IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2000 MTWCC 32

WCC No. 9903-8176

KESTER C. ROMANS,

Petitioner,

vs.

LIBERTY MUTUAL FIRE INSURANCE COMPANY,

Respondent/Insurer for

SUPERVALU, INCORPORATED,

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: 43-year-old pro se claimant hurt right foot while working for grocery store. He settled claim, reserving only medical and hospital benefits, but now seeks to reopen settlement on ground of mutual mistake of fact with regard to nature and extent of his injury. Claimant testified that he was "totally disabled" and had been under "extreme duress" and on medication at the time of settlement.

Held: Although much medical and other evidence was presented through documents, depositions, and trial testimony, there is no credible evidence that the parties were mutually mistaken about claimant's condition. In particular, the Court finds no evidence that claimant's present condition involves significant pathology or requires surgery or further treatment. Further, claimant was not a credible witness and the Court finds he has consciously exaggerated his symptoms. Request to reopen denied.

Topics:

> **Settlements: Reopening: Mistake of Fact.** No mistake of fact regarding claimant's medical condition at time of settlement where no credible evidence suggests significant pathology requiring surgery or further treatment and claimant's testimony of total disability was not credible and was in conflict with overwhelming medical evidence.

Witnesses: Exaggeration. Overwhelming medical evidence suggested claimant was not disabled as he claimed. Court concluded claimant was consciously exaggerating his symptoms or even malingering.

¶1 The trial in this matter was held on February 25, 2000, in Butte, Montana. Petitioner, Kester C. Romans (claimant), was present and represented himself. Respondent, Liberty Mutual Fire Insurance Company (Liberty), was represented by Mr. William J. Mattix. The record remained open pending the taking and submission of the depositions of Dr. Dennis Rich, Dr. John A. Vallin, and Mr. Gary Lusin, RPT. A partial trial transcript was prepared.

¶2 Exhibits: Exhibits 1 through 45 were admitted without objection. Respondent prepared and submitted 1 through 24 as joint exhibits. Claimant submitted exhibits 25 through 44. When organizing the exhibits according to Court instructions by provider and chronologically, the page numbers used by claimant were no longer sequential. Consequently, in an effort to carefully identify documents cited in this decision, the Court has bate stamped exhibits 25 through 44 with sequential page numbers. When a citation is made to exhibits 25 through 44, it will include the bate stamped page number used by the Court and the page number used by Mr. Romans to identify the document. For example (Ex. 32 at 1[45].) If an exhibit is duplicated, the Court will only cite to one document.

¶3 At trial claimant withdrew his offer of a "Videotape of Functional Capacities Evaluation (FCE)" after Mr. Mattix objected to its admission. The claimant then offered it at the deposition of Gary Lusin, RPT as Exhibit 48. Mr. Mattix again objected on grounds of foundation and incompleteness. The Court has viewed the exhibit and sustains the objections. The tape was either edited or filmed to show selected tasks; it is unknown who made the tape and it ends abruptly. There is no explanation of the circumstances of the filming and there is no way to determine the time taken by the claimant to complete the various tasks. Exhibit 13 at page 92 shows that the FCE was a five hour standardized test, the video tape is approximately one hour in length. Exhibit 48 is refused.

¶4 Exhibit 45 consists of six MRI films taken of Mr. Romans on February 14, 1997. There was no objection to Exhibit 45 and it was admitted. At the deposition of Dr. John A. Vallin on March 15, 2000, Exhibit 46, a radiology report dated November 25, 1997, was offered without objection and the exhibit was admitted. At the deposition of Dr. Dennis Rich on March 21, 2000, Exhibit 47, *Pathoanatomic Basis or Pain in Lumbar Disk Extrusion*, was objected to based on foundation and failure to exchange. The objections are sustained and the exhibit is refused.

¶5 Witnesses and Depositions: Claimant and his son, Andy Romans, were sworn and testified. The parties were granted leave to take the post-trial depositions of Dr. Dennis Rich, Dr. John A. Vallin, and Mr. Gary Lusin, RPT. These depositions are submitted for the Court's consideration.

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

1. Whether the Full and Final Compromise Settlement should be reopened based upon a mutual mistake of fact.

2. If so, whether claimant is permanently totally disabled.

3. Whether claimant is entitled to an award of costs.

¶7 Having considered the final pretrial 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

¶8 Claimant is presently 43 years old. He has a high school education.

¶9 On October 12, 1993, claimant was working as a stocker at the Livingston County Market. While in the course and scope of his employment the claimant injured his right foot while pulling on a loaded pallet jack. (Ex. 1.)

¶10 At the time of the injury, Liberty insured Livingston County Market. It accepted liability for the injury and paid medical and compensation benefits.

¶11 Claimant has not worked, in any capacity, since approximately November 15, 1993. (*Id*. at 135.)

I. Settlement

¶12 Claimant entered into a petition for compromise and release settlement on March 31, 1997. The agreement provided that the parties "have agreed to fully and finally conclude **all compensation payments** due the claimant under the Workers' Compensation Act" for $19,381.68. (Ex. 2, emphasis added.) It reserved medical and hospital benefits. It further provided that the settlement was on a "compromise and release" basis and that upon approval of the settlement his claim would "be fully and finally closed" and could not be reopened. (*Id.*) The Department approved the settlement on April 8, 1997. (*Id.*)

II. Request to Set the Settlement Aside

¶13 In this action the claimant seeks to set aside the settlement and obtain permanent total disability benefits. He alleges that the settlement was based on a mutual mistake of fact with respect to the extent of his disability and the nature and extent of a back injury he allegedly suffered while undergoing an FCE requested by Liberty.

¶14 At trial claimant testified that at the time he entered into the settlement he was "totally disabled", under "extreme duress", and on medication. After listening to his testimony and considering all of the evidence in the case, I did not find his testimony credible.

III. Pre-Settlement History

A. Early Evaluation and Treatment

¶15 On October 13, 1993, the day following the injury, claimant was treated by Dr. John G. Peterson, an internist. Dr. Peterson diagnosed "Achilles tendonitis secondary to injury." He wrapped the ankle in an ace bandage, instructed claimant to ice and elevate his foot, and prescribed Naprosyn. Claimant was given a medically excused absence from work for the next day. (Ex. 14 at 126.)

¶16 Claimant was next seen on October 26, 1993, by Dr. Thomas Rowe, another internist. (Ex. 22 at 203.) Dr. Rowe ordered x-rays to be taken of the foot. On November 8, 1993, the doctor wrote an office note stating that claimant had called to request an earlier x-ray appointment because he had "[p]lans to go hunting." (*Id.*) The x-rays were taken the following day, November 9th. Dr. J. Jutzy, radiologist, reported:

> The top of the dome of the talus cannot be visualized on this study. The right foot is otherwise normal without evidence of fracture, lytic, blastic change, or bony destruction. There is a bone island in the superior aspect of the posterior calcaneous which can be a normal anatomical variant.

(Ex. 12 at 86.) On November 10, 1993, Dr. Rowe referred the claimant to Dr. John D. Campbell at the Bridger Sports Medicine Orthopedic Clinic (ex. 15 at 127) and wrote a release to return to "limited duty with no lifting at this time." (Ex. 22 at 205.)

¶17 Dr. Campbell initially examined the claimant on December 6, 1993. His impression was: "His main problem is tarsal tunnel syndrome, probably." (Ex. 15 at 127.) He injected claimant with Xylocaine and Aristospan and took him off work for two weeks. (*Id.*) The doctor noted that if the injections helped claimant's symptoms he would proceed with "tarsal tunnel workup", but if there was no improvement he would consider getting a bone scan of the foot. (*Id*.)

¶18 In a letter to Sandy Scholl (Scholl), claims adjuster, Dr. Campbell wrote that he thought the claimant was capable of a job where it was

> mainly sitting, no walking, where he did paperwork and that kind of thing. My note of December 6 stated that I was going to keep him off a couple of weeks, but I would be willing to modify that if they can modify the job for him.

(*Id*. at 128.)

¶19 Claimant's next appointment was on December 29, 1993, at which time he reported the injection had not helped and that his symptoms were worse. (*Id.* at 127.) Claimant was placed in a short leg walking cast for a month. (*Id.*)

¶20 A recheck was done by Dr. Campbell on January 27, 1994. He noted claimant was "[b]asically unimproved from the cast." (*Id.* at 127.) The diagnosis continued to be "severe Achilles's tendonitis." The doctor prescribed physical therapy and medication. (*Id*.) Claimant thereafter underwent physical therapy treatments from February 4, 1994, up through March 4, 1994. (Ex. 19 at 161-64.)

¶21 The insurer referred claimant to Dr. John S. Diggs, who specializes in physical medicine and rehabilitation pain management, for "diagnosis, prognosis, recommendation for further treatment, question of maximum medical improvement status and impairment rating if appropriate, as well as opinion regarding return to work status." (Ex. 21 at 200.) Dr. Diggs examined claimant on March 9, 1994. Based on his exam and nerve conduction velocity studies, Dr. Diggs opined "I don't believe his continuing chronic pain five and a half months later is due to tendinits [sic], but I suspect has turned into a chronic pain syndrome . . . ." (*Id.* at 201.)

¶22 Claimant returned to Dr. Campbell on March 9, 1994, reporting that he was still having a significant amount of Achilles tendonitis pain. (Ex. 15 at 129.) Dr. Campbell ordered an MRI (*id*.), which was thereafter done on March 23, 1994. The radiologist reported:

> NORMAL APPEARANCE OF THE ACHILLES TENDON. NO SUGGESTION OF TEAR, EITHER PARTIAL OR COMPLETE, OR TENDINITIS. LIKEWISE THE CALCANEUS DEMONSTRATES A NORMAL APPEARANCE WITHOUT EVIDENCE OF BONE BRUISE OR ABNORMAL MARROW PATTERN. THE ETIOLOGY OF THE PATIENT'S TENDERNESS IS NOT APPARENT ON THESE IMAGES.

(Ex. 18 at 159, capitalization in original.)

¶23 On April 7, 1994, the claimant returned to Dr. Campbell, who noted the "normal" MRI and claimant's lack of improvement. He was "at a loss as to what else to do for him." (Ex. 15 at 129.) The doctor recommended an FCE to determine claimant's physical limitations and indicated that without any other treatment claimant was at maximum medical improvement (MMI). (*Id*.)

B. First FCE

¶24 A five hour FCE was performed on May 9 and 10, 1994, by Gary Lusin, a physical therapist. (Ex. 13 at 92, Lusin Dep.) The overall results of the test placed claimant's functional abilities in the "LIGHT-MEDIUM PHYSICAL DEMAND LEVEL." (*Id.,* capitalization in original.) Mr. Lusin observed that the claimant generally cooperated and was willing to perform all of the tasks; that he demonstrated both a consistent and inconsistent performance during the FCE; that he demonstrated poor body mechanics during lifting which increased the load to the low back region; and that claimant reported pain through the right foot and low back. (*Id*.) Regarding the claimant's stated low-back pain, Mr. Lusin noted:

> Specific to the low back, even though Mr. Romains [sic] reported of low back pain during the test, his movements during tasks as well as in between tasks did not display a change in his movement pattern and did not decrease his quality of movement through the lumbar region secondary to his pain.

(*Id.* at 93.) Mr. Lusin believed that the results of the FCE were a valid representation of the claimant's "current level of function." (*Id.* at 95.) While recommending that claimant was capable of light-medium work, Mr. Lusin cautioned that,

> Within any job he may pursue he most likely will need some alteration in his standing time and allowing appropriate breaks to sit down and relieve standing stress would be suggested.

(*Id.*)

¶25 Claimant returned to Dr. Campbell on June 22, 1994, for a "[r]echeck [of the] right foot". (Ex. 15 at 130.) The doctor wrote that claimant reported that "after the FCE he had difficult [sic] ambulating and could barely ambulate for a couple of weeks. . . . He is very concerned because the rating that Gary Lusin gave him was light medium demand level." (*Id.*) Given claimant's disagreement with Mr. Lusin regarding his work level and because the claimant felt he should have another FCE, Dr. Campbell noted, "[T]he only thing I can offer him is to delay the impairment rating." (*Id.*) He went on to recommend that claimant followup with another orthopedist, and get another FCE. The doctor felt that claimant would need to be retrained for more sedentary work as he would not be able to go back to physical work. (*Id.*)

C. Independent Medical Examinations - 1994

¶26 Liberty arranged for an independent medical examination (IME) at the Billings Clinic on August 1, 1994, with Dr. William S. Shaw, who specializes in occupational medicine. (Ex. 16.) Dr. Shaw recorded claimant's chief complaints were of right foot, ankle, and low-back pain. (*Id.* at 134.) Claimant told the doctor that he developed low-back pain during the FCE and "practically had to be in bed for the next month." (*Id.* at 135.) Claimant reported he had been seeing a chiropractor for six weeks for the pain,[(1)] which was located in the mid-lumbosacral region. He described the pain as "sharp and stabbing in nature." (*Id.*) Dr. Shaw's impressions were:

> Mr. Romans presents with diffuse foot pain. His symptoms today are more suggestive of plantar fasciitis and pain over the deltoid ligaments than they are of an Achilles tendinitis, however, there are findings which are **inconsistent with these diagnoses as well.** There is certainly no evidence of instability. There is little further in the way of workup or treatment that I can suggest at this time. I would think that if a further evaluation by a foot specialist is desired, Dr. James Elliott at Orthopedic Surgeons, PSC in Billings would be a good candidate. . . . If Dr. Elliott does not have

> further treatment which he deems appropriate then I believe this man would be considered to have reached maximum medical improvement. [Emphasis added.]

(*Id.* at 137.)

¶27 Upon Dr. Shaw's referral, Dr. Elliott, an orthopedic surgeon, saw claimant on September 1, 1994. Claimant's symptoms were mainly pain in the posterior heel pad. Claimant reported that pain occasionally extended up into his Achilles into his calf, and that occasionally he felt "a squeezing or a spasm in this region." (Ex. 4 at 8.) Dr. Elliott diagnosed plantar fasciitis of the right heel and right heel syndrome. He concurred with Dr. Shaw's assessment that there was nothing to be done surgically at that time and that claimant was rapidly approaching MMI since his foot condition had not significantly improved in over a year.

¶28 Dr. Shaw reviewed Dr. Elliott's report on or about September 13, 1994, and found claimant at MMI. Referring to the American Medical Association Guidelines for Impairment (4th ed.), he found no provisions warranting an impairment rating for the claimant's condition. (Ex. 16 at 138.) The doctor stated, "At this point I believe it is safe for this man to perform any activity which he can subjectively tolerate." (*Id.*) He went on to note the FCE demonstrated claimant could perform at the light-medium demand level of work, but that in general "prolonged standing or walking should be avoided." (*Id.*)

D. Vocational Rehabilitation Services - 1994

¶29 In August 1994, the insurer instituted vocational rehabilitation services for the claimant. Susan J. Kern (Kern), of Independent Rehabilitation Providers of Montana, was the rehabilitation counselor.

¶30 Kern and the claimant first met on August 31, 1994. (Ex. 24 at 214.) They met a second time on September 14, 1994. A third scheduled meeting was cancelled by the claimant, reportedly due to back pain. (*Id.*)

¶31 Kern contacted claimant's time-of-injury employer and was advised it would not be possible to hire the claimant back under any circumstances as he had been a no show, and to hire him back would be in violation of their union contract. (*Id.* at 222.)

¶32 Claimant voiced an interest in purchasing a locksmith business in Livingston. He agreed to take the General Aptitude Test Battery (GATB) at Job Service and to contact the Livingston School District for information regarding computer classes. (*Id.* at 221.) However, claimant did not follow through with taking the GATB; he missed two scheduled appointments and never contacted Job Service to reschedule. (Ex. 24 at 223.) A job service employee quoted the claimant as saying, "I have a long term disability and I don't have to hurry to get employment. My caseworker just wants me to start doing something." (*Id.*)

¶33 Meanwhile, Kern wrote Dr. Elliott asking for his input regarding claimant. The doctor responded by letter dated October 3, 1994. He provided a copy of the September 1, 1994 visit and opined wrote further:

> I do feel that the patient has, in all likelihood, reached his maximum medical improvement. As far as permanent restrictions, it may be difficult for him to return to a job that requires being on his feet all the time or doing a large amount of walking. However, I feel there are many kinds of jobs that he would be suited for.

(Ex. 4 at 11.)

¶34 On October 27, 1994, Kern reported that she had completed a Vocational Diagnostic and Residual Employability (VDARE) worksheet for claimant. (Ex. 24 at 235.) Claimant told her he was interested in settling his claim so he could use the money to develop a lodge that he co-owned with other members of his family. (*Id.* at 234-35.) Kern again encouraged claimant to take the GATB. (*Id.* at 236.)

¶35 Kern submitted a final rehabilitation report on November 1, 1994. The report discloses that Kern had developed and submitted job analyses for dump truck driver and pricer to Dr. Shaw and that he had approved both jobs on a trial basis. (Ex. 16 at 139; Ex. 24 at 238.) The labor market information analyzed by Kern showed the availability of both these jobs, with the wage level for the dump truck driver being $10.00 per hour and that of a pricer $4.75 per hour. Kern wrote that claimant had agreed he could do both of these jobs. She also noted that the two jobs were only samples of jobs which the claimant could perform. Finally, Kern wrote:

> Mr. Romans declined placement services **because he wants to settle his claim** and use the money to work on a lodge that will be completed on a piece of property jointly owned by his family.

(*Id.* at 241, emphasis added.)

E. Legal Representation and Settlement Discussions - 1995

¶36 On February 13, 1995, the claims adjuster was notified by letter from Mr. Tom L. Lewis of his representation of the claimant. (Ex. 32 at 1 [45].) Mr. Lewis' representation came at a time that claimant was not being actively treated for either his foot or back conditions. The exhibits do not contain any medical records for treatment from approx-imately September 1994 until May 8, 1995.

¶37 Following notice of Mr. Lewis' representation, Scholl communicated an offer of settlement to Mr. Lewis. The offer was made on April 18, 1995. Scholl noted that claimant had reached MMI and was deemed employable. The offer of settlement included: age - 2%; education - 0%; medical - 0% (not rateable); 15% labor restriction; and wage 0% for a total of 59.5 weeks at $119.64 for a permanent partial disability payment of $7,118.58.

Additionally, she offered $957.12 for an 8 week job placement benefit. She noted that all permanent partial benefits paid would be deducted. (Ex. 26 at 3 [46].) Mr. Lewis advised the claimant that the offer was inadequate. (Ex. 32 at 2 [47].)

F. Continuing Medical Treatment 1995-1996

¶38 On May 8, 1995, medical treatment resumed. On that date, claimant was examined by Dr. R. E. Losee. Dr. Losee's office note records claimant's chief complaint as pain in his right heel. (Ex. 5.) He diagnosed "Baxter-Thigpin calcaneal neuritis and tarsal tunnel syndrome of his right foot" (*id*.) and recommended that claimant see Dr. Thomas Johnson, an orthopedic surgeon, for evaluation and a possible "decompression procedure." (*Id*.)

¶39 On May 24, 1995, claimant was examined by Dr. Johnson whose impression was "[e]ntrapment of the calcaneal branch of the posterior tibial nerve." (Ex. 4 at 13.) The doctor recommended surgery involving "decompression in the calcaneal branch of the posterior tibial nerve." (*Id*.)

¶40 Following that recommendation, Mr. Lewis wrote Scholl a letter on June 7, 1995, in which he asserted that the claimant continued to be temporarily totally disabled. (Ex. 32 at 3 [57].) He requested payment of Dr. Losee's bill, approval of the referral to Dr. Thomas Johnson, and reinstatement of temporary total disability (TTD) benefits. (*Id*.)

¶41 On July 12, 1995, Scholl approved surgery by Dr. Johnson. (Ex. 26 at 4 [53].) On July 18, 1995, Dr. Johnson preformed the surgery. (Ex. 20 at 181.)

¶42 Claimant continued to see Dr. Johnson post-surgery. On October 4, 1995, the claimant reported continued improvement from the surgery. At this appointment he asked Dr. Johnson to look at some x-rays of his back which he had brought with him. After reviewing the x-rays, the doctor noted, they "look fairly normal to me." Dr. Johnson recommended claimant be evaluated by one of his partners. (Ex. 4 at 16.)

¶43 Dr. Robert K. Snider, one of Dr. Johnson's partners and an orthopedic surgeon, examined the claimant on November 7, 1995, with regard to his back pain. In his office note, Dr. Snider wrote:

> X-RAYS: **Reveal no significant abnormalities except for some mild thinning of the discs all through the lumbar spine probably in association or related more to his smoking than to anything else.** [Emphasis added.]
>
> IMPRESSION:
>
> 1. Back sprain.
>
> PLAN/RECOMMENDATIONS: There is no evidence of neuropathy. I think that the patient has had a back sprain which will probably be self-limiting. I have recommended that he use a 3/8" leg lift on this left side to see if this will help some

of his symptoms. He will not require any surgery. His condition is at maximum medical benefits. The impairment rating for a back sprain is 0%. It may possibly go as high as 1%.

(Ex. 4 at 17.)

¶44 Claimant returned to Dr. Johnson on November 27, 1995, and reported he was not having any problems with his foot and would like to have a release for work. Dr. Johnson's note indicates that he gave the release for the "coming week." (*Id*. at 18.)

¶45 But on January 25, 1996, claimant returned to Dr. Johnson with a "flareup of neuritis in this [right] ankle." (*Id*. at 18.) Dr. Johnson injected claimant's foot with Xylocaine and Dalalone.

¶46 Claimant's ankle condition did not improve and he continued to treat with Dr. Johnson. (*Id*. at 18-19.) Dr. Johnson wrote to the claims adjuster on May 24, 1996, and advised that claimant had not reached MMI. (*Id*. at 23.)

¶47 On August 19, 1996, Dr. Johnson determined that claimant was at MMI and that there was no further surgical treatment indicated. (*Id*. at 19.) Dr. Johnson referred claimant to physical therapist Becky VandeZande for measurements on which he could base an impairment rating. (Ex. 23.) On August 21, 1996, Dr. Johnson rated claimant's impairment at "17% of the lower extremity. . . based on the AMA Guides to the Evaluation of Permanent Impairment - 4th Edition." (Ex. 4 at 19.) Later, on September 19, 1996, Dr. Johnson stated that the "Impairment rating would be a 12 percent impairment of the whole person or 17 percent of the lower extremity . . . ." (*Id*. at 20.)

G. Second FCE

¶48 On September 26, 1996, claimant participated in a second FCE under the direction of Todd Cadby, a physical therapist in Livingston. He wrote:

ASSESSMENT

Patient was very focused on his lumbar pain, if not more than equal to his right "ankle pain". This appeared to be a significant factor in his ability or lack thereof to perform basic functional maneuvers.

Patient was consistent in his compensation of avoidance of weight bearing on his right lower extremity, this perpetuated altered biomechanics when performing functional maneuvers, even with light weights.

Overall it appears he has minimal to no symptoms when sedentary or non weight bearing on his right ankle. I believe he has developed some mild contralateral hip/lumbar pain from his consistent antalgic gait. I believe he could perform light

> duty to sedentary work with occasional breaks. He does appear focused on his pain and dysfunction.

(Ex. 19 at 168.)

H. 1996 Rehabilitation Services

¶49 Meanwhile, in early April 1996, the insurer requested Kern to reopen the claimant's rehabilitation file and formulate a rehabilitation plan. (Ex. 24 at 242.) Kern wrote to claimant and his attorney, Mr. Lewis, on April 4 and April 24, 1996, requesting a time to meet. (*Id.* at 242-44.) In her Vocational Rehabilitation Update, dated June 7, 1996, Kern reported telephone conversations with the claimant on April 9 and 24, 1996, during which he described himself as unemployable. Claimant also stated that he had been advised by his attorney not to talk to anyone about his claim. (*Id.* at 247.) Claimant advised Kern that he had "applied for Social Security Disability Benefits and Rail Road Disability Benefits." (*Id.*)

¶50 Following the determination that claimant had reached MMI, Kern proceeded with her analysis and on October 27, 1996, she prepared a report. In her report she noted that claimant had again been contacted by telephone but "[n]o actual face to face meeting occurred because the client does not want a rehabilitation plan, **he wants to settle his claim**." (*Id.* at 250, emphasis added.)

¶51 Nonetheless, Kern prepared job analyses for a variety of positions and sent them to Dr. Johnson for his review. In December of 1996 and early January 1997, Dr. Johnson reviewed job analyses for the positions of 1) motel clerk; 2) dump truck driver; 3) night stocker; 4) pricer; 5) photo finishing technician; and 6) self-service gas station cashier. (*Id*. at 258-74.) The doctor disapproved the positions of dump truck driver and night stocker (*id.* at 258-63); approved the job of pricer with the comment that claimant must be allowed to take frequent breaks (*id.* at 264-66); and approved without qualification the positions of motel clerk, photo finishing technician, and self-service gas station cashier. (*Id.* at 254-57, 267-74.)

I. Claimant's Application for Railroad Benefits Based on His Back

¶52 Claimant testified that some time prior to June 7, 1996, he applied for retirement benefits from the railroad **based on his belief that he was totally disabled**. (Trial Test.)

¶53 On June 7, 1996, the claimant was examined by Dr. Thomas Hildner in Bozeman, Montana. Dr. Hildner did a "cardiometrics examination" and filled in a physical residual functional capacity assessment form. Dr. Hildner's history stated:

> This is a gentleman who says he was working for the railroad three years ago. **Was doing some lifting and injured his low back. Since that time he's had persistent pain, aching and stiffness which is constant and he's been unable to work since that time.** He cannot stand or sit for very long without developing pain, nor can he

> bend over, stoop or crawl because of the discomfort. The time he feels the best is when he's laying flat.

(Ex. 3 at 4.) In assessing the claimant's credibility, it is noteworthy to the Court that his statement concerning not working after his railroad injury is untrue, as evidenced by the very claim at issue in this case, and that he was reporting to other doctors that his back pain was caused by his first FCE.

¶54 Dr. Hildner's assessment was:

> 1. Degenerative disc disease in the lumbar spine, primarily based on history and decreased range of motion of the lumber spine.
>
> 2. Possible chronic neuropathy of the right foot.

(*Id*.)

¶55 Claimant qualified for benefits under the Railroad Retirement Act, and was awarded disability benefits retroactive to April 1, 1995. (Ex. 42 at 1 [160].)

J. Claimant's Request for a Second IME

¶56 On January 10, 1997, claimant's attorney, Mr. Andrew Huppert, wrote to claims adjuster Scholl with the information that claimant was experiencing serious low-back pain which he attributed to the FCE done May 9 and 10, 1994. He requested an evaluation of the claimant's back pain by a "qualified orthopedic specialist". (Ex. 32 at 10 [73].)

¶57 Of significance to the Court in assessing claimant's credibility, there is no mention in Mr. Huppert's letter of the claim for railroad retirement benefits based upon an injury while working for the railroad.[(2)] Back in 1994, claimant had told Kern that "he was relatively healthy and had no significant barriers to employment until the accident at County Market in Livingston . . . ." (Ex. 24 at 215.) There is no indication that the claims adjuster was aware of the railroad disability claim or the claimant's back injury while working for the railroad.

¶58 The insurer set up an appointment for an IME on January 24, 1997, with Dr. John Vallin, who is board certified in physical medicine and rehabilitation.[(3)] (Ex. 26 at 7 [77].) Additionally, an MRI was scheduled for February 14, 1997.

¶59 Dr. Vallin wrote a lengthy, detailed report of his examination and evaluation of claimant. While the report discloses that claimant told Dr. Vallin he was applying for railroad disability (ex. 17 at 151), it does not appear that he disclosed that his application was based on a back injury. With respect to claimant's back complaints, the history provided by claimant was as follows:

> Kester states he was evaluated by Dr. [sic] Gary Lusin, physical therapist, May 9 and 10, 1994 for a Functional Capacity Evaulation [sic] (FCE). During the FCE, Kester

states he injured his low back lifting items. Kester states as a result, he has "never been the same…I'm ruined." Following his injury, Kester states he was unable to get out of bed for one month and as a result has been unable to hold a job.

(*Id*. at 150-51.)

¶60 Dr. Vallin's report noted exaggerated behavior by claimant and indicated that claimant had likely suffered only a mild strain during the Lusin FCE. He wrote:

IMPRESSION:

. . . .

2. Lumbar strain as a result of FCE, May 9/10, 1994.

3. Multiple nonorganic/behavioral signs to physical examination with marked overt pain behavior, unexplainable on an organic basis.

DISCUSSION:

. . . .

With respect to his low back, Mr. Kester [sic] demonstrated marked symptom over-amplification, as noted by the overt pain behavior he demonstrated during the interview and physical, exhibiting positive Waddell's signs, which are nonorganic or behavioral overreactions to the physical examination.

It would be my medical opinion that Mr. Romans perceives himself as much more disabled than he is in reality. However, in order to better objectify Mr. Romans's subjective symptoms, I would highly recommend he undergo an MRI of his lumbar spine, so as to determine what Mr. Romans would be capable of doing as it pertains to his low back.

My overall impression is that most likely, Mr. Romans sustained a mild lumbar strain at the time of his FCE testing in May of 1994. His symptoms at that time and presently do not suggest he herniated a disc, as he has never had radicular symptoms radiating into his lower extremities.

It would be my medical opinion that Mr. Romans has recovered completely from said lumbar strain in 1994 and should be considered at maximum medical improvement if he has not already been determined to be so by Dr. Johnson.

(Ex 17 at 152-53, emphasis added.)

¶61 In his deposition Dr. Vallin explained the use of Waddell's signs. He said that Waddell's signs have been "adopted in the medical literature to describe behavioral over reactions to a physical exam that cannot be explained on an organic or physiologic basis." (Vallin Dep.

at 9.) In his January 24, 1997 report (ex.17 at 152) five signs were listed, all of which were positive for claimant. In his deposition the doctor explained why these signs indicate symptom exaggeration:

- The first Waddell's test involves "lightly pinching the skin on somebody's back." (Vallin Dep. at 9.) That test elicited from claimant a complaint of "low back pain, pinching a wide area of his lumbosacral skin." (Ex. 17 at 152.) This maneuver does not cause pressure to a nerve, a disk, or a lumbar disk segment and there is no movement in the spine to cause pressure to a segment that could potentially cause claimant's reported pain. (Vallin Dep. at 9.)

- The second maneuver was "a vertical load . . . placed over the top of his skull when his shoulders and pelvis were passively rotated together in the same plane as he stood relaxed with his feet together." (Ex. 17 at 152.) Claimant reported low-back pain in response to the maneuver. (*Id*.) Dr. Vallin testified that the maneuver will "transmit no forces whatsoever to the low back. . . . You're causing actually no movement of the lumbar spine at all. So there's no forces applied to the lumbar spine with that maneuver." (Vallin Dep. at 10.)

- The third maneuver involved straight leg raising (SLR). Claimant reported "low back pain during supine SLR at 40°" but did not report pain "during seated SLR to 90°." (Ex. 17 at 152.) Dr. Vallin explained that the claimant's response was non-organic because both supine and seated SLR stretches the sciatic nerve, therefore the two SLR maneuvers should generate the same response. (Vallin Dep. at 10.) Dr. Vallin further noted that in the supine position at 40° the sciatic nerve is not being stretched, rather the stretch generally begins to occur at about 60°. (*Id.* at 11.)

- The fourth test involved pinpricks. Claimant reported a "lack of sensation to pinprick in a patchy, nondermatomal distribution in both legs, both proximally and distally." (Ex. 17 at 152.) The doctor explained that there are "discrete sensory dermatomes or portions of the thigh, the leg, the foot, which correspond to sensation directly related to a nerve root coming out of the lumbar spine." (Vallin Dep. at 12.) "So when a patient has loss of sharp touch everywhere in the legs that's not physiologic." (*Id*. at 13.)

- The fifth test involves applying a force to an extremity and asking the patient to oppose the resistance. (*Id*. at 13.) In claimant's case he had "diffuse give-way weakness of the lower extremities, which were unable to be explained on neurological basis." (Ex. 17 at 152.) Dr. Vallin explained "that type of weakness diffusely in the legs would be consistent with either severe neurologic impairment

such as cauda equina where you have a massive disk herniation essentially impinging all the nerve roots coming off the spinal cord below L2 . . . Otherwise, if they have giveway weakness but yet they have normal demonstrated strength in terms of their ability to propel their legs forward and walk without foot drop, what have you, then that would be nonorganic." (Vallin Dep. at 14.)

¶62 On March 23, 1997, Dr. Dennis L. Rich, a radiologist, performed MRI imaging of claimant's lumbar spine. His impression was:

> At L5-S1, there are manifestations of early degenerative disk disease associated with nominal general posterior bulging of the disk annulus. No evidence of focal disk protrusion, nor compromise of adjacent neural structures. Character of the nerve root sleeves suggestive of conjoined character bilaterally.

(Ex. 18 at 160.) Dr. Vallin interpreted the MRI as:

> The impression was that of mild early degenerative disc disease at L5/S1 with a small central disc bulge with no significant protrusion or neural compromise. The discs at the remaining levels were within normal limits.

(Ex. 17 at 157.) The doctor in his letter to Scholl on February 18, 1997, wrote:

> I have informed Kester I have no medical explanation for his ongoing low back pain in the face of a relatively normal MRI. I **have no further recommendations and continue to be of the opinion that Kester appears to perceive himself as much more disabled than he is.** [Emphasis added .]

(*Id*.)

IV. Circumstances of Settlement

¶63 Up until February 1997, claimant was represented by counsel. In February his counsel terminated their services. On February 19, 1997, Mr. Huppert wrote the claimant and advised:

> Despite our effort to explain these matters to you, it is apparent that you are dissatisfied with our efforts and that your settlement expectations are unrealistically high. Given your expectations and our inability to meet them, we agree that it would be best if you retained other counsel to represent you in your workers compensation case.

(Ex. 32 at 13[81].)

¶64 Claimant proceeded on his own to negotiate a settlement of his claim for $19,381.68. In March 1997 he entered into the petition for compromise and release settlement

providing for the lump-sum payment of that amount. (Ex. 2.) (*See* ¶ 12 for further details regarding the settlement.)

¶65 Claimant testified at trial that at the time of settlement, and indeed for several years prior to settlement, he believed he was unable to work and permanently totally disabled. His testimony is consistent with the claims of total disability he related to vocational consultant Kern.

V. Post-Settlement Medical History

¶66 Claimant returned to Dr. Johnson on April 2, 1997. He told Dr. Johnson his back condition was preventing him from doing a lot of the jobs. (Ex. 4 at 21-22.) Dr. Johnson suggested by letter to the claimant on May 5, 1997, that he see Dr. Gregory McDowell, "who is specially trained in spine problems." (*Id.* at 25.)

¶67 On June 5, 1997, claimant went to see Dr. Dennis L. Noteboom, a family practitioner, at the Park Clinic. The documentation of the visit consists of a short, two paragraph letter addressed by Dr. Noteboom "To Whom It May Concern." In the letter, Dr. Noteboom states:

> Kester C. Romans (DOB: 1/11/57) was seen at Park Clinic on June 5, 1997. He states that he has had severe intermittent lower back discomfort since 1994 and has been unable to do any type of sustained work. He is occasionally comfortable working one to two hours and then he will develop severe lower back pain that is only relieved by lying flat.
>
> It is unrealistic for this patient to do any type of general work in his current circumstances and he certainly is not employable at this time. Thank you for your consideration in this matter.

(Ex. 36 at 1 [92].) On its face, this letter does no more than set out what claimant told the doctor. It provides no medical support for claimant's assertions in this case.

¶68 On June 16, 1997, claimant was examined by Dr. Gregory McDowell, who is an orthopedic surgeon. The doctor noted claimant was reporting back pain in the lumbar area radiating into the buttocks but not below and that the pain was non-radicular. The doctor also observed that the claimant was "really interested in a total disability request . . . which he has apparently pursued with the railroad but he has not obtained this yet. . . ." (Ex. 4 at 26.) Dr. McDowell's physical examination revealed:

> PHYSICAL EXAMINATION: I found him lying down exerting inconsistent motor efforts. There is no sensory disturbance. There is no evidence of atrophy, wasting or fasciculations. He has a 34 cm bilateral calf circumference. There is myoclonic jerks in the right leg. Reflex examination is non-focal as is the sensory and motor examination to my exam today. Long tract findings are not present. The hip and vascular examinations are non-focal. **The back examination is benign. I have gone**

> **over his studies and I see no evidence of abnormality in the MRI.** [Emphasis added.]

(*Id*.) Dr. McDowell recommended the claimant be seen by Dr. Herb Prussack, a neurologist. (*Id*. at 27.)

¶69 Arrangements were made and the claimant was seen by Dr. Prussack for an "assessment of jerky legs" on July 7, 1997. (Ex. 11 at 80.) Based on his neurological exam, Dr. Prussack opined:

> I suspect that Mr. Romans has a post traumatic myoclonus of the lower extremities. If this is the case it may respond to Klonopin.
>
> I believe that a second opinion in a movement disorder clinic would be important and have made arrangements for him to go down to see Dr. John Roberts at Salt Lake City.

(*Id*. at 81.) At a follow-up visit on September 15, 1997, the claimant reported that there had not been any significant change in his symptoms. (*Id*. at 83.) On examination the doctor reported:

> He has normal sensation to touch and pin. He has normal movement of his spine. There is no pain on spinal percussion although he indicates that he gets pain simultaneously in his low back and right ankle. Percussion over the spine is normal and straight leg raising is the sitting position is normal.

(*Id*.) Dr. Prussack prescribed Klonopin and told claimant to return in one week. Ten days later on September 25th, claimant was in for a follow-up visit at which time he was taken off the Klonopin and urged to keep an appointment with Dr. Roberts in Salt Lake City. (*Id*. at 84.)

¶70 On October 16, 1997, the claimant was examined by Dr. Roberts at the University of Utah. Dr. Roberts, a specialist in movement disorders and on the faculty of the neurology department, noted the claimant's chief complaint as "[i]nvoluntary twitching of the legs." (Ex. 10 at 77.) The doctor reviewed claimant's February 1997 MRI scan of his spine and concurred with the radiologist's reading of it being "within normal limits with the exception of mild disc bulging at multiple levels." (*Id*.)

¶71 The claimant told Dr. Roberts that in approximately 1994, while he had been receiving physical therapy for his foot pain, the therapist "twisted his back during a therapeutic maneuver which produced back pain." Claimant told the doctor that since that time he had experienced "nearly constant irregular twitching of the right foot." (*Id*.) The medical records do not support the history he gave. The first mention of twitching was by Dr. McDowell on June 16, 1997.

¶72 Dr. Roberts considered various possibilities which might cause the claimant's jerky foot condition but was unable to form a definitive diagnosis. (*Id.* at 79.) He was doubtful that the claimant had "a radiculopathy or peripheral neuropathy based on his physical exam findings and lumbar spine MRI findings." (*Id*.) The claimant was told he could return to the clinic as needed, however, the doctor's notes indicated he would return to Dr. Prussack.

¶73 Claimant next went to Dr. Richard A. Nelson, a neurologist practicing in Billings, on October 21, 1997. The history he related to Dr. Nelson included information regarding the foot injury and the incident with the physical therapist during testing. (Ex. 9 at 72.) Claimant told the doctor he had "hurt his back he feels in low portion and perhaps up into mid and lower cervical portion. " (*Id.*) Claimant also opined to the doctor that his "low back is getting worse and [the] movement disorder that he exhibits is getting worse as well." (*Id.*) Dr. Nelson was unable to make a specific diagnosis and indicated he wanted to review claimant's MRI studies before he went any further. (*Id*.) He thereafter received and reviewed the MRI films. In an office note dated "10-38-97 [sic]," he indicated the "[p]lain films appear normal." (*Id.* at 74.) As to the MRI he noted it showed on axial views "obliteration of the lateral recess at L5, S1, L4-5 regions and needs to be looked at with CT myelogram for further detail in that region as soon as practicable." (*Id*.)

¶74 There is no record of claimant being examined by Dr. Nelson again, nor of any further testing. However, on November 25, 1997, Dr. Nelson wrote to the claimant with the opinion that the "[a]ctual diagnosis continues to be that of discal herniation and protrusion into lateral recess." (*Id.* at 75.) The doctor then went on to state that a CT scan should be conducted to "further clarify this . . . ." Dr. Nelson stands alone among the many specialists who have seen claimant in diagnosing a herniated disk and I am not persuaded by his opinion in light of the other, overwhelming medical evidence.

¶75 Liberty arranged for the claimant to be evaluated by an independent medical panel at St. Patrick's Hospital in Missoula, Montana, on July 13 and 14, 1998. The examining physicians were Dr. Dana Headapohl, occupational medicine; Dr. Henry Gary, neurosurgery; Dr. Martin Cheatle, behavioral medicine; Dr. Flynn Sherick, podiatry; and Dr. Ethan Russo, neurology.

¶76 The panel issued a joint report on August 6, 1998. In significant part the panel reported:

Identified medical problems include:

1. Chronic and post foot pain with unclear etiology.

2. Chronic low back pain without radicular symptoms - unchanged since settlement.

3. Functional (psychophysiological) movement condition.

His neurological examination, including electrodiagnostics, is normal.

. . . .

Prognosis

The overall medical prognosis is good.

(Ex. 6 at 59.) The panel reported that claimant had reached MMI and that his impairment rating was 0%. (*Id.* at 60.) Finally, the panel addressed the issue of causation and stated:

> Based upon the available information, to a reasonable degree of medical certainty, there is no clear causal relationship between Mr. Roman's current complaints and the reported injury.

(*Id.*) Contributing to the joint report, each panel participant made an individual report.

¶77 Dr. Cheatle, who conducted an independent pain/psychological examination, reported in part:

> The patient presents in a very exaggerated fashion and **clearly perceives himself as unable to return to gainful employment but has considered possibly opening an antique store.** If the medical evaluations obtained during the panel evaluation are unremarkable as has been the majority of his past studies and opinions, then I would strongly suggest that this is an individual with either a significant somatoform pain disorder or possible compensation neurosis. The patient has multiple disincentives for returning to gainful employment or improving including possibly maintaining his railroad disability and that he has ongoing litigation against the physical therapist who performed the FCE and is also pursuing a perm total determination on his Worker's [sic] Compensation claim. Once again **if medical evaluations are unrevealing** it would be my sense that **the patient could return to gainful employment within his documented limitations** and clearly this would not be a case of permanent total disability. [Emphasis added.]
>
> . . . I do not see any indication that he would require any further efforts at rehabilitation and **again prevailing data does not support his claim of severe pain and related dysfunction**. [Emphasis added.]

(*Id.* at 38.)

¶78 Dr. Headapohl observed that the history provided by claimant was inconsistent with his medical records, which she reviewed. (*Id.* at 39.) She concluded

Diagnoses

> 1. SP plantar fasciitis, right heel; sp neurolysis calcaneal branch of posterior tibial nerve.

2. Chronic low back pain, no radicular findings; MRI consistent with degenerative disc disease - pre-existent.

3. Myoclonic type jerking of both lower extremities, not following any clear pattern for known myoclonic disorders.

The subjective complaints are not consistent with the objective findings. Symptom magnification behavior was evident. The "jerking" did not match the clincial [sic] findings of myoclonus. [Emphasis added.]

(*Id*. at 50-51.) Dr. Headapohl went on to discuss examples of myoclonic disorders and noted that claimant's symptoms did not match those discussed. (*Id*.)

¶79 Dr. Gary evaluated claimant for "persistent low back pain, right foot, leg pain, and abnormal involuntary movements of the body." (*Id*. at 61.) The history elicited by Dr. Gary was that claimant's low-back pain began at the time of the FCE in May 1994. Additionally, claimant stated that the involuntary jerking of his lower extremities began at the same time. As noted earlier, there is no medical documentation of jerking prior to June 1997. Also, as previously noted, in seeking railroad benefits, claimant reported he suffered a back injury while working for the railroad. In any event, Dr. Gary reviewed the MRI scan and made the following observations:

He has had an MRI scan that shows a very minimal disc space narrowing at L5-S1. The spinal alignment is normal. There is some loss of the water density of the L5-S1 disc. There is a very slight posterior bulge midline in this disc. There is no herniated disc. The nerve roots fell out normally. There is no nerve root distortion. The anatomy of the spinal canal appears normal throughout the lumbar and lumbosacral junction area. He has no spondylolysis or spondylolisthesis noted.

(*Id*. at 62.) Dr. Gary's impressions were:

1. Chronic right posterior foot and leg pain of unknown etiology. . . .

2. Chronic low back strain secondary to lifting. He has no radicular components to this. No abnormalities structurally on MRI scanning. . . .

3. Abnormal movement disorder that developed at the time of his low back pain other than a temporal relationship I am uncertain as to the association of this to his industrial accident. . . . I would have to defer to the neurologist the exact diagnosis and relationship with that with the industrial accident.

(*Id*. at 62-63.)

¶80 Dr. Russo, a neurologist, examined claimant and performed electrodiagnostic tests. His assessment was:

> This 41 YO male had what seemingly was a minor on-the-job accident involving the right ankle. He subsequently had surgery for indications that are unclear to me. There is continuing complaint of pain. . . . The patient also has a claim for back pain related to the FCE for which I see no significant basis. It is apparent from his films that this is not a surgical condition. There is no indication of neurologic compromise on exam or on electrodiagnostic testing. I feel that his "myoclonic" movement is **functional in origin**. [Emphasis added.]

(Ex. 8 at 69.) "Functional" in the context of Dr. Russo's report means "affecting physiological or psychological functions but not organic structure." Merriam-Webster Medical Dictionary, online at www.medscape.com.

¶81 Lastly, the claimant was examined by Dr. Flynn Sherick, a podiatrist. The claimant told Dr. Sherick, "I crushed my foot with a pallet" (ex. 7 at 64), which is a different description of the injury than found in medical records and the claim filed by claimant. The doctor noted claimant's muscle strength to be 5/5 for all lower extremity groups, including the posterior tibial tendon; that the Achilles tendon was intact and not weak. (*Id*. at 65.) Perhaps the most telling note made by Dr. Sherick was made regarding the claimant's gait. He wrote:

> Patient was observed in gait and noted to be extremely antalgic on the right side, literally did not want to put his heel to the ground. He was limping significantly. **(it should be noted, however, my window does face towards the parking lot and i watched him walk across the parking lot once he left my office. he was limping but minimally at this time and his cadence and gait had increased significantly from what it was in the office.)**

(*Id*. at 65, capitalization in original, emphasis added.)

VI. MRI Evidence

¶82 At trial, the claimant introduced the MRI images and requested the Court to review them. He insisted that the images showed significant pathology[(4)]

in his lumbar spine which had been missed. I permitted claimant to go through the MRI films to point out what he thought they showed pathologically. Dr. Vallin and Dr. Rich were questioned closely regarding the MRI films which are Exhibit 45. They reviewed the films in detail and patiently answered all questions. To briefly summarize questions which were raised:

- Exhibit 18 at 160 and Exhibit 45, x-ray 2, both reveal a "small Schmorl's node" at L2-3. Dr. Vallin testified to a reasonable degree of medical certainty that "that Schmorl's node is an incidental radiographic finding as of no clinical significance." (Vallin Dep. at 21.) Dr. Rich testified that a Schmorl's node is a "normal anatomic variant." (Rich Dep. at 27.) In his medical opinion the Schmorl's node would not be

causing the claimant to experience pain. He had never heard of it causing pain. (*Id*. at 35.)

- Next, the radiology report indicates at the L5-S1 there is "early desiccation of this disk in addition to nominal posterior bulging of the disk annulus." (Ex. 18 at 160.) The desiccation is not an abnormal finding for a person of the claimant's age. (Rich Dep. at 22; Vallin Dep. at 25.) As to the "bulge," Dr. Vallin stated it was not impinging on the nerve root and that the claimant's central canal was "very capacious or roomy." (*Id*. at 24.) Dr. Rich explained that his use of the word "nominal" when describing the "posterior bulging of the disk annulus" (ex. 18 at 160) is a descriptor for "when something is mild or maybe less than mild. . . ." (Rich Dep. at 11.) Dr. Vallin emphasized that claimant has a normal spinal canal with no impingement at any level. (Vallin Dep. at 36-39.)

- A question regarding the significance of "conjoined" nerve roots was answered by Dr. Vallin, who explained it was a "congenital thing. It's nothing abnormal. It's very common." (*Id*. at 47.)

- Claimant asked Dr. Vallin questions regarding the suggestion in the medical report of Dr. Tony Toehne, whom the claimant identified as a neurosurgeon in Spokane, that a diskogram be performed. (Ex. 41.) Dr. Vallin testified that he would never recommend a lumbar diskogram in someone with the claimant's MRI findings. (Vallin Dep. at 42.)

VII. Resolution

¶83 There is simply no credible support for finding that the parties were mutually mistaken about claimant's condition in this case. Claimant's beliefs notwithstanding, his MRI was read properly and does not disclose significant pathology requiring surgery or further treatment.

¶84 The evidence strongly suggests, and I find, that claimant is consciously exaggerating his symptoms or even malingering. Dr. Vallin noted positive findings on all five of the Waddell's tests. Claimant's jerky leg cannot be explained by any known medical condition and does not correlate with objective findings. Some doctors noted symptom magnification. Several noted claimant's preoccupation with obtaining total disability status. One observed claimant's limping during an examination but then saw claimant walking with only a minimal limp after he left the office. Claimant told different doctors different stories. For purposes of obtaining railroad disability benefits he said he injured his back while working on the railroad and that he never worked again thereafter. For purposes of his workers' compensation claim, he claims he injured his back during an FCE and failed

to disclose any back injury while working for the railroad. In Court, claimant laid down during much of the trial. My impression was that he was "putting on a show" for the Court's benefit.

¶85 The overwhelming medical evidence does not support claimant's contention that he is unable to work and is totally disabled, and I do not find his contention credible. Moreover, claimant asserted and says he believed that he was totally disabled at the time of settlement and for several years prior to settlement. If he was correct, which I find he is not, then he was not mistaken about his disability. The parties were not mutually mistaken concerning the nature or degree of claimant's disability.

CONCLUSIONS OF LAW

¶86 The 1993 version of the Workers' Compensation Act applies in this case since it was the law in effect at the time of the claimant's October 12, 1993 industrial injury. *Buckman v. Montana Deaconess Hospital,* 224 Mont. 318, 321, 730 P.2d, 380, 382 (1986).

¶87 Claimant/petitioner has the burden of persuasion. *See Ricks v. Teslow Consolidated,* 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wicken Bros. Construction Co.,* 183 Mont. 190, 598 P.2d 1099 (1979).

¶88 The full and final settlement entered into by the parties is a contract, thus contract law governs the agreement. *Kienas v. Peterson*, 191 Mont. 325, 329, 624 P.2d 1, 3 (1980). A contract may be rescinded when the parties were laboring under a mutual mistake regarding a **materia**l fact when the contract was made. *South v. Transportation Ins. Co.*, 275 Mont. 397, 401, 913 P.2d 233, 235 (1996). The contract may be rescinded only where "the parties share a common misconception about a vital fact upon which they based their bargain." *Mitchell v. Boyer*, 237 Mont. 434, 437, 774 P.2d 384, 386 (1989) (citations omitted).

¶89 The Supreme Court has addressed the effect of mistakes of fact concerning a worker's medical condition. *E.g., Wolfe v. Webb*, 251 Mont. 217, 227-28, 824 P.2d 240, 246 (1992) and *South*. In *Wolfe* the Court characterized its prior precedents as follows:

> [W]e have previously held that a mistake about the nature or extent of the claimant's physical condition is a "material" mistake of fact when applied to a workers' compensation settlement agreement.

251 Mont. at 227-28, 824 P.2d at 246. While that language arguably suggests that a mistake as to claimant's physical condition is **always** material, *South,* which is the more recent precedent, reiterates the requirement that the mistake of fact must also be material:

> In order to justify rescission, the mutual mistake must be regarding a fact that is vital to the completion of the contract. *Wray*, 879 P.2d at 725. Further, it must be "so substantial and fundamental as to defeat the object of the parties in making the

contract." *Wyman v. DuBray Land Realty* (1988), 231 Mont. 294, 298, 752 P.2d 196, 199 (citing *Johnson v. Meiers* (1946), 118 Mont. 258, 164 P.2d 1012).

275 Mont. at 401, 913 P.2d at 235.

¶90 In this case the claimant testified to his belief that a mutual mistake of fact was made because at the time the parties entered into the settlement agreement they were unaware that he was "totally disabled" and were also unaware of the nature and severity of a back injury which he allegedly sustained at the time of the 1994 FCE. (petition for hearing.) As I have found, there was no mutual mistake with regard to claimant's medical condition or the nature of his disability. Accordingly, there is no basis for setting aside the settlement.

JUDGMENT

¶91 1. Claimant is not entitled to rescind his 1997 settlement. His petition is **dismissed with prejudice.**

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

¶93 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 June, 2000.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Mr. Kester C. Romans - Certified Mail
Mr. William J. Mattix
Submitted: April 14, 2000

1. Exhibit 29 verifies that claimant received a number of chiropractic treatments in June and July 1994.

2. It is possible, if not probable, that Mr. Huppert was not aware of the railroad claim.

3. Just prior to the IME, on January 14, 1997, the insurer sent claimant notification that his TTD benefits were being terminated in 14 days and that his file would be reviewed for possible entitlement to permanent partial disability and rehabilitation benefits. (Ex. 26 at 6 [75].)

4. The word "pathology" means, among other things, "all the conditions, processes, or results of a particular disease" and "any abnormal variation from a sound or proper

condition". Webster's New World Dictionary and Thesaurus, software edition (1997). The word is used in those senses.