IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2001 MTWCC 14

WCC No. 2000-0041

AUBREY SCHNEIDER

Petitioner

vs.

LIBERTY NORTHWEST INSURANCE CORPORATION

Respondent/Insurer for

JOEL BOS, d/b/a BOS TOP DAIRY

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary of Case: Claimant allegedly injured his neck, left arm, and head in a fall from a ladder which was attached to a large milk tank. The insurer initially accepted liability and paid medical and temporary total disability benefits. It ceased paying TTD benefits when claimant dropped out of a work-hardening program after one day and an IME physician reported him at MMI. The Department and the Court then entered an order requiring the insurer to pay 49 days of benefits pursuant to section 39-71-610, MCA. Meanwhile, the insurer alleged that the claim was fraudulent in that the accident was staged.

Held: Claimant is not credible and has a long history of what he claims to be debilitating headaches. At the time of the alleged accident he had been fired by a previous employer a month previous, allegedly on account of loss of work due to headaches, and was actively attempting to get a prescription for narcotic drugs from his physician. He had also been told that his employment at the dairy was not likely to last. He has a previous history of drug abuse, and following the alleged accident obtained additional narcotic and barbiturate drugs by telling his physician that one narcotic was not working, that his drugs had been stolen or flushed down the toilet, that the pharmacy never filled his prescription, and other similar stories. Coworkers' testimony about conversations with claimant on the day of the alleged accident, as well as the accident scene itself, raise significant questions as to whether the accident in fact occurred. Except for a superficial cut on his hand, there was no objective evidence of any injury. The Court finds that the accident did not occur and further finds that even if it did happen, he reached MMI by the time his benefits were cut

off. Recommendations by the treating physician of further physical therapy are unpersuasive as claimant's medical records demonstrate he has been non-compliant in previous PT attempts. Other recommendations for treatment are either refuted by the IME doctor, who testified, or have been tried and provided little relief.

Topics:

Benefits: Interim Benefits. Claimant must repay interim temporary total disability benefits awarded under section 39-71-610, MCA (1999), where the Court finds that the insurer properly terminated TTD benefits and that he is not entitled to them.

Fraud. Claimant's lack of credibility, his drug-seeking behavior, his attempts to obtain narcotics from a physician four days prior to his alleged industrial accident, his knowledge that he was unlikely to keep his current job, his recent history of allegedly debilitating headaches which he claimed got him fired a month and a half previously from a previous job, his odd statements to his coworkers, the incongruity between the manner in which he claimed the accident occurred and the physical layout of the place of the accident, his subsequent drug seeking behavior, and his documented lies persuade the Court that the claimed industrial accident was staged and was fraudulent.

Montana Code Annotated: 39-71-610 (1999). Claimant must repay interim temporary total disability benefits awarded under section 39-71-610, MCA (1999), where the Court finds that the insurer properly terminated TTD benefits and that he is not entitled to them.

Maximum Medical Improvement. Where claimant's symptoms are subjective and where he has a history of non-compliance with respect to recommended treatment, or the treatment has been previously attempted and was unsuccessful, there is no reasonable prospect for further, material improvement in his condition, and he has reached MMI.

Proof: Conflicting Evidence: Medical. Treating physician's opinions are given less weight where the treating physician chose to believe claimant's patently questionable stories about his need for further narcotics, especially where the physician could have readily checked the stories with claimant's wife but failed to do so. The physician's trust in his patient was unwarranted and showed a lack of objectivity.

Proof: Conflicting Evidence: Medical. Medical opinions which are based on subjective symptoms reported by a claimant who is not credible are not persuasive.

Witnesses: Credibility: Drug Abuse. Claimant's lack of credibility, his drug-seeking behavior, his attempts to obtain narcotics from a physician four days prior to his

alleged industrial accident, his knowledge that he was unlikely to keep his current job, his recent history of allegedly debilitating headaches which he claimed got him fired a month and a half previously from a previous job, his odd statements to his coworkers, the incongruity between the manner in which he claimed the accident occurred and the physical layout of the place of the accident, his subsequent drug-seeking behavior, and his documented lies persuade the Court that the claimed industrial accident was staged and was fraudulent.

¶1 The trial in this matter was held on September 6, 2000, in Bozeman, Montana. Petitioner, Aubrey Schneider, (claimant), was present and represented by Mr. Geoffrey C. Angel. Respondent, Liberty Northwest Insurance Corporation (Liberty), was represented by Mr. Larry W. Jones. A trial transcript has not been prepared.

¶2 Exhibits: Exhibits 1 through 3, 5, and 15 were admitted without objection. Pages 156 and 157 of Exhibit 1 are missing in the exhibit notebook, however the intended pages are found in Exhibit 1 to Dr. Ross' deposition. Exhibit 4 was withdrawn. Exhibit 6 was admitted for impeachment purposes only and over Mr. Angel's confidentiality objection. Exhibits 9 (page 1, lines 22-26, page 2, lines 1and 2) and 14 (page 6, lines 8 through 23 only) were admitted over objections but were admitted only for impeachment purposes. Exhibits 7, 8, and 10 through 13 were refused. Proposed Exhibit 16, which was to be prepared by Mr. Angel, was never submitted.

¶3 Mr. Angel objected to respondent's contentions in the Final Pretrial Order which concern prior criminal convictions and bad acts. The Court will disregard those contentions in accordance with its ruling on the motion in limine.

¶4 Witnesses and Depositions: The parties agreed that the depositions of Scott K. Ross, M.D., Robert A. Jackson, M.D., and Aubrey Schneider of May 10, 2000, (Schneider Dep. I,) and June 13, 2000, (Schneider Dep. II,) shall be considered by the Court. Claimant, Merle Joseph Ferrier and Scott VanDyke were sworn and testified.

¶5 Issues Presented: The issues, as stated in the Final Pretrial Order, are as follows:

1. Whether Gene Schneider suffered an industrial accident on March 14, 1999?
2. Whether Gene Schneider reached MMI on September 21, 2000 [sic]?
3. Whether Gene Schneider should repay the Section 610 benefits Liberty Northwest paid pursuant to this Court's order?
4. Whether Liberty Northwest should pay the costs and attorney's fees incurred by Gene Schneider in pursuing this Petition?
5. Whether Liberty Northwest's refusal to pay medical and wage loss benefits was unreasonable?

¶6 Having considered the Final Pretrial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the depositions, the exhibits, and the

arguments of the parties, the Court makes the following:

FINDINGS OF FACT

Claimant

¶7 At the time of trial, claimant was 43 years old. In the 25 years since graduating from high school he has worked in a number of jobs, including work in the oil fields and on power lines, farming, and guitar manufacturing.

¶8 Over the years, claimant has suffered a number of injuries, including numerous work-related injuries, nine of which are documented. He has undergone back and neck surgeries. The latest surgery was 1996, when he underwent a C6-7 anterior cervical diskectomy and fusion. (Ex. 1 at 181.)

Medical History and Preexisting Medical Conditions

¶9 I begin these findings of fact with an overview of the claimant's prior medical history and preexisting medical conditions. The overview is limited to claimant's back, neck, and headaches. The overview is important in evaluating claimant's complaints following his alleged injury and in evaluating his credibility.

¶10 In 1989 claimant was injured in an automobile accident and underwent a diskectomy, apparently at the lumbar level, which left him with a 10% impairment rating. (Ross Dep. Ex. 3 at 2.)

¶11 On September 27, 1995, claimant injured his neck and upper shoulder girdle when attempting to lift a heavy steel cabinet while working for Gibson Guitar. (Ex. 1 at 58, 64, 110.) He subsequently returned to work with no restrictions (id. at 55), however, he re-injured himself on February 19, 1996, while moving a fully-loaded guitar rack (Id. at 64, 111). An MRI of the cervical spine was remarkable for a C6-7 protrusion. (Id. at 110.) After a protracted course of physical therapy and multiple medications, including narcotic analgesics, in May 1996 he underwent a C6-7 anterior cervical diskectomy with fusion and a decompression of the left C7 nerve root. (Id. at 110, 181.) He was subsequently found to also have a stress fracture of the spinous process of C7. (Id. at 181.)

¶12 Although he continued to have residual chronic headaches, Dr. Robert Jackson, who is claimant's family physician, placed claimant at maximum medical improvement (MMI) as of February 12, 1997. (Id. at 130, 182.) On March 10, 1997, Dr. Eugene J. Dolan, the neurosurgeon who operated on claimant, placed him at MMI in relation to his neck injury and restricted him to intermittent lifting of 20-40 pounds. (Id. at 177-78.) Dr. John Vallin, a physiatrist, conducted an independent medical examination (IME) on November 12, 1996, and placed him at MMI at that time. (Id. at 110-11.) Dr. Vallin rated claimant with a 5% whole person impairment pertaining to his cervical disk fusion and subsequent diskectomy

and a 5% whole person impairment regarding his upper extremities. (Id. 110-12.) On March 10, 1997, Dr. Thomas L. Schumann evaluated claimant at Dr. Dolan's request and assigned him a 15% whole person impairment per the AMA guides. (Id. at 182.)

¶13 After recovering from his 1997 cervical diskectomy and fusion, claimant continued to experience severe headaches. Dr. Jackson testified that the history of headaches went back to at least 1994. (Jackson Dep. at 6.)

¶14 Dr. Jackson's record documents severe headaches during the six months preceding the alleged accident at issue in this case.

- On September 11, 1998, claimant reported "continuing to have pounding headaches on the right side of the head. They start at the neck posteriorly and then radiate forward to the orbit." (Ex. 1 at 28.)
- On September 23, 1998, claimant called Dr. Jackson and reported he had a "persistent headache now for three or four days." (Id. at 27.)
- On December 23, 1998, claimant reported his headaches were "about the same." (Id.)
- On January 16, 1999, claimant reported "he's had a headache for several days." He requested a prescription for Tylenol #4. (Id. at 26.)
- On January 28, 1999, a month and a half prior to the claimant's alleged accident at issue in this case, Dr. Jackson wrote, "Patient has a long history of headaches which have been resistant to medication. He has had neck surgery, a neck fracture, and injury to a nerve from the neck which causes his headaches. His prognosis is poor to ever be 100% free of headaches." (Ex. 1 at 143.) Dr. Jackson contemplated referring claimant "to a pain specialist for further evaluation." (Id.) Dr. Jackson noted that claimant's diagnoses of occipital cervical neuralgia and muscle tension was originally made by Dr. Joav Kofman, a neurologist with the Billings Clinic, on May 19, 1997. (Jackson Dep. at 7.) He explained that "occipital neuralgias" indicated that claimant has probable traction on occipital nerves which can cause pain, as well as trigger headaches. (Id. at 6-7.)
- On February 1, 1999, Dr. Jackson made the following note:

> Patient reports that he was fired from his job because of his headaches and the fact that he missed three days of work. . . . His pain had been getting slowly worse, and he was seeking Tylenol #4 on several occasions . . . . There's some tenderness in the posterior neck and it feels that there's something "loose" in there. He's having headaches now in the same area as before as well, from the right vertex to the right orbit. . . .

(Id. at 26.)

- On February 8, 1999, Dr. Jackson recorded no change in the headaches. (Id. at 25.)
- On March 10, 1999, four days prior to the alleged injury, claimant called Dr. Jackson and requested Tylenol #4. Dr. Jackson refused the request, noting that claimant should "stick to one type of pain med." (Id.) At that time, claimant was taking Darvocet-N 100 (id.), which is a combination of a narcotic analgesic and Tylenol, which is a non-narcotic analgesic. Physicians Desk Reference at 1254 (1992 Ed.). Then on March 12, 1999, claimant obtained a prescription for Fioricet, which is a barbiturate with acetaminophen.

¶15 A review of claimant's medical records shows he has a history of drug addiction and alcoholism. (Ross Dep. at 13; Ex. 1. at 181-82, 184, 193; Ex. 2 at 1.)

History of the Present Claim

¶16 On or about March 9, 1999, claimant went to work as a probationary employee at Bos Top Dairy ("Bos"), which is a dairy farm.

¶17 Claimant alleges that on March 14, 1999, while working at Bos, he fell off a ladder attached to a milk tank and injured his neck, shoulder, back, and left hand. His primary complaints since the alleged accident are severe headaches and pain in his neck, shoulders, arm, and back.

¶18 At the time of the alleged accident, Bos was insured by Liberty, which accepted liability for the claim. Liberty thereafter paid temporary total and medical benefits.

¶19 In July of 1999, Liberty referred claimant to Dr. Scott Ross, a physician specializing in occupational medicine. Dr. Ross prescribed a work-hardening program. Claimant began the program on September 20, 1999, but after one day of the program he declined to continue. Dr. Ross then found him at MMI. Based on that finding, on December 22, 1999, Liberty terminated claimant's temporary total disability (TTD) benefits.

¶20 Claimant did not return to work at Bos. He did not become employed again until three or four weeks prior to trial, when he took a job with Metra RV in Billings. He works at Metra RV 25 to 30 hours a week.

This Proceeding

¶21 This action followed the December 22, 1999 cutoff of benefits. The petition, docketed March 3, 2000, seeks payment of further compensation and medical benefits.

¶22 Shortly after the filing of the petition, Liberty appealed a decision of the Department of Labor and Industry (Department) ordering it to pay claimant 49 days of TTD benefits under section 39-71-610, MCA (§ 610). That appeal was made a part of this action. Initially, the

Court ruled in Liberty's favor, however, upon reconsideration and after receipt of a further medical report supporting claimant's allegation that he has not reached MMI, the Court affirmed the Department's decision and ordered Liberty to pay the section 610 benefits. (Further Order Regarding Section 39-71-610, MCA, Benefits (June 7, 2000).)

¶23 Liberty contends that claimant has reached MMI and is not entitled to further benefits. While not raised in its initial Response To Petition For Hearing, in subsequent notices regarding its contentions in this case, Liberty alleged that the claim in this case is fraudulent. In its second notice, Liberty affirmatively alleged, inter alia:

> The claimant did not injure himself as he claims.
>
> The claimant has fraudulently claimed and received workers' compensation benefits.

(Respondent's Second Notice of Additional Contentions, Witnesses and Exhibits at 1 (docketed July 7, 2000).) In a fourth notice, Liberty made its fraud allegations more specific. It alleged:

> The claimant s testimony and reports to others about his alleged injury, pain, and disability is totally unbelievable and is a continuation of his intent, by a prepared plan, to claim and receive workers compensation benefits fraudulently with the full knowledge that he is not now and has not been entitled to them.

(Respondent's Fourth Notice of Additional Contentions, Witnesses and Exhibits at 3 (docketed July 10, 2000).) It went on to allege that the accident was faked so that claimant could obtain narcotic drugs:

> After the claimant learned on 3-13-99 that he would not be [permanently] hired by Bos Top Dairy, he formed the motive and intent to use the next day at work for the opportunity to carry out knowingly his prepared plan to fake an accident and obtain workers compensation benefits and receive narcotics and other pain and mood altering medications for his alleged injury.

(Id. at 2.)

¶24 As set forth in the Final Pretrial Order, the fraud issue has been condensed by the parties into the broad question, "Whether Gene Schneider suffered an industrial accident on March 14, 1999?" (¶5.)

¶25 Other than the section 610 benefits, Liberty is not seeking reimbursement for benefits already paid; it only seeks to avoid payment of further benefits.

The Alleged Accident

¶26 The alleged accident at Bos was unwitnessed. Claimant testified that at about 8:30 a.m., on March 14, 1999, he was standing on a ladder attached to one of the milk tanks and was attempting to hook up pipes when he fell. (Schneider Dep. I at 5-9.) He testified in his first deposition that he was reaching for the pipes and leaning back when his foot gave out and slipped, and that there was nothing to catch onto to stop his fall. (Id.; Schneider Dep. II at 39; Ex. 1 at 154, emphasis added.) He testified he hurt his shoulder area, his head, his left hand, and the left side of his face.

¶27 In various statements to physicians, claimant maintained that he fell ten feet. Dr. Robert A. Jackson, who had been treating him prior to the alleged accident, recorded on March 15, 1999, the day after the alleged accident, that claimant called him and reported "he fell about ten feet off the back of a tank truck, landed on his left side." (Ex. 1 at 25, emphasis added.) Dr. Kofman's May 7, 1999 note states that claimant reported "he slipped and fell 10'." (Id. at 144.) Dr. Speth recorded on May 4, 2000, that claimant reported he "had fallen 10' from a ladder . . . ." (Ex. 2 at 1.) Dr. Vallin's note of May 30, 2000, states that claimant "fell 10 feet off a ladder." (Ex. 3 at 1.) Dr. Ross' note of July 30, 1999, states that claimant reported he "fell a distance of approximately 10 feet . . . ." (Ross Dep., Ex. 1 at 1.)

¶28 At his second deposition on June 13, 2000, the claimant was shown photos of the milk tanks and ladder where the accident allegedly occurred. (Schneider Dep. II at 21-24, 40.) Claimant, however, denied that the photos were of the accident site, asserting that "[s]omething doesn't look right about these pictures, and I don't know what it is." (Id. at 40.) Referring to the ladder which is shown in the photos, he further testified, "This is not the ladder I fell from, none of these I just seen here. There was more steps. I couldn't have reached from here. I'm too short." (Id. at 23, emphasis added.) He further testified that "the one [ladder] I was using I know had another step because I was almost to the ceiling." (Id. at 24.)

¶29 Upon cross-examination at trial, claimant conceded that the photos shown to him in his deposition were in fact of the tank and ladder from which he claims to have fallen. Presented with the physical measurements shown in the photos, he conceded that the step from which he allegedly fell was only 40 inches off the ground, which is a far cry from the 10 feet from which he initially claimed. When asked to explain his numerous statements that he "fell 10 feet" when he only actually fell only 3 ½ feet, claimant testified, "[I]f you take my height into consideration . . . I just figured I fell about 8 or 10 feet from the top of my head. The way I fell would be about 8 feet all the way down." (Trial Test.) I am unpersuaded by his explanation.

¶30 Claimant's description of his fall is also troublesome. He told some of his medical providers that when he fell he landed on the left side of his body. (Ex. 1 at 25, 154; Ross Dep., Ex. 1 at 1; Ex. 2 at 1; Ex. 3 at 1.) However, he also told at least one medical provider (Dr. Kofman) that he "fell backwards" (ex. 1 at 144) and testified at trial that he was "leaning

back" on the ladder when he slipped and fell. Most significantly, claimant denied hitting the wall, any part of the ladder or anything else before hitting the floor. (Schneider Dep. I at 7; Trial Test.)

¶31 The photos of the alleged accident scene shows that the distance between the step on which claimant was standing and the wall was 30 ½ inches. (Schneider Dep. II, Dep. Exs. 1-4.) While I do not consider the physical measurement and characteristics of the accident scene absolutely incompatible with claimant's description of the accident, the constricted space where the alleged fall occurred, the existence of a side rail on the ladder, and claimant's statements that he was leaning "back" when he fell, make it difficult to envision that claimant could have fallen without any part of his body striking the wall behind him.

¶32 The testimony of coworkers also raise questions concerning claimant's credibility and whether in fact he was injured in an industrial accident. Merle Ferrier (Ferrier) worked the night shift and was finishing up his work on the morning of claimant's alleged accident. Ferrier testified he saw claimant when returning from feeding calves. According to Ferrier, claimant was sitting down on a five-gallon bucket, holding his head, and moaning, however, Ferrier did not see any cuts, scrapes, or blood while standing less than three feet from claimant. When Ferrier asked claimant what had happened, claimant told him that he had fallen from the milk tank when trying to hookup the line above. Ferrier testified that at one point during this first conversation, claimant stated, "You don't believe me."

¶33 Ferrier left for about 15-20 minutes to complete some additional work and then returned to the milk tank area. There he saw claimant again and they talked. (Trial Test.) Ferrier testified that claimant then showed him his right hand with a couple of scrapes on the top of the hand, and that he told Ferrier he had broken his watch when he fell. He was certain that it was claimant's right hand that was bleeding slightly. (Id.) Ferrier saw the broken crystal on the ground, but did not remember seeing any broken watch. (Id.)

¶34 Claimant testified at trial that he did not recall talking to Ferrier at all and in fact did not even recall Ferrier working at Bos. After listening to Ferrier and claimant, I am unpersuaded by claimant's testimony. I found Ferrier the far more credible witness.

¶35 Scott VanDyke (VanDyke), claimant's supervisor at Bos, testified that on the morning of March 14th, Ferrier came out from the milk tank area and told him that "Gene says he fell off the tank and hurt his neck." VanDyke went into the barn and asked claimant if he was all right. Claimant replied that his "neck hurts pretty bad. I hope I didn't break it again." (Trial Test.) Claimant also told VanDyke that his arm was numb and he could not feel it. He then showed VanDyke "his arm which had a little blood on it and his broken watch." (Id.) VanDyke stated that claimant "had some superficial cuts on his right arm . . . or his right hand." (Id.) VanDyke also said that claimant kept asking him if he had a bruise on his face, but he saw only "a little red mark. . . which looked like he had been hit by an "elbow in the

face" although the "skin was not broken." (Id.) He testified that this mark was on the right side of claimant's face.

¶36 VanDyke testified that claimant asked if Bos had Workers' Compensation. VanDyke suggested to claimant that he go see a doctor to find out how bad he was hurt first and that Bos would pay for it. Claimant's response was: "Let's do this by the book." (Id.) VanDyke testified that they then went upstairs to the office to get the workers' compensation phone number from the poster. They looked at the list of doctors approved to treat work-related injuries and Dr. Jackson, a physician already treating claimant, was on the approved list.

¶37 Testimony concerning claimant's prospect for continued employment at Bos was also conflicting. Claimant testified that VanDyke told him "he caught on fast" with his work. Claimant asserted that within a week he expected to move into a house on dairy property which the dairy provided to permanent workers. VanDyke contradicted the testimony. He testified that claimant was not catching on to the job and had poor performance. The day before the accident he told claimant that "this might not be the job for him." According to VanDyke, claimant acknowledged that he was kind of feeling the job was not right for him but asked for a chance to keep trying. Claimant said, "Let me try it tomorrow and I'll give 100%." (Trial Test.) "Tomorrow" was the day of the alleged accident.

Subsequent Medical Treatment

¶38 Claimant contacted Dr. Jackson, his family physician, on March 15, 1999, the day following his alleged accident. Claimant reported that he had fallen 10 feet, landing on his left side, and that "[h]e had an immediate, severe headache and remembers bumping his head." (Ex. 1 at 25.) Of interest to the Court in evaluating this case is the fact that claimant obtained a prescription for the narcotics (Tylenol #4) that Dr. Jackson had refused him five days previous. (See ¶14.)

¶39 Dr. Jackson examined claimant on March 17, 1999. Dr. Jackson's office note for that date states in relevant part:

> Patient fell on March 14 about ten feet off of the top of a milk tank, landed on his left side of his body and hit his head somewhat, but did not lose consciousness. The fall was unwitnessed. He got himself up, and noted immediately that there was pain in the left arm, around the scapula, and a headache. The left arm pain is especially present at the elbow and into the biceps. He's noticed some numbness in the left hand, now confined to fingertips of digits two, three and four. The headache hasn't been helped at all by the Tylenol #4 that I called in the other day. The pain is now coming around onto his face on the left side. He's stopped weightlifting temporarily.

He's also got some pain on the back of his left hand, which was abraded at the time of his fall. He states that he broke his wristwatch at that time. He's noticed a bit of swelling on the back of the hand.

(Id. at 22.) The only objective findings noted by Dr. Jackson were: "There is an abrasion and a small laceration that have dried spontaneously [on the back of the left hand]. There's some marginal erythema, slight swelling over the dorsum of the [left] hand . . . The arm has no obvious bruising." (Id.; Jackson Dep. at 13.) Dr. Jackson did not find any other bruises on claimant's body. (Id. at 14.) He did not detect any muscle spasm. (Id. at 13.)

¶40 Dr. Jackson diagnosed: "1) cervical muscle strains secondary to trauma; 2) prior cervical diskectomy and fusion, apparently stable; 3) mild peripheral neuropathies in the left arm, suspect some nerve root impingement secondary to trauma; 4) muscle tension headaches and occipital neuralgia, chronic, now worse; 5) possible early wound infection on the back of his left hand." (Ex. 1 at 22.) He prescribed Oxycodone (id.), another narcotic drug. The prescription was for fifty tablets to be taken four times a day, in other words, a twelve-day supply.

¶41 Three days later, on March 20, 1999, claimant talked to Dr. Jackson by telephone and reported he had cramps and diarrhea, which he attributed to the Oxycodone. (Ex. 1 at 22.) Dr. Jackson prescribed fifty tablets of Tylenol #3, which is acetaminophen with codeine, two tablets three times a day, or an eight-day supply.

¶42 On March 29, 1999, Dr. Jackson examined claimant. (Id.) At that time, claimant reported a "bilateral headache." (Id.) He prescribed a refill of the Tylenol #3. (Id.)

¶43 During those months following the alleged accident, claimant's complaints were principally of headaches and neck pain.

¶44 On April 5, 1999, claimant called to request a prescription of Fioricet (id. at 22), which is a barbiturate drug with acetaminophen. Dr. Jackson recorded, "He's on Tylenol #3, says it's not working, has been taking up to six at a time. We are back to the same pattern as before." (Id.)

¶45 Claimant's drug history thereafter is noteworthy. Following his alleged accident, at least the following drugs were prescribed:

MS Contin	Narcotic	Long acting morphine
Oxycodone	Narcotic	A synthetic opiate
Tylox	Narcotic	Acetaminophen and Oxycodone
Tylenol #4	Narcotic	Acetaminophen with codeine
Darvocet N-100	Narcotic	Acetaminophen with codeine-type narcotic
Vioxx	NSAID	Non-steroidal anti-inflammatory
Diazepam	Benzodiazepine	Anxiolytic – Antianxiety

Klonopin	Benzodiazepine derivative	Anti-convulsive and for panic disorder
Xanax	Benzodiazepine	Anxiolytic – Antianxiety
Alprazolam	Benzodiazepine	Anxiolytic – Antianxiety, panic disorder
Valium	Benzodiazepine	Anxiolytic – Antianxiety
Fioricet		Barbiturate with acetaminophen
Wellbutrin		Antidepressant

¶46 From April 1999 to late February 2000, claimant made numerous requests for additional narcotics and other drugs, claiming that medications were not working, had been lost, had been stolen, had not been provided by the pharmacy, or had been destroyed. The history is so suggestive of drug abuse that it cannot be ignored in considering claimant's motives and veracity in this matter.

- April 5, 1999 - "Phone call from the patient to staff requesting return to Fioricet. He's on Tylenol #3, says it's not working, has been taking up to six at a time. We are back to the same pattern as before. Called Rx Fioricet, #30 with no refills, up to six per day maximum." (Exhibit 1 at 22, emphasis added.)
- May 10, 1999 - Claimant called Dr. Jackson requesting Tylox, saying that he left his Tylox at his mother-in-laws. (Id. at 20, emphasis added.)
- July 26, 1999 - Claimant called Dr. Jackson's office and said that "Tylox not helping." Dr. Jackson prescribed Tylenol #4. (Id. at 17, emphasis added.)
- August 3, 1999 - Claimant reported increased pain and said that he could not tolerate Oxycodone. The doctor called in a prescription for Tylenol #4 with the proviso that claimant bring in the unused Oxycodone. The note goes on to indicate that a call from the pharmacy stating that claimant's wife "threw [O]xycodone down the toilet." (Id. at 16, emphasis added.)
- August 24, 1999 - Note indicates claimant requested Tylenol #4, and stated that he had "run out of MS-Contin (unsure why) . . . . " (Id. at 15, emphasis added.)
- August 26, 1999 - Dr. Jackson recorded that claimant was "back for a refill of his morphine" and that his pain was worse despite Tylenol #4. The note says, "Patient's [sic] apparently had medication stolen from his house, uncertain, but may have been a family member who's given him trouble previously. This happened within the last week." The doctor prescribed more MS-Contin. (Id. at 15, emphasis added.)
- September 7, 1999 - Claimant presented at Dr. Jackson's office but apparently saw another doctor who recorded that claimant was complaining of low-back pain

radiating into his leg which he attributed to a prior lumbar diskectomy and laminectomy. Claimant reported he had to double up on his MS-Contin and had run out of the medication. The doctor prescribed more MS -Contin, however, later that day the claimant called and stated that the dosage of MS-Contin was not relieving his pain and the doctor authorized a higher dosage. (Id. at 14, emphasis added.)

- November 4, 1999 - Claimant reported that his wife had dumped his Fioricet down the toilet and that his counselor had recommended he receive Xanax. Dr. Jackson prescribed Xanax. (Id. at 10-11, emphasis added.)
- November 9, 1999 - Claimant requested more Tylenol #4. Dr. Jackson refused the request. (Id. at 10.)
- November 12, 1999 - Dr. Jackson's office note reflects "[s]everal phone calls back and forth to the pharmacy, Albertson's in Bozeman." The doctor had prescribed 60 tablets of Klonopin on November 1, 1999, and claimant asserted he did not receive them, whereas Albertson's computer indicated he did receive them and had, in fact, signed for them. Dr. Jackson authorized 30 additional Klonopin, indicating "we'll try to sort this out at a later date." (Id., emphasis added.)
- December 7, 1999 - An office note by another physician in Dr. Jackson's office states that claimant was "requesting pain meds." The doctor wrote that "I had seen him back in August and indicated I would no longer give him any narcotic pain meds, that I felt he needed to get these through Dr. Jackson." (Id. at 8.) The note went on to state that claimant said that he was "having difficulty getting a hold of Dr. Jackson." The doctor prescribed 10 Tylenol #4.
- December 18, 1999 - On December 15, 1999, Dr. Jackson prescribed Alprazolam, Klonopin and Wellbutrin-SR. On December 18th, claimant called and stated that all of the medications were "gone." He took it & believes he lost some of it. He called asking for more medicine. He states he feels very nervous ‘like he is going to explode!' feels like pins are sticking all over him. Refuses to be seen. States that his wife would rather ‘slit his throat' before talking to him." (Id. at 8, emphasis added.) Two days later, on December 20, 1999, Dr. Jackson examined him and noted that claimant had "consumed six to eight bottles of NyQuil . . . in an attempt to control his headache," and had not slept in four or five days. Claimant asserted that his wife had "flushed his Klonopin, Xanax and Wellbutrin down the toilet." (Id. at 7.)
- January 12, 2000 - Claimant saw Dr. Jackson about "more back and shoulder pain along with worsening headaches." (Id. at 6.) Dr. Jackson noted the day before he had "shoveled an entire four car driveway of our new snowfall," that claimant had been taking up to 20 ibuprofen a day, and that claimant wondered "if other pain

medications might be available to him." (Id., emphasis added.) The doctor refused to prescribe further narcotics. (Id. at 5.)

- January 21, 2000 - Claimant asserted further problems in filling his prescriptions. Dr. Jackson's note reads: "Several phone calls back and forth with Wal-Mart Pharmacy. They state that he got 90 Alprazolam on December 30th, 40 on the 10th of January, and 50 on about the 17th of January. He claims that he was shorted twice. The pharmacist says that the Inventory has turned out to be exactly right for the number of tablets in stock. Therefore, it is unlikely that he was shorted. . . . " (Id. at 5, emphasis added.)

- February 23, 2000 - Claimant reported that he had "flushed" approximately 90 tablets of [Al]przolam "down the toilet." (Id. at 3, emphasis added.) At the time of his report, he had already been started on Lorazepam. In his office note, Dr. Jackson recorded, "I choose to believe him at this time about destroying the [A]lprazolam. Will cancel his refill available on this, however." (Id.)

- February 25, 2000 - Dr. Jackson's note indicates what can only be characterized as a deliberate abuse of medications. His note reads: S: Phone call from Highland Park Pharmacy, inquiring about him obtaining medications. They wanted to know who to bill for some Alprazolam. He presented a prescription from December 20, 1999, see copy in the chart. They filled it for him for this medication, although they were admittedly suspicious about it. I have not confronted the patient about that at this time. A: Appears to be deliberate, surreptitious misuse of prescription medications. Patient is fully aware that he is confined to Lorazepam only. P: Will ponder this further – it's unclear to me at this time whether his action is clearly a violation of the law, since I did write this prescription for him. At the least, however, it is a violation of trust. Therefore, he will be discharged from the practice, and will be required to seek further care elsewhere. I will be happy to forward records to another provider. (Id. at 3.)

¶47 Until February 25, 2000, Dr. Jackson did not question claimant's excuses, choosing to believe him. (Jackson Dep. at 52.) He did not even contact claimant's wife, who would have been able to verify or refute some of the excuses. (Id. at 19, 52.) In the face of the claimant's multiple excuses and his prior drug history, the doctor's failure to inquire into claimant's various excuses is astounding to the Court. It raises serious questions about the doctor's objectivity in diagnosing and treating the claimant.

¶48 On April 23, 1999, claimant reported to Dr. Jackson that he was "having worsening problems with pain in the head. He tried a few simple weightlifting techniques, but found that the neck became extremely painful with any movement. He has discontinued this at this time." (Id. at 21.) In making his assessment, Dr. Jackson's entry of May 6, 1999, noted that claimant is "doing some light physical exercise, mostly curls, and even that seems to

worsen his headache somewhat. He also has an exercise bike, is trying to maintain his weight at around 185 pounds." (Id.) Dr. Jackson noted in claimant's file: "Chronic pain, little patience with medications which offer only partial relief of his pain. Incredible tolerance to medications of all sorts." (Id.)

¶49 On May 7, 1999, Dr. Joav Kofman, a neurologist with Billings Clinic, saw claimant. Dr. Kofman had also seen claimant on May 7, 1997, and June 18, 1997, for a 1996 neck injury. (Id. at 144, 183-87.) On May 7, 1997, he had opined that claimant's headaches were multifactorial with an element of left occipital neuralgia, common migraine, and muscle tension. (Id. at 186.)

¶50 On May 7, 1999, claimant reported to Dr. Kofman that he had been working out regularly and had lost 60 pounds. (Id. at 144.) Dr. Kofman noted that claimant had headaches on the left side before March 14, 1999, but that he now had bilateral headaches that radiated from the occipital region towards the top of the head and towards the eye. (Id.) Dr. Kofman attributed the bilateral headaches to muscular spasm and possibly occipital neuritis bilaterally, and the pain in the right medial scapular region as due to muscle spasm. He performed bilateral occipital nerve blocks and claimant reported significant improvement to the tenderness to palpitation around this region within ten minutes. (Id.) Dr. Kofman also injected claimant with 100 units of botulinum toxin into four different sites of the right medial scapular region. (Id. at 146.)

¶51 On June 17, 1999, Dr. Jackson prescribed physical therapy and noted he needed a work-hardening program and guidance with his home weight program. (Id. at 194; Ross Dep., Ex 1. at 6.) He noted that claimant was "now off of weightlifting, exercise of all forms." (Ex. 1 at 20.) On July 6, 1999, claimant began physical therapy. (Ex. 1 at 154.)

¶52 Claimant returned to Dr. Kofman on June 25, 1999, reporting that none of the May 7, 1999 injections that he received to the occipital nerve or to the parascapular muscles on the right side "helped at all." (Id. at 189; Ross Dep., Ex. 1 at 2; emphasis added.) Claimant complained his bilateral headaches continued daily. As in 1997, Dr. Kofman again attributed claimant's chronic headaches to occipital neuritis and muscular tension. (Ex. 1 at 190.)

¶53 As of July 29, 1999, claimant discontinued his physical therapy treatments. (Ross Dep., Ex. 1 at 4.) Claimant told Dr. Ross that the therapist stopped the therapy because he was concerned about the possibility of a cervical disk injury/herniation. (Id.) His statement has utterly no support in the medical record. I note that on July 24, 1999, Dr. Jackson wrote that he expected claimant to continue with physical therapy for another two months. (Ex. 1 at 150.) Moreover, claimant's statement is inconsistent with Dr. Jackson's recommendation on November 17, 1999, of additional physical therapy. (Id. at 162.)

¶54 On July 30, 1999, Dr. Scott K. Ross performed an IME at the request of Liberty for a second opinion. (Ross Dep. at 9.) At the time of Dr. Ross' examination, claimant denied any "history of headaches prior to the injury on 3/14/99" (Ross Dep., Ex. 1 at 4), which of course was not true. Claimant reported his 1996 cervical surgery but denied "any other significant or relevant past medical history" (id.), which also was not true.

¶55 Dr. Ross noted claimant's continued complaints of pain in his neck, right upper back and headache in spite of a large quantity of narcotic analgesics. (Id.) He also noted that no x-rays, CT scans, or MRIs have been performed, nor had nerve conduction studies been done. (Id. at 3.) Even though Dr. Ross found the claimant had subjective complaints of pain without objective correlation, he determined that claimant was not at MMI and recommended: 1) discontinuing claimant's narcotic analgesic medications; 2) cervical spine x-rays; 3) consideration of cervical spine MRI; and 4) a one to two week work-hardening program at the Deaconess Rehabilitation Facility in Billings, to include an entry and exit functional capacity evaluation (FCE). (Id. at 6.)

¶56 In Dr. Jackson's treatment notes from September 15, 1999, he noted that claimant "was okayed for the work-hardening program next week. He was to continue with home exercise, and, in fact, has started weightlifting again with up to 30 pounds, in a supine position only." (Ex. 1 at 13, emphasis added.)

¶57 Claimant underwent a "physical therapy work conditioning initial evaluation" on September 20, 1999. (Ross Dep., Ex. 2 at 1.) After his exam on September 20, 1999, claimant began the actual work-hardening program. (Ross Dep., Ex. 3 at 1.) After the first day of the work-hardening program, where claimant lifted weights of up 60 to 100 pounds, he began experiencing some low-back discomfort, pain in the latissimus dorsi region on the right, and headaches. (Id., Trial Test.)

¶58 On September 21, 1999, claimant called the Rehabilitation Department and stated he was in a great deal of pain, and was not coming in for the second day of work-hardening. (Ross Dep., Ex. 3 at 1). Dr. Ross contacted claimant and requested him to come in to be examined. Claimant complied. Upon examining claimant, Dr. Ross noted that his primary complaints were of pain at the base of the neck posteriorly which extended up and over the head, pain in the right latissimus dorsi region, and pain in the right hip accompanied by some numbness. (Id. at 1, 3.)

¶59 Dr. Ross noted inconsistencies in claimant's neck movements during his examination. Claimant sometimes moved his neck fluidly and at other times quite guardedly. (Id. at 3.) Dr. Ross noticed claimant was able to unlace and remove his shoes quite readily, as well as put them back on without any apparent difficulty, pain, or discomfort in the low back, upper back, or neck. (Id. at 4.) Dr. Ross testified there was no cervical paraspinous spasm upon examination, nor was there any palpable or visible abnormality in the cervical spine or cervical paraspinous region even though claimant reported pain of 8/10 intensity upon

gentle palpation. No trigger points or spasms were noted in the cervical paraspinous musculature. (Id.) He noted claimant did not have any palpable or visible abnormalities of the latissimus dorsi muscles bilaterally; nor was there any pain with palpitation of the posterior spinous processes of the lumbar spine. (Id.)

¶60 Dr. Ross determined that claimant exhibited exaggerated pain responses throughout the evaluation. (Ross Dep., Ex. 3 at 4.) He advised claimant to return to the work-hardening program but to avoid lifting anything greater than 25 pounds, and also relayed his advice to the staff of the program. (Ex. 1 at 172.) Dr. Ross testified that he clearly told claimant to continue with the work-hardening program. (Ross Dep. at 20.)

¶61 Claimant did not return to the work-hardening program. Although Dr. Jackson thought "to the best of his recollection" that he "probably" told claimant to discontinue the rehabilitation program (as evidenced by his deposition testimony on June 2, 2000), his September 22, 1999 treatment note generated during the actual time frame of claimant's participation in the work-hardening program states:

> Several phone calls from the patient in Billings, says that he's flat on his back in bed, having a great deal of difficulty tolerating the rehabilitation program. He's in a lot of pain, complains of a bad headache, difficult to sleep, feels like "he cracked his neck." According to him, his lawyer has told him that he cannot see a doctor in Billings, which I find difficult to understand. [Emphasis added.]

(Ex. 1 at 13; Jackson Dep. at 31, 47, 71.) Dr. Jackson's September 24, 1999 treatment note also underscores the fact that claimant left the work-hardening program on his own or based upon the advice of his attorney, not because of any medical advice he received. Under the subjective findings it states in relevant part:

> Complicated situation. Patient was in the work hardening program for 24 hours. He over-performed on the testing on 9/20. Overnight, he developed a fairly severe headache and increasing low back and neck pain. The following day, he asked to see the physician there for something to relieve his pain. He has been continuing to take Vioxx. Dr. Ross, the physician associated with the Occupational Medicine Department at Billings Deaconess, according to the patient, called him "stupid" several times for having overdone the performance the day before. Patient says he was only following directions. He was not given anything for pain relief. He apparently did see a neurologist at the Billings Clinic who gave him some Halcion for sleep in the last couple of days. The patient has been in quite a bit of pain, also contacted his attorney, who advised him not to continue with the work hardening program at this time and not to be seen by Dr. Ross further.
>
> Patient's now having much the same symptoms – severe headache, sensitivity to the light, lots of neck stiffness. His low back is worse, and he reports considerable

> pain radiating into the right buttock and leg. He feels that his right foot is turned inward, due to muscle weakness.

(Ex. 1 at 12, emphasis added.) In addition, Dr. Ross' testimony reflects his understanding that claimant's refusal to continue his participation in the work-hardening program was based upon his attorney's advice. (Ross Dep. at 21.) In light of Dr. Jackson's contemporaneous notes, as well as the doctor's tendency to believe his patient without verifying his statements (¶47), I find that Dr. Jackson did not direct claimant to discontinue the work-hardening program and claimant quit either on his own or after talking to his attorney.

¶62 After examining claimant on September 24, 1999, Dr. Jackson felt claimant should attempt to return to the work-hardening program, however, he suggested waiting two to three weeks before doing so, to allow the patient's pain to subside. (Id.) Dr. Jackson recommended: "At that time he might return, but he'll need special coaching and so forth about his performance expectation in the work-hardening program." (Id.)

¶63 On September 25, 1999, Dr. Ross concluded that claimant had reached MMI regarding his March 14, 1999 injury as of September 21, 1999, the date he left the work-hardening program. (Ross Dep., Ex. 4 at 1.) He noted that any restrictions or limitations that he found as of September 25, 1999, were related to claimant's previous injuries, not the March 14, 1999 injury. (Ross Dep. at 22.; Ross Dep., Ex. 4 at 1.) Dr. Ross went on to state that claimant was permanently limited secondary to previous work-related injuries and surgeries (lumbar spine and cervical spine) where he received whole person impairment ratings for both injuries. (Ross Dep., Ex. 4 at 1.) Furthermore, he opined that claimant did not have any permanent physical limitations or impairment attributable to his March 14, 1999 injury at Bos.

¶64 On October 7, 1999, claimant saw Dr. Jackson who noted:

> Rather than returning to the work hardening program in Billings, I will see if we can get him started in physical therapy again. Perhaps a therapist who knows him can start slowly with him, keep him within normal kinds of limits, as he's increasing his strength. He has yet to reach maximum medical improvement.

(Ex. 1 at 12.)

¶65 On October 28, 1999, Dr. Jackson saw claimant again and noted headache, neck, and low-back pain. (Id. at 11.) He noted that claimant was waiting to hear from workers' compensation regarding further physical therapy. (Id.) During October and early November, Dr. Jackson also recorded that claimant was depressed and had abdominal pain. (Id. at 10-11.) On November 10, 1999, Dr. Jackson noted "more of a headache recently, especially in the left orbital region," but also noted that claimant had "been doing 100 push-ups, 200 ‘crunches,' 50 sit-ups." (Id. at 10, emphasis added.) Of note, Dr. Jackson wrote that he

planned to try and get claimant "hooked up with a physical therapist, "mostly to act as a ‘brake' to his exuberant use of weightlifting." (Id., emphasis added.)

¶66 Claimant resumed physical therapy on November 29, 1999. Of significance, the therapist's note states that claimant "has been lifting weights on his own at home; however, has been lifting extremely heavy weights working mostly on primary movers." (Id. at 166, emphasis added.) The therapist provided a schedule of home exercises and planned gym sessions twice a week for four weeks. (Id. at 167.) There are no follow-up notes for physical therapy.

¶67 On December 1, 1999, Dr. Jackson noted in claimant's file that he was not to receive any further narcotics. (Id. at 9.) He testified that this decision was based on claimant's "longstanding pattern of misuse of the medications and the fact that there was no therapeutic progress being made with their use, that we would discontinue that approach permanently." (Jackson Dep. at 36.)

¶68 On March 2, 2000, Dr. Jackson permanently discharged claimant from his practice (ex. 1 at 2, 173) because he received a phone call from a pharmacy alerting him to the fact that claimant had filled a prescription for Alprazolam even though Dr. Jackson specifically told him he was limited to using just one drug, Lorazepam. (Jackson Dep. at 5, 34-35, 41-42.) Dr. Jackson thought this was a deliberate, surreptitious misuse of prescription medications and a violation of his trust. (Ex. 1 at 3; Jackson Dep. at 35.)

¶69 After claimant was discharged from Dr. Jackson's practice on March 2, 2000, he saw Dr. Steven R. Speth, who evaluated him on May 4, 2000. (Ex. 2 at 1.) Dr. Speth noted that claimant had intermittent headaches that were predominately right-sided until his injury on March 14, 1999, whereupon he began experiencing holocranial headaches. He noted that claimant was not particularly tender to palpation throughout the cervical spine including regions over the greater occipital nerve. (Id. at 2.) Dr. Speth referred claimant "to Dr. Vallin for evaluation and treatment, to consider C2 dorsal root ganglion blockade." He further suggested that if the recommended treatment was unsuccessful, then cervical imaging and anteriography should be considered, as well as a neurology consult. (Id.)

¶70 Claimant was then examined by Dr. John A. Vallin on May 30, 2000. (Ex. 3 at 1.) Dr. Vallin noted that "claimant was doing well until 3/14/99 when he fell 10 feet off a ladder, landing on his left side, hitting the left side of his head and neck." (Id.) Claimant's statement about doing well until March 14, 1999, was, of course, untrue. In any event, Dr. Vallin noted claimant was diffusely tender overlying the left cervical facets with no similar tenderness on the right. (Id.) Claimant was also tender in the midline over the C6 and C7 spinous processes. Dr. Vallin diagnosed cervical degenerative disk disease at C5/6, C7/T1. (Id.) In addition, Dr. Vallin stated that claimant's "mechanical neck pain" was more likely than not related to his industrial fall of March 14, 1999. Dr. Vallin recommended facet injections and

physical therapy. In the event claimant did not elect this course of treatment, Dr. Vallin opined that claimant was most likely reaching MMI. (Id. at 2.)

¶71 Neither Dr. Vallin nor Dr. Speth testified in this matter.

Medical Evidence of Injury

¶72 Other than a small laceration on the left hand, there is no objective evidence of injury in this case. While some of the doctors identified muscle spasm and tenderness, those symptoms are not inconsistent with claimant's preexisting condition and complaints. Moreover, often there was no muscle spasm present in examinations of claimant.

¶73 Dr. Jackson noted that the left-sided headaches appeared to follow from the injury (ex. 1 at 22), however, Dr. Kofman reported on May 7, 1997, that "left posterior occipital pain which radiates to the top of the head and towards the left eye" and "also some pain which does occasionally radiate from the cervical region into the left upper extremity." (Id. at 183.) I am not persuaded that the left-sided aspect of claimant's headaches are new.

¶74 Dr. Jackson testified that it was not possible to objectively verify if claimant exacerbated the occipital neuralgia and back pain, but he thought "the clinical findings . . . were adequate to tell us whether he had a substantial worsening of the cervical fusion" and that the "worsening of his pain was consistent with some type of injury." (Id. at 60-61, 74, emphasis added.) However, Dr. Jackson admitted that he was essentially relying on claimant's subjective reports of pain when he made his medical conclusions.

> Q. Is it accurate to say what happened after the March '99 injury is, there's no objective evidence those [preexisting] conditions changed, we simply have his complaints of increased pain and discomfort.
>
> A. Yes, thank God they [the preexisting conditions] did not change.

(Id. at 49.)

Other Evidence of Claimant's Credibility

¶75 In prior findings, I have cited a number of instances which call claimant's veracity into question. There are additional examples, including the following instances.

¶76 At his May 10, 2000 deposition, the claimant was asked what he did after seeing Dr. Speth on May 4, 2000, only six days previous. He testified that he "went right home" because he had his family with him, arriving home at approximately 1:00 or 1:30 pm, and then spent the rest of the afternoon sitting in his chair at home. (Schneider Dep. I at 27-29.) However, a video surveillance film (ex. 5) shows that after he left Dr. Speth's office on May 4th claimant did a number of errands and did not arrive home until nearly 5:00 p.m. Given the fact that claimant's testimony was only six days after the events in question, I find it

difficult to believe that claimant did not recollect what he did after the appointment. Indeed, I am persuaded that he lied during his deposition.

¶77 Claimant testified that when he saw Dr. Ross on September 21, 1999, he believed that Dr. Ross "said to go home." He further testified that he was unclear as to what he was supposed to do. Dr. Ross' office note and testimony flatly contradict claimant's testimony. (Ross Dep. at 20; Ross Dep., Ex. 3.) Moreover, Dr. Jackson's office note of September 22nd indicates that claimant had contacted his lawyer about the matter and his note of September 24th reports that claimant said that his lawyer had told him to discontinue the work-hardening program and not return to Dr. Ross. (Ex. 1 at 12-13.) I do not believe claimant's testimony that he was told to go home by Dr. Ross and do not believe there was any misunderstanding on his part.

¶78 At trial the claimant denied ever "scamming" or lying to Dr. Jackson in order to obtain drugs. On its face, that denial is difficult to believe. As set forth in paragraph 46, just since claimant's alleged injury he has told Dr. Jackson that the pharmacy did not fill a prescription (the pharmacist repudiated the allegation and even did a pill count); that his drugs were stolen; that he left his drugs behind; and that his wife flushed his drugs down the toilet. The number and nature of the stories he told Dr. Jackson leave no doubt in my mind that he was lying at least part of the time, if not all of the time, in the instances recited in paragraph 46. Claimant was confronted with a statement made to a police officer in 1997 wherein he said he had told Dr. Jackson false stories in order to obtain additional drugs, including:

> I lost them.
> They fell in the toilet.
> They fell in the sink.
> I lost my prescription.
> They fell out of the car and I ran over them.
> My son stole them.

(Ex. 6 at 4-5.) Claimant testified he did not recall making the statements, but admitted he might have. His attorney stipulated that the statements were made but that claimant denied that they were true. On redirect, claimant said that he may have made the statements to the police officers while on morphine and that he was scared of going to jail. In response to questions I put to him, he conceded that what he told Dr. Jackson may not always have been true and that he may have lied, but that if he did so it was while he was in a narcotics haze. I think this is as "close" to the truth that claimant ever got in his testimony.

¶79 Claimant testified that despite Dr. Jackson discharging him from his practice, Dr. Jackson asked him if he would like the doctor to continue treating him. Dr. Jackson denied

the assertion during his deposition (Jackson Dep. at 42-43, 45), and I find claimant's assertion to be false.

Resolution

¶80 I find that the alleged industrial accident did not in fact occur. My reasoning is as follows:

- The claimant is not a credible witness. In fact, I have found that he has lied in his testimony and has lied to his treating physician.
- Claimant has a history of drug abuse antedating his alleged industrial accident.
- There is substantial, persuasive evidence claimant repeatedly lied to his treating physician in order to obtain additional drugs, especially narcotics.
- Four days previous he sought additional narcotic drugs from his physician and was refused.
- At the time of his alleged accident, claimant was aware he would probably not be hired on a permanent basis. The day before the alleged accident he had asked for another chance to prove himself at work. He, by his own admission, had been terminated from his previous job just over a month prior, allegedly on account of sick days due to headaches, and knew it was likely he would be jobless once again.
- Claimant exaggerated the distance of his fall to his physicians. He reported a fall of 10 feet. The distance he could have fallen was in fact only 40 inches, a little less than 3½ feet. While claimant attempted to explain away the discrepancy, his explanation was unpersuasive and not credible.
- The physical evidence of a fall -- a broken watch and a scratch on the back of the left hand -- was minimal and easily fabricated. Other evidence of a significant fall, such as bruising of his arm, head or neck, or muscle spasm was lacking.
- Claimant asserts he landed on his left side and did not strike a wall or anything else when he fell. The hand rail on the ladder, the short distance between the ladder and the back wall, and the claimant's statements that he was leaning "back" when he fell, make it difficult to envision that claimant could have fallen without any part of his body striking the wall behind him.
- Statements made by claimant to a coworker and to his supervisor following the alleged accident were odd and indicate that claimant was focused on making a workers' compensation claim. Claimant's statement to Ferrier that "you don't believe me" indicates he was concerned at the time that his claim was suspicious. His instruction to VanDyke that he wanted his claim to be "by the book" indicate that making his claim was of paramount importance to him.

- If claimant is to be believed, his headaches at the time of the alleged accident were already severe and debilitating. As noted already, he sought additional narcotics for his headaches just four days prior to his alleged accident. Of further significance, just a month and a half prior to the alleged accident, he claimed to have been fired from his previous job because he missed work on account of his headaches.
- Medical opinions finding that claimant suffered an injury or aggravation are predicated on claimant's reports concerning his fall and on his subjective complaints. The medical opinions therefore are no better than claimant's credibility.

¶81 Even if claimant suffered an industrial injury as he claims, I find that he reached MMI as of September 21, 1999, the date on which Dr. Ross found him at MMI. On that date he refused to continue the prescribed work-hardening program. Dr. Ross testified that the primary purpose of the work-hardening program was to objectively determine what claimant could physically do. (Ex. 39.) Claimant's failure to pursue the program, as with his failures to previously pursue physical therapy, frustrated that purpose. Without his cooperation participation in work-hardening or physical therapy, those programs are pointless and will not improve his condition.

¶82 Dr. Jackson's opinion that claimant needs additional physical therapy is unpersuasive. Claimant had the opportunity to continue with the work-hardening program and refused. Claimant's previous involvement with physical therapy indicate that any further physical therapy is unlikely to help. In 1990, Dr. Michael A. Sousa, who performed lumbar surgery on claimant, noted that claimant "was noncompliant with regard to a recommendation for physical therapy." (Ex. 1 at 132.) Claimant quit the physical therapy program prescribed by Dr. Jackson in June 1999. His explanation for quitting is not supported in the medical records and, like many of his other excuses, not credible. On his own, claimant engaged in vigorous weightlifting. I find it unlikely that claimant would follow through with physical therapy or benefit from it.

¶83 Dr. Speth made recommendations for possible further treatment but referred claimant to Dr. Vallin, thus deferring to Dr. Vallin. Dr. Vallin recommended facet injections and physical therapy, but noted that if claimant did not pursue either then he was at MMI. As found in the previous paragraph, I find it unlikely that claimant would pursue and benefit from physical therapy. As to the facet injections, that recommendation assumes claimant's complaints are true. I have found him incredible. Moreover, injections recommended by Dr. Vallin had been done previously by Dr. Kofman (Jackson Dep. at 64-65), and had only short-term effect. Dr. Ross testified that Dr. Speth's diagnosis of possible "upper cervical radiculopathy" was not borne out by the findings on his exam, or the cervical spine MRI, or the x-rays. (Ross Dep. at 36.)

Insurer's Conduct

¶84 Irrespective of the outcome of this case, the insurer acted reasonably when it terminated benefits.

CONCLUSIONS OF LAW

¶85 The claimant's alleged injury occurred on March 14, 1999, therefore the 1997 version of the Workers' Compensation Act applies. Buckman v. Montana Deaconess Hospital, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶86 Liberty alleges that the claim in this case is fraudulent. In Haag v. Montana Schools Group Ins. Authority, 274 Mont. 109, 115, 906 P.2d 693, 697 (1995), the Supreme Court held that an insurer must plead all elements of fraud with specificity. In that case, the insurer failed to plead fraud and the issue was not set out in the pretrial order. In this case, the matter was pled. Whether the pleading was sufficient is not before the Court since claimant never challenged the sufficiency of the pleading and agreed to reduce the issue to whether the accident in fact occurred. Thus, the issue of whether the claimant suffered an industrial accident, and whether he is entitled to any benefits, is properly before the Court. Since the claim was accepted, however, Liberty bears the burden of proving that an accident did not occur, i.e., that the claim was fraudulent. Taylor v. State Compensation Ins. Fund, 275 Mont. 432, 437, 913 P.2d 1242, 1245 (1996).

¶87 I have found as fact that no industrial accident occurred and that the claimant lied about the accident for the purpose of obtaining workers' compensation benefits. Accordingly, claimant is not entitled to any further benefits.

¶88 The next issue is whether the claimant should be required to repay the additional 49 days of section 610 benefits Liberty paid pursuant to this Court's Order. The termination of benefits by an insurer is governed by section 39-71-610, MCA, which states:

> Termination of benefits by an insurer– department order to pay disputed benefits prior to hearing or mediation – limitation on order – right of reimbursement. If an insurer terminates biweekly compensation benefits and the termination of compensation benefits is disputed by the claimant, the department may, upon written request, order an insurer to pay additional biweekly compensation benefits prior to a hearing before the workers' compensation court or prior to mediation, but in no event may the biweekly compensation benefits be ordered to be paid under this section for a period exceeding 49 days or for any period subsequent to the date of the hearing or mediation. A party may appeal this order to the workers' compensation court. If after a hearing before the workers' compensation court it is held that the insurer was not liable for the compensation payments ordered by the department, the insurer has the right to be reimbursed for the payments by the claimant. [Emphasis added.]

Liberty is not liable for further temporary total disability benefits and is therefore entitled to reimbursement of the 49 days of benefits ordered by the Department and this Court.

¶89 Since claimant has not prevailed, he is not entitled to costs or attorney fees. Moreover, even had he prevailed, the insurers' denial of further benefits was reasonable and he would not be entitled to attorney fees in any event. § 39-71-611, MCA (1997).

JUDGMENT

¶90 Claimant did not suffer an industrial accident on March 14, 1999, and is not entitled to compensation, medical, or any other benefits. Even if injured, he is not entitled to further temporary total disability benefits since he reached MMI. The claimant's petition is dismissed with prejudice.

¶91 Claimant shall repay the 49 days of additional benefits ordered by the Department and this Court under section 39-71-610, MCA. The Court reserves jurisdiction to determine the amount of those benefits should the parties be unable to agree on the amount.

¶92 Claimant is not entitled to costs or attorney fees.

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

¶94 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 20th day of April, 2001.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. Geoffrey C. Angel
Mr. Larry W. Jones
Date Submitted: October 18, 2000