**IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA**

**2013 MTWCC 12**

**WCC No. 2012-3019**

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**LOREN CHAPMAN**

**Petitioner/Appellant**

**vs.**

**SMURFIT-STONE CONTAINER ENTERPRISES, INC.**

**Respondent/Insurer**

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ORDER AFFIRMING DEPARTMENT OF LABOR & INDUSTRY, EMPLOYMENT RELATIONS DIVISION'S ORDER DIRECTING MEDICAL EXAMINATION

**Summary:** Petitioner appeals an order of the Department of Labor & Industry, Employment Relations Division directing a medical examination, requiring Petitioner to submit to a two-day psychiatric evaluation by William Stratford, M.D. Petitioner argues that this independent medical evaluation is neither reasonable nor necessary under the Workers' Compensation Act.

**Held:** Sufficient grounds exist for an evaluation of Petitioner's psychological and cognitive conditions after being on temporary total disability benefits over seven and a half years. Respondent may pursue an independent psychiatric examination to evaluate Petitioner's condition.

**Topics:**

> **Constitutions, Statutes, Regulations, and Rules: Montana Code Annotated: 39-71-605.** Although Petitioner has previously submitted to three IMEs since his May 2005 industrial accident, he has been on temporary total disability benefits for over seven years and has seen a host of medical and psychological specialists with no discernible improvement in his condition and with far-ranging opinions as to the cause

of his complaints. Compelling reasons exist for an IME by a forensic psychiatrist, consistent with the intent of § 39-71-605(2), MCA, to evaluate Petitioner's mood disorder and cognitive impairment, and to determine whether psychotropic medication would be an appropriate method of treatment for his various subjective complaints.

**Independent Medical Examination: Generally.** Although Petitioner has previously submitted to three IMEs since his May 2005 industrial accident, he has been on temporary total disability benefits for over seven years and has seen a host of medical and psychological specialists with no discernible improvement in his condition and with far-ranging opinions as to the cause of his complaints. Compelling reasons exist for an IME by a forensic psychiatrist, consistent with the intent of § 39-71-605(2), MCA, to evaluate Petitioner's mood disorder and cognitive impairment, and to determine whether psychotropic medication would be an appropriate method of treatment for his various subjective complaints.

¶ 1 This matter is before the Court pursuant to a Notice of Appeal[1] filed by Petitioner Loren Chapman from an Order Directing Medical Examination by the Department of Labor & Industry, Employment Relations Division (ERD Order) dated September 27, 2012.[2]

¶ 2 By Order dated October 5, 2012,[3] this Court set a briefing schedule on Chapman's appeal. Thereafter, Chapman filed a motion to stay the two-day psychiatric evaluation scheduled for November 19 and 20, 2012, with William Stratford, M.D.[4] Chapman contended that Respondent Smurfit-Stone Container Enterprises, Inc. (Smurfit-Stone) refused to stay the evaluation unless Chapman agreed to forfeit his benefits pending this Court's ruling on his appeal, which Chapman was unwilling to do.

¶ 3 On November 5, 2012, I held a telephonic hearing on Chapman's motion to stay, following which I granted the motion.[5] The Order[6] granting Chapman's motion clarified that Chapman's appeal of the ERD Order would be meaningless unless the medical

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[1] Docket Item No. 1.

[2] Order attached to Notice of Appeal; Respondent's Brief in Opposition to Appellant's Appeal of Department's Order Directing Medical Examination (Respondent's Brief), Ex. F, Docket Item No. 12.

[3] Notice on Appeal; Order to Transmit Record; Order Setting Briefing Schedule, Docket Item No. 2.

[4] Appellant's Motion to Stay, Docket Item No. 3.

[5] Minute Book Hearing No. 4431, Docket Item No. 7.

[6] Docket Item No. 8.

evaluation was stayed pending his appeal. The Order also made clear that if I affirmed the ERD order and if benefits were thereafter terminated, Smurfit-Stone reserved the right to seek reimbursement for benefits paid during the period which it otherwise would not have paid benefits had I not granted the stay.

¶ 4 For the reasons set forth below, I affirm the ERD Order Directing Medical Examination.

## BACKGROUND[7]

¶ 5 Chapman suffered two work-related injuries in the course and scope of his employment with Smurfit-Stone.[8] The first occurred on April 13, 2005, when equipment Chapman was operating suddenly malfunctioned, injuring Chapman's scalp, back, and knees. The second injury occurred on May 5, 2005, when the log hauler Chapman was operating struck a conveyor belt bridge, causing the bridge to collapse onto the cab of the log hauler and causing injuries to various parts of Chapman's body.[9] Chapman has now been on temporary total disability benefits for over seven and a half years.[10]

¶ 6 Post-injury, Chapman received treatment from a variety of medical professionals and underwent three independent medical examinations (IMEs). The first was a panel IME on June 13, 2006, consisting of orthopedic surgeon Catherine C. Capps, M.D., neurologist Lennard S. Wilson, M.D., and neuropsychologist John R. Harrison, Ph.D.[11]

¶ 7 Dr. Harrison's report recounts Chapman's two injuries as described to him by Chapman. After the first injury on April 13, 2005, Chapman was treated in the emergency room at St. Patrick Hospital where his scalp wound was sutured. Chapman was also informed by a physician there that he may have received a minor concussion. The next day Chapman felt excruciating pain in his back, neck, shoulder, head, and knee.[12] Chapman returned to work but did not operate any equipment for approximately ten days. The second accident occurred on May 5, 2005, when a conveyor belt bridge collapsed onto the cab of the vehicle Chapman was operating. Chapman was taken to the emergency room at Community Medical Center where a CT scan of his head was

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[7] Numerous medical and other records were either attached to the parties' briefs or were referenced in the attached records. Only those records found pertinent to this decision are referred to herein.

[8] Respondent's Brief in Opposition to Appellant's Motion to Stay at 1, Docket Item No. 4; Appellant's Brief Opposing Department's Order Directing Medical Exam (Appellant's Brief) at 2, Docket Item No. 11.

[9] *Id*.

[10] Appellant's Motion to Stay at 2.

[11] Appellant's Brief, Ex. A at 1; Respondent's Brief, Ex. G at 1.

[12] *Id*. at 1, 2.

taken and was reported as normal. Chapman hurt all over the next day, with an increase in his symptoms from his first accident.[13]

¶ 8 Dr. Harrison's impressions of Chapman included adjustment disorder with depressed and anxious mood, undifferentiated somatization disorder, probable secondary gain influencing symptom maintenance, and chronic pain syndrome with probable narcotic pain habituation.[14] Dr. Harrison recommended that Chapman's narcotic pain medication be reduced, and then evaluate him for appropriate psychological and physical treatment on a non-narcotic basis.[15]

¶ 9 The June 13, 2006, IME report of Drs. Capps and Wilson is referred to in the IME report of John A. Vallin, M.D., dated September 6, 2012.[16] Their report stated that Chapman's predominant complaints at the time were headaches, vertigo, low back and neck pain, mild right shoulder pain post-surgery, with minimal objective neurological findings. Drs. Capps and Wilson are quoted as noting: "We are concerned that Mr. Chapman is developing a well-entrenched chronic pain syndrome with a lot of relatively unusual complaints post closed-head injury. . . . It is difficult to determine post head injury function when someone is on a lot of narcotics, etc. We do not pick up any physical neurologic findings related to a head injury at this time."[17]

¶ 10 In the months following the May 2005 injury, Chapman was seen by a pain specialist (Steve Kemple, D.O.), a psychologist (Julie Hergenrather, Ph.D.), a neuropsychologist (William Patenaude, Ph.D.), a neurologist (Anthony P. Williamson, M.D., Ph.D.), physical therapists (Aric Thorne-Thomsen, M.S., P.T.; Nelson McGeary, P.T.; Chad Kay, M.S.P.T.), an osteopath (Karl Buechsenschuetz, D.O.), a physician's assistant to undergo an audiogram and an ENG (Josh B. Moser, PA-C), and an orthopedic surgeon (Larry Stayner, M.D.).[18] The latter performed surgery on Chapman's right shoulder on February 7, 2006, and again on February 27, 2007.[19]

¶ 11 Chapman's use of narcotic medication worried some of the physicians who followed his care post-injury. Dr. Buechsenschuetz's office note of June 15, 2006, is quoted in Dr. Harrison's January 2, 2009, Neuropsychological Addendum attached to

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[13] *Id*. at 2.

[14] *Id.* at 10.

[15] *Id.* at 12.

[16] The report of Drs. Capps and Wilson was not included in the exhibits attached to the parties' briefs.

[17] Respondent's Brief, Ex. C at 10.

[18] *Id*. at 5-18.

[19] *Id*. at 9, 14.

both parties' briefs: "We have made a concerted effort toward moving away from narcotics, which has been unsuccessful. . . . I think he needs to be weaned off of his narcotics completely and go through an intensive rehab program directed at functionally getting back to work."[20]

¶ 12 Dr. Vallin's IME report quotes Dr. Williamson's pertinent office notes as follows: (February 3, 2006) - "I explained to the patient that it would be absolutely impossible to help him as long as he was on narcotics. I also explained that I was distressed to find that most of his drugs are those which are highly addictive and often abused, i.e. OxyContin, Lortab, and Valium";[21] (October 9, 2007) - "Certainly, it is fairly alarming that this patient continues to have considerable difficulty in the setting of being on an opiate, a nonsteroidal antiinflammatory agent, a serotonin/norepinephrine reuptake inhibitor, and now an anti-epileptic medication. . . . All of these occur in the setting of some fairly ill-defined and vague neurological complaints."[22]

¶ 13 Both Drs. Williamson and Buechsenschuetz attributed Chapman's complaints of headaches, at least in part, to a "rebound" effect from his use of narcotics.[23]

¶ 14 Neurosurgeon Robert F. Hollis, M.D., performed the second IME on November 27, 2007, finding that Chapman "demonstrated significant symptomatic spondylosis, as well as substantial myofascial overlay. Dr. Hollis also noted demonstration of Waddell's findings and pain behavior."[24] Dr. Hollis did not feel Chapman was a surgical candidate, but did believe Chapman's pain was causally related to his two accidents at work. Dr. Hollis opined that Chapman was at maximum medical improvement (MMI).[25]

¶ 15 Bill S. Rosen, M.D., a specialist in pain medicine and rehabilitation, took over primary treatment for Chapman's injuries on April 22, 2008, when Chapman was referred to him, "specifically to address his issues related to the possibility of head injury with residual postconcussive syndrome and for me to assume primary care for all other work-related injuries."[26]

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[20] Appellant's Brief, Ex. C at 3; Respondent's Brief, Ex. M at 3.

[21] Respondent's Brief, Ex. C at 9.

[22] *Id*. at 15.

[23] *Id*. at 9.

[24] Appellant's Brief, Ex. H at 1.

[25] *Id*.

[26] Respondent's Brief, Ex. H at 1.

¶ 16 Following his second office visit with Chapman on May 27, 2008, Dr. Rosen noted his impression that Chapman had "2 distinct reports of concussions with ongoing neck pain and a residual postconcussive syndrome with narcotic dependency, sleep disorder, and possibly associated urologic difficulties."[27] Dr. Rosen referred Chapman for a urologic work-up and to William Patenaude, Ph.D., for a neuropsychological evaluation.[28] He also increased Chapman's OxyContin dosage to 40 mg per day in the mornings and evenings and 30 mg at midday, and decreased his hydrocodone to one tablet per day or less.[29]

¶ 17 Dr. Patenaude evaluated Chapman over a four-day period from August 18 to September 18, 2008. His notes reflect that Dr. Rosen referred Chapman for "clarification of Mr. Chapman's cognitive and psychological status."[30] Following his testing, Dr. Patenaude diagnosed depressive disorder, cognitive disorder, and found Chapman's test results to be consistent with post-concussive syndrome.[31] Dr. Patenaude recommended stabilization of Chapman's moods through psycho-pharmacology, psychotherapy, a cognitive rehabilitation program and physical rehabilitation, with a re-evaluation following cognitive rehabilitation.[32]

¶ 18 Dr. Harrison's Neuropsychological Addendum offered a different opinion of Dr. Patenaude's test results. Cautioning that it was difficult to determine the medications Chapman was taking and their side effects which could have impacted Dr. Patenaude's testing, Dr. Harrison concluded that Chapman's test scores "are more consistent with severe brain injury than a mild concussion. Further, there has not been the expected recovery which is the hallmark of most mild traumatic brain injuries."[33] Dr. Harrison also opined that, in the absence of clear-cut evidence of a concussion, "diagnosis of a concussion as a result of the two industrial accidents cannot be made on a more probable than not basis."[34]

¶ 19 Dr. Rosen saw Chapman again on March 19, 2009, by which time Chapman was taking 40 mg of OxyContin in the morning and afternoon and 60 mg at night, and continuing to complain of neck and low-back pain, and headaches. Dr. Rosen told

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[27] Respondent's Brief, Ex. I at 1.

[28] *Id*. at 2.

[29] *Id*.

[30] Appellant's Brief, Ex. B at 1; Respondent's Brief, Ex. J at 1.

[31] *Id*. at 7-8.

[32] *Id*. at 8.

[33] Appellant's Brief, Ex. C at 17-18; Respondent's Brief, Ex. M at 17-18.

[34] *Id*. at 16.

Chapman to switch the higher dose of OxyContin to the morning, and referred him back to Dr. Patenaude for counseling.[35]

¶ 20 By January 24, 2012, Chapman was up to 60 mg of OxyContin 3 times per day, and seeking to increase his evening dosage to 80 mg. However, Dr. Rosen explained that "60 mg 3X a day is actually a fairly high dose and increasing this will likely only lead to additional problems with tolerance."[36]

¶ 21 Dr. Rosen's office notes between March 19, 2009, and January 24, 2012, were not provided by either party; however, those records are referenced in Dr. Vallin's IME report (the third IME requested by Liberty) dated September 6, 2012.[37] Dr. Vallin's credentials include Diplomate of the American Board of Physical Medicine and Rehabilitation, with a sub-specialty in Pain Medicine.[38]

¶ 22 As noted by Dr. Vallin, on August 9, 2010, Dr. Rosen evaluated Chapman for an impairment rating. Aside from the 5% whole person impairment assigned by Dr. Capps on July 19, 2006, for Chapman's thoracolumbar spine,[39] and the 2% rating given by Dr. Stayner for Chapman's right shoulder on February 18, 2008,[40] Dr. Rosen assigned Chapman a 16% impairment rating based on his cognitive deficits and related issues.[41]

¶ 23 Dr. Vallin noted that on December 6, 2010, Dr. Rosen re-evaluated Chapman, with no change in his symptoms. Dr. Rosen also sent Chapman for a urine toxicology screen "[t]o verify compliance."[42] The toxicology screen was apparently read into Dr. Rosen's office note on April 4, 2011, as negative for codeine, morphine, hydrocodone and hydromorphone, and low for oxycodone -- 7,446 ng/mL, "whereas expected low range would be 63,526 ng/mL and a high range would be expected to be 69,785 ng/mL."[43]

¶ 24 The IME report of Dr. Vallin noted the following: "On examination of Mr. Chapman, I was struck by how physically fit he appeared and how alert he was with

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[35] Respondent's Brief, Ex. N.

[36] Respondent's Brief, Ex. O at 2.

[37] Respondent's Brief, Ex. C.

[38] *Id*. at 57.

[39] *Id*. at 12.

[40] *Id*. at 16.

[41] *Id*. at 25.

[42] *Id.*

[43] *Id*.

no evidence of being oversedated despite his assurance to me that he has been taking daily doses of OxyContin, Lortab, Skelaxin, ibuprofen, Lyrica, Ambien, Provigil, Lexapro, and Zofran."[44] Dr. Vallin also noted Chapman's display of painless range of motion of his cervical and thoracolumbar spine and no neurologic deficits. This was in contrast to Chapman's pain diagram showing diffuse, generalized pain throughout his body.[45]

¶ 25 Dr. Vallin's report further states:

> Mr. Chapman appeared very physically fit with well-muscled upper and lower extremities and a flat, muscular abdomen. His physical appearance, demeanor, and normal physical exam findings are not consistent with his diffuse subjective pain complaints and/or chronic pain nor is his presentation consistent with an individual suffering from chronic diffuse pain who has been disabled for approximately seven years on multiple medications, which would result in numerous side effects due to the medications themselves as well as the numerous drug-drug interactions associated with the combination he allegedly is taking.
>
> In summary, Mr. Chapman subjective complaints/symptoms are not consistent with my observations or his physical examination findings.[46]

¶ 26 Dr. Vallin also noted Chapman's normal score of 15 on the Glasgow Coma Scale following his injuries, with no loss of consciousness and no evidence of amnesia.[47] Dr. Vallin opined that, in the absence of objective findings such as an abnormal Glasgow Coma Scale or intracranial bleeding, mild closed-head injuries normally resolve "without sequelae."[48]

¶ 27 With regard to Dr. Rosen's 16% impairment rating for Chapman's closed-head injury, Dr. Vallin quoted the American Medical Association's 6th edition Guides to the Evaluation of Permanent Impairment that "symptoms of mild traumatic brain injury generally resolves in days to weeks and leaves the patient with no impairment."[49] Dr. Vallin concluded there was no scientific justification that a mild traumatic brain injury

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[44] *Id*. at 41.

[45] *Id.* at 41, 58.

[46] *Id*. at 42-43.

[47] *Id*. at 41, 43.

[48] *Id.* at 46.

[49] *Id*.; R. Rondinelli, M.D., Ph.D., *et al*. (eds.), *American Medical Association Guides to the Evaluation of Permanent Impairment*, 6th ed., AMA Press, 2008.

results in a permanent impairment.[50] On more than one occasion, Dr. Vallin's report defers to the expertise of a forensic neuropsychologist or psychiatrist for evaluation and treatment of Chapman's cognitive complaints.[51] Finally, Dr. Vallin opined that, in the absence of objective medical findings to support Chapman's continued need for polypharmacy, Chapman's care had not been consistent with the usual standards of care for the type of injuries Chapman incurred.[52]

¶ 28 Dr. Rosen took exception to Dr. Vallin's IME findings. In a letter to Chapman's attorney dated December 12, 2012, Dr. Rosen first notes that Dr. Vallin's suggestion of psychometric testing and evaluation by a forensic psychiatrist even before Dr. Vallin conducted his IME,[53] called into question Dr. Vallin's objectivity.[54] Dr. Rosen suggested that if such testing were indicated, it should be conducted by a "qualified fellowship trained neuropsychologist" like Dr. Patenaude, who had already conducted such tests on Chapman and "[s]ince then, no need for repeat neuropsychometric testing has arisen."[55] Dr. Rosen also noted that Dr. Vallin's report "misrepresents facts in the medical record and also discusses matters that are beyond the scope of physiatry."[56] Dr. Rosen's letter did not elaborate on what he perceived were Dr. Vallin's misrepresentations or matters he believed were beyond the physiatrist's field. Instead, Dr. Rosen emphasized the "deficient nature" of Dr. Vallin's evaluation.[57] Specifically, Dr. Rosen noted that the physiatrist's failure to conduct a cognitive evaluation or to test Chapman's balance, coordination, and motor abilities for residual post-traumatic sequelae calls Dr. Vallin's opinions into question. Dr. Rosen concluded: "[T]here is no medical basis for a psychiatric evaluation of Mr. Chapman, forensic or otherwise."[58]

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[50] Respondent's Brief, Ex. C at 47.

[51] "With respect to psychotropic medications to treat Mr. Chapman's depression/mood disorder(s), I would defer this to a psychiatrist knowledgeable in the diagnosis and treatment of said condition(s)." *Id*. at 53; "Presently, Mr. Chapman's subjective complaints are not consistent with any objective findings save for his right shoulder. I would defer Mr. Chapman's cognitive impairment/diagnosis to a forensic neuropsychologist and/or psychiatrist . . . ." *Id*. at 54-55; "Finally, Mr. Chapman may benefit from ongoing psychotropic medication to treat his mood disorder(s), which will be deferred to a forensic psychiatrist knowledgeable in the evaluation and treatment of mood disorders and/or generalized pain disorders." *Id*. at 56.

[52] *Id*. at 55, 56.

[53] Respondent's Brief, Ex. A.

[54] Appellant's Brief, Ex. I at 1.

[55] *Id*.

[56] *Id*. at 2.

[57] *Id*.

[58] *Id*.

¶ 29 Dr. Patenaude likewise penned a handwritten note to Chapman's counsel on September 25, 2012, writing, "If the question of traumatic brain injury remains evaluation by neuropsychology, neurology, or pertinent related professional (e.g. physiatry) would be more appropriate than psychiatry."[59]

¶ 30 On December 13, 2012, Dr. Rosen wrote to Chapman's attorney on the issue of urine screening over the past four years to verify Chapman's compliance with his medical regime.[60] On the four occasions he tested Chapman, Dr. Rosen found Chapman to have "always been compliant and results have been consistent with the medications prescribed." Dr. Rosen also noted that Chapman was dependent on opiate medication to treat his chronic pain, and had never exhibited "deviant behaviors, including drug-seeking, suggesting addiction or diversion."[61] Dr. Rosen further stated that Chapman has been "consistent with very specific urine spectroscopy analysis."[62]

¶ 31 By the time of Dr. Rosen's December 13, 2012, letter, he had reviewed and commented on Dr. Vallin's IME report. Yet Dr. Rosen does not address Dr. Vallin's reference to the toxicology screen taken from Chapman on December 6, 2010, and read by Dr. Rosen into his office note of April 4, 2011, as low for expected levels of oxycodone (*see* ¶ 23 above). In his letters to Chapman's attorney, Dr. Rosen also failed to comment on the following statement in Dr. Vallin's IME Report:

> Therefore, I cannot exclude the possibility of malingering and/or the possibility that Mr. Chapman may be diverting his opiod analgesics and/or other prescriptions. This final opinion is also based on Mr. Chapman's physical appearance today in that he presented himself as a very alert, coherent gentleman who appeared extremely physically fit and did not present himself as an individual with diffuse cognitive deficits, chronic diffuse total body pain, nor an individual taking high-dose opioid analgesics, daily skeletal muscle relaxants, high-dose anticonvulsants, nightly sedative hypnotics, sustained-release centrally acting stimulants, antidepressants, and daily centrally acting antiemetics.[63]

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[59] Appellant's Brief, Ex. F.

[60] Appellant's Brief, Ex. G.

[61] *Id.* at 1.

[62] *Id*.

[63] Respondent's Brief, Ex. C at 55.

## ANALYSIS AND DECISION

¶ 32 The Court has jurisdiction of this appeal pursuant to § 39-71-204(3), MCA, and ARM 24.5.350, which provides this Court with appellate authority over Department of Labor & Industry orders, other than an appeal of a department order regarding payment of benefits under § 39-71-610, MCA.

¶ 33 This case is governed by the 2003 version of the Montana Workers' Compensation Act since that was the law in effect at the time of Chapman's injuries.[64]

¶ 34 Section 39-71-605(1)(a), MCA, provides: Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, the employee shall, upon the written request of the insurer, submit from time to time to examination by a physician, psychologist, or panel that must be provided and paid for by the insurer and shall likewise submit to examination from time to time by any physician, psychologist, or panel selected by the department or as ordered by the workers' compensation judge.

¶ 35 Pursuant to § 39-71-605(1)(b), MCA, an IME is to be conducted at a set time and place with regard to the employee's physical condition, convenience, and ability to attend, and as close as practical to the employee's place of residence.

¶ 36 Chapman has so far submitted to three IME's, including a panel evaluation by a neurologist, an orthopedic surgeon, and a neuropsychologist; a neurosurgical evaluation; and an evaluation by a physiatrist. Since his accident in May 2005, Chapman has continued to receive TTD benefits while seeing medical, psychological, and other providers for diverse complaints including headaches, nausea, chronic pain, and cognitive difficulties, with little discernible improvement. While there is no doubt Chapman sustained injuries as a result of his two accidents, requiring suturing of a scalp wound and shoulder surgeries, the majority of his complaints are subjective in nature and cannot be verified by testing.

¶ 37 As held in *Liberty Northwest Ins. Corp. v. Marquardt*:

> The plain purpose of section 39-71-605, MCA, is to allow insurers to obtain independent opinions and information concerning a claimant's disability status, his or her current medical condition and need for further treatment, and the relationship of the claimant's condition to the industrial injury or disease. In line with that purpose, they cannot be demanded for arbitrary or whimsical reasons. . . . On the other hand, an insurer is

[64] *Ford v. Sentry Cas. Co.*, 2012 MT 156, ¶ 32, 365 Mont. 405, 282 P.3d 687; § 1-2-201, MCA.

> entitled to obtain a second, third, or even more IMEs or FCEs where there is an indication that claimant's medical condition has changed or there is some other sound reason for doing a repeat examination . . . .[65]

¶ 38 The complexity of this case is augmented by the differing opinions of the medical and psychological providers who have evaluated and treated Chapman's disorders. Here, the IME conducted by Dr. Vallin called into question Chapman's healthy physique with full range of motion of his entire spine while complaining of diffuse, chronic, whole-body pain. Dr. Vallin also questioned how someone supposedly compliant with ingesting large amounts of opioids, anti-depressants, muscle relaxants and other prescribed medication on a daily basis could be as lucid and alert as he found Chapman to be during his examination, particularly in light of the low toxicology screening results of December 6, 2010.

¶ 39 In contrast, Chapman's treating physician, Dr. Rosen, maintained in his December 13, 2012, letter to Chapman's attorney that his patient had always been compliant with his medication, and his urine screening consistent with his prescribed medications. However, if Dr. Vallin's recitation of the toxicology screening results is accurate, Chapman's compliance with his daily opiate regimen would appear incongruous with the screening results in which an expected low result of 63,526 ng/mL of oxycodone is compared to Chapman's actual oxycodone reading of 7,446 ng/mL. After reviewing Dr. Vallin's IME report, Dr. Rosen does not directly address this incongruity. Further complicating the situation, are the divergent views of the two neuropsychologists, Drs. Harrison and Patenaude, when reviewing the results of Dr. Patenaude's testing. Dr. Patenaude read the results as consistent with post-concussive syndrome. Dr. Harrison read the results as more indicative of severe brain injury, which would be inconsistent with Chapman's normal Glasgow Coma Scale results.

¶ 40 As a general rule, the opinion of a treating physician is accorded greater weight than the opinions of other expert witnesses. However, a treating physician's opinion is not conclusive. To presume otherwise would quash the role of the fact finder in questions of an alleged injury.[66] In the matter before me, I am not required to ascertain which opinions should be accorded greater weight; I need only determine whether sufficient grounds exist to permit another IME.

¶ 41 Despite the opinions of Drs. Rosen and Patenaude that a psychiatrist is not an appropriate physician to review Chapman's condition, I find that Dr. Vallin cites compelling reasons to the contrary. These reasons include a forensic evaluation of

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[65] 2003 MTWCC 63, ¶ 6.

[66] *EBI/Orion Group v. Blythe*, 1998 MT 90, ¶¶ 12-13, 288 Mont. 356, 957 P.2d 1134.

Chapman's mood disorder and cognitive impairment, and a determination whether psychotropic medication would be an appropriate alternative method of treatment for Chapman's various subjective complaints.[67] Given that Chapman has seen little improvement in seven and a half years of treatment, an evaluation by a forensic psychiatrist would be consistent with the intent of § 39-71-605(2), MCA, which requires a claimant to submit to an examination by a physician with "adequate and substantial experience in the particular field of medicine" involved in a dispute concerning a claimant's disability or condition.

¶ 42 I therefore conclude that Smurfit-Stone has offered sound reasons for the requested forensic psychiatric evaluation by Dr. Stratford to evaluate and recommend treatment for Chapman's mood disorder, cognitive impairment, and other psychological conditions.

## JUDGMENT

¶ 43 For the foregoing reasons, the Department of Labor & Industry, Employment Relations Division's Order Directing Medical Examination is **AFFIRMED**.

DATED in Helena, Montana, this 5th day of June, 2013.

(SEAL)

/s/ JAMES JEREMIAH SHEA
JUDGE

c: Steven S. Carey
Jeffrey B. Smith
Submitted: February 25, 2013

[67] *See* note 53, *supra*.