana, this 8th day of June, 1999.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. Bernard J. Everett
Mr. David A. Hawkins
Date Submitted: April 30, 1999