IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2001 MTWCC 6

WCC No. 2000-0156

JOYCE PEONE

Petitioner

vs.

LIBERTY NORTHWEST INSURANCE

Respondent/Insurer for

MISSION MOUNTAIN ENTERPRISE

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Case Summary: Claimant, a certified nurses aid, fell and injured her back in April 1998 but returned to work and continued working until August 1999, when she quit work. She claims that her doctor told her to quit working on account of her back pain and seeks temporary total disability benefits.

Held: Claimant did not prove entitlement to temporary total disability (TTD) benefits. She was not a credible witness. Her story about quitting work was contradicted in numerous aspects. The Court finds that she did not quit work on account of her back condition and that her wage loss is not the result of her injury. Moreover, the medical evidence failed to establish that she had not reached maximum medical improvement at the time she ceased working.

Topics:

> **Benefits: Temporary Total Benefits**. Where claimant quit work for reasons unrelated to her industrial injury her wage loss is not the result of her injury and she is not entitled to temporary total disability benefits.
>
> **Benefits: Temporary Total Benefits**. Where medical opinion that claimant has not reached maximum medical improvement is based on the fact that claimant would benefit from physical therapy, and the claimant has had the opportunity for the

therapy but failed to pursue it, the claimant has reached MMI and is not entitled to temporary total disability benefits.

Maximum Medical Improvement. Where medical opinion that claimant has not reached maximum medical improvement is based on the fact that claimant would benefit from physical therapy, and the claimant has had the opportunity for the therapy but failed to pursue it, the claimant has reached MMI and is not entitled to temporary total disability benefits.

¶1 The trial in this matter was held on November 27, 2000, in Kalispell, Montana. Petitioner, Joyce Peone (claimant), was present and represented by Ms. Laurie Wallace. Respondent, Liberty Northwest Insurance (Liberty), was represented by Mr. Larry W. Jones. No trial transcript has been prepared.

¶2 Exhibits: Exhibits 1 through 11 were admitted without objection.

¶3 Witnesses and Depositions: The Court received and has considered the depositions of claimant, Dr. Victor M. Davis, and Gary Schild. Claimant, Connie Fryslie, and Walter Woyden were sworn and testified at trial.

¶4 Issues: The issues stated in the pretrial order are:

1. Whether the Petitioner is entitled to temporary total disability benefits from the date she was released from work, August 23, 1999, and continuing until alternative positions can be identified or the Petitioner is released to return to her time-of-injury position.

2. Whether Petitioner is entitled to a 20% increase of award for refusal to pay benefits pursuant to section 39-71-2907, MCA.

3. Whether Petitioner is entitled to reasonable attorney fees and costs pursuant to section 39-71-611, MCA.

(Pretrial Order at 3.)

¶5 At trial, counsel for claimant waived oral argument on the penalty issue, but reserved the right to brief that issue should the Court find claimant is entitled to additional temporary total disability (TTD) benefits.

¶6 Having considered the pretrial order, the testimony presented at trial, the demeanor and credibility of the witnesses, the depositions and exhibits, and the arguments of the parties, the Court makes the following:

FINDINGS OF FACT

¶7 Claimant is 40 years old. She has worked as a certified nurses aid since the early 1980s.

¶8 In 1996, claimant began working for Mission Mountain Enterprise (Mission Mountain). Mission Mountain provides in-home assistance to mentally and physically disabled people.

¶9 In 1998, the claimant ordinarily worked with one client, Michelle. Claimant's regular duties with Michelle were to assist her in making her bed, cleaning house, bathing, and other household duties. Michelle was described by claimant and claimant's supervisor as "challenging."

¶10 On April 6, 1998, as claimant was leaving Michelle's residence, she slipped and fell on the sidewalk. Immediately following the accident, she began to have pain across her buttocks, into her hip, and down into her right leg. (Peone Dep. at 11.)

¶11 At the time of the accident, Mission Mountain was insured by Liberty, which accepted liability for the accident and paid medical benefits.

¶12 Claimant sought medical care on April 14, 1998. Because her regular physician, Dr. Victor M. Davis, was unavailable, she was treated by another doctor in the same clinic, Dr. Robert Schure. (Ex. 7 at 2; Peone Dep. at 11.) Dr. Schure diagnosed "[c]ontusion right buttocks" and prescribed pain medication. (Ex. 7 at 2.)

¶13 On May 5, 1998, claimant followed up with Dr. Davis. She reported that she had "increasing back pain in the right side and now radiating down her *left* leg into her left calf." (Ex. 5 at 2, italics added.) The doctor's reference to "left" leg pain was in error. His subsequent records, as well as claimant's testimony, show that the pain was in the right leg. (Ex. 5 at 5; Peone Dep. at 10-11.) Dr. Davis thought claimant had a possible disk herniation with nerve root compression. (Ex. 5 at 2.)

¶14 Claimant returned to Dr. Davis on May 19, 1998. (*Id.* at 3.) He noted that "leg pain, weakness and numbness are all new findings since the accident." (*Id.*)

¶15 On May 22, 1998, an MRI was done of claimant's lumbar spine. Dr. Roy Zimmer, a radiologist, read the films, finding as follows:

> Mild left lateral disc bulge at L4-5 which creates mass effect upon the left subarticular recess and anterior aspect of the left neural foramen. While there is no obvious nerve root impingement, this does appear to encroach upon the left L5 nerve root within the lateral recess.

(Ex. 3 at 4.) Both Dr. Davis and Dr. David T. Schloesser, a neurologist who later examined claimant, noted that if the disk bulge imaged on May 22, 1998, were causing radicular symptoms then those symptoms should have been in her left leg, however, claimant in fact had no left leg symptoms. (Ex. 2 at 1; Ex. 5 at 5.) Thus, it was unlikely that the disk bulge was clinically significant.

¶16 Claimant continued to be symptomatic, however, she also continued to work.

¶17 In June 1998, claimant was referred for physical therapy. She attended a couple of sessions but did not follow through. (Exs. 9 at 1 and 5 at 5; Davis Dep. at 12; Trial Test.)

¶18 During July claimant obtained medication for her pain. (Ex. 5 at 6-7.)

¶19 Claimant continued to have back pain. She saw Dr. Davis on November 11, 1998. He noted:

> Need to write to W.C. to see if they are interested in work evaluation or further rehab. Patient states PT is quite painful for her. Not certain that she's doing any stretching exercises. States she had a mechanical LB injury working at the nursing home in 1991 or 1992, states this is much more severe, much more longer lasting and the 1st was not associated with any leg pain.

(*Id*. at 10.)

¶20 On November 20, 1998, Dr. Davis wrote Liberty's claims adjuster, stating in part:

I feel most of Ms. Peone's symptoms are due to muscle tightness, lack of mobility at the present time. However she also clearly has an unstable back which is likely to respond only to time. I believe she is somewhat limited in her current work activities with limitations placed on bending, lifting any thing greater than 15 pounds, walking on unstable ground, sitting for more than 45 minutes, stooping or bending. I expect these limitations will continue.

(*Id*. at 12.) Dr. Davis testified the limitations set out in his letter were not intended to be permanent. (Davis Dep. at 10.) At that time, based on the claimant's May 1998 MRI, he was concerned claimant might reinjure her back. (*Id*.)

¶21 Claimant testified she took a note from Dr. Davis setting out her lifting restrictions to her employer, and gave it to either Connie Fryslie (Fryslie) or Carol Hoover (Hoover). Fryslie supervised claimant from 1996 through 1999, except for approximately six months when Fryslie was on medical leave. According to Fryslie, claimant did not give her any note regarding restrictions.

¶22 Walter Woyden (Woyden), who supervised the program in which claimant worked, testified that Hoover handled payroll matters, including workers' compensation and time off issues. Woyden could recall nothing about work restrictions for claimant while she was employed. Hoover did not testify.

¶23 Claimant's Mission Mountain personnel file does not contain any reference to Dr. Davis' November 1998 work restrictions. (Ex. 10.)

¶24 Claimant was not a credible witness and I am unpersuaded that she ever notified her employer of the November 1998 work restrictions.

¶25 On June 20, 1999, claimant reinjured her back while helping Michelle bathe. She was seen by Dr. Davis the next day. At that time he noted: "Hurt back worse lifting pt yesterday - pain radiating into R leg with leg weakness." (Ex. 5 at 22.) However, Dr. Davis considered the incident an aggravation of her prior injury with "no new physical findings." (Davis Dep. at 13.) He testified that acute symptoms from the aggravation improved within six weeks, leaving claimant with her existing chronic low-back problems. (*Id.* at 15.) Claimant testified that her back and leg pain after the tub incident did eventually return to "pretty much the same" as before that incident. (Trial Test.)

¶26 Claimant testified that during the June 21 examination, she and Dr. Davis discussed whether she should seek different work. According to claimant, Dr. Davis advised her to get out of the work she was doing. Dr. Davis acknowledged suggesting that claimant ask to work with other clients, particularly after the tub incident. Claimant told him, however, that her employer refused to assign her to a different client. Dr. Davis testified: "Joyce finally told me, she told me that they weren't giving her anybody else. They were just telling her, if you want to keep working here, you keep working with Michelle." (Davis Dep. at 13.) He acknowledged his only information about the employer's alleged refusal of accommodation came from claimant. (*Id.* at 41-42.) He testified: "I assume everything my patients tell me is true until proven otherwise or given some reason to suspect their veracity." (*Id.* at 42.)

¶27 Claimant testified she then went to Fryslie and told her the doctor had restricted her lifting and asked to be switched to another client who would be easier to handle. According to claimant, Mission Mountain did nothing in response to her request. She recalled being transferred to another client for one weekend after an incident with Michelle but testified that the transfer was due to the incident and not on account of her back problems.

¶28 Claimant testified that she "asked about" three different openings at Mission Mountain and that she made it clear to her supervisors that her requests were on account of her back problems. According to claimant, "Nothing was done." (Trial Test.) Claimant also testified that she applied for an opening at the Work Activity Center operated by Mission Mountain, however, she conceded she did not tell her employer she was seeking the job on account of her back condition.

¶29 Both Fryslie and Woyden testified claimant never asked to be moved to other clients on account of back problems or any other physical restriction. Fryslie did recall that claimant complained about Michelle's aggressive conduct and that she responded by scheduling claimant to work with a different client the next weekend. However, claimant did not show up to work with that client that weekend and was thereafter rescheduled to work with Michelle.

¶30 Fryslie also recalled meeting with claimant after the incident where claimant was hurt helping Michelle bathe. Fryslie reminded claimant of Mission Mountain's policy against its

employees placing themselves at risk of injury when attending clients. Fryslie testified that claimant did not request she be assigned a different client.

¶31 Fryslie testified that if she or Mission Mountain had been requested to reassign claimant on account of her back condition, they would have attempted to do so.

¶32 Obviously, the testimony concerning claimant's request to change clients is conflicting. I am unconvinced by claimant's testimony and do not find her credible. I find that she did seek to change clients after one incident involving Michelle, where Michelle attempted to attack her with a knife. I also find that she failed to take the new assignment to another client, voluntarily returned to care for Michelle, and, in any event, never asked to change clients on account of her back condition.

¶33 On July 20, 1999, claimant returned to Dr. Davis. She reported hurting her right leg while getting into a pickup truck. (Ex. 5 at 24.) Dr. Davis' handwritten notes are difficult to decipher, but appear to refer to a "swollen area" on claimant's right shin. (*Id.*) At deposition, claimant testified: "I banged my leg on the bumper. I was going to get in back of the truck and went to pull myself up and banged my leg and it caused a bruise. And possibly he called it a blood clot." (Peone Dep. at 24.)

¶34 Dr. Davis rechecked claimant's leg on July 28, 1999. (Ex. 5 at 25.) The medical record states: "Leg still sore see prior note. Bumped it on bumper - jumping into car." (*Id.*) Claimant did another recheck days later. (*Id.* at 26.) Dr. Davis testified he was watching this injury closely because he was worried about the possibility of infection due to claimant's diabetes. (Davis Dep. at 18.)

¶35 Meanwhile, claimant stopped attending Mission Mountain meetings and classes put on by her employer. According to Fryslie, claimant called in with excuses a couple of times, but missed other scheduled meetings without any excuse. Woyden testified that some time prior to her last day of work he had a talk with claimant about her failure to attend scheduled meetings and classes. The conversation was between a month to six months before she stopped working.

¶36 Claimant's last day of work was August 16, 1999. On August 17, Fryslie received a voice mail from claimant stating, "On the advice of my doctor, I'm resigning my job." (Trial Test.) Fryslie testified she then tried but was unable to contact claimant. She had previously had difficulty contacting claimant and had sometimes sent messages to claimant through a friend. Fryslie tried that method, and even stopped by claimant's residence, but could not locate her.

¶37 Claimant maintains she quit work on the advice of her doctor. She testified: "I went into my doctor - - well, I was going into my doctor off and on quite a bit over the months. And he wrote me a note and told me that I - - medically I could no longer do that position, to find a new job." (Peone Dep. at 5.) Claimant testified she gave the note to Woyden. (*Id.* at 6.) She

also testified that she called Fryslie, but testified the call was not made on August 17, 1999, but afterwards. (*Id.* at 6-7.)

¶38 On August 23, 1999, claimant visited Dr. Davis. His note reads:

> (1) leg pain.
>
> (2) c/o leg pain since 6/20/99 - reinjured L5 spine. Then aggravated by severe contusion - jumping into back of pick up 7/20/99. Has not been able to stand or walk well [illegible].

(Ex. 5 at 30.) That same day, Dr. Davis wrote the following on a prescription form: "Work excuse 8/23 - 9/12/99 due to leg injury." (*Id.* at 31.)

¶39 Dr. Davis acknowledged claimant had told him that her back hurt worse after the pickup incident. That was not, however, his concern in treating claimant on August 23, 1999. He testified:

> Based on my notes and the fact that we were following her up for this potential infection that I was quite worried might turn into something much more serious than what it did, I was assuming we were referring to the leg pain in the right leg caused by her bruise and possible infection. And that's what I thought she was saying when she said she couldn't stand up and walk on it. Because there's nothing in that note, I don't think, referencing physical exam of her back. Except to say her seated straight leg raises were negative. . . .
>
> . . . .
>
> The only thing I can say about it was I was not dealing with her back at that visit . . . I was dealing with her leg injury.

(Davis Dep. at 69-72.)

¶40 Dr. Davis testified he did **not** write claimant a note to support her termination of employment. He explained:

> Well, I had written the original excuse on account of one injury, which was totally unrelated to her back injury. But she decided on her own that she wasn't going to go back to work there because it was too much of a struggle on her back. Eventually, the leg bruise resolved completely and she would have been able to continue to work from that standpoint. But she was just tired of putting herself at risk, lifting these difficult patients, and wouldn't give her anybody she thought she could work with a little better, so she just decided not to go back to work. I said I did not specifically authorize or recommend that because she didn't come to me and say, Doc, I can't go back to work, my back hurts too much. But had she done so, I would have said that's reasonable.

(*Id*. at 25-26.)

¶41 Dr. Davis testified that his *after-the-fact* support for claimant's decision to quit working was based on the understanding he **then** had of her back condition. (*Id*. at 61-63.) As noted below, after an MRI conducted in June of 2000, Dr. Davis revised his opinion of what claimant's condition was at the time she quit work.

¶42 According to claimant, she was under the impression Dr. Davis took her off work due to her back condition. Although the August 23 note only took claimant off work through September 12, claimant maintained she believed Dr. Davis took her off work permanently. She testified that she brought the release to Woyden just after receiving it from Dr. Davis. Initially, she testified this was on August 23 and that she had worked the day before, August 22. She testified she made the phone call to Fryslie after this point to make sure she understood what had happened.

¶43 On cross-examination, which commenced after a recess following claimant's direct examination, claimant testified she was no longer sure whether or not she had worked for Mission Mountain after August 17. Later, she testified that after thinking about it, she believed she called in sick around then and may not have worked after August 17.

¶44 Time records show claimant last worked for Mission Mountain on August 16, 1999. (Ex. 10 at 11, 28, 34.)

¶45 Woyden recalled seeing Dr. Davis' August 23rd note, although he was not sure whether claimant gave it to him personally or it came through Fryslie.

¶46 I find claimant's testimony concerning her cessation of work **not** credible. Her story is not supported by Dr. Davis, who took her off work temporarily on account of her leg. She quit work August 17th, which is prior to his taking her off work. She then disappeared and her supervisors at Mission Mountain were unable to find or contact her.

¶47 On September 9, 1999, claimant returned to Dr. Davis for back pain. Dr. Davis interpreted his handwritten record from that date as follows: "Back pain was still hurting. Complains of right leg pain to the knee. She quit her job secondary to the lack of accommodation, wouldn't transfer her to a less difficult patient, parentheses, client, still has difficulty sleeping due to her chronic pain." (Davis Dep. at 24; Ex. 5 at 32.) His exam indicated no change in her condition: "Still stiff in the back and still tender and sore." (Davis Dep. at 24.)

¶48 On September 30, 1999, Dr. Davis completed a "tribal general assistance doctor's statement" for claimant, indicating a diagnosis of "degenerative disc disease." (Ex. 5 at 33.) In response to the question, "How long before this Patient can return safely to work or to training?" Dr. Davis wrote: "Permanent." (*Id*.) He also indicated that claimant should be referred to other public assistance programs such as S.S.I. (*Id*.)

¶49 Around January 2000, counsel for claimant wrote the insurer demanding TTD benefits. (Ex. 10 at 4-5.) The insurer refused, noting the employer's position that claimant had not asked for accommodation regarding her physical condition, had merely quit, and had only received, at the time, a work excuse for three weeks. (*Id.*)

¶50 On January 25, 2000, an independent medical examination was conducted by Dr. Patrick Robins in Missoula. (Ex. 1 at 1.) Claimant reported low-back pain, with radicular symptoms into her leg. (*Id.*) Dr. Patrick's impression was:

> Mechanical low back pain secondary to degenerative disc disease, mild, L5-S1 and herniated nucleus pulposus L4-5. Right subjective leg sciatica with normal neurologic exam. At this time, I feel that she has reached maximum medical improvement and utilizing AMA Guide to Evaluation of Permanent Impairment, 4th Edition, Table 75, page 3/113 I would estimate her permanent whole person impairment to be 5%.
>
> As far as treatment recommendations are concerned, I would strongly discourage any short term continued narcotic use. The patient has not had a trial of epidural steroid injections and I highly recommend this to hopefully diminish her pain, increase her functional capacity and decrease her use of narcotics. This treatment of itself, however, will not effect her MMI or impairment. She wishes to discuss this further with Dr. Davis, which I feel is indicated.

(Ex. 1 at 3.)

¶51 Claimant visited Dr. Davis' clinic intermittently over the next few months. During February 2000, she reported "severe fatigue, listlessness." (Ex. 5 at 42.) In early March, she reported she "feels lousy all the time." (*Id.* at 43.)

¶52 On June 6, 2000, claimant was examined by Dr. David T. Schloesser, a neurologist, on referral from Dr. Davis. (Ex. 2 at 1.) Dr. Schloesser found claimant's right lower extremity pain was "suggestive of an L5 radiculopathy," but found EMG testing normal. He recommended another MRI scan of the lumbar spine with attention to the right L5 nerve root. (*Id.*)

¶53 On June 22, the recommended MRI was done. Dr. Thomas Layne read the scan as **not** indicating disk bulge or other significant abnormality. He wrote:

> The patient has had two previous MR scans of the lumbar spine; one done in 1992, and one done in 05/98. On the study in 1998, there was suggestion of mild disc bulge on the left side laterally. While it encroached on the foramen in the lateral recess there was no definite nerve root impingement. At the present time, I do not see this abnormality, and it may well have resolved on its own.
>
> IMPRESSION:

The patient has some minimal facet disease at L5-S1 with slight narrowing of the disc with no herniation or focal nerve root abnormality.

(Ex. 3 at 5.)

¶54 After reviewing the June 2000 MRI, Dr. Davis acknowledged that claimant's situation in August and September of 1999 was likely less serious than he had believed at the time. He testified:

Q. Now, this particular case, her reliability as a historian is going to be very important to the weight to give your opinions as to what she could do and couldn't do physically because of back problems?

A. Correct. Well, that is true except that I interpreted that study as indicative - the MRI of 1998 as being indicative of a problem that was much worse than actually existed.

Q. Could you explain that?

A. I gave more credence to that report of 1998's MRI as indicative of a major problem. And then when it was not redemonstrated in June, it was only then that I realized that things were not quite as serious as they were. But I didn't have the report of the June study to indicate that things had reversed or things had corrected.

Q. Taking a look at the 2000 study, it says at L4-5 there's a left lateral disk bulge which partially defaces the left subarticular recess and the inferior aspect of the left neuroforamen.

A. Back in '98, correct.

Q. That's '98. I'm sorry. And then you have Dr. Layne's interpretation?

A. I have Dr. Layne's interpretation, 2000 study. And he states specifically in his comments, not in the impression but in the narrative, on the study in 1998 there was suggestion of disk bulge on the left side laterally, with encroachment on the foramen in the lateral recess, there was no definite nerve root impingement. At the present time I do not see this abnormality and it may well resolve on its own.

Q. This idea that had she asked you in August or September of '98 to be taken off of work because of her low back, you testified, had she asked you back then, you would have, correct?

A. I would have said that was a prudent course of action.

Q. And that would be based on her complaints, correct?

A. Correct. And based on the fact that I thought there was more pathology in her

> disk. There was objective evidence for more pathology in her disk than actually existed.

(Davis Dep. at 61-63.)

¶55 On July 15, 2000, Dr. Davis responded to an inquiry from the insurer as follows:

> This letter is in response to your letter of August 14, 2000. In answer to your questions, number one, Joyce Peone was given a work excuse on 08/23/99 due to acute knee pain and swelling, which made it impossible for her to walk. She subsequently did not return to work because she did not feel it was safe to continue her employment there due to an aggravation of her injury, which occurred when her main client intentionally went limp while being transferred. The sudden increase in weight further sprained her back. She repeatedly asked her employers to transfer her to a more manageable client who was more cooperative in her daily care, but the employer refused. **I did not specifically authorize or recommend this cessation of work**, but given the circumstances, I concurred with her decision. It should be noted that Ms. Peone worked for sixteen months after the injury with very limited time off from work as a result of her pain and suffering. I believe she made a good faith effort to work through her illness, pain and injury, but was met with increasing resistance by her employer. I do not feel she was able to return to her previous position and job without facing substantial risk for re-injury and aggravation of her condition.
>
> As regards her return to maximum medical improvement, I am aware that EMG and studies were normal and the most recent MRI in 06/00 did not demonstrate the previous disk herniation at L-5, S-1 on the left side. Therefore, I believe she has probably returned to maximum medical improvement with the following reservations: 1) She is likely to experience some continued chronic pain as a result of this injury; and 2) She was never given an adequate course of physical therapy following the injury and does not currently have a stretching and flexibility exercise program, which would improve her mobility and, probably, pain and future status. I have recommended this to her on several occasions in the last eight months. She is willing to attempt this, but your company has been unwilling to authorize it.

(Ex. 5 at 51, emphasis added.)

¶56 Dr. Davis testified he was still not sure claimant had reached MMI because she had not had the opportunity for physical therapy. (Davis Dep. at 67-68.) He acknowledged, however, that lack of physical therapy was "partly due to the patient's lack of pursuing this fully." (*Id.* at 28.)

¶57 Claimant testified she found assembly work after leaving Mission Mountain, but left after approximately one month because the work hurt her back. She maintains her back condition still interferes with her ability to work.

Resolution

¶58 Claimant was not a credible witness. Her testimony regarding her last day of work shifted during the trial. Documentary evidence and testimony demonstrates that she quit her job before she got an excuse to be off from work for three weeks and that she was not told to quit work by her doctor, as she claims. Although she claims that her physical therapist told her in June 1998, not to come in, the therapist's records indicate that she was a "no show" and that he had asked claimant to come in even if she was hurting so her program could be revised. (Ex. 9 at 1.) Although she was not pursuing physical therapy, when claimant visited Dr. Schure on July 14, 1998, she told the doctor she was. (Ex. 5 at 6.) Her testimony that she asked for accommodations from her employer and to change clients was contradicted by her supervisors.

¶59 I find that claimant did **not** quit because of her back condition or because of her employer's refusal to accommodate her back condition by changing her clients. I also find no credible evidence that claimant was in fact temporarily totally disabled when she left employment with Mission Mountain. While Dr. Davis testified he *would have* supported a decision by claimant to leave employment, he also testified that this would have been based on his understanding at that time of claimant's condition. After the June 2000 MRI he recognized there was no evidence of the pathology he thought existed. His post-hoc support for claimant's leaving her job was also based on his erroneous belief Mission Mountain had refused to accommodate claimant.

CONCLUSIONS OF LAW

¶60 Claimant was injured on April 6, 1998,[(1)] therefore the 1997 version of the Workers' Compensation Act applies. *See, Buckman v. Montana Deaconess Hospital,* 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶61 Section 39-71-701, MCA (1997), governs temporary total disability benefits. It provides in pertinent part:

> (1) Subject to the limitation in 39-71-736 [regarding no compensation for the first six days of lost wages] and subsection (4) of this section [regarding return to work], a worker is eligible for temporary total disability benefits:
>
> (a) when the worker suffers a total wage loss **as a result of an injury** and until the worker reaches maximum healing; or
>
> (b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements. [Emphasis added.]

¶62 The claimant bears the burden of proving by a preponderance of the evidence that she is entitled to compensation. *Ricks v. Teslow Consolidated,* 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wicken Bros. Construction Co.*, 183 Mont. 190, 598 P.2d 1099 (1979).

¶63 Claimant has not carried her burden. I am unpersuaded she quit her job on account of her back condition or that she sought transfer to a different, less troublesome client. She has failed to prove that a client and situation she could handle were unavailable to her had she sought accommodation from her employer. Further, Dr. Davis' testimony that he was not sure that claimant had reached MMI by August 1999 was predicated upon her not having had a sufficient opportunity for physical therapy, however, claimant failed to pursue therapy when offered. Since the failure is attributable to her, Dr. Davis' testimony does not establish she had not reached MMI. Because the claimant failed to pursue physical therapy, she is at MMI since she is lacking a commitment to pursue therapy, her condition will not likely improve.

JUDGMENT

¶64 1. Claimant is not entitled to temporary total disability benefits and her petition is **dismissed with prejudice**.

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

¶66 3. Any party to this dispute may have 20 days in which to request a rehearing from these findings of fact, conclusions of law and judgment.

DATED in Helena, Montana, this 1st day of February, 2001.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Ms. Laurie Wallace
Mr. Larry W. Jones
Submitted: November 27, 2000

1. As set out in paragraph 25, she also suffered a temporary exacerbation on June 20, 1999. However, the medical evidence established that she returned to her pre-June 20th condition within a short time. It does not appear that a claim was made with respect to the July 20th incident and claimant's petition is based entirely on the April 1998 injury.