IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2001 MTWCC 43

WCC No. 2000-0130

ALEXIS MUNROE

Petitioner

vs.

MONTANA ELECTRIC & TELEPHONE POOL

Respondent/Insurer for

SUN RIVER ELECTRIC CO-OP, INCORPORATED

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Case Summary: Claimant with degenerative spine problems and nearly twenty-year history of pain problems, eventually including her back, legs, and neck, brought petition seeking authorization for cervical, thoracic, and lumbar spine surgery which she alleges is related to a May 1997 industrial accident. She also seeks temporary total disability benefits. The insurer denied liability for the surgery and the spinal conditions, as well as for TTD benefits.

Held: Only one physician weakly attributed claimant's present situation to the May 1997 industrial accident and his testimony was not persuasive when opposed by four other physicians, including two who had treated claimant for much longer, and three who had similar surgical expertise. Together with claimant's medical history, the opinions of the other four physicians establish that the only condition related to the 1997 incident is claimant's shoulder condition, which reached MMI on October 20, 1999. She suffered no wage loss prior to reaching MMI and is therefore not entitled to temporary total disability benefits and is not entitled to medical benefits for the unrelated spinal conditions.

Topics:

> **Benefits: Medical Benefits: Surgery.** Claimant is not entitled to medical benefits for surgery for conditions which are unrelated to her industrial accident.
>
> **Evidence: Expert Testimony: Physicians.** Where one physician recommended surgery at three levels of claimant's spine and weakly opined that the surgery was

related to a work accident, his opinions are unpersuasive. He failed to review and consider claimant's extensive medical records and history. The claimant's statements to him regarding her history of pain were inaccurate in important respects and his opinions were contradicted by four other physicians, including two who had treated claimant for a longer period of time and three who had similar surgical experience.

Injury and Accident: Causation. Court will not order insurer to pay for proposed surgery on three levels of claimant's spine that is not related to a 1997 industrial accident.

Causation: Medical Condition. Court will not find current spinal condition was caused by an industrial accident where claimant's medical history, which demonstrates that claimant has long history of chronic pain problems and a long history of degenerative spine problems, and persuasive medical testimony shows that her spinal problems are not related to her industrial accident.

Physicians: Conflicting Evidence. Where physician recommended surgery at three levels of claimant's spine and opined the surgery was related to a relatively minor 1997 industrial accident, his opinions are unpersuasive. He failed to review and consider claimant's extensive medical records and history. The claimant's statements to him regarding her history of pain were inaccurate in important respects and his opinions were contradicted by four other physicians, including two who had treated claimant for a longer period of time and three who had similar surgical experience.

Proof: Conflicting Evidence: Medical. Where physician recommended surgery at three levels of claimant's spine and opined the surgery was related to a relatively minor 1997 industrial accident, his opinions are unpersuasive. He failed to review and consider claimant's extensive medical records and history. The claimant's statements to him regarding her history of pain were inaccurate in important respects and his opinions were contradicted by four other physicians, including two who had treated claimant for a longer period of time and three who had similar surgical experience.

Witnesses: Credibility. Detailed review of claimant's medical history demonstrates that claimant was not a reliable historian, hence the Court finds the medical records more persuasive as to the onset of claimant's complaints than her testimony.

¶1 The trial in this matter was held on March 27, 2001, in Great Falls, Montana. Petitioner, Alexis Munroe (claimant), was present and represented by Mr. William O. Bronson.

Respondent, Montana Electric & Telephone Pool, was represented by Mr. Michael P. Heringer and Ms. Lisa A. Speare. A trial transcript has not been prepared.

¶2 Exhibits: Exhibits 1 through 15 were admitted without objection.

¶3 Witnesses and Depositions: Claimant and Vonda Fifield testified at trial. The parties submitted the depositions of claimant and Drs. Nicholas Bonfilio, Ronald Peterson, Stuart Goodman, Lee Finney, and Paul Gorsuch for the Court's consideration.

¶4 Issues Presented: The issues stated in the Pre-Trial Order are as follows:

> 1. Whether the Petitioner's current medical problems, including, but not limited to, pain and discomfort in her thoracic and low back and neck, were caused by the May 16, 1997 injury?
>
> 2. Whether the medical treatment requested by Petitioner, including surgery of her cervical, thoracic and low back, is related to the May 16, 1997 injury?
>
> 3. Whether the Respondent/Insurer is liable for payment of medical expenses associated with the problems identified in Issue No. 1 above?
>
> 4. Whether the Petitioner is temporarily totally disabled as result of the medical conditions described in Issue No. 1 above, and if so, whether she is entitled to temporary total disability benefits?
>
> 5. Whether the conduct of the Respondent/Insurer in this matter has been unreasonable, thus entitling Petitioner to a penalty on any benefits awarded, as well as attorney's fees and costs?

¶5 Having considered the Pre-Trial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the depositions, and exhibits, the Court makes the following:

FINDINGS OF FACT

¶6 Claimant is 48 years old. Over the years, she has worked as a secretary, gas station attendant, bartender, waitress, in construction, for a floral shop, and as a meter reader. (Ex. 9 at 1.) She has also helped her husband in his yard business as recently as the spring of 2000. (Munroe Dep. at 5.) Claimant began working as a rural meter reader for Sun River Electric Cooperative, Incorporated (Sun River) in 1987 and continued working at that job for over 12 years. The work was part time, involving two to three days work per month. (Ex. 12; Munroe Dep. at 33.) This matter arises from a fall claimant had on May 16, 1997, while working as a meter reader with Sun River.

Medical History - Background

¶7 Prior to her 1997 industrial accident, claimant had an extensive and long history of back, leg, and neck pain. Her history provides background to her current complaints and the medical opinions rendered in this case. I therefore will summarize it before turning to the 1997 accident.

¶8 Claimant suffered a left ankle injury on August 2, 1982 and thereafter underwent tarsal tunnel surgery in 1983. (Ex. 5-H at 12.) Nonetheless she continued to report leg pain into and including 1986. (Exs. 5-I and 5-J.) In 1985 one physician - Dr. Dennis W. Dietrich, a neurologist - commented that he was "unable to find a clear etiology for the patient's left leg pain" and that "sensory disturbance does not correspond to the normal anatomic distribution for any roots or peripheral nerves." (Ex. 5-I at 2.) He went on to say that "[t]he sharp upper border suggests that the sensory changes are non-organic" and characterized claimant as suffering from "chronic pain syndrome." (*Id*.)

¶9 By June of 1986 claimant's pain complaints were up her entire left leg and into her buttocks. (Ex. 5-G at 87.) A lumbar MRI was done at the direction of Dr. John Hilleboe, an orthopedic surgeon in Kalispell, and disclosed "what appears to be a degenerated disc with some herniation into the foramine of the L4-5 level on the left side, the side she has the symptoms on and at this time, I think the diagnosis is one of speculation, rather than certainty as to whether or not this is causing her problems . . . ." (*Id*. at 87.)

¶10 Over the next two and three quarter years, claimant was seen by numerous physicians for low-back and leg pain. She saw Dr. Henry Gary, a neurosurgeon (Ex. 5-G at 83); Dr. James A. Meyer (*Id*. at 7-8, 10-11); Dr. Gary Cooney, a Missoula neurologist (Ex. 5-P at 1); Dr. James Seeley, an orthopedic surgeon in Seattle (Ex. 5-G at 76-77, 106); Dr. Alexander C. Johnson, a Great Falls neurosurgeon (*Id*. at 72-74, 91); Dr. John Avery; Dr. James Hilleboe; and Dr. John M. Grollmus, a Spokane neurosurgeon. Numerous imaging studies were done during that time. The studies revealed mildly bulging lumbar disks at three levels but electrodiagnositic studies were negative and until March 1989, the physicians found insufficient objective evidence to do surgery. In some instances, the physicians noted that claimant's complaints did not correlate with her objective findings:

- Dr. Seeley, who examined claimant on July 20, 1987, noted that while claimant had "mildly bulging disks" in the lumbar spine, he could "certainly find no objective evidence of significant disease" or a basis for surgery; he recommended a pain clinic. (*Id*. at 76.)

- Dr. Johnson, who examined claimant on July 29, 1987, observed that claimant's symptoms did not match expected pain distributions and that she seemed to be limiting her movements. He diagnosed "atypical low back and predominantly left leg pain as described." (*Id*. at 74.) Although Dr. Johnson considered an L-5 segmental pain pattern given claimant's history, he found her "multiplicity of symptoms . . . do not correlate well with this" and noted "a rather marked lack of clear cut objective

findings, either on manipulative tests or neurologic evaluation, including some findings suggesting significant non-organic overlay, particularly with reference to sensory alteration up into thoracic segments." (*Id.*)

¶11 In October 1988, claimant reported neck pain. Cervical x-rays disclosed some calcification of the anterior anulus ligament consistent with degenerative changes. (Ex. 5-B at 190.)

¶12 In February 1989, claimant was hospitalized for 16 days on account of low-back and leg pain.

¶13 Claimant then went to see Dr. Grollmus in Spokane. Additional MRI studies were done at his direction on March 10, 1989. The studies were read as within normal limits for the thoracic and upper lumbar spine. Dessication and some bulging were noted at the L4-5, L5-S1 levels, which the radiologist viewed as consistent with earlier studies. (Ex. 5-G at 69.) However, Dr. Grollmus felt that the "small disc herniation at L4-5 level . . . would be amenable to an automated percutaneous lumbar discectomy." (Ex. 5-G at 68; Ex. 5-T at 4.) He performed the recommended surgery seven days later. (Ex. 5-N at 6; Ex. 5-T at 3.) Dr. Meyer provided post-surgical care and concluded in September 1989 that claimant's condition had improved considerably but she still had "some residual dysfunction." (Ex. 5-G at 114.)

¶14 On November 14, 1991, claimant fell while reading meters for Sun River. Following the fall, she complained of both right and left leg pain, tail bone pain, back pain up to the lower level of her scapulae, and occasional neck pain. (Ex. 5-G at 4.) Lumbar x-rays taken on November 20, 1991, and a lumbar MRI done December 19, 1999, disclosed early osteoarthritic changes, degenerative disk disease, and an "annular fullness to the L4-5 intervertebral disc" which did not appear to cause impingement. (*Id.* at 22.)

¶15 Thereafter, claimant continued to experience back and leg pain, along with occasional neck pain. She treated with Dr. Meyer during 1992, complaining of low-back, hip and leg pain. (*Id.* at 3, 6.) In November 1992, Dr. Meyer referred her to Dr. Bradley D. Root, a physiatrist, who thereafter treated her for most of 1993. Dr. Root diagnosed piriformis[(1)] syndrome. (*Id.* at 54.) On August 30, 1993, following claimant's report of extreme back pain, Dr. Root suspected claimant had a L5-S1 radiculopathy and referred her to Dr. Dale Shaeffer, a Great Falls neurosurgeon. Dr. Shaeffer examined claimant on October 11, 1993, and reviewed claimant's MRI. His examination revealed no significant objective findings and he read the most recent MRI as unchanged from prior studies, showing only "fairly mild degenerative changes in the L4/5 and L5/S1 discs with very minimal bulging of the anulus." (Ex. 5-R at 2.) He concluded: "I do not think that this is a surgical lesion even though she is quite insistent that surgery will help her." (*Id.*)

¶16 Claimant then treated with Dr. James D. Hinde, another physiatrist, beginning May 24, 1994, and concluding in March 1995. (Exs. 5-G at 43 and 5-S.) He treated her for low back, buttock, and leg pain. On July 7, 1994, claimant fell from a truck, fracturing her elbow and hurting her wrist . (Ex. 5-B at 50-51.) Claimant told Dr. Hinde that her fall was caused by her left leg giving way and was therefore attributable to her 1991 injury. (Ex. 5-G at 40.) Dr. Hinde was skeptical of her claim (*Id*. at 39) but because of her complaints and prior history ordered another MRI. (*Id*. at 41.) Both the radiologist and Dr. Hinde observed no significant change from her 1991 MRI; Dr Hinde found no basis for surgery. (*Id*. at 39.) On March 30, 1995, Dr. Hinde placed claimant at maximum medical improvement (MMI) .

¶17 During his treatment of claimant, Dr. Hinde noted at times that claimant's pain reports were out of proportion to physical findings. On May 24, 1994, he commented that claimant was in "no acute distress," noting, "[s]he has a lot of verbal pain behaviors but not a lot of withdrawal or inhibition of effort." (*Id*. at 43.) On January 11, 1995, following an essentially normal exam, Dr. Hinde commented, "She has a significant response to even light touch over the lumbar paraspinous muscles and gluteal muscles on the left. With distraction this improves." (*Id*. at 38.)

¶18 After Dr. Hinde's March 1995 MMI determination, there was a hiatus in treatment until March 8, 1996, when claimant obtained a prescription from Dr. Patsy M. Vargo, a family practitioner in Great Falls, for chiropractic treatments of her neck. While the parties list Dr. Vargo's records in their index to the exhibit book (they should be exhibit 5-Q[(2)]), the exhibit book does not in fact contain her records, however, the records of Dr. Richard J. Murack, a chiropractor, contain a copy of a March 8, 1996 prescription from Dr. Vargo for chiropractic treatment of claimant's upper neck. (Ex. 5-F at 19.) Dr. Murack's office notes also reflect a phone call to Dr. Vargo on March 8th to obtain permission to treat claimant's low back; permission was given. (*Id*. at 21.) In a followup letter to Dr. Vargo, Dr. Murack stated that claimant "presented . . . on March 8, complaining of Low Back Pain with left SI and left posterior leg pain, also Cervical pain and Headache." (*Id*. at 18, caps in original.) Dr. Murack provided 19 treatments through the end of May (*id*. at 9-21), and in early June 1996, reported that claimant's neck pain and headache were better but that she continued to have good and bad days with respect to leg and low-back pain. (*Id*. at 8.)

¶19 At deposition, claimant testified that she "quit doctoring" in late 1996 and early 1997. She quit near the time she was treating with Dr. Vargo and testified she "got no relief from the doctor, and I got into a problem with all the prescribed medications, and I quit. I quit [the] doctors, I quit everything." (Munroe Dep. at 73.)

¶20 In November 1996, claimant experienced upper right quadrant abdominal pain. (Ex. 5-C at 1.) An x-ray disclosed a "questionable undisplaced fracture of the seventh rib on the left in its anterior aspect laterally." (Ex. 5-B at 42, caps in original.) Dr. Newbrough, who treated her in connection with the abdominal pain, found no connection between

claimant's reports of pain and the rib fracture (Ex. 5-C at 2), rather the cause was a hemangioma for the right lobe of the liver. (Exs. 5-Q at 4 and 5-C at 2.) A December 9, 1996 office note of Dr. Newbrough also indicates claimant was also experiencing right back pain at that time. (Ex. 5-C at 3.)

¶21 Claimant's hemangioma was treated by withdrawing the hormonal treatment she had been receiving post-menopausally. (Exs. 5-Q at 4 and 5-C at 2.) However, withdrawal of the hormonal treatment resulted in uterine bleeding, which in turn was treated by surgical hysterectomy on January 22, 1997. (Ex. 5-C at 5.) These facts are mentioned here because claimant testified that following her hysterectomy her back pain disappeared, which might suggest that her back pain in late 1996 and early 1997 was attributable to either her hemangioma and/or her uterine bleeding. Contrary to her testimony, however, Dr. Newbrough's medical records show that on March 4, 1997, claimant sought care for "leg cramps, right sided abdominal pain and low back pain." (*Id.* at 7.)

May 16, 1997 Injury

¶22 On May 16, 1997, claimant fell while reading meters for Sun River; her pant leg became caught on a barbed wire fence she was climbing over. (Ex. 1 at 1.) She continued reading meters and completed her work for that day.

¶23 At the time of her fall, Sun River was insured by the Montana Electric and Telephone Pool (Pool). The Pool accepted liability for the injury.

¶24 Claimant first sought medical care on May 22, 1997, from her family physician, Dr. Newbrough. Claimant told Dr. Newbrough that she had "landed on her right shoulder and right chest." (Ex. 5-C at 7.) She complained of "pain to her right chest, pain to her right shoulder and pain to her neck and numbness down her right arm." X-rays taken at that time showed moderate spondylosis[3] or arthritis (*id.* at 7-8, 48), but were otherwise unremarkable. (*Id.*) In his physical examination of claimant, Dr. Newbrough noted tenderness in the right paraspinous cervical region and over the deltoid muscle, along with "subjective parenthesis and numbness along the right arm and forearm." However, claimant had good range of movement of her neck and shoulder. (*Id.*) His assessment was:

1. Cervical strain.

2. Old cervical arthritis.

3. Right shoulder pain, rule out rotator cuff injury.

4. With subjective numbness of the right arm consider bruise of brachial plexus.

(*Id.*, caps in original.) Dr. Newbrough treated claimant with analgesic and muscle relaxant medications and recommended the use of heat and rest. (Ex. 5-C at 8.)

¶25 At trial claimant testified that Dr. Newbrough told her she had broken ribs. Neither x-rays nor Dr. Newbrough's medical records support her claim of broken ribs.

¶26 On June 3, 1997, Dr. Newbrough referred claimant to Dr. Nicholas D. Bonfilio, an orthopedic surgeon who had previously treated claimant. (*Id*.) Dr. Bonfilio examined claimant on June 30, 1997. (Ex. 5-J at 9; Bonfilio Dep. at 5.) She told Dr. Bonfilio that following her fall she experienced "significant pain in the right paracervical region, right shoulder, while the right arm and forearm was affected by pain and dysesthesias." (Ex. 5-J at 9.) Dr. Bonfilio did not record any complaints by claimant concerning her ribs, hip, or leg. (Bonfilio Dep. at 5.) He testified that had she had such complaints, he would have recorded them. (*Id*. at 6.)

¶27 During physical examination of claimant, Dr. Bonfilio found moderate spasm in the paraspinous muscle of the cervical spine. (Ex. 5-J at 9.) He noted "some anterior osteophytes" on the cervical x-rays which had previously been taken but saw "no significant disc space narrowing noted. No significant foraminal changes." (*Id*.) He testified it was "difficult to truly pinpoint exactly what was going on." (Bonfilio Dep. at 6.) His assessment at the time was of a possible herniated cervical disk and mild rotator cuff tendinitis. (*Id*.; Ex. 2-J at 9.) He prescribed conservative treatment consisting of physical therapy and home exercise. (Bonfilio Dep. at 7.)

¶28 Of significance to later discussion in this decision, on June 30, 1997, claimant told Dr. Bonfilio that "most all medication is either intolerable or just does not work." (Ex. 2-J at 9.)

¶29 Claimant's trial of physical therapy failed. After two days she reported that her neck was worse and demanded an "MRI <u>now</u>." (Ex. 5-B at 29, emphasis in original.) She terminated physical therapy and went to see Dr. Paul L. Gorsuch, a neurosurgeon, about her neck.

¶30 Dr. Gorsuch examined claimant on July 23, 1997. He took the following history:

> This is a 44 year old female who was injured May 16 on the job. In her capacity as a meter reader she was climbing over a fence and caught her pants on the barbed wire and fell. She states she can't remember the impact but she landed on her right side. She had immediate, severe right shoulder pain as well as pain on the whole right side; that includes her head, shoulder, arm and leg. She's now begun to get left leg pain for the last 2 weeks. She feels it's getting worse. She feels like she has a broken shoulder. Her right hip is giving out. She states she's losing feeling in her arm, hand <u>and</u> leg.

(Ex. 5-A at 12; emphasis added.) This was the first time claimant reported leg pain following her May 16th fall. By this time, over two months had elapsed.

¶31 Dr. Gorsuch examined claimant's shoulder and neck. He found limited range of motion in the cervical spine and shoulder, as well as pain upon examination. Following the examination, Dr. Gorsuch recommended new cervical, lumbar and right shoulder MRIs and a "4 extremity EMG." (*Id*. at 14.)

¶32 He then had what he characterized as "a very unusual conversation" with the claimant. (*Id*. at 15.)

> After I went to talk to her after the exam at the conclusion to discuss the plan, we had a very unusual conversation.
>
> I initially told her I thought this could be a combination of cervical disc, shoulder injury, myofascial syndrome or some combination. She then stopped me to tell me about her right hip, buttock and leg pain getting worse all the time; about how she could hardly sit or stand immediately after the accident. It was at that point that I decided we add the lumbar MRI to her evaluation.
>
> We then started to talk about medication trials. I told her that I thought she should probably try a muscle relaxer to start with. She was immediately a little defensive wanting to know which one stating that Dr. Newbrough had her on Norflex and it wasn't helping. I told her Flexeril. At that point she told me she could not tolerate that due to side effects. I asked her why she hadn't told us that she'd been on Norflex and couldn't tolerate Flexeril when we'd asked her about her allergies and other medications that she was on. She then told me that she was also on Relafen and that wasn't helping. I then talked about anti-depressants and Paxil and she said, "Oh, I've been on Paxil and I can't take that. It causes a headache". I asked her why she hadn't told us about that one either and she states, "Well, she'd been on Wellbrough, Ultram, Valium", all of which she couldn't tolerate. I asked her why she hadn't told us about any of these medications that she'd been on and that she couldn't tolerate and she says, "Well, she didn't think it was related" and that she'd been on those for her back pain and she didn't think this was like her back pain. I asked her why and she said, "Well, because her back doesn't hurt". I asked her what she means by "her back doesn't hurt" when she'd just told me that her buttock and leg and back hurt her so much that she could hardly sit or stand and that she'd talked to Dr. Newbrough about it. She stated, "Well, it didn't hurt like it did with my previous back surgery". I asked her what she meant by that as she'd told me about her previous back surgery and that the pain had been located in the left leg, the whole left leg and the buttock and I'd asked her three times where the pain was prior to that surgery. She states, "Well, it just didn't seem the same" and she didn't think it was connected.
>
> She then told me that many of these medications have been tried by Dr. Vargo. I then asked her why she didn't tell me that she'd been seeing Dr. Vargo and she told me,

> "Well, I didn't see her for this problem. I saw Dr. Newbrough for this problem". I asked her why she hadn't told me that she'd seen Dr. Vargo in the past when I specifically asked her who she'd doctored with in the past and she stated she just didn't think it was important.
>
> I told her that I felt that we should go ahead with the studies, that I would be happy to look for a surgical problem in her but I did not think I would be able to manage her problems if there was not a surgical issue. I told her that she wondered why if there wasn't some medication that could be used. [sic] I then told her that she just described to me how she was not a pill taker, that she hated pills and that she'd gone through a whole list of medications that she couldn't tolerate. She cannot tolerate physical therapy, she does not want aerobic exercise. I told her she'd eliminated all of the options open to me except surgery and that I had no magic wand. She replied that of course, she understood that.
>
> We finally settled that we'd get the tests and she'd return after those tests and I'd go over them with her.

(*Id.* at 15.) As Dr. Gorsuch's note reflects, claimant initially failed to disclose information requested about her medical history. She also portrayed herself as unable to tolerate a multitude of medications or physical therapy, and she rejected aerobic exercise. Dr. Gorsuch was concerned that she had a chronic pain problem.

¶33 MRIs of the right shoulder and the cervical and lumbar spine, as well as nerve conduction studies, were done on July 28, 1997. The MRI of the shoulder showed a small amount of fluid within the subacromial bursa, possibly indicating bursitis, and a "[s]mall fluid collection along the biceps tendon which could represent a synovial cyst," but no rotator cuff tear. (Ex. 5-A at 4.) The MRI of the lumbar area was negative for disk herniation, spinal stenosis, and nerve root compression but did disclose degenerative changes "consistent with degenerative disc disease involving the L4-5 and L5-S1 without a significant change compared to 1/2/96."[(4)] (*Id.* at 1.) The MRI of the *cervical spine* was reported as follows:

> Mild degenerative disc disease, particularly at C5-6. Small posteriorly protruding osteophyte at C5-6 in the left parasagittal location with slight compression of the left anterior aspect of the cal sac and spinal cord. Exam is otherwise unremarkable.

(*Id.* at 2, 17.) Nerve conduction studies were normal. (*Id.* at 10-11.)

¶34 Following the imaging and nerve conduction studies, Dr. Gorsuch concluded that surgery was unwarranted. (*Id.* at 17.) He noted that the cervical compression was on the left side, whereas her complaints were on the right side, thus indicating that the compression was not causing her complaints. (*Id.*)

¶35 Claimant then returned to treat with Dr. Bonfilio. He saw her on September 12, 1997, at which time she complained of "aching discomfort in the neck and low back as well as radiating pain into the right upper extremity and both lower extremities." (Ex. 5-J at 7.) She did not complain about her chest, ribs, or hip. Dr. Bonfilio prescribed an anti-inflammatory. (Bonfilio Dep. at 11.)

¶36 On November 5, 1997, claimant returned to Dr. Bonfilio, complaining of "diffuse problems about the neck, low back, right shoulder, right arm and both legs." (Ex. 5-J at 5.) She reported no significant improvement. The doctor referred her for chiropractic treatment because

> [w]ell, frankly, I was running out of options. Indications were, from Dr. Gorsuch, that there was not a surgical lesion to treat. The shoulder problem did not appear at that time to be, again, surgical or necessitate a surgical treatment. She was unable to tolerate the physical therapy. She couldn't take medication, and so I figured, well, maybe we'll try Dr. Murack and see if chiropractic intervention may make some difference.

(Bonfilio Dep. at 24.) The subsequent chiropractic treatments were no more successful than other treatments. Claimant reported no benefit and the chiropractor reported, "There is a possibility the patient is developing a chronic pain syndrome . . . ." (Ex. 5-F at 24.)

¶37 Meanwhile, claimant was also seeing Dr. Warren Liebers, an internist associated with Dr. Newbrough. On August 13, 1997, claimant requested that he prescribe "Miacalcin, nasal spray for her osteoporosis and compression fractures in her lower back." (Exs. 5-C at 9; 5-E at 4; Bonfilio Dep. at 17.) Claimant has never been diagnosed as suffering from either osteoporosis or compression fractures. (Bonfilio Dep. at 17-18, 21.) Her statement to Dr. Liebers is another instance of either a misunderstanding or exaggeration on her part.

¶38 Dr. Bonfilio saw claimant once more on January 21, 1998. She complained of increased right shoulder pain. (Ex. 5-J at 5.) Dr. Bonfilio did not record any lower back, leg, or hip pain complaints. (Bonfilio Dep. at 28.) Upon examination he found positive impingement signs of rotator cuff tendonitis. (*Id*.) He commented: "Not long ago, the shoulder itself was remarkably mobile and causing only minimal discomfort. It is interesting that with essentially no trauma that the shoulder has come to the forefront." (Ex. 5-J at 5.) He prescribed Voltaren, which has analgesic and anti-inflammatory properties, and told claimant to return in one month. (*Id*.)

¶39 Despite Dr. Bonfilio's instructions that she return for a follow up examination in one month, claimant did not seek treatment again with respect to her neck, shoulder, back, hip, or leg complaints for over one year.[(5)]

¶40 The next relevant medical record is dated February 26, 1999. Claimant returned to Dr. Newbrough and reported "chronic problem with her shoulder after falling off a fence." (Ex.

5-C at 14.) She told the doctor "she was sitting in a chair today and she heard a large, loud pop in the right shoulder and since then she had pain in the shoulder and can't raise the shoulder above 90 degrees." (*Id.*) On examination claimant reported tenderness and pain on moving her shoulder above 90 degrees. (*Id.* at 14.) Dr. Newbrough referred claimant to physical therapy. (*Id.*)

¶41 On March 1, 1999, physical therapist Vince Carlson (Carlson) began treating claimant, prescribing passive modalities of treatment and "active rest" of the arm. (Ex. 5- B at 13-14.) Two days later, Carlson noted that claimant "[r]eports continuing to use rt [right] UE [upper extremity] to lever the school bus door open & closed." (*Id.* at 14.) Carlson concluded claimant was "abusive to her body" and was not complying with her recommendation to rest the right arm. (*Id.*)

¶42 Another MRI of the shoulder was done March 17, 1999, and this time disclosed a possible partial rotator cuff tear. (Ex. 5-C at 40.)

¶43 Claimant then returned to Dr. Bonfilio. His examination on March 22, 1999, was "much more consistent with a true rotator cuff tendonitis" (Bonfilio Dep. at 34), and on March 29, 1999, he performed arthroscopic surgery. He found a partial tear and removed scar tissue and some bone. (*Id*. at 37-38.)

¶44 Claimant's post-surgery recovery presents a contradictory picture. Throughout April, she complained of severe pain and received Demoral injections and other pain medications. (Ex. 5-B at 8; Ex. 5-J at 12, 17.) On the other hand, an April 12, 1999 report of a physical therapist providing post-surgery therapy prescribed by Dr. Bonfilio indicated that claimant was doing outside activities inconsistent with her complaints:

> This 46 year old female was initially evaluated by P.T. on this treatment regime on 4/7/99 and followed by us for a total of 3 visits with a discharge date, last visit date, on 4/12/99. Diagnosis was S/P rotator cuff tear and repair on 3/29/99. The patient had significant complication during course of treatment in which she reported severe pain. Patient was reporting significant activity outside of therapy such as assisting with her husband's lawn business. Patient was referred back to Dr. Bonfilio and on 4/13/99 this office was phoned by the patient to inform us that physician ordered no physical therapy x 10 days at which time she was to be in the sling and she was then to contact the physician and followup with new orders at that time. No contact has been made with this patient formally, however, patient was seen in a social setting and noted to be doing well with shoulder rehab independently. Discharge at this time with last visit being 4/12/99 with goals not met.

(Ex. 5-B at 6.)

¶45 The physical therapy note raises a significant question as to claimant's truthfulness. The therapist reported claimant doing outside activities inconsistent with her statements.

(*See* previous paragraph.) Dr. Bonfilio denied prescribing a sling for claimant and noted that a sling would have been a "step backwards." (Bonfilio Dep. at 56.) He also denied ordering claimant to discontinue physical therapy. (*Id*.)

¶46 On June 16, 1999, Dr. Bonfilio found claimant "progressing very well." (Ex. 5-J at 11.) She had returned to "some limited work activities at the tree service company" and was "tolerating them reasonably well." (*Id*.) Physical exam showed her to have "essentially full, pain-free range of motion of the shoulder in all axes." (*Id*.) Strength is "full and symmetric." Dr. Bonfilio encouraged her to be careful with her activities and to gradually increase activities as tolerated. (*Id*.) He put her at "very close to maximum medical improvement." (Bonfilio Dep. at 50.)

¶47 Claimant returned to Dr. Bonfilio on August 11, 1999, reporting more activity and "increased discomfort about the shoulder and arm." (Ex. 5-J at 10.) She complained that "when she is 'stressed,' the arm will hurt from the base of the neck all the way out to the forearm and hand," that repetitive activities caused her discomfort, and that when sleeping on her stomach or elevating her arm, her arm went numb. (*Id*.) Claimant admitted "that she will tend to push activities further than she should, as a result, exhausting the muscle units of the shoulder and increasing the local discomfort." (*Id*.) Dr. Bonfilio's examination of claimant, showed no significant limitations in claimant's strength or range of motion.

¶48 Dr. Bonfilio testified that at the time of his August 11th exam, claimant had complaints of "numbness from the neck all the way to the fingertips, [which] is what we refer to as a non-dermatomal distribution," meaning that the numbness did not correspond to physiological nerve distributions. (Bonfilio Dep. at 51-52.) With regard to the surgery, Dr. Bonfilio continued to believe "she was doing very well." (*Id*. at 52.) He advised claimant to maintain a reasonable level of activities.

¶49 In October 1999, three significant things occurred. On October 11, 1999, claimant telephoned Dr. Bonfilio's office to request a referral to Dr. Lee Finney, a neurosurgeon. (Ex. 5-J at 10.) Second, on October 20, 1999, Dr. Bonfilio put claimant at maximum medical healing. (Exs. 2, 4, and 5-J at 17.) Finally, at the end of October 1999, claimant's job with Sun River was eliminated due to installation of automated meters which transmit meter readings directly to the central office. Claimant had known for at least six months prior to her termination that her job was going to be eliminated. (Munroe Dep. at 35.)

¶50 Dr. Lee Finney is a board certified neurosurgeon practicing in Great Falls. (Finney Dep. at 3-4.) He first examined claimant on October 19, 1999. (*Id*. at 4-5.) Her primary complaint was "right shoulder, right arm, and right medial scapular and right chest pain." (Ex. 5-K at 7.) Dr. Finney summarized claimant's history as follows:

> 47-year-old female, who 2 years ago fell on the job. She's had this difficulty since. It's been progressive. Two years ago, Dr. Gorsuch ordered MRI of the lumbar and

> cervical spine, without any significant findings, she also had negative EMG at that time. She subsequently had right shoulder surgery by Dr. Bonfilio. She's still having problems.

(*Id*.) Dr. Finney examined claimant and recorded:

> Normal with symmetric reflexes. Plantar stimulation is flexor; there's no ankle clonus. There's no specific numbness though the right arm frequently falls asleep, first with the last 3 fingers of the right hand and then later on with the thumb and index finger of the right hand, though she doesn't describe any radicular pain in her right upper extremity. Her symptoms sound like spinal cord compression, perhaps from the cervical and certainly very much like spinal cord compression in the thoracic area.

(*Id*.) Based on the limited findings of his examination and claimant's subjective complaints, and without the benefit of claimant's medical records or imaging studies, Dr. Finney concluded that claimant had spinal cord compression at the thoracic and cervical levels, and possible nerve root compression from a herniated disc at the L2-3 level. (*Id*.; Finney Dep. at 5, 8.)

¶51 Dr. Finney ordered new MRI imaging studies (Ex. 5-K at 7), which were done in November and December of 1999 (Ex. 5-M at 3-5 and 7-8.)

¶52 The MRI of the thoracic level disclosed a disk protrusion "central and paracentral on the left side" at the T9-10 level with mild compression of the cord but no nerve root compression. (*Id*. at 5.) However, the radiologist who read the images indicated that the cord compression did not explain claimant's right-sided symptoms. "There is no compression on the right side. . . . The is no evidence of right-sided involvement with regard to the right-sided symptoms." (*Id*.) Plain x-rays of the cervical spine showed "minimal degenerative disc disease." (*Id*. at 3.) The MRI of the cervical area was read as showing: "Minimal spinal stenosis at C5-6. Narrowing of the right C5-6 neural foramen." (*Id*. at 4.) Plain x-rays of the lumbar spine showed "[d]iffuse degenerative change and narrowing of the L5-S1 disc space." (*Id*. at 7.) The MRI of the lumbar spine was reported by the radiologist as showing findings in pertinent part stated:

> . . . No disc herniation, spinal stenosis or neuroforaminal stenosis is evident at L1-2, L2-3 or L3-4.
>
> Disc desiccation and a mild broad based disc bulge which produces effacement of the anterior margin of the cal sac without spinal stenosis is again evident at the L4-5 level. The neuroforaminal do not appear stenotic. The exiting L4 nerve roots do not appear displaced by the disc bulge.

> At L5-S1 there is persistent evidence of disc space narrowing and disc desiccation. A broad disc bulge is again noted. There has been interval development of central disc protrusion which compresses the anterior margin of the cal sac and produces mild narrowing of the spinal canal. The disc protrusion is at the level of the origin of the S1 nerve roots bilaterally. The L5-S1 neuroforaminal are not stenotic.
>
> Clinical correlation is needed.

(Ex. 5-M at 8.)

¶53 On November 4, 1999, Dr. Finney took claimant off work (Ex. 5-K at 6), however, she was no longer working for Sun River. Although Dr. Finney has never approved her to return to work, since November 4, 1999, claimant has on occasion worked as a bus driver and in her husband's yard business.

¶54 During November 1999, claimant also saw both Dr. Newbrough and Dr. Bonfilio. On November 5th she reported "severe right shoulder pain to Dr. Newbrough" and told him that she had seen Dr. Finney, who had diagnosed a C6 cervical disk. (Ex. 5-C at 18.) She received a shot of Demoral for pain. On November 10th she saw Dr. Bonfilio, who was perplexed by claimant's shoulder complaints. He wrote:

> Interestingly, whereas she was doing exceptionally well over the last several visits, today she is doing very poorly. She does not indicate that anything in particular changed as regards the right shoulder. If anything, she has been very protective of the shoulder. She states that for an indeterminate period of time, she has noted diffuse aching basically from the base of the skull, about the whole supra clavicular area down to the axillary region, medial arm, diffusely about the chest wall.
>
> It remains difficult to quantitate Alexis' current complaints. These current symptoms do not appear to be related to the right shoulder, especially given her excellent progress postoperatively.
>
> In discussion with Alexis, she is now being evaluated by Dr. Finney. Certainly, a longstanding concern is the possibility of an underlying cervical spine problem. He is evaluating this at this time.
>
> At this time, the patient was reassured that nothing new appears to have gone on with the shoulder. It appears to be worthwhile to pursue Dr. Finney's evaluation and recommendations. At this time, no further follow-up appears necessary in this office.
>
> As regards the right shoulder, the patient is considered at MMI.

(Ex. 5-J at 16.) Dr. Bonfilio testified that diffuse aching reported by claimant was different from what she had noted in August in that "there was a larger area down into the chest, the

armpit area, where in August it was from the neck to the fingertips, basically just the arm and shoulder." (Bonfilio Dep. at 53.) Dr. Bonfilio found no "reproducible neurologic basis for neck, arm or shoulder pain." (*Id.* at 63.)

¶55 On November 18, 1999, Dr. Finney reported that "Alexis [claimant] wants everything looked at and taken care [sic]." (Ex. 5-K at 5.) He went on to say:

> She's having a lot of trouble with her right hip. It feels like it's being pulled out of socket. She had lumbar surgery for left lower extremity radiculopathy in Seattle sometime ago and it's not bothered her since. We'll get a lumbar MRI to look at L2-3 and L3-4. Her right side is worse by far than the left. She also has evidence of ulnar neuropathy on the right with Tinel's sign and palpation of the right ulnar nerve. She so far has cervical cord compression at C6-7, lower thoracic disc, ulnar neuropathy on the right and we'll look for lumbar problems.

(*Id.* at 5.)

¶56 On December 3, 1999, following the lumbar MRI, Dr. Finney recommended surgery at the cervical, thoracic, and lumbar levels in a single surgical procedure. He wrote:

> Her lumbar MRI shows centrally herniated disc L5 S1. We should probably go ahead and operate all three of her lesions, the lumbar, the thoracic and the cervical at one time so she can recover from all of those at the same time and then she'll only be off work about 6 or 8 weeks.

(*Id.* at 4.)

¶57 Meanwhile, Liberty had requested an independent medical examination. Claimant was referred to Dr. Ronald Peterson, who specializes in occupational and sports medicine. Dr. Peterson saw claimant on December 7, 1999, (Ex. 5-L at 1-6), four days after Dr. Finney's three level surgery recommendation.

¶58 When examined by Dr. Peterson, claimant described daily headaches, "constant midline lower neck pain that radiates into her fingers," "'terrible pain' in her anterior right shoulder" and down the right arm, and "constant mid back pain between her shoulder blades." (*Id.* at 2.) Dr. Peterson found claimant a "vague historian, [who] has difficulty with specifics." (*Id.* at 3.) Claimant completed a pain diagram, which Dr. Peterson characterized as "[a]bnormal, patient states she has 'all types of sensation, all-inclusive areas of her body'." (*Id.* at 6.)

¶59 Based on examination and review of imaging reports, physical therapy notes, and medical records, Dr. Peterson had the following impression:

- (729.1) Myofascial neck, right shoulder, mid back, right thigh and right chest pain, consider fibromyalgia.

- (723.4) Right cervical radiculitis.
- (726.19) Right shoulder impingement, status post arthroscopic rotator cuff repair, March 1999.
- (728.9) General muscular de-conditioning.
- (300.4) Major depression.
- (306.9) Somatization syndrome.
- (V67.0) Remote history of lumbar surgery, 1989 and low back in 1991.

(*Id.* at 4-6.) He felt that the work-related injury of May 16, 1997 directly contributed only to claimant's right shoulder condition (impression #3). (Ex. 5-L at 6.) He continued:

> It is important to note that Ms. Munroe was felt to have had an excellent result of the surgery, but over time the shoulder pain has returned and seems now to parallel all of her other constellation of complaints. It could be argued that her cervical radiculitis symptoms have been caused by the May 16, 1997 injury, but based on available medical records and Ms. Munroe's history, I believe that it is much more probable that both her neck and mid back symptoms are from her general de-conditioning and somatization.[(6)]

(*Id.* at 6.) While he believed claimant might benefit from "psychological or psychiatric help in terms of dealing with her somatization and depression," Dr. Peterson also opined that claimant's need for psychological treatment was not related to the 1997 injury. (*Id.*) Finally, he agreed claimant was at MMI with respect to her May 16, 1997 injury. (*Id.*) He found no physical restrictions attributable to the May 1997 injury. (*Id.*)

¶60 Thereafter, on April 4, 2000, the claims adjuster notified claimant's counsel that Sun River was not responsible for claimant's cervical complaints. "[O]ur position remains that the only condition attributed to the above-captioned claim of 05/16/97 is Ms. Munroe's right shoulder symptoms, which has reached MMI." (Ex. 3 at 1.)

¶61 In light of Sun River's denial of liability for claimant's conditions other than her shoulder, Dr. Finney did not proceed with surgery. However, he asked Dr. Newbrough to provide claimant with narcotic medications. (Ex. 5-C at 19.) Beginning in December 1999, and continuing throughout 2000 and into at least January 2001, Dr. Newbrough and his associate, Dr. Todd Gianarelli, provided claimant with Demoral both in tablet form and injection. (Exs. 5-C at 18-19, 28, 58; 5-D at 1-8.) During that time, the doctors generally noted claimant's exam was unchanged. (*Id.*)

¶62 On June 23, 2000, claimant filed her present petition. She seeks authorization for the surgery proposed by Dr. Finney, along with other medical benefits.

¶63 Following the filing of the present petition, Dr. Finney wrote a letter dated November 14, 2000, in which he indicated that the need for surgery was urgent. He wrote inter alia:

> She comes in today with the same difficulties as she had when I saw her a year ago but they are now more severe. She's having more leg weakness, more numbness in the lower extremities, more thoracic spine pain, more cervical pain and headaches and more numbness and weakness in her upper extremities, all consistent with her radiographic findings of spinal cord compression at two levels and two herniated discs of the lumbar spine.
>
> Alexis asked what might happen if these go untreated and I said often times symptoms just become progressively worse as hers have in the last year and occasionally a disc will suddenly rupture and cause enough spinal cord compression to cause permanent paralysis from that level on down. If it occurs in the cervical spine, she'll be quadriplegic, if it occurs in the thoracic spine, she will lose function of her lower extremities and will no longer have control of her bowels or bladder. If it occurs in her lumbar spine, she'll very likely be able to have emergency surgery with correction of her problems and won't be left with any permanent numbness or weakness.
>
> . . . .
>
> . . . It's certainly important that we get this done as soon as possible to prevent any catastrophic irreparable damage to Mrs. Munroe.

(Ex. 5-K at 2-3.)

¶64 Subsequently, on March 9, 2001, the insurer obtained another IME, this time from Dr. Stuart Goodman, a board certified neurosurgeon practicing at the Deaconess Billings Clinic. (Ex. 15; Goodman Dep. at 6-7.) Dr. Goodman reviewed medical records and imaging studies from 1976 to the present. He also interviewed and examined claimant. (Goodman Dep. at 7-8.)

¶65 The only aspect of claimant's medical condition Dr. Goodman found related to the May 16, 1997 fall, was her right shoulder condition, which he found to be abnormal on clinical examination. He opined that her right shoulder problems were ongoing. (Ex. 5-T at 7.) As for claimant's other complaints, he found she suffers from longstanding degenerative spine disease unrelated to the May 1997 incident. With respect to her lumbar complaints, he explained:

> She has had low back pain since 1976. There are degenerative changes shown on all lumbar MRI studies. She has had neck pain complaints since 1982. Degenerative changes are seen on all cervical films at the C5-6 and C6-7 levels. Degenerative changes are seen on all lumbar studies at the L4-5 and L5-S1 level with progression

> of the L5-S1 degeneration between 1988 and 1989 noted after the exascerbation [sic] of pain when Ms. Munroe helped her daughter move at Carroll College. Her lumbar spine films reveal multiple traction spurs at numerous levels suggesting ligamentous laxity that is likely congenital and the source of her disc degeneration.

(*Id*. at 6.) He specifically found no relationship between the May 16, 1997 industrial accident and claimant's present cervical spine problems. He wrote:

> Ms. Munroe has been having neck pain throughout her medical history. She has had documented degenerative discs for years. I do not appreciate any significant change in the MRI pictures from 7/97 to 12/99 and there is no other objective evidence to relate the MRI diagnosis to the May 1997 fall. She may have some nerve root irritation related to the degenerative changes but this would exist irregardless [sic] of the fall in May of 1997.

(*Id*. at 6-7.) Finally, he found it more likely that claimant's thoracic condition resulted when claimant fell from a truck and not from the May 1997 incident. (*Id*. at 7.)

¶66 With respect to surgery, Dr. Goodman concluded that "[s]urgical intervention with a discectomy at L5-S1 is reasonable but not related to the May 16, 1997 accident." With respect to the proposed thoracic and cervical surgeries, he wrote:

> Dr. Finney has recommended cervical and thoracic discectomies to prevent spinal cord injuries. Although there is some minimal stenosis at C5-6, her risk of spinal cord injury, without surgery, is not significantly different than the general population. Her risk of paralysis from the herniated thoracic disc is also not much different than would be the risk of the general population. Her decision to have these discs removed is strictly based on taking a chance that she will be more comfortable after the surgeries than she is now. Again, the need for surgery for the cervical and thoracic herniated discs is not related to the fall of May 16, 1997. The thoracic disc most likely occurred when she fell out of the truck and fractured her ribs. The cervical disease is long standing and not necessarily related to any injury.

(*Id*.)

¶67 Finally, Dr. Goodman did not believe claimant was at any more risk for spinal cord injuries at the cervical or thoracic levels than the general population. He believed her "decision to have these discs removed is strictly based on taking a chance that she will be more comfortable after the surgeries than she is now." (*Id*. at 7.)

¶68 Dr. Finney, as well as Drs. Bonfilio, Peterson, Gorsuch, and Goodman were deposed and their depositions submitted to the Court for its consideration. In general, the opinions of Drs. Bonfilio, Peterson, Gorsuch, and Goodman contradict Dr. Finney's opinions and in some instances their testimony was highly critical of Dr. Finney. Resolution of this case

turns on whether I find Dr. Finney's testimony more persuasive than that of the other four doctors.

¶69 Before turning to the medical testimony, I note that claimant also testified to matters relating to her medical history which, if true, would bolster her claims.

¶70 At trial she testified that she had never experienced neck pain prior to May 16, 1997, and that following her January 1997 hysterectomy her back pain totally remitted and she was having no difficulties with her low back. I did not find claimant to be an accurate historian and I did not find this testimony credible. As set forth in earlier paragraphs, medical records demonstrate that claimant was treated for neck pain prior to the 1997 injury and was documented as still experiencing low-back pain six weeks after her hysterectomy. It is also clear from claimant's medical history that her low-back complaints long preceded and were persistent prior to the emergence of the hemangioma and uterine bleeding.

¶71 At her August 14, 2000 deposition, she testified that since her May 16, 1997 fall, she has had continuous pain in her right "shoulder, my arm, my chest, my ribs, my right hip and leg. That has not changed any since the accident." (Munroe Dep. at 10.) However, her medical records, reviewed in detail above, contradict her assertions. They show that she did not initially report pain in her ribs, hip and leg following the May 1997 injury. Those complaints arose months later. I am unpersuaded by her testimony and find the medical records a more reliable gauge of the dates on which she experienced pain in the various parts of her body.

¶72 I further find, after listening to claimant's testimony at trial and reviewing the medical records, that claimant is a poor historian and misinterprets information provided to her by medical providers. There is also persuasive medical evidence that her pain is not always as bad or as debilitating as she reports; that over the years her pain has persisted for long periods of time and has been difficult to treat with conventional methods; and that some of her pain is psychogenic.

Dr. Lee Finney's Testimony

¶73 When deposed, Dr. Finney declined to renew his recommendation for surgery, stating he would need to re-evaluate claimant. (Finney Dep. at 18.) He acknowledged he had seen claimant on only two, possibly three, occasions: October 19, 1999, November 14, 1999, and probably on November 18, 1999, although that last date is in question. (*Id*. at 22.) However, he defended his original recommendation based on the information available to him at the time. That information did not include any of claimant's medical records except 1997 MRI reports (*id*. at 22, 26) and the doctor relied on claimant's statements to him concerning her prior history in formulating his opinions (*id*. at 26, 64).

¶74 With respect to his recommendation of cervical surgery at the C5-6 level (*id*. at 51), Dr. Finney conceded that his neurological examination of claimant was normal (*id*. at 29) but opined that claimant had cord compression in the neck on her subjective *complaints* of pain in the right shoulder, right arm, right chest, and the dysesthetic feeling in the right axilla and anterior chest and over the right clavicle. (*Id*. at 12.) He testified that a cervical MRI "showed there was a narrowing at the C5-6 level," which he believed explained claimant's symptoms. (*Id*. at 13.) When questioned about the proposed decompression of the nerve root, he conceded that the MRI provided no evidence of nerve root compression and that other objective signs of nerve root compression (atrophy, weakness and distribution of changes in sensation) were lacking, but testified that the MRI is right only 80 percent of the time (*id*. at 39-40, 52), and that he was basing his recommendation on claimant's complaints. (*Id*. at 39, 53.)

¶75 With respect to his thoracic level surgical recommendation, Dr. Finney testified that the MRI indicated spinal cord compression at the T9-T10 level, which he believed correlated with claimant's reported symptoms. (*Id*. at 9.) When asked how he correlated claimant's right-sided symptoms with the left thoracic disk herniation, he explained that in the cervical and thoracic areas "equally will we find that the compression is on the opposite side where the patient is having symptoms." (*Id*.) Later in his testimony, Dr. Finney clarified that the pain reported by claimant in relationship to the thoracic spine suggested *nerve root compression*, not spinal cord compression. He acknowledged that nerve root compression was not indicated by the MRI. (*Id*. at 35-36.) Nonetheless, he maintained that the MRI was "not inconsistent with the lady's difficulties." (*Id*. at 36.) Finally, he agreed that thoracic spinal surgery is difficult and dangerous but testified he has had good results. (*Id*. at 64.)

¶76 With respect to proposed lumbar surgery, Dr. Finney noted "protrusion of the central disk at L5-S1" and "a mild bulge at L4-5." (*Id*. at 15.) He believed this correlated with claimant's report of pain from the low back to the right hip and might also "be the beginning of L4 or L5 or S1 radiculopathy." (*Id*. at 16.) He agreed that the herniated disk at the L5-S1 level apparently arose after claimant's July 1997 MRI but testified that the 1997 MRI may have been misread or may simply not have revealed the problem. (*Id*. at 61.)

¶77 Dr. Finney proposed operating on all three levels in a single surgery in order to minimize the time claimant would be off work. (*Id*. at 17.) He "absolutely" estimated that claimant would be able to return to work within six to eight weeks after surgery on all three levels. (*Id*. at 65.)

¶78 The doctor was also asked about causation, specifically whether anything provided in a narrative provided by claimant's counsel was "inconsistent in terms of her symptoms today with what she said happened to her when she fell in May of 1997." (*Id*. at 21.) He replied, "No, there's nothing inconsistent." (*Id*.) He conceded in cross-examination that his

opinions regarding causation were based entirely on the history claimant gave him. (*Id*. at 26.)

Dr. Nicholas Bonfilio's Testimony

¶79 Dr. Bonfilio, who treated claimant over a substantial period of time, disagreed with Dr. Finney in almost every respect. He reviewed Dr. Finney's records and the reports of the 1999 MRIs ordered by Dr. Finney. He testified that he did not "see any substantive indication or need for surgical intervention at any levels in any of those areas, either by Dr. Finney's examinations or by the MRI readings, all performed by very capable radiologists." (Bonfilio Dep. at 79.)

¶80 Dr. Bonfilio found little change in the cervical spine images since he had treated claimant. Referencing the report of the 1999 cervical MRI, he testified: "The spinal stenosis may, in fact, be what was referred to initially as a degenerative disk disease and perhaps a little more narrowing, but as called it says minimal." (*Id*. at 66.) The MRI reflected a "mild degree of narrowing at the C5-6 and 6-7 interspaces, but no evidence of disk bulges, no spinal stenosis." (*Id*. at 70.) Dr. Bonfilio noted the C5-6 and 6-7 levels are the areas of greatest stress in the cervical spine, making it "very common even in a young, asymptomatic individual to find changes there. It doesn't necessarily mean they necessitate operative intervention." (*Id*. at 70.)

¶81 Based on the 1999 lumbar spine MRI report, Dr. Bonfilio noted a "not particularly large disk herniation at L5-S1," which he supposed was "the lumbar region that Dr. Finney is considering operating upon." (*Id*. at 68.) Dr. Bonfilio did not understand Dr. Finney's reference to operation at the L5-S level given his other references to clinical findings suggesting L3, 4, and 5 level involvement.

¶82 Similarly, Dr. Bonfilio did not understand the need for surgery on the thoracic spine. (*Id*. at 68.) He testified:

> The dorsal or thoracic spine MRI shows a T9-10 paracentral disk herniation. His concerns were at T5 distribution. His concerns were right sided. This paracentral disk herniation is five levels down, but according to the reading, there's no evidence of right-sided involvement with regard to the right-sided symptoms. So I'm confused.

(*Id*. at 68-69.)

¶83 When asked to review Dr. Finney's November 14, 2000 letter in which Dr. Finney warned that claimant could suffer a catastrophic cord event without surgery, Dr. Bonfilio testified:

> I'm composing myself. I think this letter is inflammatory. Based, and, again, I am reading readings, but I don't see anything here that shows that she is subject at any

> moment to a catastrophic disk herniation and quadriparesis. I don't see anything documented in these examinations that seems to be consistent with these findings. And am at a loss to explain or to - given what I've seen so far, I'm at a loss to be able to substantiate the need for a three-level spine surgical intervention.

(*Id*. at 70-71.) Dr. Bonfilio testified he would want to "see a much more substantive and exhaustive examination documenting deficit, documenting reproducible symptoms or signs before I would suggest surgery." (*Id*.)

¶84 With regard to relationship of the recommended surgery to the May 1997 injury, Dr. Bonfilio testified the examinations he and Dr. Gorsuch performed in 1997, and the MRI evidence from before and after the May 16, 1997 incident, did not support a conclusion the contemplated surgeries related to the accident. (*Id*. at 71-73.)

Dr. Paul Gorsuch's Testimony

¶85 Although refusing to give an ultimate opinion as to whether Dr. Finney's proposed surgery is appropriate, Dr. Gorsuch's testimony raises serious questions about the wisdom of the proposed surgery.

¶86 He reviewed and commented upon of 1999 MRI reports. He found little change in the cervical spine. (Gorsuch Dep. at 49.) Moreover, in his opinion the 1999 MRI findings did not correlate with claimant's reports of symptoms; lacking such correlation, there is a high risk of failure for any surgery. (*Id*.) Regarding the bone spur on the cervical spine showed by the July 1997 MRI, Dr. Gorsuch testified it was significant that the spur was on the left, while claimant's symptoms were on the right. "Because generally you expect the compressing lesion and the symptoms to be on the same side. So one would conclude that the left-sided C5-6 bone spur was probably not causing her right-sided pain." (*Id*. at 42.)

¶87 Regarding thoracic surgery, Dr. Gorsuch stated, "that the general category of operating on a thoracic disk in somebody without signs of cord compression but with pain symptoms is extraordinarily controversial and considered one of the most difficult decisions to make in terms of spinal surgery." (*Id*. at 56.)

¶88 Dr. Gorsuch also indicated that claimant's widespread reports of pain decreases the prospects that surgery will be successful. Claimant circled nine pain descriptors on a pain questionnaire, describing her pain as occurring on a wide range of places on her body. (*Id*. at 7.) In his experience, this decreased the likelihood surgery would change her perception of pain. Dr. Gorsuch noted that aspects of claimant's condition suggested fibromyalgia or a myofascial condition, conditions not improved by surgery. (*Id*. 18-19.) Dr. Gorsuch also identified anatomic inconsistencies in claimant's examination, such as her change of report of sensation at the midline, which he considered generally a "histrionic feature" suggestive that psychological factors play a significant role in the patient's pain perception.

(*Id*. at 22.) In general, claimant "had these sensory complaints that I couldn't localize, and she had multiple areas of pain that I couldn't localize." (*Id*. at 36.)

¶89 Dr. Gorsuch opined that there is a high risk of failure of any surgery in light of claimant's mild to moderate imaging findings, huge amount of symptoms, and her previous failure to follow through on physical therapy. (*Id*. at 78-79.)

¶90 With regard to the risk of paralysis from rupture of a cervical disk, Dr. Gorsuch opined that the chance of that happening in claimant's case is less than one percent, which is also the risk of dying in surgery. (*Id*. at 70.) He also testified that in his own practice, he does not achieve satisfactory results when operating on more than one level of the spine in one operation. (*Id*. at 66.)

Dr. Ronald Peterson's Testimony

¶91 Dr. Peterson declined to second guess Dr. Finney's surgical recommendation, noting that Dr. Finney is a neurosurgeon while he is not. (Peterson Dep. at 40.) However, he also said that when he examined claimant on December 7, 1999, which was four days after Dr. Finney recommended three level surgery, he found no evidence necessitating surgery and would not have referred claimant to a surgeon. (*Id*. at 41-42.)

¶92 Dr. Peterson also reiterated his opinion that the only condition related to claimant's May 1997 industrial accident was her shoulder condition. (*Id*. at 33-35.) While he agreed it was possible that the fall could have given rise to claimant's "cervical radiculitis symptoms," upon review of claimant's medical records and history he opined that it was more likely due to other factors.

¶93 His review of cervical MRIs showed "mild degenerative changes, mostly at the C5/6 level." (*Id*. at 22.) The 1999 study showed "some minimal narrowing of the spinal canal, and minimal narrowing of the C5/6 neural foramina on the right." (*Id*. at 22.) There was a protruding osteophyte at C5-6 on the left, which Dr. Peterson thought "was part of the degenerative process." (*Id*. at 23.) He did not "find any objective evidence that would support a finding of neurologic injury" at any level on account of the fall. (*Id*. at 34-35.)

¶94 Finally, Dr. Peterson considered the pain diagram which claimant completed for his exam to be abnormal. He explained: "It's felt to be abnormal when patients choose all descriptors and the entire extremity. We try to ask them to be specific in terms of where they're having burning or where they're having sharp, stabbing pain, and in Ms. Munroe's case, she chose all of the descriptors in the entire right upper and lower extremities, as well as the right side of her neck." (*Id*. at 26.)

Dr. Stuart Goodman's Testimony

¶95 During his deposition, Dr. Goodman addressed both causation and Dr. Finney's proposed surgery.

¶96 He opined that the claimant's cervical, thoracic, and lumbar conditions were not related to her May 1997 industrial accident. He testified that her cervical and lumbar problems are attributable to "long standing degenerative changes," not the accident. (Goodman Dep. at 21.) While he agreed that claimant now suffers from a herniated disk at the L5-S1 level, and that surgery on that disc is reasonable, he testified that the herniated disk developed after the May 1997 fall and was not related to it; and that leg pain prior to the herniation was due to a natural progression of her degenerative disk disease. (*Id*. at 21, 28.)

¶97 Dr. Goodman also agreed that claimant has a herniated thoracic disk but opined that the herniation was "more likely the result of the time when she fell out of a truck and fractured her ribs rather than the May 16, 1997, accident." (*Id*. at 22.) His written report noted "She had a fall off a truck and developed left rib fractures in 1996, according to hospital records. The thoracic disc could very well have occurred at this time and is not necessarily related to the fall in May of 1997." (Ex. 15 at 6.) Dr. Goodman testified that rib fractures and thoracic spine injuries "commonly occur together." (Goodman Dep. at 45.)

¶98 However, Dr. Goodman was not convinced claimant's herniated thoracic disk is contributing to her clinical symptoms. He noted that the thoracic MRI indicated a left-side herniation, that claimant's complaints were of right-sided pain, and that the right-sided pain was "probably not" related to the left-sided herniation. (*Id*. at 24.) Similarly, he opined that the findings at the C5-6 level, which were left-sided, were not causing claimant's right arm symptoms. (*Id*. at 31-32.)

¶99 Moreover, Dr. Goodman opined that claimant is not a good candidate for thoracic surgery because "the thoracic disk was so small and . . . the risks of that particular operation are so great that I don't think you can justify it." (*Id*. at 22.) He noted:

> You can operate on [the thoracic problem] in an open fashion, but then you have to open the patient's chest, move their lung and heart aside and take out the disk and put in some major hardware, and that's very risky and it also is one of the most painful procedures I've ever seen done, and it always leaves the patient with residual pain just from the surgery itself.

(*Id*. at 22-23.) Dr. Goodman believed the "pain that she would have after that surgery would be at least two orders of magnitude greater than the pain that she could possibly have from that disk right now." (*Id*. at 23.) He noted that a posterior thoracic discectomy was also possible "but the spinal cord is in the way, so the risk of paralysis is very high." (*Id*. at 23.)

¶100 Dr. Goodman also recommended against surgery on the cervical spine because he saw no evidence of spinal cord compression. (*Id*. at 35.) He believed it reasonable for claimant to elect surgery at the C5-6 level as "it might make her feel somewhat better,"

however, he reiterated that any such surgery would not be related to the May 16, 1997 incident. (*Id*. at 48.)

MMI Opinions

¶101 Drs. Peterson, Goodman, and Bonfilio all testified that claimant has reached maximum medical healing with respect to her shoulder condition, which is the only condition the insurer concedes is related to her May 1997 industrial accident.

Resolution

¶102 I am unpersuaded by Dr. Finney's opinions. He saw claimant on only two occasions and possibly a third. He never reviewed claimant's medical history. He relied totally on claimant's oral report of her medical history, and as I have found earlier, claimant is not a reliable historian and her statements are contradicted on important points by medical records. Moreover, Dr. Finney was contradicted on important points by the other four doctors who testified in this matter. Two of those physicians were treating physicians, two were neurosurgeons, and one was an orthopedic surgeon whose specialty overlaps neurosurgery when it comes to spinal surgery. The four doctors considered claimant's medical history in rendering their opinions.

¶103 Dr. Finney provided the only testimony which arguably supports a finding that claimant's cervical, thoracic, and lumbar conditions were caused or aggravated by her May 16, 1997 industrial accident, and even then his opinion was not on a more-likely-than-not basis. He testified only that her current spinal symptoms are "not inconsistent" with the history she provided concerning her May 1997 accident. This testimony falls short of constituting an affirmative medical opinion, on a more-probable-than-not basis, concerning causation. Moreover, Dr. Finney took claimant at her word concerning her history. One of the things she told him was that all of her various pains commenced immediately after her fall, a statement that the Court has found is contradicted by medical records and is untrue. Drs. Goodman and Peterson, on the other hand, provided medical opinions that the cervical, thoracic, and lumbar conditions were not related to the May 1997 fall. Dr. Bonfilio testified that the proposed surgeries were not related to the fall. Their opinions are supported by their references to claimant's medical history and numerous prior imaging studies. They are the more persuasive. Claimant has failed to persuade me that her spinal conditions or the proposed surgeries are related to her May 1997 industrial accident.

¶104 Moreover, notwithstanding Dr. Finney's opinions, there is persuasive medical evidence from both Dr. Gorsuch and Dr. Goodman that claimant's clinical pain complaints, which are on her right side, are not related to the MRI findings of possible left-sided impingement at the cervical level. Based on Dr. Goodman's testimony, the same is true with respect to the thoracic level.

¶105 Consistent with the foregoing findings, I further find that the three level surgery proposed by Dr. Finney in late 1999 is not related to the claimant's May 1997 industrial accident.

¶106 Even if the proposed surgeries were related to the claimant's May 1997 industrial injury, I find that the proposed surgery at the thoracic level is not reasonable and that the cervical surgery is purely elective. Again, in the face of testimony by four other experienced and well qualified physicians, I am unpersuaded by Dr. Finney's testimony that the thoracic surgery is safe or that the cervical surgery is essential.

¶107 I further find that claimant has reached MMI with respect to her shoulder injury. Dr. Peterson found at the time of his examination of claimant on December 7, 1999, that she was at MMI. (Ex. 5-L at 6.) Dr. Goodman expressly agreed with Dr. Peterson. (Ex. 5-T at 7; Goodman Dep. at 30.) Most importantly, Dr. Bonfilio, who treated claimant's shoulder and performed the shoulder surgery, found claimant at MMI on October 20, 1999. (Ex. 4; Ex. 5-J at 17.) Claimant lost no time from her Sun River job prior to October 20, 1999, and her employment ceased at the end of October because she was technologically displaced and laid off work.

¶108 Finally, I find that the insurer has not acted unreasonably in refusing to authorize Dr. Finney's proposed surgery or accept liability for conditions other than claimant's shoulder conditions or in denying temporary total disability (TTD) benefits.

CONCLUSIONS OF LAW

¶109 The 1995 version of the Workers' Compensation Act applies to this claim as that was the law in effect at the time of the alleged injury. *Buckman v. Deaconess Hospital,* 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶110 Claimant bears the burden of proving by a preponderance of the evidence that she is entitled to the additional benefits she seeks. *Ricks v. Teslow Consolidated*, 162 Mont. 469, 512 P.2d 1304 (1973).

¶111 Under the 1995 Workers' Compensation Act, and, for that matter, under other versions of the Act, an insurer is liable only for medical conditions which were caused or aggravated by the industrial injury; it is not liable for unrelated conditions. Claimant "has the burden of proving a causal connection [between the accident and his medical condition] by a preponderance of the evidence." *Brown v. Ament,* 231 Mont. 158, 163, 752 P.2d 171, 174 (1988). Claimant in this case has failed to carry her burden except with respect to her shoulder condition, a condition for which the insurer has accepted liability. Accordingly, she is not entitled to medical benefits with respect to her cervical, thoracic, and lumbar spine conditions and complaints, or for spinal surgery, or for any condition other than her right shoulder condition.

¶112 Under section 39-71-701, MCA (1995), claimant is entitled to TTD benefits only so long as she has a wage loss attributable to her injury and has not reached maximum medical improvement. The section 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;
>
> . . .

The claimant does not claim TTD benefits prior to her termination of employment with Sun River in late October 1999, and she had reached MMI by the time of her termination. She therefore is not entitled to TTD benefits.

¶113 Claimant's request for attorney fees and a penalty requires that she prevail and that she also prove that the insurer's denial of benefits was unreasonable. §§ 39-71-611, -612, -2907, MCA. She has done neither and therefore is not entitled to a penalty or attorney fees and costs.

JUDGMENT

¶114 None of claimant's current medical problems, with the exception of her shoulder condition, was caused by the May 16, 1997 injury, and she reached maximum medical improvement with respect to her shoulder prior to losing work. Therefore, the insurer is not liable for the surgeries proposed by Dr. Lee Finney or for any other treatment related to claimant's neck, thoracic and low-back conditions, or for any condition other than the shoulder condition. It is also not liable for TTD benefits or for attorney fees, costs, and a penalty. Her petition is dismissed with prejudice.

¶115 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.

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

DATED in Helena, Montana, this 16th day of August, 2001.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. William O. Bronson
Mr. Michael P. Heringer

Ms. Lisa A. Speare
Date Submitted: April 23, 2001

1. The piriformis is "a muscle that arises from the front of the sacrum, passes out of the pelvis through the greater sciatic foramen, is inserted into the upper border of the greater trochanter of the femur, and rotates the thigh laterally." 1997 Merriam-Webster Medical Dictionary, online at https://www.medscape.com.

2. Exhibit 5-Q consists of Dr. Mark Newbrough's records.

3. Spondylosis refers to degenerative conditions of the spine. Merriam-Webster Medical Dictionary (1997), online at https://www.medscape.com.

4. Dr. Gorsuch is referring to a prior MRI done on January 2, 1996, more than a year prior to claimant's 1997 fall.

5. During 1998 she received intermittent medical care for cough, fever, sore throat, ear pain, and high cholesterol but not for her other complaints. (Exs. 5-C at 11, 5-E at 2-5.)

6. Somatization is the "conversion of an emotional, mental, or psychosocial problem to a physical complaint." Merriam Webster.