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

**2010 MTWCC 19**

**WCC No. 2008-2181**

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**SCOTT SHERWOOD**

**Petitioner**

**vs.**

**WATKINS & SHEPARD TRUCKING and GREAT WEST CASUALTY COMPANY**

**Respondents/Insurers.**

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# FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

**Summary:** Petitioner suffered numerous industrial injuries over several years of working as a commercial truck driver. Petitioner's employer terminated him after he was missing for several hours with his truck. Although he was unable to account for his disappearance at the time, Petitioner later alleged that he fell and lost consciousness the day before his disappearance, which caused him to become confused the following day. Petitioner alleges that the sum of his industrial injuries and the medications he takes have rendered him totally disabled and that either of two previous employers should be liable for his condition.

**Held:** The Court does not believe that Petitioner's alleged fall and loss of consciousness occurred. The Court does not find Petitioner's report of another alleged industrial accident to be credible. Therefore, the employer at the time of Petitioner's previous, undisputed industrial injuries is liable for his present condition. Petitioner has presented no evidence that he is at MMI and therefore he is not entitled to permanent total disability benefits. Based on the evidence presented, the Court concludes Petitioner is entitled to temporary total disability benefits as of September 28, 2009.

**Topics:**

> **Constitutions, Statutes, Regulations, and Rules: Montana Code Annotated: 39-71-701.** A claimant who lost his job for performance issues

and not because of his industrial injuries did not suffer a total loss of wages as the result of an injury.

**Wages: Wage Loss.** A claimant who lost his job for performance issues and not because of his industrial injuries did not suffer a total loss of wages as the result of an injury.

**Constitutions, Statutes, Regulations, and Rules: Montana Code Annotated: 39-71-701.** Where the treating physician expressed reservations about the claimant's ability to continue in his chosen career, but stopped short of taking the claimant off work, the Court concluded the claimant was no longer released to return to his time-of-injury employment only after an IME physician opined at a later date that he could not return to his time-of-injury employment, therefore making him eligible for TTD benefits.

**Benefits: Temporary Total Disability Benefits.** Where the treating physician expressed reservations about the claimant's ability to continue in his chosen career, but stopped short of taking the claimant off work, the Court concluded the claimant was no longer released to return to his time-of-injury employment only after an IME physician opined at a later date that he could not return to his time-of-injury employment, therefore making him eligible for TTD benefits.

**Injury and Accident: Subsequent Injury.** Where the Court found the claimant lacked credibility regarding his claim that he suffered new industrial injuries, the Court concluded the insurer for the claimant's previous, accepted claim was liable for paying TTD benefits after an IME physician opined that the claimant could no longer continue in his time-of-injury occupation.

¶ 1 The trial in this matter occurred on November 6, 2009, in the Workers' Compensation Court, Helena, Montana. Petitioner Scott Sherwood (Sherwood) was present and represented by Norman H. Grosfield. Leo S. Ward represented Respondent Watkins & Shepard Trucking (Watkins & Shepard). Geoffrey R. Keller represented Respondent Great West Casualty Co. (Great West).

¶ 2 Exhibits: Exhibits 1 through 32 were admitted without objection at the start of trial. Exhibits 33 through 35 were introduced during trial and were admitted without objection.

¶ 3 Witnesses and Depositions: The parties agreed that the depositions of Sherwood, Joseph K. McElhinny, Psy.D., Bill S. Rosen, M.D., and Catherine Capps, M.D., can be considered part of the record. Sherwood, Dawn Sherwood, Connie J. Hoffman, and Lynda Marie Kuhn were sworn and testified at trial.

¶ 4 Issues Presented: The Pretrial Order states the following contested issues:

> ¶ 4a Whether Petitioner is entitled to total disability benefits against either insurer; and
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> ¶ 4b If Petitioner is entitled to total disability benefits, for what period of time should such benefits be retroactively paid.[1]

## FINDINGS OF FACT

¶ 5 On November 4, 1993, May 14, 1996, and January 31, 1997, Sherwood suffered industrial injuries arising out of and in the course of his employment with Watkins & Shepard. At the time of these accidents, Watkins & Shepard was self-insured. It accepted liability for the claims and paid compensation and medical benefits.[2]

¶ 6 Sherwood has filed claims for injuries he alleges occurred on April 1, 2008, and June 4, 2008. At the time of these alleged injuries, Sherwood was employed by Hoovestol, Inc. (Hoovestol), which is insured by Great West. On November 10, 2008, Great West began paying benefits under a reservation of rights.[3]

¶ 7 Sherwood resides in Basin, Montana, with his wife and daughter. Sherwood has a G.E.D. and has primarily worked as a commercial truck driver.[4]

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[1] Pretrial Order at 2.

[2] Pretrial Order, Uncontested Facts.

[3] Pretrial Order, Uncontested Facts.

[4] Trial Test.

¶ 8 Prior to his work-related injuries, Sherwood had a back injury which led to three surgeries including a fusion at L4-5. The last of these surgeries occurred in approximately 1977. Sherwood testified that he did not have any problems with his back when he began to work for Watkins & Shepard in 1992.[5]

¶ 9 Sherwood worked as a cross-country truck driver for Watkins & Shepard. In November 1993, he suffered an injury to his back while off-loading a heavy piece of furniture. In May 1996, he suffered a second injury to his low back while off-loading a roll of carpet. On January 31, 1997, Sherwood jackknifed a truck north of Dillon, Montana, and suffered a third injury. Sherwood has no clear memories of the January 31, 1997, accident. He was apparently unconscious for a time, but he does not know for how long. He returned to work on March 10, 1997.[6]

¶ 10 On April 14, 1997, Sherwood was opening a trailer door when a strong gust of wind caught it and slammed him against the trailer.[7] He injured his shoulder, low back, and possibly his neck. He experienced increased headaches afterward.[8] Sherwood recalled that he was off work for approximately 10 days from this accident.[9]

¶ 11 Sherwood transferred into a non-driving position as a freight bill auditor at Watkins & Shepard. Sherwood testified that he lost this job after his office manager caught him sleeping at his desk for the second time. Sherwood stated that a contributing reason to his termination was his refusal to attend an Independent Medical Examination (IME) which Watkins & Shepard had arranged. Sherwood admitted that he refused to attend the IME appointment because he was working a second job at Eagle Ambulance Service in Montana City, and he was scheduled to work on the day of the IME.[10]

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[5] Trial Test.

[6] Trial Test.

[7] Sherwood Dep. 13:19 - 14:1.

[8] Sherwood Dep. 14:2-15.

[9] Sherwood Dep. 14:21-25.

[10] Trial Test.

¶ 12 Sherwood testified that his job at Eagle Ambulance Service involved working as an emergency medical technician (EMT), including performing hospital transports and answering emergency calls. The position required heavy work, including loading patients onto the ambulance.[11] Sherwood worked at Eagle Ambulance Service for approximately a year and two months. He testified that he quit when his paychecks bounced.[12] However, Katherine Jackson, owner of Eagle Ambulance Services, informed the Unemployment Insurance Division of the Montana Department of Labor and Industry that Sherwood voluntarily resigned his position on May 17, 2006, to seek employment elsewhere.[13]

¶ 13 Sherwood was hired by Bullock Contracting, LLC, on May 15, 2006, as a truck driver.[14] It is unclear from the record how long Sherwood worked there.

¶ 14 Hoovestol hired Sherwood on March 26, 2007.[15] His job duties were to haul mail between Seattle and Butte and between Butte and the Minneapolis and Chicago areas. This job was a "no-touch loading" job.[16]

¶ 15 In June 2007, Sherwood was involved in an accident while driving a truck for Hoovestol. He stated that he was blinded by oncoming headlights and he went off the road, damaging his truck and sustaining a concussion. Sherwood did not file a workers' compensation claim for that incident.[17]

¶ 16 On April 1, 2008, Sherwood allegedly slipped off a tire while cleaning the windshield of his truck in Rocker, Montana. Sherwood stated that he felt like he had compressed his back and had pain in his leg. The accident occurred across the street from an urgent care center. Sherwood immediately sought treatment. No one witnessed the accident.

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[11] Trial Test.

[12] Sherwood Dep. 27:4-9.

[13] Ex. 27 at 20.

[14] Ex. 28 at 6.

[15] Ex. 30 at 58.

[16] Trial Test.

[17] Sherwood Dep. 31:5 - 32:2.

Sherwood reported the incident to Hoovestol but stated that he did not intend to file a claim. He paid for his urgent care visit with his own funds.[18]

¶ 17 Although Sherwood saw Michael Schabacker, M.D., who was already treating Sherwood for pain management, on April 16, 2008, he did not tell Dr. Schabacker about the April 1, 2008, accident. At around this time, Dr. Schabacker changed one of Sherwood's medications and told Sherwood that he needed to notify Hoovestol about the change in medication. Sherwood admitted that he probably did not do so. Although Dr. Schabacker believed that Hoovestol was aware of Sherwood's prescription medications, including opiates, Sherwood denies telling Dr. Schabacker that his employer was aware of his prescriptions and testified that it is unlikely that Hoovestol knew about these medications.[19]

¶ 18 On April 25, 2008, Sherwood signed a Medical Examination Report for Commercial Driver Fitness Determination on which he represented in the driver questionnaire that he had no "Head/Brain Injuries, disorders or illnesses," no "Loss of, or altered consciousness," no "Spinal Injury or disease" and no "Narcotic or habit forming drug use." Sherwood answered "Yes" to "Chronic low back pain."[20] At trial, Sherwood testified that he did not know why he answered "No" to the question about narcotic or habit forming drug use. He admitted that at the time he answered the question, in addition to the pain pump, he took oral opiates.[21] In the medical examiner's section, the examiner answered in the negative to "Spine, other musculoskeletal: Previous surgery, deformities, limitation of motion, tenderness." The examiner approved Sherwood for a two-year certificate, representing that he met the standards in 49 C.F.R. 391.41.[22]

¶ 19 On May 6, 2008, Connie J. Hoffman (Hoffman), Senior Claims Examiner for Intermountain Claims, Inc., wrote to Sherwood regarding his report of an industrial accident on April 1, 2008. Hoffman noted that Sherwood had informed her via telephone that he did

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[18] Trial Test.

[19] Trial Test.

[20] Ex. 29 at 9.

[21] Trial Test.

[22] Ex. 29 at 11.

not wish to file a claim, and that he had reported that he had sought medical attention for problems related to this incident, but had paid for that medical treatment himself.[23]

¶ 20 Sherwood alleges that on June 4, 2008, he fell at a truck stop in Washington,[24] striking his head on the pavement and losing consciousness for one to two hours. Sherwood reported that the accident occurred at approximately 5:00 p.m. However, at trial he testified that he has no idea what time the accident occurred and only remembers that he saw stars when he awoke.[25]

¶ 21 Sherwood arrived on time at his Seattle destination on the evening of June 4, 2008. Shortly after midnight on June 5, 2008, Sherwood picked up a trailer at the terminal. He was scheduled to pick up this trailer at 8:00 a.m., but he picked it up early. At approximately 10:00 or 11:00 a.m., he returned to the Seattle terminal with the trailer he had picked up at midnight. Sherwood cannot account for his whereabouts from the time from left the terminal to when he returned 10 or 11 hours later. When Sherwood returned to the terminal, he informed his employer that he had returned because he had a repair done in Ellensburg, Washington. Sherwood had no invoice for the repair and he later concluded it probably did not occur. Because Sherwood was disoriented, his employer called an ambulance and EMTs evaluated Sherwood's condition. Sherwood did not report falling the previous day. Sherwood testified that at the time, he had not yet recalled that he had fallen and lost consciousness the previous day. After the EMTs released Sherwood, Hoovestol relieved him of his driving duty and transported him back to Montana. On June 6, 2008, Hoovestol terminated Sherwood's employment.[26]

¶ 22 A note in Sherwood's Hoovestol personnel file, dated June 5, 2008, states:

> Scott Sherwood called me today at about 11:30 am (Pacific time) from the Seattle BMC. He said he had just gotten to the BMC because he had some belt trouble with his truck the night before and had stopped . . . to get

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[23] Ex. 34 at 1.

[24] Sherwood's testimony was unclear as to whether he alleges this accident occurred in Clallam County, Washington, or Cle Elum, Washington.

[25] Trial Test.

[26] Trial Test.

> it repaired. He said the repair had taken about 4 hours. Since he was due into the BMC at 21:45 the night before, I then asked Scott what he had been doing for the other 10 hours, and he said that he had probably fallen asleep.
>
> I then told Scott that he needed to get his load . . . . Scott replied by saying that trip 803 was not ready to go yet. I told Scott that he was . . . supposed to take the 801. He said that the 801 was gone already. . . .
>
> He told me that the BMC had said that the 801 would not be ready until the following morning. . . . [T]hen Scott said that the BMC told him the 801 from this morning had left the BMC at about midnight. I asked Scott if he knew who had taken that load, and he said that he had taken it. . . . [W]e found out that Scott indeed had taken that load out and then brought it back to the BMC 12 hours later with no explanation.
>
> Upon figuring this out, we came to the conclusion that Scott is very confused and probably should not be driving a tractor/trailer. . . .
>
> The local EMT . . . checked on Scott and decided that he needed a lot of rest. . . .
>
> [W]e called a part-time driver . . . to take the 803 to Butte with Scott riding in the sleeper. . . .[27]

¶ 23 On June 9, 2008, Sherwood filed a Claim for Compensation with Hoovestol, alleging that on April 1, 2008, he suffered an industrial injury when he slipped off of a tire on which he was standing while cleaning his windshield.[28] Also on June 9, 2008, he filed a Claim for Compensation for the fall and loss of consciousness which he alleged occurred on June 4, 2008. Sherwood alleged, “While getting out of my truck, I slipped or missed a step, and fell backward onto asphalt paving, on my back, and hit my head on the asphalt. I was unconscious for possibly one to two hours.”[29] Sherwood testified that his June 4, 2008, fall injured his right shoulder, and he suffered a concussion, developed permanently blurred vision and headaches, experienced ongoing memory loss, and experienced an increase in back and leg pain.[30]

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[27] Ex. 30 at 16.

[28] Ex. 26 at 2.

[29] Ex. 26 at 3.

[30] Trial Test.

¶ 24  On June 13, 2008, Sherwood filed a statement with the Unemployment Insurance Division and alleged that he had lost consciousness in a rest area for one to two hours. At trial, Sherwood explained that he is not sure exactly how or when he recalled that he had fallen, but that it was two or three days after the fall. He did not seek medical treatment until June 13, 2008. Sherwood admitted that his log books for June 4 and 5 do not reflect a gap of one to two hours.[31]

¶ 25  Sherwood's daily log for June 4, 2008, indicates the following schedule:

Midnight to 9:00 a.m.: off duty
9:00 a.m. to 9:15 a.m.: on duty (not driving)
9:15 a.m. to approximately 2:00 p.m.: driving
Approximately 2:00 p.m. to 2:30 p.m.: on duty (not driving)
2:30 p.m. to 2:45 p.m.: driving
2:45 p.m. to 3:00 p.m.: on duty (not driving)
3:00 p.m. to 3:30 p.m.: off duty
3:30 p.m. to 8:15 p.m.: driving
8:15 p.m. to 8:30 p.m.: on duty (not driving)
8:30 p.m. to 8:45 p.m.: on duty (not driving)
8:45 p.m. to 9:00 p.m.: driving
9:00 p.m. to midnight: off duty[32]

¶ 26  Sherwood's daily log for June 5, 2008, indicates the following schedule:

Midnight to 12:15 a.m.: on duty (not driving)
12:15 a.m. to approximately 10 a.m.: sleeper
Approximately 10:a.m. to approximately 10:15: on duty (not driving)
Approximately 10:15 to approximately 2:00 p.m.: off duty
Approximately 2:00 p.m. to midnight: sleeper[33]

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[31] Trial Test.

[32] Ex. 31 at 4. Sherwood received and signed a notice from his employer acknowledging that time is only logged as "off-duty" time if all of the following criteria are met: The stops must be for at least 30 minutes, but must not exceed 2 hours; during the stop the driver is relieved from all responsibility for the care and custody of the truck and its cargo; and during the stop, the driver is free to pursue activities of his own choosing and is free to leave the premises where the truck is parked. Ex. 30 at 87.

[33] Ex. 31 at 5.

¶ 27 Sherwood testified that throughout his career, he has always filled out his log books once a day right before bed. He estimates the amount of time it should take him to drive the distance he covered that day and fills in the log book accordingly.[34]

¶ 28 On June 16, 2008, Hoovestol informed the Unemployment Insurance Division that Sherwood had been terminated from his employment for misconduct.[35] On June 18, 2008, Sherwood filed the following statement with the Unemployment Insurance Division:

> On 6/4/08 I stopped at rest area fell on the asphalt, hit my head and passed out for one to two hours. I did not know this had happened and was unable to verify where I had been when my employer asked me. There was about twelve hours of time I could not account for. On 6/5 my employer told me they could not accept the fact that I could not account for the time and they discharged me. I recalled the information on 6/6 - late in the day - that I had fallen. I called my attorney the same day and then he notified my employer 6/9. I went to the emergency room on 6/13, due to pressure in my head and double vision. The neurosurgeon and the emergency room doctor both advised me not to work until more tests are done. . . .[36]

¶ 29 Sherwood has been unemployed since June 6, 2008.[37] Sherwood contends that he has been totally disabled since June 2008 and that he became totally disabled as the result of his multiple injuries and complex medical history. He alleges that either Watkins & Shepard or Great West, or both, are liable for his condition and that he is entitled to benefits retroactive to his termination from Hoovestol.[38]

¶ 30 Sherwood testified that he takes several prescription medications on a regular basis. In addition to Fentanyl he receives via an intrathecal pump, he takes Avinza, Acteek,

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[34] Trial Test.

[35] Ex. 30 at 15.

[36] Ex. 30 at 13.

[37] Trial Test.

[38] Pretrial Order at 2.

OxyContin, oxycodone, Neurontin, Lunesta, hydromorphone, Flomax, Avodart, and Soma.[39] Sherwood stated that he has never had any side effects from any of his medications.[40] Sherwood stated that he also performs self-catheterization because his bladder does not empty correctly. Watkins & Shepard pays for the associated medical costs of his catheterization as well as his other medications.[41]

¶ 31 Sherwood does not currently have a treating physician. Sherwood testified that Bill S. Rosen, M.D., P.C., has offered to accept him as a patient if Sherwood were tested to see if he was a candidate for a pain management and opiate reduction program. Sherwood stated that he wants to treat with Dr. Rosen and he is willing to undergo the necessary testing.[42]

¶ 32 Hoffman testified at trial. I found her to be a credible witness. Hoffman has worked for Intermountain Claims for approximately eight years. She was the adjuster assigned to Sherwood's April 1, 2008, claim for compensation. Hoffman testified that on April 9, 2008, she contacted Sherwood to discuss the incident. Sherwood informed Hoffman that he did not intend to file a claim. Sherwood stated that he had visited Traveler's Health Care in Rocker for a single appointment which he paid for out-of-pocket. Sherwood told Hoffman that he did not intend to seek further treatment. Hoffman informed Sherwood that if he did not wish to pursue the claim, she would likely deny it. Hoffman testified that Sherwood did not argue with this statement and she ended the conversation.[43]

¶ 33 Lynda Marie Kuhn (Kuhn), Safety Director at Hoovestol, testified. I found Kuhn to be a credible witness. Kuhn's job duties include monitoring and investigating accidents, workers' compensation claims, and general safety compliance. Kuhn testified that drivers are required to maintain a log. The log is supposed to be current to their last change of

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[39] Trial Test.

[40] Sherwood Dep. 80:25 - 81:8.

[41] Trial Test.

[42] Trial Test.

[43] Trial Test.

duty status. Drivers cannot wait until the end of the day to fill out the log for the entire day.[44]

¶ 34 Kuhn had no record of Hoovestol receiving Dr. Schabacker's October 10, 2007, letter which advised Sherwood not to drive while taking oral narcotics in conjunction with his pain pump. Kuhn further testified that she has found no indication that Sherwood ever informed Hoovestol that he had a pain pump, nor that he consumed oral narcotics. Hoovestol performs random drug screenings, but Sherwood had not been selected for a random screening during the time he worked for Hoovestol. Kuhn noted that Sherwood had submitted to a drug screen prior to hiring and that his test came back negative.[45]

¶ 35 Kuhn investigated the June 4-5, 2008, incident when Sherwood was missing for several hours. Kuhn testified that on June 4, 2008, Sherwood passed a state inspection in Spokane at approximately 1:30 p.m. Pacific Time. Kuhn reviewed Sherwood's driver's log for that day and confirmed that the inspection was recorded as occurring at 2:30 p.m. Mountain Time. Kuhn testified that Sherwood's log is consistent with the inspection report, and that she presumes his log was current when he was inspected. Otherwise, he would have been cited for having a non-current log.[46]

¶ 36 From Hoovestol's and the Postal Service's records, Kuhn determined that Sherwood had arrived at the "in gate" of the BMC at 8:15 p.m. Pacific Time on June 4, 2008, turned in his trailer, and left with an empty trailer at 12:30 a.m. Pacific Time on June 5, 2008. He returned to the BMC at 10:23 a.m. Pacific Time on June 5, 2008, with the empty trailer and unable to account for his location for the past 10 hours.[47]

¶ 37 Kuhn testified that when Sherwood did not arrive at the terminal at the scheduled time, she attempted to locate him by calling his cell and home phones. Sherwood did not answer his cell phone. Sherwood's wife, Dawn Sherwood (Dawn) answered the home phone. Kuhn informed Dawn that Hoovestol could not locate Sherwood, and Dawn indicated that she would make some calls and try to locate him. Kuhn testified that Dawn

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[44] Trial Test.

[45] Trial Test.

[46] Trial Test.

[47] Trial Test.

did not tell her that she had spoken to Sherwood recently and Dawn did not state that Sherwood had been disoriented or confused when speaking with her. A short time after Kuhn spoke with Dawn, Sherwood called the terminal.[48]

¶ 38 Dawn testified at trial regarding Sherwood's alleged industrial accident of June 4, 2008, his ongoing pain complaints, his other medical problems, and how his conditions affect the family's home life. Dawn testified that on June 4, 2008, Sherwood called her from the road and he sounded confused and disoriented. Sherwood told Dawn that it was dark and that he could see stars, but the call occurred during daylight hours. On June 5, 2008, Sherwood called and reported that he had arrived in Seattle. Dawn believed Sherwood was supposed to be arriving at his employer's Montana terminal at about that time. Sherwood did not tell Dawn that he had recently fallen or lost consciousness. He called her after checking in at the Seattle terminal to report that he had been examined by emergency medical personnel who determined that he was exhausted. He informed Dawn that he would be returning to Montana in the sleeper with another driver operating the truck.[49]

¶ 39 Dawn testified that she constantly supervises Sherwood at home, that he falls frequently, and that he often has bruises, bumps on his head, or other visible injuries which he cannot account for. Dawn also stated that Sherwood frequently mixes up words and says one noun when he means another. Dawn testified that Sherwood loses his temper or becomes upset for no apparent reason.[50]

¶ 40 I did not find Dawn to be a credible witness. I give her uncorroborated testimony regarding Sherwood's abilities little weight. My lack of faith in Dawn's credibility arose as her testimony regarding Sherwood's memory loss and mental impairment evolved into a wholly unbelievable tale as her testimony unfolded. In particular, Dawn testified that Sherwood's falls increased in frequency after June 4, 2008, and that on one occasion, he fell, struck his head, and became so disoriented that he did not recognize his home nor recall that he was presently unemployed. Dawn testified that Sherwood kept trying to leave for work and that she had to call their adult son and ask him to stay at the home to help her

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[48] Trial Test.

[49] Trial Test.

[50] Trial Test.

prevent Sherwood from leaving while in a disoriented state. Dawn testified that Sherwood was disoriented and unable to recognize his environment for ***six days***, requiring 24-hour supervision by family members who slept in shifts. However, Dawn further testified that she never sought medical care for Sherwood during the six days in which, according to her testimony, he was so confused that he could not recognize his own home.[51]

¶ 41 Dawn further testified that Sherwood suffered "hallucinations" sometime after June 4, 2008, but prior to June 13, 2008, when she took him to St. James Healthcare for evaluation at the recommendation of his attorney's office. Dawn testified that she did not think that Sherwood needed to see a medical provider during any of the periods when he was allegedly hallucinating because she was capable of "watching him at home." Dawn also testified that she informed one of Sherwood's treatment providers in Salt Lake City about the hallucinations and stated that she does not know why the provider did not record this in any medical report.[52] Although it is certainly possible that a medical provider may fail to document everything, I find it incredible that medical providers would fail to note Sherwood was suffering profound hallucinatory episodes. I further find it incredible that Dawn would not have sought medical care for Sherwood if he was unable to recognize his surroundings for six days. The medical records in this case record that Dawn was an active participant in Sherwood's medical care and she was present at most, if not all, of Sherwood's medical appointments. Particularly after Sherwood received the intrathecal pump, the Sherwoods were constantly reminded of serious risks associated with the intrathecal pump and were urged to seek immediate medical attention if Sherwood's condition underwent any dramatic changes. I do not find it believable that Dawn would have ignored these dire warnings if Sherwood's condition were anywhere near as severe as she represented in her testimony. Furthermore, although Dawn testified that Sherwood called her on June 4, 2008, sounding confused and disoriented, not only did she not call Hoovestol at that time, but when Kuhn called her the next day and reported that the company could not locate Sherwood, Dawn merely stated that she would try to locate him. She did not tell Kuhn that the last time she spoke to Sherwood, he was disoriented. I do not believe that, had Sherwood called Dawn confused and disoriented, she would not have reported this to Hoovestol out of concern for his safety.

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[51] Trial Test.

[52] Trial Test.

## Medical Records and Testimony

Medical Treatment After the November 4, 1993, Industrial Accident

¶ 42 Dr. Glen Sublette, M.D., examined Sherwood on January 25, 1994, regarding his November 4, 1993, industrial accident. Sherwood had returned to work without restrictions approximately three weeks after his accident, but complained of ongoing upper back and neck pain, frequent headaches, dizziness, and radicular symptoms into his left elbow. Sherwood had been prescribed Soma, Parafon Forte, and codeine, and was currently taking Darvocet. Dr. Sublette prescribed a Medrol-dose pack, Soma, Nortriptyline, Toradol, and Zantac. Dr. Sublette found no objective medical findings to support Sherwood's complaints, but noted:

> I think Mr. Sherwood's complaints are multi-factorial. I think he probably does have a soft tissue injury, but also he apparently incurred a considerable amount of indebtedness during his illness, and seems to be working more diligently in an effort to get many of his bills paid off. Also, he seems rather "high strung", which is probably further aggravating his complaints.[53]

¶ 43 On June 6, 1994, Sherwood complained of intermittent parathesias in his right arm. Dr. Sublette examined Sherwood and ordered diagnostic testing, but saw no objective medical findings to support the right arm condition.[54]

¶ 44 Gary D. Cooney, M.D., saw Sherwood for an IME on October 31, 1994. Dr. Cooney noted that in spite of medical treatment, Sherwood continued to complain of "virtually constant achy discomfort in the lower interscapular midline"[55] and daily headaches with associated nausea since his November 1993 industrial accident. Sherwood reported recently developing burning sensations radiating into his forearms. Sherwood reported that he had problems sleeping because of pain.[56]

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[53] Ex. 1 at 1-3.

[54] Ex. 1 at 4-9.

[55] Ex. 2 at 2.

[56] Ex. 2 at 1-6.

¶ 45 Dr. Cooney's examination was unremarkable except for some percussion tenderness over the mid- to lower-thoracic spine and some tenderness to palpation over the adjacent paraspinous musculature.[57] The only abnormality in Dr. Cooney's neurological evaluation was slightly hyperactive results in upper and lower extremities. Dr. Cooney's impression was that Sherwood suffered from a cervical strain/sprain, thoracic strain/sprain, and scalp muscle contraction headaches secondary to a work-related injury on November 4, 1993. Dr. Cooney further noted possible depression, NSAID intolerance, and a codeine allergy.[58] Dr. Cooney noted that Sherwood's job appeared to aggravate his symptoms. He recommended lighter duty and a 35-pound lifting restriction. Dr. Cooney further stated:

> It also appears that he is unable to tolerate long periods of driving. . . . I have advised him that it may be necessary for him to consider an alternative occupation in some less physically demanding job, if he is unable to satisfactorily perform his present occupational duties.[59]

¶ 46 On November 9, 1994, Dr. Cooney released Sherwood to return to work for Watkins & Shepard as a relief driver. Dr. Cooney recommended that Sherwood lift no more than 35 pounds maximum on an occasional or infrequent basis.[60] On November 14, 1994, Dr. Cooney released Sherwood to short-haul truck driving and predicted that Sherwood would be able to lift up to 50 pounds in the future.[61]

¶ 47 Sherwood continued to see Dr. Cooney, who noted on September 18, 1995, that Sherwood had shown no improvement in constant, achy discomfort in the dorsal cervical and interscapular region with associated generalized headaches. Dr. Cooney recommended that Sherwood take a month off work and adopt a physical therapy regime.[62]

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[57] Ex. 2 at 4.

[58] Ex. 2 at 5-6.

[59] Ex. 2 at 6.

[60] Ex. 2 at 8.

[61] Ex. 2 at 9.

[62] Ex. 2 at 10.

On October 17, 1995, Dr. Cooney opined that Sherwood had reached MMI, noting that he was released to return to work in his time-of-injury job on October 16, 1995.[63]

¶ 48 On January 8, 1996, Dr. Cooney reported that Sherwood complained of worsening headaches as well as constant achy discomfort in the dorsal cervical and interscapular regions. Sherwood reported that his headaches were worse in the morning and were associated with nausea and occasional vomiting. While Sherwood's headaches initially appeared to be scalp muscle contraction headaches, they now had some characteristics consistent with migraine headaches. Dr. Cooney noted probable depression secondary to Sherwood's other medical problems.[64]

¶ 49 On February 14, 1996, Sherwood reported worsened headaches. Sherwood had been unable to work for the last three days and his headaches were aggravated with physical activity. Dr. Cooney recommended that Sherwood remain off work for one month and adjusted Sherwood's medications.[65]

¶ 50 Dr. Cooney wrote to Watkins & Shepard's claims adjuster on March 5, 1996:

> It is my impression that Mr. Sherwood continues to experience problems with pain in the cervical, thoracic, and head related to injuries he sustained on 11-4-93. At present, I am advising him to remain off work for this month starting from 2-14-96. . . . I am uncertain as to when Mr. Sherwood will be able to return to his time of injury job at this point. Whether the patient is going to continue to experience disabling pain in the head, interscapular, cervical and shoulder girdle region is uncertain, as well. I believe that the patient has been at maximum medical improvement, as I previously noted in a letter to you dated October 17, 1995. It is difficult to predict the course of the sort of subjective symptoms Mr. Sherwood appears to be experiencing. He appears to be highly motivated to return to his usual job, within the physical limitations

[63] Ex. 2 at 11.

[64] Ex. 2 at 12.

[65] Ex. 2 at 13.

which his cervical, thoracic and headache symptoms have imposed upon him.[66]

¶ 51 On March 19, 1996, Dr. Cooney reported that Sherwood had experienced some improvement to his headaches and received excellent relief from MS Contin. Sherwood reported that his headaches were still virtually constant, but gradually improving. Dr. Cooney took Sherwood off work for another month.[67]

¶ 52 On May 1, 1996, Dr. Cooney wrote to Watkins & Shepard's claims adjuster. He opined that Sherwood's headaches were directly related to his November 4, 1993, industrial injury. Dr. Cooney's conclusion was based entirely on Sherwood's subjective description of his symptoms and no objective medical findings supported his conclusion; however, he explained that headache complaints are almost never associated with specific objective abnormalities.[68]

Medical Treatment After the May 14, 1996, Industrial Accident

¶ 53 Dr. Cooney next saw Sherwood on May 21, 1996. Sherwood's complaints of neck and interscapular pain and headaches had increased. Sherwood had suffered a low-back injury a week earlier while attempting to pull a pad out from underneath a heavy carpet. Sherwood reported that since that incident, he had suffered severe pain in his lower back radiating into his legs. Dr. Cooney diagnosed Sherwood with a lumbar strain/sprain secondary to his May 14, 1996, lifting accident. Dr. Cooney took Sherwood off work for six weeks.[69]

¶ 54 On May 29, 1996, Sherwood reported urinary problems as well as continuing pain in his neck, interscapular region and low back. Dr. Cooney noted that a cranial MRI performed on May 21, 1996, had been normal. Sherwood reported that his right leg

[66] Ex. 2 at 14.

[67] Ex. 2 at 15.

[68] Ex. 2 at 16.

[69] Ex. 2 at 17-18.

collapsed unexpectedly at times. Sherwood's headaches were worsening and he was on medical leave from work.[70]

¶ 55 On June 17, 1996, Sherwood reported no improvement in his low-back or leg pain and reported that he was now having problems with his left leg. Sherwood reported continuing problems with urinary urgency. Dr. Cooney noted that a May 31, 1996, MRI revealed a disk protrusion at L4-5 and L5-S1 with a hemorrhage within the superior and posterior aspect of the disk space at L4-5, suggesting a possible more recent disk protrusion at that level. Dr. Cooney noted that the hemorrhage at L4-5 and disk protrusion at L4-5 and L5-S1 might be related to Sherwood's May 14, 1996, industrial accident.[71]

¶ 56 On July 1, 1996, Sherwood was having significant problems with pain in his low back and left leg. Dr. Cooney noted:

> An EMG of the left lower extremity reveals collapsing weakness and decreased power in the anterior compartment and triceps surae and quadriceps musculature which is more suggestive of submaximal effort than of bonafide organic weakness. He does have occasional positive sharp waves and fibrillation potentials in the left gluteal, hamstring and anterior compartment musculature, consistent with a recent injury to the left L5 nerve root. . . .[72]

¶ 57 On July 3, 1996, Sherwood attended a neurosurgical consultation with Richard C. Dewey, M.D. Dr. Dewey reviewed an MRI and examined Sherwood. He recommended additional radiographic studies to help determine if surgery was warranted.[73] After reviewing the results of a CT myelogram, Dr. Dewey opined that Sherwood would benefit from a laminotomy and micro-diskectomy at L5-S1.[74] Dr. Dewey performed the surgery on

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[70] Ex. 2 at 19.

[71] Ex. 2 at 20.

[72] Ex. 2 at 22.

[73] Ex. 2 at 24-25.

[74] Ex. 2 at 25A.

July 23, 1996.[75] Dr. Dewey released Sherwood to return to local short-haul truck driving on August 23, 1996.[76] On August 29, 1996, he released Sherwood to return to no touch, long-haul truck driving.[77] However, on September 11, 1996, he took Sherwood off work.[78]

¶ 58 On November 7, 1996, Dr. Dewey released Sherwood to return to work as a no touch, long-haul driver.[79] On December 6, 1996, Dr. Dewey returned Sherwood's care to Dr. Cooney. He noted that Sherwood's back and legs were "doing fine," but that he continued to have severe headaches which had been ongoing since his first industrial accident.[80]

¶ 59 Dr. Cooney saw Sherwood on December 11, 1996, noting he was reporting increasing problems with pain in the right upper cervical region associated with his headaches. Sherwood's headaches included nausea, photophobia, and sonophobia. Sherwood complained of intermittent numbness in his right arm. Sherwood appeared to experience daily migraine headaches since his November 4, 1993, industrial accident which had increased in frequency and intensity over the last few months.[81] Nerve conduction studies of Sherwood's right arm were normal.[82]

¶ 60 On January 6, 1997, Dr. Cooney noted that Sherwood was experiencing daily headaches with a very severe headache approximately every two weeks. Dr. Cooney opined that the majority of Sherwood's headaches were scalp muscle contraction headaches with occasional migraine headaches. Dr. Cooney adjusted Sherwood's prescriptions and warned him not to take Soma while driving.[83]

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[75] Ex. 2 at 26-27.

[76] Ex. 2 at 30-31.

[77] Ex. 2 at 32.

[78] Ex. 2 at 33.

[79] Ex. 2 at 34A.

[80] Ex. 2 at 36.

[81] Ex. 2 at 38.

[82] Ex. 2 at 40.

[83] Ex. 2 at 42.

Medical Treatment After the January 31, 1997, Industrial Accident

¶ 61 On February 3, 1997, Dr. Cooney saw Sherwood a few days after his jackknife accident near Dillon. Sherwood struck his head and believed he had been unconscious but did not know for how long. Sherwood complained of a constant headache with nausea, lassitude, and photophobia. He described this headache as similar to his usual headaches, but "ten times as bad." Sherwood also complained of increased neck pain. Although he described no objective medical findings in his medical note, Dr. Cooney diagnosed Sherwood with a cerebral concussion, post-concussion headaches, and a cervical strain/sprain, all secondary to his January 31, 1997, driving accident. Dr. Cooney advised Sherwood to take a few days off work and to obtain a CT scan.[84] The subsequent CT scan was negative.[85]

¶ 62 On February 19, 1997, Dr. Cooney performed an electroencephalogram on Sherwood. Dr. Cooney's impression was:

> This is a[n] abnormal tracing characterized by the presence of intermittent low voltage left temporal spike and sharp wave activity. These discharges may have epileptogenic potential. These do not appear to be associated with any observed clinical phenomena, however.[86]

¶ 63 On February 20, 1997, Sherwood again reported constant neck pain and headaches. Sherwood returned the remainder of his MS Contin prescription, stating that he did not believe it was alleviating his pain. Dr. Cooney then gave him a prescription for Tylox.[87] On March 3, 1997, Sherwood reported that his headaches had improved and that he was actually headache-free for three days during the previous week. Dr. Cooney

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[84] Ex. 2 at 43.

[85] Ex. 2 at 44.

[86] Ex. 2 at 46.

[87] Ex. 2 at 47.

continued his Tylox prescription for use only with severe headaches.[88] Dr. Cooney released Sherwood to return to work on March 5, 1997.[89]

¶ 64 Sherwood returned to see Dr. Cooney on April 14, 1997, reporting that he had been injured at work when wind caught his truck door while he was closing it, causing injury to his neck, interscapular region, and lower back. Sherwood complained of pain and numbness radiating into his left arm, and an increase in the severity of his headaches.[90] On May 2, 1997, Dr. Cooney wrote to Watkins & Shepard's claims adjuster and opined that Sherwood had not yet reached MMI for his January 31, 1997, industrial accident.[91]

¶ 65 On May 12, 1997, Sherwood complained of frequent headaches, neck pain, interscapular pain, and low-back pain. Sherwood reported that his headaches never disappeared.[92] On June 2, 1997, Sherwood reported persistent pain in his neck and interscapular region with intermittent pain radiating into the dorsum of the left brachium, forearm, and hand, and increasing low-back pain radiating into his legs. Dr. Cooney noted that a May 23, 1997, MRI revealed disk bulges at C4-5, C5-6, and C6-7 without evidence of nerve root compression. Dr. Cooney took Sherwood off work for ten days.[93]

¶ 66 On June 9, 1997, Sherwood reported that his low-back pain was worse. Dr. Cooney recommended a lumbar MRI.[94] On June 16, 1997, Sherwood complained of low-back pain unchanged from his last visit. Dr. Cooney recommended that Sherwood stay off work. Dr. Cooney noted that the lumbar MRI revealed fibrosis surrounding the left S1 nerve root at the L5-S1 level consistent with postoperative scar tissue at the L5-S1 level.[95] Dr. Cooney wrote to Watkins & Shepard's general counsel and stated that he had given Sherwood a

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[88] Ex. 2 at 48.

[89] Ex. 2 at 51.

[90] Ex. 2 at 52.

[91] Ex. 2 at 54.

[92] Ex. 2 at 55.

[93] Ex. 2 at 56-57.

[94] Ex. 2 at 58.

[95] Ex. 2 at 59.

10-day prescription for MS Contin due to unresolved back pain and that Sherwood was not to drive while taking this medication.[96] On June 25, 1997, Dr. Cooney wrote to Watkins & Shepard's claims adjuster and opined that Sherwood's low-back symptoms were an aggravation of a preexisting problem rather than a new injury. Dr. Cooney noted that the recent lumbar MRI revealed no evidence of a new injury although it showed some fibrosis affecting Sherwood's left S1 nerve root related to previous low-back surgeries.[97] Dr. Cooney recommended that Sherwood remain off work an additional two weeks.[98]

¶ 67 On July 8, 1997, Dr. Cooney noted that Sherwood's low-back pain had improved substantially. Sherwood informed Dr. Cooney that he was looking for a non-driving, sedentary job. Sherwood's headaches continued intermittently.[99] Dr. Cooney released Sherwood to drive his personal vehicle, but not a commercial truck.[100]

¶ 68 Sherwood reported continued improvement on July 16, 1997. Sherwood was searching for a sedentary job. Dr. Cooney opined that he did not believe Sherwood should drive a truck, but that he could work in a sedentary or light-duty position.[101]

¶ 69 On July 28, 1997, Sherwood reported improvement in his low-back pain although Dr. Cooney noted that he was "significantly symptomatic." Sherwood was released to return to work as a driver with restrictions on lifting, chaining, or touching. Dr. Cooney recommended that Sherwood limit his use of Lortab to 30 per week while driving.[102]

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[96] Ex. 2 at 60.

[97] Ex. 2 at 61.

[98] Ex. 2 at 61A.

[99] Ex. 2 at 62.

[100] Ex. 2 at 63.

[101] Ex. 2 at 64.

[102] Ex. 2 at 65.

¶ 70 On September 2, 1997, Sherwood reported that his low-back pain had worsened significantly with leg pain. Dr. Cooney took Sherwood off work for three weeks and recommended an epidural block.[103]

¶ 71 Sherwood returned to see Dr. Cooney on September 8, 1997. Sherwood had been unable to obtain an epidural block. Sherwood complained of low-back and leg pain and leg weakness. Sherwood walked with a significant limp. Dr. Cooney noted that an EMG of both lower extremities revealed prominent positive sharp waves and occasional fibrillations in the left lower lumbar paraspinous musculature, usually enervated by the L5 nerve root. Dr. Cooney concluded that these were consistent with a recent injury to the left L5 nerve root. In light of the new findings, Dr. Cooney recommended rescheduling the epidural block and conducting a repeat lumbar MRI.[104]

¶ 72 On September 23, 1997, Dr. Cooney noted that Sherwood had ongoing low-back and left leg pain at about the same intensity as his previous visit. Sherwood had not received the epidural block and he reported taking more than his prescribed dose of MS Contin. Sherwood further reported that he continued to have problems with unexpected collapsing in his left leg which had caused him to fall down stairs a few days earlier. Dr. Cooney noted that a September 8, 1997, MRI revealed a small left paracentral disk protrusion at L5-S1 and a small central disk protrusion at L4-5 with moderate facet arthropathy at the L5-S1 and L4-5 levels, but no evidence of any specific nerve root compression. Dr. Cooney continued Sherwood's restriction from work.[105]

¶ 73 On October 14, 1997, Sherwood told Dr. Cooney that he had improved in the past week. Sherwood had increased his MS Contin and Valium consumption. Sherwood experienced increased numbness in his left arm. Dr. Cooney continued his restriction from work.[106]

¶ 74 Orthopedic surgeon Michael D. Lahey, M.D., P.C., examined Sherwood on October 22, 1997. Dr. Lahey's impression was that Sherwood suffered from chronic back gluteal

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[103] Ex. 2 at 68.

[104] Ex. 2 at 69-70.

[105] Ex. 2 at 71.

[106] Ex. 2 at 73.

leg pain, scarring surrounding the left S1 nerve root, chronic pain syndrome with significant potential for high narcotic use, hamstring contractures with limitation in flexibility, and "unrealistic expectations" regarding returning to driving a truck. Dr. Lahey recommended nonsurgical options including evaluation by a behavior pain program, possibly the use of antidepressants, and better management of Sherwood's prescriptions.[107]

¶ 75 On November 12, 1997, Dr. Cooney noted that Sherwood's low-back and left leg symptoms remained unchanged. Dr. Cooney continued Sherwood's restriction from working.[108] On December 8, 1997, Dr. Cooney noted that Sherwood reported increasing problems with pain in his left leg and buttock as well as several falls which he attributed to weakness in his left leg.[109]

¶ 76 Catherine C. Capps, M.D., conducted an IME of Sherwood on December 4, 1997. Dr. Capps reviewed Sherwood's medical records relating to his industrial accidents of November 4, 1993, May 14, 1996, and January 31, 1997. At the time of this IME, Sherwood had been off work since September 1997.[110] Dr. Capps examined Sherwood and viewed x-rays taken during Sherwood's appointment with Dr. Lahey. Dr. Capps diagnosed Sherwood with narcotic addiction and a possible pseudoarthrosis at the L4-5 fusion. Dr. Capps noted that Dr. Lahey's films indicated that the L4-5 fusion was not healed. Dr. Capps could not opine whether Sherwood had motion in this fusion prior to his industrial accidents because no previous flexion/extension films existed. She noted that Sherwood possibly broke apart the fusion and rendered it symptomatic during one of his industrial accidents. At the time of Dr. Capps' evaluation, Sherwood reported that the majority of his pain complaints were in his left leg, and Dr. Capps attributed that pain to the fibrosis at the left S1 nerve root and not the pseudoarthrosis. Dr. Capps was skeptical as to whether any surgical procedure would improve Sherwood's condition. Dr. Capps recommended a pain clinic program and detoxification.[111]

[107] Ex. 5.

[108] Ex. 2 at 73B.

[109] Ex. 2 at 75-76.

[110] Ex. 6 at 5.

[111] Ex. 6 at 8-9.

¶ 77 In light of Sherwood's previous back surgeries and his opiate usage, Dr. Capps opined that his prognosis was poor and that he was unlikely to return to work as a truck driver. Dr. Capps stated, "I feel the patient cannot return to [work as] a truck driver now or in the future. I feel the occupational demands of truck driving including the vibratory forces across the spine would worsen the patient's condition." Dr. Capps recommended light-duty employment.[112] Dr. Capps further opined that Sherwood was not at MMI and that he required additional treatment, possibly including a fusion at L4-5.[113]

¶ 78 On January 26, 1998, E. Warren Stadler, M.D., of the Intermountain Spine Institute at Cottonwood Hospital in Salt Lake City, Utah, saw Sherwood for an IME. Dr. Stadler reviewed Sherwood's medical records and examined him. Among other findings, his impression was that Sherwood was "unstable" at L4-5 without subluxation.[114] Dr. Stadler suggested that Sherwood's prognosis was better nonsurgically. He noted that Sherwood had high hypochondriasis and hysteria scores with covert anxiety and substance dependence. Dr. Stadler considered Sherwood to be a "complex" patient who needed psychological counseling, physical therapy, and medical intervention. He recommended a nonsurgical program and a team approach to getting Sherwood non-dependent on his medication.[115] Dr. Stadler concluded that Sherwood was at MMI for his back condition.[116] Dr. Stadler opined that Sherwood's likelihood of returning to driving a truck was poor, but that Sherwood could work in a light-duty occupation.[117]

¶ 79 On January 29, 1998, psychologist Darrell H. Hart, Ph.D., also evaluated Sherwood. Dr. Hart reviewed Sherwood's medical records, interviewed Sherwood and his wife, and conducted psychological testing. Dr. Hart concluded that Sherwood suffered from a mild to moderate chronic pain disorder. Dr. Hart noted that Sherwood had scores indicating hypochondriasis and hysteria and opined that Sherwood is "high-strung and intense," and that Sherwood's physiological pain is magnified by his psychological process, although he

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[112] Ex. 6 at 10.

[113] Ex. 6 at 11.

[114] Ex. 7 at 4.

[115] Ex. 7 at 5.

[116] Ex. 7 at 6.

[117] Ex. 7 at 7.

did not believe Sherwood exhibited any conscious malingering.[118] Dr. Hart further opined, "Mr. Sherwood's psychology is the kind that works against him in the healing process and in the perception of pain."[119]

¶ 80 On February 17, 1998, Dr. Cooney noted that Sherwood had been evaluated at the Intermountain Spine Institute in Salt Lake City. The evaluators' opinion was that Sherwood's best options were nonsurgical and that he should undergo physical therapy with psychological counseling. Dr. Cooney further noted that after the IME, Sherwood ceased to take his prescription opiates without medical supervision and thus required hospitalization. Dr. Cooney noted that Sherwood was now reducing his opiate use with medical supervision, and he was transferred to a non-driving job at Watkins & Shepard. Sherwood reported that he was having difficulty sleeping and that his headaches had returned.[120]

¶ 81 On April 2, 1998, Dr. Cooney reported that Sherwood had completed a three-week pain clinic program. Sherwood was no longer taking diazepam or opiates and he had learned techniques for dealing with back pain without the use of medication. Sherwood reported headaches two or three times per week.[121]

¶ 82 On April 22, 1998, Dr. Cooney calculated Sherwood's impairment rating as a 17% whole person impairment rating. On April 29, 1998, in response to an inquiry from a claims adjuster, Dr. Cooney noted that Sherwood's whole person impairment rating for low-back problems related to his May 1996 industrial injury was 12%. Dr. Cooney further noted that Sherwood had no impairment regarding his closed head injury.[122]

¶ 83 On May 13, 1998, Dr. Cooney noted that Sherwood reported more problems in his L1 region. Sherwood reported that he enjoyed his sedentary job although he made less

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[118] Ex. 7 at 22.

[119] Ex. 7 at 23.

[120] Ex. 2 at 82. See also Ex. 3 at 5-8 regarding Sherwood's admission to St. Peter's Hospital for delirium due to withdrawal from Valium.

[121] Ex. 2 at 84.

[122] Ex. 2 at 84A.

money. Sherwood suffered daily migraine headaches.[123] On July 14, 1998, Sherwood reported constant discomfort in his neck and headaches. He informed Dr. Cooney that he was doing well at work and that he did not believe stress was a factor in his headaches.[124] On September 9, 1998, Sherwood reported constant, daily headaches at home and at work. He also reported constant achy discomfort in his neck and low back.[125]

¶ 84 On June 17, 1998, Dr. Sublette saw Sherwood for an IME. Sherwood had last treated with Dr. Sublette on June 13, 1994. In his June 17, 1998, IME report, Dr. Sublette noted that Sherwood suffered another industrial accident on May 14, 1996, while moving a roll of carpet. Dr. Sublette stated that Sherwood saw Dr. Cooney a few days later and eventually had more tests performed:

> EMG of the left lower extremity on 7/1/96 showed "collapsing weakness and decreased power in the anterior compartment, and quadriceps musculature" suggesting submaximal effort rather than bona fide organic weakness.[126]

However, Dr. Sublette further noted that neurosurgeon Richard Dewey, M.D., had examined Sherwood on July 3, 1996, and a lumbar MRI showed a disk protrusion at L4-5 and L5-S1 with associated hemorrhage at L4-5. A July 16, 1996, lumbar myelogram followed by CT scan showed arachnoiditis at L4-5 and an inner body fusion at L4-5. A laminectomy and diskectomy at L5-S1 was performed on July 23, 1996.[127]

¶ 85 Dr. Sublette noted that Sherwood reported additional work-related injuries including a January 1997 jackknife incident in which Sherwood reported he lost consciousness for 30-45 minutes; an April 14, 1997, injury to his neck and upper and lower back when he was struck by a truck door; and a May 1997 injury to his back and calf from pulling and lifting a release bar. Dr. Sublette noted that a June 12, 1997, MRI of the low back showed a disk

[123] Ex. 2 at 85.

[124] Ex. 2 at 86.

[125] Ex. 2 at 87.

[126] Ex. 1 at 10-12.

[127] Ex. 1 at 12.

bulge at L4-5 and fibrosis at L5-S1, but no "true recurrent disc herniation."[128] Dr. Sublette further noted that Sherwood attended an IME at the Intermountain Spine Institute on January 28, 1998. Sherwood was hospitalized in February 1998 after he attempted a "cold turkey" withdrawal from his opiate medications, and he later underwent a supervised withdrawal in March 1998. Dr. Sublette further noted that Sherwood underwent an MMPI with Darrell H. Hart, Ph.D., and that Dr. Hart noted significantly elevated "T" scores on the hysteria and hypochondriasis scales and placed Sherwood in the top 5% of medical patients with some degree of psychological overlay. Dr. Hart felt that Sherwood's condition was chronic, but only mild to moderate.[129]

¶ 86 Dr. Sublette recorded Sherwood's current complaints as constant, daily, stabbing, "blinding" headaches which prevent Sherwood from sleeping, headache-associated nausea, back pain, left leg paresthesias, paresthesias in the fifth finger of the left hand, and bilateral tinnitus.[130] Dr. Sublette performed a physical examination that was largely unremarkable, and further noted that his review of Sherwood's medical records indicated that Sherwood has had multiple minor injuries with very few "hard physical findings." Dr. Sublette further noted, "His psychological evaluation would suggest high degree of hysteria and hypochondriasis. In short I think many of Mr. Sherwood's symptoms are exaggerated." Dr. Sublette further noted drug dependency and recommended that Sherwood not be given further opiate medications.[131] Dr. Sublette found no causal relationship between Sherwood's complaints at the time of the IME and the January 31, 1997, industrial accident.[132]

¶ 87 On November 9, 1998, Sherwood reported that he was having headaches three or four times a week which were not responding to medication. Dr. Cooney noted, "On a scale of 1-10, he notes that the severe ones are 'at least 25 or 30.'" Dr. Cooney further noted, "He appears convinced that if he had access to a small amount of Lortab 7.5's that

[128] Ex. 1 at 12.

[129] Ex. 1 at 13.

[130] Ex. 1 at 13.

[131] Ex. 1 at 14-15.

[132] Ex. 1 at 16.

this would afford him much better symptomatic relief. . . ." Dr. Cooney advised Sherwood not to use an opiate such as Lortab because of his propensity to overuse opiates.[133]

¶ 88 On March 31, 1999, Dr. Cooney noted that Sherwood stated that he was doing reasonably well with pain, except for daily headaches.[134] Sherwood reported similar complaints on June 2, 1999,[135] and September 28, 1999.[136]

¶ 89 Beginning on April 5, 1999, Sherwood treated with Lynn R. Webster, M.D., for his headaches.[137] Dr. Webster performed a diagnostic block on that date, but later noted that it was unclear whether the block provided Sherwood with substantial pain relief.[138] On April 16, 1999, a repeat of the procedure provided Sherwood with excellent relief and they decided to proceed with a radio-frequency neurotomy.[139] On July 16, 1999, Dr. Webster performed a cervical facet rhizotomy, which had previously been effective for Sherwood.[140] On September 7, 1999, Dr. Webster noted that the cervical neurotomy had provided relief only for a short period of time. Dr. Webster suggested peripheral nerve stimulation.[141] On October 19, 1999, Dr. Webster noted learning that Sherwood was treating with Dr. Cooney and was receiving opioid prescriptions through Dr. Cooney's office, in violation of his opioid agreement with Dr. Webster's clinic.[142]

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[133] Ex. 2 at 88.

[134] Ex. 2 at 90.

[135] Ex. 2 at 91.

[136] Ex. 2 at 92.

[137] Ex. 9 at 1.

[138] Ex. 9 at 3.

[139] Ex. 9 at 4.

[140] Ex. 9 at 6-7.

[141] Ex. 9 at 10-11.

[142] Ex. 9 at 12-14.

¶ 90 On November 9, 1999, Dr. Webster tried Botox injections to treat Sherwood's headaches.[143] On December 7, 1999, Dr. Webster noted that the injections had failed to provide any relief. Dr. Webster increased Sherwood's OxyContin prescription and discontinued the injections.[144] On January 4, 2000, Dr. Webster noted that Sherwood had improved.[145] Dr. Webster requested approval for an occipital stimulator on January 4, 2000.[146] Dr. Webster continued to treat Sherwood's headaches with various medications while awaiting approval for the stimulator.[147] On October 13, 2000, Dr. Webster wrote apparently in response to an inquiry from Watkins & Shepard's claims adjuster:

> I appreciate your concern regarding the amount and type of medications Mr. Sherwood is receiving. Mr. Sherwood has a chronic pain disorder requiring large amounts of medication. We continue to explore options of reducing his need for the medication. . . .
>
> On his next visit we will reexamine his condition to see if there is a way for us to mitigate his need for the medication. However at this time I do not foresee a change in his condition or requirement for medication.[148]

¶ 91 Sherwood had an MRI of his thoracic spine taken on December 29, 1999. The findings indicated minimal disk bulges at 4-5, 5-6, and 6-7, with no evidence of significant attenuation of the lateral recess, central canal, or neural foramina at any level and an unremarkable cord. The radiologist further noted no evidence of appreciative disc desiccation.[149]

¶ 92 John C. Oakley, M.D., examined Sherwood at Yellowstone Neurosurgical Associates, P.C., on August 30, 2001. Sherwood had been identified as a possible

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[143] Ex. 9 at 17-18.

[144] Ex. 9 at 19-20.

[145] Ex. 9 at 22-23.

[146] Ex. 9 at 23A.

[147] Ex. 9.

[148] Ex. 9 at 33.

[149] Ex. 3 at 12C.

candidate for a subcutaneous occipital nerve stimulation system and had been referred to Dr. Oakley for a second opinion. Dr. Oakley reviewed Sherwood's medical history from his November 4, 1993, industrial accident forward.[150]

¶ 93 Sherwood reported three areas of pain: interscapular lower neck pain radiating into the arms; occipital headaches, right greater than left; and low-back and leg pain. Sherwood reported that his leg pain was so severe at times that his legs gave out on him. Sherwood reported that his pain was at best 2 out of 10 and at worst 8 out of 10, with average daily pain of 5 out of 10. Sherwood's current prescriptions included OxyContin, Percocet, Methadone, and Neurontin.[151]

¶ 94 Dr. Oakley found some mild decrease in pin sensation to Sherwood's left arm, in the thumb, and the lateral surface of the arm. He also found decreased sensation predominantly in the L5 distribution in his left leg. Dr. Oakley noted normal reflexes except for the absence of ankle reflexes. Dr. Oakley's impression was that Sherwood suffered from diffuse nociceptive and neuropathic pain syndrome. Dr. Oakley opined that the extent of Sherwood's nociceptive pain made it unlikely that stimulation would resolve his pain syndrome. Dr. Oakley suggested that Sherwood would benefit from a drug administration system. Dr. Oakley also suggested that Sherwood undergo a neuropsychological evaluation prior to interventional pain management.[152]

¶ 95 Sherwood transferred his medication management to Dr. Oakley and returned to see him on November 13, 2001. Dr. Oakley planned to reduce Sherwood to fewer prescriptions to better assess his pain management. Dr. Oakley reworked Sherwood's prescriptions, eliminating the use of Methadone, Duragesic, and Fentanyl suckers, while increasing his dosage of OxyContin.[153]

¶ 96 Joseph K. McElhinny, Psy.D., saw Sherwood on November 21, 2001, on referral from Putman & Associates. Dr. Oakley had identified Sherwood as a potential candidate for a pain pump, and Dr. McElhinny evaluated Sherwood to clarify his current psychologic

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[150] Ex. 10 at 1-5.

[151] Ex. 10 at 2-3.

[152] Ex. 10 at 3-4.

[153] Ex. 10 at 6.

functioning to assist Sherwood's doctors in determining appropriate treatment. Dr. McElhinny observed Sherwood, reviewed his medical records, discussed Sherwood's medical and personal history with him, and conducted psychological assessments. Dr. McElhinny opined that Sherwood's personality traits likely adversely affected his medical condition. Dr. McElhinny noted that Sherwood was likely dependent on opiates. Dr. McElhinny opined that Sherwood did not require ongoing mental health intervention.[154]

¶ 97 On January 22, 2002, Sherwood had a drug administration pump with an intrathecal catheter surgically implanted by Dr. Oakley.[155] On February 4, 2002, Sherwood saw Joanie Smith, R.N. (Smith) to check the pump. Sherwood was receiving 3 milligrams of morphine daily, and he reported that it was 70% effective in controlling his pain. Smith adjusted Sherwood's oral prescriptions to eliminate one dose of OxyContin and scheduled a follow-up appointment.[156]

¶ 98 Sherwood continued to attend follow-up appointments for pump refills.[157] On February 25, 2002, Dr. Oakley released Sherwood to return to work in a sedentary job.[158] On March 7, 2002, Sherwood reported that the most recent change in his pump had lessened his pain control, and the dosages were increased at his request.[159] He requested another dosage increase a week later, and his dosage was increased to 6.7 milligrams per day of morphine.[160] Sherwood received another dosage increase at his request on March 20, 2002.[161]

¶ 99 Ronald K. Hull, M.D., evaluated Sherwood on March 27, 2002. Dr. Hull began managing Sherwood's pain medications, including the dosages he received through the

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[154] Ex. 11 at 1-7.

[155] Ex. 10 at 10.

[156] Ex. 10 at 17.

[157] Ex. 10 at 18-19.

[158] Ex. 10 at 20.

[159] Ex. 10 at 21.

[160] Ex. 10 at 22.

[161] Ex. 10 at 22a.

intrathecal pump.[162] On April 10, 2002, Dr. Hull expressed concern that Sherwood was taking his oral pain medications at a faster rate than prescribed.[163] On April 18, 2002, Dr. Hull recommended that Sherwood return to Dr. Oakley.[164]

¶ 100 On May 1, 2002, Smith noted that Sherwood was receiving 19.397 milligrams of morphine daily. Sherwood reported that he had daily headaches. Smith noted that Sherwood's headaches could be analgesic headaches from the morphine. Smith added Clonidine to Sherwood's dosage and decreased the morphine dosage to try to alleviate the headaches.[165] However, on June 3, 2002, Sherwood returned for a follow-up appointment and reported an increase in both his low-back pain and his headaches.[166]

¶ 101 Sherwood underwent an examination with Mary Jozwiak, M.D., on June 25, 2002. Dr. Jozwiak interviewed Sherwood about his pain complaints and examined him. She opined that Sherwood suffered from chronic neck pain and recalcitrant headaches, with likely pain generators including: cervical osteophytic spondylosis with multi-level facet joint arthropathy; progression of cervical disk degeneration, possibly at C4-5 and C6-7; post-concussive headaches; and possible chronic myofascial inflammation of cervical paravertebral, levator scapular, and thoracic spinalis muscles, occipital neuralgia, and tension headaches with a migrainous element.[167] She further opined that Sherwood suffered from chronic back and radiating leg pain, with likely pain generators including: lumbar arachnoiditis; L4-sacrum fusion with L3-4 junctional stenosis; referred pain from abdominal and pelvic adhesions; and chronic myofascial inflammation of lumbar paravertebral muscles.[168] Dr. Jozwiak also noted possible malabsorption syndrome secondary to subtotal gastrectomy, erectile dysfunction, situational depression, and sleep dysfunction. Dr. Jozwiak recommended adjustments to Sherwood's medications. She further suggested additional diagnostic tests, including a cervical and lumbar MRI, DEXA

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[162] Ex. 12 at 1-2.

[163] Ex. 12 at 3.

[164] Ex. 12 at 4.

[165] Ex. 10 at 24.

[166] Ex. 10 at 26.

[167] Ex. 10 at 31.

[168] Ex. 10 at 31-32.

scan, and an ergonomic chair for work. Dr. Jozwiak recommended that Sherwood's testosterone levels be checked to determine if his chronic opiate use was causing his erectile dysfunction, and recommended a psychiatric evaluation.[169]

¶ 102 Sherwood continued to have his intrathecal pump refilled and he continued to complain of headaches and other pain.[170] On July 16, 2002, Smith washed Sherwood's pump with saline in preparation for switching from morphine to Dilaudid.[171] At that time, Sherwood reported that his pain was at a 7 out of 10, that it had been as high as 8 out of 10 since his last medication adjustment, and that the lowest it had been since his last medication adjustment was 5 out of 10.[172] On July 24, 2002, Smith introduced a Dilaudid and Clonidine mixture into Sherwood's pump. She noted that since the introduction of the saline solution, Sherwood reported a sharp increase in his pain and exhibited withdrawal symptoms.[173]

¶ 103 On August 2, 2002, Dr. Jozwiak conducted a follow-up examination. She noted that a cervical MRI performed that date was an incomplete study because Sherwood was unable to lie still. The cervical MRI revealed excessive cervical lordosis, C4-5 central disk protrusion without significant canal stenosis or foraminal encroachment, and no vertebral compression fracture ligament laxity or spondylolisthesis. A thoracic-lumbar MRI revealed removal of L4 and L5 spinous process from the previous posterior lumbar interbody fusion, incomplete L4-5 lumbar interbody fusion, central canal patent with no significant foraminal encroachment, and loss of normal lumbar lordosis. The thoracic-lumbar MRI was also an incomplete study. Dr. Jozwiak's impression included: chronic neck pain and recalcitrant headaches with likely pain generators of cervical osteophytic spondylosis with multi-level facet joint athropathy and progressive C4-5 disk degeneration and post-concussive headaches; and chronic back and radiating leg pain with likely pain generators of lumbar arachnoiditis and chronic myofascial inflammation of lumbar paravertebral muscles.[174] Dr.

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[169] Ex. 10 at 32.

[170] Ex. 10 at 32a-33.

[171] Ex. 10 at 34.

[172] Ex. 10 at 35.

[173] Ex. 10 at 37.

[174] Ex. 10 at 40.

Jozwiak recommended adjustments to Sherwood's oral medications and an increase in the Dilaudid and Clonidine dosages received via the intrathecal pump. Dr. Jozwiak noted that Sherwood's pain might be partially psychogenic. She noted that his MRI studies did not differ substantially from previous studies, and that his head injury may have affected his "perception of pain." She further noted that the possibility of substance abuse existed, given his use of oral opiates along with his intrathecal pump. Dr. Jozwiak recommended a reevaluation in one to two months, noting that she found a discrepancy between Sherwood's symptomatic complaints and her objective physical findings.[175]

¶ 104 Sherwood returned for follow-up medication adjustments. His pump dosages increased each time.[176] On August 12, 2002, he reported his current pain as an 8 out of 10, with his worst pain since his last adjustment being an 8 out of 10 and the least being 7 out of 10.[177] Over the next several appointments, Sherwood's dosages increased, but he reported only a slight improvement in his pain levels.[178] On September 9, 2002, Dr. Jozwiak wrote to Sherwood, explaining:

> Your constellation of symptoms . . . were discussed at our recent monthly patient care conference. . . .
>
> It is unclear if you are experiencing any residual cognitive deficits from the brain contusion you sustained during a motor vehicle accident in 1996, or how this is impacting upon your perception of pain.

Dr. Jozwiak added that Dr. Oakley had requested Sherwood undergo a neuropsychiatric assessment.[179]

¶ 105 On October 4, 2002, K. Becky Davis, Ph.D., conducted a neuropsychological assessment of Sherwood. She concluded that Sherwood had good attention skills, low-

[175] Ex. 10 at 41.

[176] Ex. 10 at 43a-44.

[177] Ex. 10 at 45.

[178] Ex. 10 at 46-50.

[179] Ex. 10 at 51.

average memory, and a resistance to accepting limitations placed on his vocational activities because of medication usage or pain.[180]

¶ 106 Over the next several appointments, Sherwood reported the same or an increased level of pain in spite of increases in his Dilaudid and Clonidine dosages. He also increased his use of oral medications.[181] On October 2, 2002, Dr. Jozwiak recommended a "drug holiday" to evaluate Sherwood's condition.[182] Sherwood met with Dr. Jozwiak, Smith, Beth Degenhart, R.N. (Degenhart), and Dr. Davis, on November 20, 2002. Dr. Jozwiak reported that Sherwood and his wife had questions about the proposed "drug holiday." Sherwood was receiving a daily dosage through his pump of 5.16 milligrams of Dilaudid and 520 micrograms of Clonidine. Sherwood was not receiving prescriptions for oral opiates. Dr. Jozwiak noted that Dr. Davis found no cognitive deficits during her October 17, 2002, neuropsychiatric evaluation of Sherwood, although Dr. Davis noted in her report that other examiners had found indications of hypochondriasis, hysteria, and depression.[183]

¶ 107 Dr. Jozwiak noted that due to "obvious strife" between Sherwood and his wife and the nursing staff, Sherwood had three options for follow-up care: transfer care to another pain clinic; transfer follow-up care to Dr. Oakley exclusively at Yellowstone Neurosurgical Associates' Great Falls outreach clinic; or stay with his current provider but complete a chemical dependency evaluation at the Rimrock Foundation prior to receiving any oral opiate prescriptions. Dr. Jozwiak further noted that Sherwood's drug holiday was instituted indefinitely.[184]

¶ 108 On December 4, 2002, Sherwood informed Dr. Jozwiak that he intended to transfer his pain management to Ronald Hull, M.D.[185] However, on January 1, 2003, Dr. Hull's office informed Dr. Jozwiak that Dr. Hull was unwilling to take over Sherwood's care.[186] On

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[180] Ex. 13.

[181] Ex. 10 at 52-58.

[182] Ex. 10 at 58.

[183] Ex. 10 at 61.

[184] Ex. 10 at 62.

[185] Ex. 10 at 65.

[186] Ex. 10 at 66a.

January 25, 2003, Dr. Jozwiak opined that Sherwood had reached MMI on November 20, 2002. Dr. Jozwiak gave Sherwood permanent restrictions on heavy or repetitive lifting. Dr. Jozwiak recommended Sherwood undergo an IME with Dr. Schabacker.[187]

¶ 109 Sherwood continued to receive pump refills at the Yellowstone Neurosurgical Associates' facility in Billings until March 13, 2003, when he transferred his care to the provider's Great Falls Outreach Clinic.[188] Smith refilled Sherwood's pump in Great Falls and noted that Dr. Oakley was requesting an EEG to check for seizure activity, as Sherwood had recently reported occasional nocturnal urinary incontinence. Smith also noted that Sherwood had an x-ray to check the placement of his pump catheter after he reported a significant fall and subsequent jaw symptoms with severe headache and tremor. The x-ray indicated that his catheter remained in place.[189]

¶ 110 On April 24, 2003, Dr. Oakley wrote to Putman and Associates, stating that he suspected Sherwood may have a post-traumatic seizure disorder.[190] On June 26, 2003, Degenhart noted that Sherwood's Dilaudid had previously been decreased from 8 milligrams to 6.4 milligrams per day in the hope of decreasing his headaches, but Sherwood reported that his headaches had not decreased and his back pain with radiating pain into his right buttock, back of right leg, and feet had increased. Sherwood's pump dosages were increased to 7.68 milligrams of Dilaudid and 768 micrograms of Clonidine per day.[191]

¶ 111 On July 24, 2003, Sherwood complained of pain at a level of 7 out of 10 and asked for an increase in Dilaudid. Degenhart increased his dosage to 9.08 milligrams per day of Dilaudid and 912 micrograms per day of Clonidine.[192] At his next appointment on August 7, 2003, Sherwood reported that his pain had decreased and that he was experiencing

[187] Ex. 10 at 69.

[188] Ex. 10 at 70-71a.

[189] Ex. 10 at 71a.

[190] Ex. 10 at 74-75.

[191] Ex. 10 at 75A.

[192] Ex. 10 at 75C.

some reduction in severe headaches. However, he reported that he had to sleep in a recliner at night because of low-back pain.[193]

¶ 112 On August 15, 2003, Sherwood attended a panel IME with occupational medicine practitioner Bruce R. Belleville, M.D., MPH, FACOEM, CIME, orthopedic surgeon Michael A. Sousa, M.D., and neurologist Lennard S. Wilson, M.D. The purpose was to assess Sherwood's current diagnoses, the prognosis, any medical treatment recommendations, medication needs, and other related issues.[194] The panel reviewed Sherwood's medical records. The panel noted that Sherwood was currently working 50 to 60 hours per week as a freight auditor for Watkins & Shepard. The report listed Sherwood's current medications and stated that his symptoms included difficulty sleeping, swelling and coldness in his hands, urinary incontinence, pain between his shoulder blades, headaches, and neck pain.[195] Sherwood participated in a physical examination.[196] The panel further considered diagnostic studies that were available for its review.[197]

¶ 113 After reaching various diagnoses, the panel concluded that Sherwood's prognosis was fair to poor. The panel agreed that Sherwood reached MMI, as per Dr. Jozwiak's opinion, on November 20, 2002. The panel recommended that Sherwood have a urology consultation, and that he have massage therapy, stress reduction, and an ergonomic evaluation of his workplace. The panel agreed that Sherwood should continue working in the freight auditor position for Watkins & Shepard.[198] The panel also qualified its opinion regarding MMI, stating that further evaluation of Sherwood's incontinence complaints and some arm symptoms warranted further evaluation prior to reestablishing MMI.[199]

¶ 114 In answering specific questions posed, the panel opined that Sherwood's chronic pain syndrome was partially due to his January 31, 1997, industrial accident, and that the

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[193] Ex. 10 at 75E.

[194] Ex. 15.

[195] Ex. 15 at 28-29.

[196] Ex. 15 at 31-32.

[197] Ex. 15 at 32-35.

[198] Ex. 15 at 36.

[199] Ex. 15 at 38.

accident was a significant new injury and an aggravation of his preexisting chronic lumbar pain syndrome. The panel further noted evidence of a residual right leg radiculopathy, but did not recommend surgery. The panel recommended evaluation by a urologist to determine if Sherwood's incontinence was a complication of the injury or a surgery.[200]

¶ 115 On September 10, 2003, Dr. Schabacker examined Sherwood, noting that Sherwood came to the clinic because he had gone to an emergency room on September 7, 2003, complaining of diffuse body pain following a fall. Sherwood told Dr. Schabacker that he fell and had subsequent leg, shoulder, and arm cramps, that he became unable to move, and that he was transported to the St. Peter's Hospital Emergency Room by ambulance. Sherwood spent three hours in the emergency room, where he was given Dilaudid and Ativan intravenously. Sherwood was given a prescription for Ativan and discharged. Dr. Schabacker noted that in addition to the Ativan, Sherwood was also taking Hydrocodone, Klonopin, and Neurontin.[201] Dr. Schabacker's impressions were: chronic daily headaches; chronic low-back pain in the setting of lumbar arachnoiditis; occasional mid-thoracic spine pain; history of concussion, further details are unknown; long history of opioid use; and depression and anxiety. Dr. Schabacker noted that Sherwood was pleased with the effect Ativan had on his muscle pain and "lobbied heavily" for a standing prescription, which Dr. Schabacker denied. Dr. Schabacker noted that Sherwood was also taking Clonazepam, and he prescribed Baclofen for a trial period.[202]

¶ 116 Sherwood continued to receive pump refills in Great Falls, and he continued to complain of pain and sleeplessness. His dosages of Dilaudid and Clonodine were incrementally increased.[203] On December 17, 2003, Sherwood reported some improvement in his pain. His dosages were set at 11.6 milligrams of Dilaudid and an unnoted dosage of Clonidine per day.[204]

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[200] Ex. 15 at 37.

[201] Ex. 10 at 76.

[202] Ex. 10 at 77.

[203] Ex. 10 at 78A-78H.

[204] Ex. 10 at 78H.

¶ 117 At his next refill on January 15, 2004, his dosages were set at 11.6 milligrams of Dilaudid and 696 micrograms of Clonidine per day.[205] On April 8, 2004, Dr. Oakley noted that Sherwood was found to have low testosterone levels and a monthly testosterone injection had improved his bladder problems.[206]

¶ 118 Sherwood's pump dosages remained steady until May 5, 2004, when Smith increased his Dilaudid dosage to 12.6 milligrams per Dr. Schabacker's order.[207] On June 3, 2004, Smith noted that Sherwood's dosage would not be increased as it was at the maximum level Dr. Oakley was comfortable with. Smith further noted:

> Functionally, the patient is doing quite well. However, he is working full-time at his long-term job. Additionally, he has added another job, in which he is working evenings and night shift for the ambulance service. This is obviously very active employment, and Dr. Oakley is quite satisfied with the patient's functional level at this point. He feels that we are most likely at optimal management levels at this point.

Smith also noted:

> **Please note: The patient will be receiving all oral medications through this office via Dr. Schabacker and our medical management side of the practice. This will be from this point on, unless Dr. Schabacker happens to be out of the office during the time that the patient is due for a refill, in which case Dr. Oakley will give a one-time order for routine refill.**[208]

¶ 119 Dr. Schabacker examined Sherwood on June 24, 2004. Sherwood reported that the pump was working well and had improved his quality of life, although he still suffered chronic pain and sleeplessness. Dr. Schabacker noted that he was willing to continue Sherwood's prescription for Klonopin "[r]ecognizing that we are more likely treating anxiety

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[205] Ex. 10 at 78J.

[206] Ex. 10 at 78L.

[207] Ex. 10 at 78O.

[208] Ex. 10 at 78Q. (Emphasis in original.)

than muscle spasms or other problems." Dr. Schabacker further noted that Sherwood remained "remarkably functional, despite his claim of significant pain and impairment," and added that Sherwood had taken a second job as a paramedic on nights and weekends because his employer had cut overtime hours.[209]

¶ 120 Sherwood continued with normal follow-up appointments for pump refills.[210] On August 25, 2004, Dr. Schabacker reported that Sherwood complained of blurred vision and requested a prescription for hydrocodone and for massage therapy. Dr. Schabacker further noted that Sherwood still had a chronic, daily headache.[211]

¶ 121 On September 23, 2004, Sherwood reported extreme headaches which were impacting his vision. Dr. Schabacker noted that the headaches seemed to primarily impact Sherwood's accounting job and not his second job. Dr. Schabacker noted that while Sherwood had been requesting trigger point injections, those had not provided lasting relief. Sherwood was again being considered for an occipital nerve stimulator. Dr. Schabacker stated, "His report of visual changes is suggestive of presbyopia; however, Mr. Sherwood does not seem particularly enamored with that idea and [prefers] to assign the visual difficulty to the headaches."[212]

¶ 122 Sherwood was subsequently examined by Dr. Oakley, who found him to be a potential candidate for an occipital nerve stimulator.[213] On November 18, 2004, Dr. Schabacker noted that Sherwood continued to complain of ongoing headaches, vision difficulties, and sleeplessness. Sherwood asked Dr. Schabacker to write him a note specifying work hours of 5 a.m. to 2 p.m. to accommodate Sherwood's afternoon headaches and visual difficulties. Dr. Schabacker refused since he did not believe he could support Sherwood's request medically. Dr. Schabacker advised Sherwood to have his eyes examined by an optometrist or ophthalmologist.[214]

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[209] Ex. 10 at 79-80.

[210] Ex. 10 at 80A-80D.

[211] Ex. 10 at 80E-80F.

[212] Ex. 10 at 81-82.

[213] Ex. 10 at 84.

[214] Ex. 10 at 85-86.

¶ 123 The next time Dr. Schabacker saw Sherwood, they again discussed Sherwood's request for specific work hours. Dr. Schabacker told Sherwood that he would not intervene with the employer with no medical rationale. Dr. Schabacker further noted that Sherwood was working a second job up to 25 hours per week. Sherwood reported that he had seen an optometrist, who told him that he had a problem with his optic nerve. Dr. Schabacker told Sherwood to follow-up with an ophthalmologist. Dr. Schabacker continued to treat Sherwood with occipital nerve block injections.[215]

¶ 124 On January 6, 2005, Dr. Schabacker noted:

> Mr. Sherwood took it upon himself to come down to Billings for evaluation. He has the perception that he is withdrawing from his intrathecal medications and that his back pain seems to be escalating. He also wants to report . . . that his headache was improved with the last [occipital] nerve block.[216]

While Sherwood was convinced his pump was malfunctioning, Dr. Schabacker suspected he had the flu. Although Dr. Schabacker did not believe Sherwood's pump was malfunctioning, he noted that an MRI to examine the catheter placement may be warranted if Sherwood's symptoms persist.[217]

¶ 125 Sherwood's concerns about his pump were warranted. On January 21, 2005, Smith informed Putman and Associates that Sherwood's pump was failing and needed to be replaced on an urgent basis. The pump was not functioning properly and Sherwood was suffering withdrawal symptoms.[218] On January 25, 2005, Dr. Oakley replaced the pump.[219]

¶ 126 On January 27, 2005, Dr. Schabacker wrote to Putman and Associates to answer questions about Sherwood's conditions. Dr. Schabacker opined that the cause of Sherwood's chronic daily headaches had not been definitively established, but that

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[215] Ex. 10 at 87-88.

[216] Ex. 10 at 89.

[217] Ex. 10 at 89-90.

[218] Ex. 10 at 93-94.

[219] Ex. 10 at 94A-94B.

migraines, occipital neuralgia, and high opioid use were all possible headache generators. Dr. Schabacker opined that Sherwood might be experiencing more than one headache type and noted that the occipital nerve stimulator would address only headaches due to occipital neuralgia and would not alleviate headaches due to opioid use.[220]

¶ 127 Sherwood resumed his intrathecal medications after receiving a replacement pump. On April 28, 2005, he informed Dr. Schabacker that he had lost his job at Watkins & Shepard and was now working as an ambulance technician. Sherwood told Dr. Schabacker that he was working 100 hours per week to make up for lost income. Sherwood complained of chronic headaches and other pain. Dr. Schabacker refilled Sherwood's pump to deliver 12.99 milligrams of Dilaudid per day. Dr. Schabacker noted that a panel which examined Sherwood had advised against an occipital nerve stimulator. Dr. Schabacker did not believe an occipital nerve stimulator was the best choice because he could not rule out opioid headaches due to Sherwood's unwillingness to take a drug holiday. Sherwood's dependence on oral opioids in spite of his intrathecal pump convinced Dr. Schabacker that an occipital nerve stimulator would not change Sherwood's pain complaints.[221]

¶ 128 On May 5, 2005, Dr. Oakley wrote a letter stating that he believed a screening trial of the occipital nerve stimulator was warranted.[222] After Watkins & Shepard denied the request, Sherwood petitioned this Court to have the occipital nerve stimulator implanted in accordance with Dr. Oakley's recommendation. This Court denied Sherwood's request, concluding that the medical evidence demonstrated that the stimulator was not medically reasonable or necessary.[223]

¶ 129 Dr. Schabacker next saw Sherwood on March 10, 2006. Sherwood complained of persistent headaches and occasional leg weakness. Although Dr. Schabacker discussed eliminating oral opioids, Sherwood was unwilling to consider it. Dr. Schabacker reviewed a recent MRI and confirmed that no sign of granuloma was present at the catheter tip. Dr. Schabacker performed trigger point injections and informed Sherwood that he was unwilling

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[220] Ex. 10 at 95-96.

[221] Ex. 10 at 97-105

[222] Ex. 10 at 106-107.

[223] *Sherwood v. Watkins & Shepard Trucking*, 2005 MTWCC 51.

to increase Sherwood's pump dosage, which was currently delivering hydromorphone at the rate of 13 milligrams per day.[224]

¶ 130 On November 9, 2006, Dr. Schabacker saw Sherwood and noted that Sherwood was complaining of multiple pain complaints including headache, cervical pain, numbness and tingling in his hands, and low-back pain. Dr. Schabacker noted that Sherwood was currently employed in a physically difficult job driving a large truck at a gravel pit.[225]

¶ 131 On December 6, 2006, Sherwood received a cervical MRI at Dr. Schabacker's request. The only significant abnormality found was a broad-based disk osteophyte complex reducing the subarachnoid space around the cord, causing mild compression of the cord and moderate bilateral foraminal encroachment at C4-5.[226]

¶ 132 On January 3, 2007, Sherwood traveled to Billings to see Dr. Schabacker. Dr. Schabacker noted that Sherwood was complaining of a headache, ongoing cervical pain, weakness and coldness in his hands, leg numbness, and low-back pain. Dr. Schabacker noted that Sherwood's description of his symptoms seemed more like a polyneuropathy than a radiculopathy. Noting that Sherwood worked as a truck driver, Dr. Schabacker stated, "The intrathecal opioids and oral opioids are not a contraindication apparently to that occupation, as Mr. Sherwood stated that he has notified his employer along with the physician performing his physical examination for fitness to drive a truck."[227]

¶ 133 Dr. Schabacker further stated:

> Mr. Sherwood remains, from his perspective, nearly disabled from the pain. His appearance is unchanged from what it has been for the several years I have been involved in his care. . . .
>
> The headache remains the most incapacitating aspect of Mr. Sherwood's condition. I have not made any meaningful headway at ameliorating [the]

[224] Ex. 10 at 108-109.

[225] Ex. 10 at 111-13.

[226] Ex. 10 at 113A.

[227] Ex. 10 at 115.

> headache. I advised that I will request permission for evaluation at the University of Utah Headache Clinic. Mr. Sherwood was quite pleased with that prospect.
>
> Mr. Sherwood was advised that through his drug administration pump, he is receiving the maximum amount of hydromorphone possible at 13 mg per day. No further dose increases will be forthcoming.[228]

Dr. Schabacker noted that Sherwood reported he had recently fallen repeatedly. Dr. Schabacker suggested a physical therapy assessment, but Sherwood refused. Dr. Schabacker also suggested that Sherwood use an assistive device, particularly a front-wheeled walker, which Sherwood also refused.[229]

¶ 134 On February 8, 2007, Sherwood was evaluated for upper extremity weakness and numbness at the neurology department of the University of Utah Hospitals and Clinics in Salt Lake City on referral from Dr. Schabacker. The evaluation revealed no objective medical findings to support Sherwood's complaints.[230]

¶ 135 On February 28, 2007, Sherwood reported to Dr. Schabacker that he was experiencing increasing pain for no known reason. Sherwood had been recently evaluated at the University of Utah Neuromuscular Disease Clinic, but Dr. Schabacker found the clinic's suggestions "unhelpful." Dr. Schabacker noted that Sherwood adamantly wanted a higher hydromorphone dosage, but his pump was already delivering the maximum safe dose.[231]

¶ 136 On June 25, 2007, Sherwood reported significant cervical and intrascapular pain and headaches to Dr. Schabacker. Sherwood requested trigger point injections, which Dr. Schabacker administered. Dr. Schabacker noted that Sherwood was working as a truck

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[228] Ex. 10 at 116.

[229] Ex. 10 at 117.

[230] Ex. 18.

[231] Ex. 10 at 119-21.

driver, but he had recently had an accident and was unsure whether he would keep his job.[232]

¶ 137 On July 23, 2007, Sherwood reported that he continued to work as a truck driver, making eight or nine trips to Seattle each month. Sherwood reported that he was only getting about three hours of sleep at a time.[233]

¶ 138 On September 26, 2007, Sherwood reported increasing pain to NP-C Wade King (King). Sherwood also reported ongoing headaches which increased in severity at dusk. King noted that Sherwood was working full-time as a truck driver, but:

> Dr. Schabacker . . . is growing increasingly concerned regarding [Sherwood's] ability to drive a truck. He has serious reservations about [Sherwood's] ability to manage these medications and safely drive the truck and is making the recommendation that he consider finding other opportunities for work. [Sherwood] indicates that this is the only thing that he knows how to do and that unless Dr. Schabacker is willing to tell worker[s'] compensation he can no longer work, that he will continue to drive truck.[234]

¶ 139 Dr. Schabacker treated Sherwood on December 17, 2007. Sherwood reported that he had intolerable pain in multiple locations and that he was unsure if he could continue working if the pain could not be controlled. Sherwood reported daily headaches, persistent cervical pain, and low-back pain. Dr. Schabacker further noted:

> Mr. Sherwood acknowledged receipt of the letter dated October 5, 2007, sent from this office on October 16, 2007. In that letter, it was advised that he in my opinion should not continue to drive while taking oral medications. Mr. Sherwood acknowledged the contents of the letter. He has chosen to ignore my advice. I again advised Mr. Sherwood of my concern. Mr. Sherwood indicated that he firmly believes that he is safe while driving. I advised that

[232] Ex. 10 at 126-29.

[233] Ex. 10 at 130-31.

[234] Ex. 10 at 132-34.

he review this issue along with my letter with the organization within the state of Montana that governs licensing of large truck operators.[235]

¶ 140 Although Dr. Schabacker apparently had concerns about whether Sherwood was following his medical advice to avoid driving while using his medications, Dr. Schabacker did not take Sherwood off work nor did he reduce Sherwood's prescriptions.

¶ 141 Sherwood continued to request medication increases. Dr. Schabacker was no longer willing to increase the doses. Dr. Schabacker informed Sherwood that the hydromorphone dosage he received through the pump was greater than the recommendations of the November 2007 Polyanalgesic Consensus Report. Dr. Schabacker explained that he would gradually reduce Sherwood's dosages to bring him into compliance with the recommendations. Dr. Sherwood reported that Sherwood "became quite agitated" at the news. Although Dr. Schabacker did not reduce Sherwood's dosage that day, he advised Sherwood that he would begin to do so with the next refill.[236] Dr. Schabacker stated, "I advised Mr. Sherwood that there are other occupations that he is capable of. Advising against driving is not an indication of disability."[237] Again, Dr. Schabacker advised Sherwood but did not take him off work.

¶ 142 At his follow-up appointment with King on January 30, 2008, Sherwood reported that he was still driving a truck and that his pain was severe and had been at best a 7 out of 10 since his previous pump refill. Sherwood expressed dissatisfaction with Dr. Schabacker's decision to lower his daily dosages of hydromorphone through the intrathecal pump. King refilled the pump at the dosage of 11.001 milligrams per day of Dilaudid per Dr. Schabacker's instructions.[238]

¶ 143 On February 16, 2008, Dr. Schabacker wrote to Mike Weigel, Senior Account Manager at Putman and Associates, in response to Weigel's recent questions. Dr. Schabacker opined that Sherwood's headaches may be related to his 1997 truck accident, and further opined that Sherwood's complaints of cervical and lumbar pain were related to

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[235] Ex. 10 at 136.

[236] Ex. 10 at 137.

[237] Ex. 10 at 138.

[238] Ex. 10 at 140-41.

that accident. Dr. Schabacker opined that Sherwood's use of intrathecal hydromorphone was a consequence of that accident. Dr. Schabacker stated that Sherwood "believes that his cervical pain warrants Norco" and further noted that Robaxin was used to address Sherwood's cervical and low-back pain. He added that Gabapentin was "presumably helpful" for Sherwood's headaches, while clonazepam, Lunesta, and lidocaine gel were prescribed by Dr. Schabacker's office but were unrelated to the industrial injury.[239]

¶ 144 Weigel asked Dr. Schabacker to list any objective medical findings which he believed were directly related to Sherwood's 1997 "truck accident claim," and Dr. Schabacker responded that Sherwood has radiographic evidence of abnormality, with mild changes in his cervical disk spaces based on a December 6, 2006, MRI which were not specific to the 1997 industrial injury and lumbar surgeries which were correlated with the accident. Dr. Schabacker opined that no objective physical findings support the presence of pathology attributable to the industrial accident. Dr. Schabacker opined that Sherwood's erectile dysfunction might be attributed to the accident by way of hypogonadism, but that Sherwood's urinary and prostate conditions were not related to the accident. Finally, Dr. Schabacker opined that Sherwood's headaches possibly have a component of post-traumatic headaches but that it would be impossible for Dr. Schabacker to definitively state that the headaches were partially or solely a consequence of his industrial injury or consequent treatment.[240] Dr. Schabacker made no comment regarding his concerns about Sherwood's driving ability.

Medical Treatment After the Alleged April 1, 2008, Industrial Accident

¶ 145 On April 16, 2008, Sherwood attended a follow-up appointment with Dr. Schabacker. Dr. Schabacker noted that Sherwood was dissatisfied with the decreases in his medications, and that his intrathecal pump was delivering a daily dosage of 9.5 milligrams of hydromorphone. Sherwood reported that he was experiencing increases in pain correlating with his reduced dosages and he believed he might become unable to work due to pain. Sherwood said he had been missing work due to pain. Dr. Schabacker noted that Sherwood continued to work as a truck driver and that Sherwood reported no safety concerns regarding his ability to drive a truck. Dr. Schabacker further noted:

[239] Ex. 10 at 142.

[240] Ex. 10 at 143.

> Mr. Sherwood is quite adamant that his pain control is not what he believes it should be or needs to be. He believes that he should have access to intrathecal opioids at the rate and concentration that serves him best. He does not believe that the Polyanalgesic Consensus Report should apply to him. . . . Absent any other plan, my focus will remain on modifying Mr. Sherwood's medication delivery system so that we eventually will become compliant with the Polyanalgesic Consensus Report. With this, Mr. Sherwood is remarkably resistant.[241]

¶ 146 Dr. Schabacker set Sherwood's pump to deliver a daily dosage of 8 milligrams per day. Dr. Schabacker wrote Sherwood a prescription for oxycodone and advised him to take great caution when taking oxycodone in conjunction with his work activities. Sherwood reiterated that his employer was aware and accepting of his medication use.[242] Dr. Schabacker recommended that Sherwood seek a non-driving job.[243] While encouraging Sherwood to seek other employment, Dr. Schabacker did not restrict Sherwood's job duties as a commercial truck driver.

¶ 147 On May 22, 2008, x-rays of Sherwood's lower thoracic spine were taken at the InterMountain Imaging Center in Butte. The radiologist noted that Sherwood had a possible inferior end plate fracture of T-11 and recommended clinical correlation.[244]

¶ 148 On May 27, 2008, Sherwood came to Dr. Schabacker's Billings office for an examination ahead of a scheduled CT myelogram. Sherwood had contacted the office earlier that day and stated that he had fallen several times over the weekend and that he was experiencing weakness in his legs. Dr. Schabacker noted that Sherwood had "led someone in the office to believe that he was nearly incapable of bipedal locomotion." However, when Sherwood arrived at the office, he reported no change in his usual level of leg numbness. Except for his belief that he had a greater propensity to fall, Sherwood noted no changes in his condition. Sherwood alleged that he had forgotten to bring his medications and requested refills. On examination, Dr. Schabacker noted that Sherwood

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[241] Ex. 10 at 146-47.

[242] Ex. 10 at 147.

[243] Ex. 10 at 148.

[244] Ex. 29 at 17.

had decreased pinprick sensation at every location tested, but he was able to go from a seated to a standing position without difficulty and exhibited good balance and the ability to heel-and-toe walk. Dr. Schabacker noted that although he was concerned from initial reports that Sherwood was experiencing a granuloma, he was less concerned after examination as there was no perceptible change in Sherwood's condition. Dr. Schabacker advised Sherwood that the CT myelogram was necessary to assess his symptoms. Dr. Schabacker again reduced Sherwood's intrathecal pump dosage, bringing the dosage down to 4 milligrams per day, in compliance with the Polyanalgesic Consensus Report. Dr. Schabacker again suggested a prescription for a front-wheeled walker and physical therapy evaluation. Sherwood refused. Dr. Schabacker offered to have Sherwood admitted to the hospital for further evaluation given his recent complaints. Sherwood refused. Dr. Schabacker appealed to Sherwood's wife. She advised Dr. Schabacker that she did not feel admission was necessary.[245]

¶ 149 On May 28, 2008, Dr. Schabacker wrote to Sherwood and stated that he had learned that Sherwood had not attended the scheduled CT myelogram. Dr. Schabacker terminated Sherwood as a patient. Dr. Schabacker noted that he would provide care until June 30, 2008, but Sherwood would have to choose a management option for his intrathecal pump. Dr. Schabacker advised Sherwood that he would arrange for him to have each of his oral prescriptions either filled or provide instructions for gradual elimination of each individual prescription by June 30, 2008. Dr. Schabacker stated that his October 5, 2007, letter advising Sherwood not to drive while taking these medications remained in effect, and opined that it was unsafe for Sherwood to drive while taking his medications.[246] However, Dr. Schabacker placed no restrictions on Sherwood's job duties.

<u>Medical Treatment After the Alleged June 4, 2008, Industrial Accident</u>

¶ 150 On June 9, 2008, Dr. Schabacker wrote to Sherwood, advising him that Sherwood had violated their medication agreement by soliciting and accepting opiate medications from a Butte clinic in contravention of his pain management agreement. Dr. Schabacker further noted that he had received a lumbar x-ray from the Butte clinic which indicated that Sherwood's intrathecal pump catheter had fractured, and that it was likely Sherwood was

[245] Ex. 10 at 149-51.

[246] Ex. 10 at 152-53.

not properly receiving his intrathecal medication. Dr. Schabacker reminded Sherwood to contact his office to discuss Sherwood's options for the intrathecal pump.[247]

¶ 151 Sherwood presented at the emergency department at St. James Healthcare in Butte on June 13, 2008, complaining of a headache and reporting that he fell out of his truck on June 4. The examination report, including a head CT scan, contains no objective medical findings. Sherwood was diagnosed with a concussion based on his report of injury.[248]

¶ 152 Sherwood's final appointment with Dr. Schabacker occurred on June 27, 2008. Dr. Schabacker noted that Sherwood was scheduled to be terminated from his clinic on July 1, 2008. Dr. Schabacker noted that Sherwood had yet to choose an option for dealing with the future of the pump. Dr. Schabacker believed Sherwood's pump was nonfunctional as a recent x-ray had indicated that one of the pump catheters was fractured. Dr. Schabacker examined Sherwood. Among other findings, he noted that Sherwood's seated straight leg raise "is associated with a great deal of theatrics and tremulousness." Dr. Schabacker was unconvinced Sherwood had any increased leg or low-back pain. Dr. Schabacker further noted, "Strength testing is complicated by a lack of participation. However, when distracted it is clear that his strength in his legs is intact."[249]

¶ 153 Surprisingly, Dr. Schabacker discovered upon review of newly taken x-rays that Sherwood's intrathecal pump catheter was intact and working properly. Dr. Schabacker concluded that Sherwood's pump was delivering the prescribed dosage. Dr. Schabacker pressed Sherwood for a decision as to the future of the intrathecal pump, and Sherwood informed Dr. Schabacker that Dr. Hull would take over the maintenance of the device. Dr. Schabacker did not believe Dr. Hull would accept Sherwood as a patient. Sherwood decided to have Dr. Schabacker wash out the pump and fill it with saline, with the pump rate adjusted to deliver the remaining hydromorphone at a rate of 2 milligrams per day. Sherwood was informed that his pump would continue to deliver saline for several weeks following the low-reservoir alarm on January 3, 2009, but that if Sherwood did not have the pump refilled, it would eventually run dry and cease to function.[250]

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[247] Ex. 10 at 154-55.

[248] Ex. 17 at 8-13.

[249] Ex. 10 at 156-57.

[250] Ex. 10 at 157-58.

¶ 154 Dr. Schabacker further noted:

> Open for discussion today was an unsubstantiated report by Mr. Sherwood that he fell out of his truck a month or so ago. He was unable to identify how or why he fell out of the truck. He believes that his legs "gave out." He believes that he landed on the ground and there was loss of consciousness. He believed that he was unconscious for an hour, but it is not possible to determine how he knows that to be the case. He then drove to Seattle, WA. He apparently was evaluated at his job site in Seattle and then allowed to return to his home driving one of the company trucks. 8 days after the fall he notified this office of the fall. He was advised to report to the Emergency Department.
>
> Mr. Sherwood reported that a CT scan of his head was done at the Emergency Department. He reported that a CT scan was unremarkable. It was suggested that he follow up with his primary care physician, which Mr. Sherwood has chosen not to do. Mr. Sherwood believes that I am his primary care physician, a position which I have advised Mr. Sherwood repeatedly that I am not.
>
> The reported fall from the truck is unsubstantiated. . . . Additionally, his today examination was unremarkable from a neurological standpoint. There is no evidence of cranial nerve deficit. There is no laterality with regard to sensory loss or strength. Much of what is observed on Mr. Sherwood's examination is non-physiological, i.e. whole-body decreased pinprick perception. His strength assessment is not congruent with what he presents in clinic, i.e. his ease to stand and walk without difficulty and that he is able to push himself up off from the examination table using both arms without difficulty.
>
> I advised Mr. Sherwood that I cannot and will not assume responsibility for treating him with regard to the unsubstantiated report of a fall out of a truck. Additionally, I advised that he seek assistance from a neurologist for evaluation if he believes there is a problem from the reported fall. Mr. Sherwood listened, but did not appear to take seriously my recommendation. I went so far as to offer to assist Mr. Sherwood in identifying a provider in his hometown to assess him from a neurological standpoint. Clearly, Mr.

> Sherwood is not interested in pursuing a workup with regard to his unsubstantiated report of a head injury.[251]

¶ 155 Sherwood returned to see Dr. Webster in Utah on July 10, 2008, to have his pump refilled. Sherwood informed Dr. Webster that he had lost his treating physician. Sherwood represented to Dr. Webster that his Dilaudid had been set at 6 milligrams per day. Dr. Webster set Sherwood's pump to deliver 4 milligrams per day.[252] Sherwood returned for a pump refill on July 28, 2008. This time he was seen by Troy D. Hunter, APRN, FNP (Hunter). Sherwood again requested his Dilaudid dosage to be set at 6 milligrams per day, which was done.[253]

¶ 156 Dr. Rosen evaluated Sherwood on August 21, 2008. Dr. Rosen noted that Sherwood had been out of work since June 4, 2008, and that he had run out of his prescription medications approximately one week prior to Dr. Rosen's evaluation.[254] Dr. Rosen reviewed Sherwood's medical records, interviewed Sherwood, and examined him. Among other findings, Dr. Rosen noted that Sherwood had significant atrophy of his right calf. Upon Sherwood's insistence, Dr. Rosen agreed to provide him with a one-month prescription for his medications. Dr. Rosen did not establish a treating relationship with Sherwood.[255]

¶ 157 On August 29, 2008, Sherwood was seen at the Lifetree Pain Clinic in Salt Lake City, Utah, by Andrew Talbott, M.D., for a pump refill. Sherwood requested an increase in his Dilaudid dosage. Dr. Talbott refilled the pump to deliver 6.5 milligrams per day.[256]

¶ 158 On November 13, 2008, Hunter refilled Sherwood's pain pump, this time with 6.5 milligrams per day of Dilaudid and 16.3 micrograms per day of Fentanyl. Hunter noted that Sherwood was off work and that he reported having a serious fall about a month previously in which his legs "went out from under" him and he struck his head. Sherwood informed

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[251] Ex. 10 at 158-59.

[252] Ex. 9 at 57-58.

[253] Ex. 9 at 59-60.

[254] Ex. 19 at 1-3.

[255] Ex. 19 at 1-3.

[256] Ex. 9 at 60A-60B.

Hunter that he had had neurologic problems since the fall, including difficulties with short-term memory, substituting words in conversation, and amnesia as to the fall itself. Sherwood also informed Hunter that he had had a similar fall previously while working. Hunter suggested that Sherwood seek treatment with a neurologist as soon as possible.[257]

¶ 159 On December 1, 2008, Sherwood informed Hunter that his pain was dramatically worse. Hunter refilled Sherwood's pump with 7.5 milligrams of Dilaudid plus 19 micrograms of Fentanyl per day. Hunter added a prescription of Avinza in addition to Sherwood's other oral medications.[258] On December 12, 2008, Hunter increased Sherwood's pump to deliver a daily dosage of 9 milligrams of Dilaudid plus 22.5 micrograms of Fentanyl. Hunter noted that Sherwood reported inadequate pain relief. Hunter added a prescription for oxycodone to provide better pain relief.[259]

¶ 160 Dr. Capps performed her second IME of Sherwood on December 18, 2008. The purpose was to assess Sherwood's condition regarding his reported back and head injuries of April 1 and June 4, 2008. Dr. Capps reviewed Sherwood's medical records from November 1993 forward and conducted an interview and physical examination of Sherwood. Sherwood informed Dr. Capps that his current symptoms included numbness in his arms and pain in his head, neck, and interscapular area. Sherwood informed Dr. Capps that since the June 4, 2008, industrial accident, he became more easily confused, his memory worsened, and he became disoriented. He also reported increased headaches, dizziness, and difficulty in remembering words. Dr. Capps reminded Sherwood that he had described these same symptoms prior to the June 4, 2008, industrial accident to his medical evaluators in Salt Lake City and Sherwood responded that all these symptoms had worsened since June 4, 2008. Dr. Capps brought up Sherwood's high opiate dosages. He refused to believe that his symptoms could be related to his medications.[260]

¶ 161 Among other findings, on physical examination, Dr. Capps noted that Sherwood had atrophy of his right calf, a very flat back secondary to his multiple surgeries, tenderness

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[257] Ex. 9 at 61-62.

[258] Ex. 9 at 64-65.

[259] Ex. 9 at 66-67.

[260] Ex. 6 at 12-55.

over his incision scars, and diffuse tenderness with left sciatic notch discomfort. Dr. Capps' diagnoses were:

1. Status post multiple surgeries of the lumbar spine with chronic low back pain, unchanged post recent incidents by history.
2. Narcotic addiction/habituation with ongoing cycles of escalating dosages prescribed.
3. Status post numerous claimed concussions, prior left temporal EEG changes, prior problems with memory, etc., with claimed worsening after the 6/4/08 incident, defer to neurologic and neuropsychiatric IME.
4. Status post multiple abdominal surgeries, including gastrectomy, cholecystectomy, and hernia repair, unrelated and unchanged.
5. Status post cervical sprain superimposed on mild degenerative changes of the cervical spine with nondermatomal complaints and findings of sensory loss to the left thumb and index finger more consistent with left carpal tunnel syndrome than radiculopathy.
6. Long history of headache complaints, in the past thought to be in part due to use of narcotics versus post traumatic verus musculoligamentous, defer to neurologist.[261]

¶ 162 In answer to questions posed, Dr. Capps opined that Sherwood's back and leg complaints may have been temporarily aggravated by his April 1, 2008, industrial accident. Dr. Capps explained that Sherwood's complaints were "extremely similar to many, many years of documented complaints, even though he now claims they are worse." Dr. Capps noted that Sherwood's pain ranges were in the same range as he reported before the April 1, 2008, incident and his complaints of arm numbness and weakness were not borne out on physical examination.[262]

¶ 163 Dr. Capps expressed skepticism as to whether Sherwood's alleged June 4, 2008, industrial accident occurred given Sherwood's confusion and lack of witnesses. Dr. Capps

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[261] Ex. 6 at 52.

[262] Ex. 6 at 53.

opined that the symptoms Sherwood attributed to this accident were the same as he complained of prior to this accident, although she noted that Sherwood's neurologic symptoms were outside her area of expertise and recommended that Sherwood attend a neurologic IME. Dr. Capps further noted that in her experience, many of Sherwood's symptoms could be explained by his "extreme" dosages of opiates and Neurontin.[263]

¶ 164 Dr. McElhinny evaluated Sherwood on January 6, 2009. He reviewed Sherwood's medical records, conducted a clinical interview and history, reviewed his November 2001 consultation report, and conducted a series of psychological assessments. Dr. McElhinny noted Sherwood's reported industrial accidents on April 1 and June 4, 2008. In his report, Dr. McElhinny emphasized Dr. Schabacker's treatment notes from around the time of these alleged injuries, noting that Dr. Schabacker was dubious about Sherwood's report of a two-hour loss of consciousness after the June 4, 2008, fall.[264]

¶ 165 After interviewing Sherwood, Dr. McElhinny administered the Word Memory Test, which Sherwood failed. Dr. McElhinny concluded that Sherwood had put forth less than adequate effort and that he was intentionally magnifying his symptoms of memory disturbance. Dr. McElhinny noted that the interview and other test results obtained supported his conclusion that Sherwood's results on the Word Memory Test were an intentional effort by Sherwood to manipulate the results. Dr. McElhinny opined:

> Mr. Sherwood is attempting to set the stage for his permanent disability. He describes two work-related incidents/accidents in April and in June of 2008 that had no immediate medical follow-up. There are no objective medical findings to any type of accident or injury in April or June of 2008.
>
> Mr. Sherwood subtly manipulates medical care providers to obtain narcotic pain medications. I would caution any of his medical care providers that they should strongly consider completing random urine drug screens on Mr. Sherwood to determine if he is actually taking the narcotic medications as prescribed versus storing/selling them. In short, Mr. Sherwood is not a reliable reporter of his physical or cognitive symptoms. Only objective medical evidence should be utilized in prescribing treatments for this patient.

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[263] Ex. 6 at 53.

[264] Ex. 11 at 8-10.

There is no evidence of a concussion and, in this examiner's opinion, his report of a loss of consciousness and other experienced symptoms after the fall on 06/04/08 has been fabricated.[265]

¶ 166 Dr. McElhinny diagnosed Sherwood as having chronic personality style and behavioral features supporting symptom magnification, malingering, and opioid dependence. Dr. McElhinny opined that no evidence indicated that any of Sherwood's medical conditions were caused by his April 1 or June 4, 2008, industrial accidents. He further opined that he could not definitively discern "what's real and what's been fabricated in Mr. Sherwood's medical history."[266] Dr. McElhinny further opined that none of the treatment Sherwood had received related to either of these two alleged industrial injuries, and opined that no treatment related to either of these incidents was warranted. As to Sherwood's prognosis, Dr. McEhinny opined, "Mr. Sherwood will proceed as he has in the past, working as he needs to and seeking narcotic pain medications as he can."[267]

¶ 167 On January 14, 2009, Hunter refilled Sherwood's pump, increasing the dosages to 10.5 milligrams of Dilaudid and 26.3 micrograms of Fentanyl per day. Sherwood requested an increase in his oral medications as well, and Hunter increased Sherwood's Actiq and oxycodone prescriptions.[268] At Sherwood's next refill appointment of February 2, 2009, Hunter adjusted the pump dosages to deliver 10 milligrams of Dilaudid and 50 micrograms of Fentanyl per day. Sherwood's oral prescriptions remained the same.[269]

¶ 168 Sherwood saw Dr. Talbott on April 14, 2009, to discuss treatment options. Dr. Talbott noted the danger of developing a granuloma. Sherwood was receiving 10 milligrams per day of Dilaudid in addition to the Fentanyl, and the risk of granuloma greatly increases when Dilaudid dosages exceed 12 milligrams per day. Sherwood informed Dr. Talbott that he believed his current medications were effective and he did not wish to change his prescriptions even in light of the granuloma risk.[270] Hunter and Tausha M.

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[265] Ex. 11 at 13-14.

[266] Deposition of Dr. Rosen, Ex. 1 at 122.

[267] Ex. 11 at 15.

[268] Ex. 9 at 68-69.

[269] Ex. 9 at 70-71.

[270] Ex. 9 at 74-75.

Jensen, APRN, refilled Sherwood's pump on April 15, 2009, with a daily dosage of 10 milligrams of Dilaudid and 75 micrograms of Fentanyl.[271]

¶ 169 Sherwood returned for a pump refill on June 22, 2009. He reported to Hunter that his pain had increased and that he had poor tolerance for physical activity. Sherwood's wife reported that activities such as grocery shopping increased Sherwood's pain to the extent that he would spend several days in bed. Hunter increased Sherwood's daily pump dosages to 10.5 milligrams of Dilaudid and 79 micrograms of Fentanyl. Sherwood also requested an increase in his oral prescription dosages, but Hunter refused.[272]

¶ 170 Dr. Rosen saw Sherwood on July 13, 2009, at the request of Sherwood's attorney. Dr. Rosen noted that he had seen Sherwood on a single occasion and had given him a one-month prescription since Sherwood was without a treating physician. However, Dr. Rosen further stated, "Because of philosophical differences, follow up care was mutually agreed upon as not being in [Sherwood's] best interest." After examination, Dr. Rosen recommended that Sherwood be evaluated for inclusion in an in-patient pain program. He also recommended a neuropsychological evaluation with Dr. William Patenaude, and electrodiagnostic studies of Sherwood's right arm and legs.[273] Dr. Rosen opined that Sherwood had been over-treated with opiates and under-evaluated. He further stated:

> Based on [Sherwood's] current medication dependency, he would be considered fully disabled on this basis alone. I cannot imagine an individual working, who is currently on the medication regimen the chart work indicates [Sherwood] is taking. Even if [Sherwood's] medication regimen can be streamlined, for [Sherwood] to realistically return to the workforce would require a rather heroic effort on [Sherwood's] part, as well as very proactive care that is multidisciplinary and would include a physician with some level of pain expertise, as well as seeing a physical therapist and a psychologist all with pain treatment experience.[274]

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[271] Ex. 9 at 76-78.

[272] Ex. 9 at 79-81.

[273] Ex. 19 at 4-6.

[274] Ex. 19 at 6.

¶ 171 Dr. McElhinny testified by deposition taken August 24, 2009. Dr. McElhinny is a clinical psychologist and neuropsychologist.[275] Dr. McElhinny's practice primarily consists of performing consultations for other medical professionals. He occasionally treats referred patients short-term.[276] He has performed approximately 150 IMEs during his career. Dr. McElhinny testified that doctors frequently ask him to evaluate a patient and give them his opinion as to whether there are any psychologic or neuropsychologic reasons that the patient is not responding as expected to a given medical treatment.[277]

¶ 172 Dr. McElhinny testified that no objective medical evidence indicates that Sherwood sustained cognitive mental impairment, psychological impact, or neuropsychological impact as a result of his April 1, 2008, industrial accident.[278] Dr. McElhinny testified that he would expect serious, debilitating effects from a one- to two-hour loss of consciousness after an acute head injury. Someone unconscious for that length of time would not be easily aroused, may not know the date, may be unable to stand up, and may not have full physical functioning.[279] Dr. McElhinny would not expect someone who was unconscious for one to two hours to rouse themselves, drive a semi-truck to their destination, and drop off their load.[280] Dr. McElhinny further testified that even though Sherwood did not have a CT scan until eight or nine days after the incident, if Sherwood was really unconscious for one or two hours, his CT scan should show some evidence of head trauma.[281]

¶ 173 Dr. McElhinny opined that from a psychological or neuropsychological standpoint, no objective medical findings suggest any accident or injury in April or June of 2008.[282] He further found nothing affecting Sherwood's ability to engage in gainful employment from

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[275] McElhinny Dep. 4:24-25.

[276] McElhinny Dep. 7:1-13.

[277] McElhinny Dep. 7:18-22; 9:1-9.

[278] McElhinny Dep. 18:7-16.

[279] McElhinny Dep. 19:10-23.

[280] McElhinny Dep. 21:8-16.

[281] McElhinny Dep. 23:3-19.

[282] McElhinny Dep. 28:11-19.

either the April 1 or June 4, 2008, reported accidents.[283] Dr. McElhinny has no opinion regarding whether Sherwood can safely operate a semi-truck given his level of medications, but would defer to Dr. Schabacker's opinion.[284] Dr. McElhinny opined that Sherwood is not disabled from a psychological or neuropsychological standpoint.[285]

¶ 174 Dr. Capps testified by deposition taken August 27, 2009. Dr. Capps is board-certified in orthopedic surgery, but currently only performs IMEs.[286] Dr. Capps clarified that in her second IME report, while she indicated that Sherwood did not need further treatment for either his April 1 or June 4, 2008, industrial accidents, she should have specifically stated that her opinion related only to his orthopedic complaints and deferred any mental issues.[287]

¶ 175 Dr. Capps had precluded Sherwood from driving when she examined him in 1997, and he was then on significantly lower doses of narcotics than he is now.[288] Dr. Capps stated that he should not be driving because of his use of high dosages of narcotics.[289] She added that it was a "big mystery" how he passed a Department of Transportation physical.[290] Although Dr. Capps initially believed Sherwood was a good candidate for a pain management program, her discussions with him revealed that he adamantly resists the idea that any of his problems could be side effects from his medications. She believes he will be unwilling to reduce his reliance on medications so long as he denies that they may be the cause of some of his problems.[291] Dr. Capps opined that Sherwood has been addicted to narcotics for many years.[292]

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[283] McElhinny Dep. 28:20 - 29:6.

[284] McElhinny Dep. 60:5-11.

[285] McElhinny Dep. 66:2-16.

[286] Capps Dep. 4:23 - 5:4.

[287] Capps Dep. 50:24 - 51:6.

[288] Capps Dep. 60:14-23.

[289] Capps Dep. 61:7-14.

[290] Capps Dep. 70:8-13.

[291] Capps Dep. 61:15 - 62:8.

[292] Capps Dep. 62:23 - 64:3.

¶ 176 Dr. Rosen testified by deposition taken September 28, 2009. Dr. Rosen testified that there are many unknowns regarding Sherwood's exact problems. Dr. Rosen does not know what effect each of Sherwood's industrial injuries have had on his level of functioning; however, Dr. Rosen opined that Sherwood's current medications would effectively preclude him from being employable.[293]

¶ 177 Dr. Rosen noted that at his first examination of Sherwood, he found Sherwood credible.[294] Dr. Rosen conceded that Sherwood may not be "a hundred percent reliable as a historian."[295] Dr. Rosen explained that Sherwood may not be fully competent to make rational decisions in light of his history of concussions and his long-term opiate use.[296]

¶ 178 Dr. Rosen testified that Sherwood's full diagnoses are unclear and he recommends a neuropsychological evaluation and electrodiagnostic studies to help determine what effect Sherwood's recent injuries have had on his condition.[297] Dr. Rosen specifically recommended Dr. Patenaude for the neuropsychological evaluation, noting that while he does not always agree with Dr. Patenaude, he respects his unbiased approach.[298] Dr. Rosen explained that his treatment recommendations for Sherwood would be very different if Sherwood had residual cognitive deficits from a brain injury, and he therefore believes further evaluation is crucial.[299]

¶ 179 Dr. Rosen testified that in August 2008, he and Sherwood discussed having Dr. Rosen become Sherwood's treating physician, but they did not agree about Sherwood's use of hydrocodone. Dr. Rosen stated that in retrospect, he believes he could have resisted Sherwood's requests to increase his hydrocodone dosage.[300]

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[293] Rosen Dep. 9:24 - 10:11.

[294] Rosen Dep. 65:22-23.

[295] Rosen Dep. 19:24-25.

[296] Rosen Dep. 74:19 - 75:2.

[297] Rosen Dep. 10:15 - 11:6.

[298] Rosen Dep. 11:7-18.

[299] Rosen Dep. 12:20 - 13:2.

[300] Rosen Dep. 15:2-16.

¶ 180 Dr. Rosen testified that he was unsure if Dr. McElhinny was an appropriate choice for a neuropsychological evaluation of Sherwood in 2009 since Dr. McElhinny had previously examined Sherwood and found him to magnify his symptoms and to be opiate-dependent.[301] Dr. Rosen opined that the evaluation Dr. McElhinny performed was not thorough and did not provide enough information to determine the best treatment options for Sherwood.[302] Dr. Rosen stated that unless Sherwood undergoes an adequate neuropsychological evaluation, he will not accept him as a patient.[303]

¶ 181 Dr. Rosen noted that the radiologist's report from May 22, 2008, indicated that Sherwood might have a T11 compression fracture, which could indicate that Sherwood's April 1, 2008, fall was severe enough to cause thoracic spine fracture.[304] Dr. Rosen stated that a T11 compression fracture could cause additional pain apart from Sherwood's pre-existing medical condition and it would likely be a permanent aggravation.[305] However, Dr. Rosen further noted that a conclusion of whether it is a permanent aggravation would depend on how reliable the interpreter found Sherwood.[306] Dr. Rosen also testified that he did not review this film or any other radiographic film and he does not know if Sherwood actually has a compression fracture at T11 or if so, whether it predated his April 1, 2008, fall.[307]

¶ 182 Dr. Rosen testified that he had noted in his reports, based on Sherwood's representations, that Sherwood suffered an increased frequency of falling after his June 4, 2008, industrial accident. However, Dr. Rosen was not aware that Sherwood's medical history records frequent falls dated back to 1997. Dr. Rosen was not provided with most of Sherwood's medical records for review.[308] Dr. Rosen only reviewed three or four of Dr.

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[301] Rosen Dep. 42:17 - 43:1.

[302] Rosen Dep. 56:3-12.

[303] Rosen Dep. 72:20 - 73:7.

[304] Rosen Dep. 16:7 - 17:12.

[305] Rosen Dep. 17:13-24.

[306] Rosen Dep. 17:24 - 18:1.

[307] Rosen Dep. 60:1-3, 60:17 - 61:12.

[308] Rosen Dep. 25:10-23.

Schabacker's treatment notes[309] and a report from Dr. McElhinny. He is unsure what, if anything, else he reviewed prior to seeing Sherwood.[310]

¶ 183 Dr. Rosen knew that Dr. Schabacker admonished Sherwood on May 28, 2008, not to drive while taking his oral medications, but Dr. Rosen could not opine whether he agreed with that assessment. Dr. Rosen asserted that opiate use with driving has not been well-studied. Each patient must be evaluated individually to determine how well they function on the level of medications they consume.[311] Dr. Rosen observed, "[I]f any one of us in this room were given even half the amount of medications [Sherwood is] currently taking, we would die of respiratory failure."[312] He opined that Sherwood has built up a tolerance.[313] However, Dr. Rosen added that Sherwood now takes more medications than he did under Dr. Schabacker's care. Dr. Rosen asserted that he would not approve Sherwood to drive a semi-truck, and if Dr. Rosen were seeing him for a commercial driver's license approval, he would not clear him to drive due to his opiate use.[314]

## Sherwood's Alleged April 1 and June 4, 2008, Industrial Accidents

¶ 184 Based on the evidence presented to the Court, I find that Sherwood has not proven that his alleged June 4, 2008, industrial accident occurred. I do not find Sherwood's account of lying unconscious on the ground, in a public rest area off of Interstate 90, with no witnesses for one to two hours to be believable. Sherwood's log book for June 4, 2008, does not support his story. No objective medical findings support his story. Dr. McElhinny testified that it would be highly unlikely that Sherwood would have been able to regain consciousness and resume driving his truck if he were unconscious due to a head injury for that length of time. The EMTs who evaluated Sherwood at the Seattle terminal on June 5, 2008, saw no sign of head trauma, but concluded Sherwood was exhausted. Although Sherwood alleges that he was unaware he had fallen until he recalled it a few days afterward, Sherwood did not seek medical treatment for the alleged fall for another week

[309] Rosen Dep. 26:8-11.

[310] Rosen Dep. 27:19 - 28:20.

[311] Rosen Dep. 32:6 - 33:15.

[312] Rosen Dep. 33:16-19.

[313] Rosen Dep. 33:19-22.

[314] Rosen Dep. 33:23 - 34:8.

beyond that. In light of Sherwood's lack of credibility and the complete absence of any corroborating evidence to support his allegation of the June 4, 2008, industrial accident, I find that his report of an industrial injury on June 4, 2008, lacks credibility.

¶ 185 As to Sherwood's account of an April 1, 2008, industrial accident where he allegedly slipped off a truck tire, "compressing" his back and causing leg pain, I am unable to find his report of this incident credible. As with the June 4, 2008, incident, this incident was unwitnessed. Although Sherwood sought medical treatment on April 1, 2008, he did not report it as an on-the-job incident to the medical care provider. When Sherwood treated with Dr. Schabacker two weeks later, he did not relate the incident to him. These inconsistencies, when viewed in light of Sherwood's general lack of credibility, make it impossible for me to conclude that this incident occurred as Sherwood claims it did.

## CONCLUSIONS OF LAW

¶ 186 This case is governed by the 2007 version of the Montana Workers' Compensation Act since that was the law in effect at the time of Petitioner's industrial accident.[315]

¶ 187 Petitioner bears the burden of proving by a preponderance of the evidence that he is entitled to the benefits he seeks.[316]

¶ 188 As set forth above, Hoovestol terminated Sherwood's employment on June 6, 2008, after Sherwood arrived at Hoovestol's Seattle facility on June 5, 2008, disoriented and unable to account for 10 or 11 hours of time. Sherwood subsequently claimed to have suffered an industrial injury on June 4, 2008, in which he allegedly slipped and fell onto the pavement at a truck stop, striking his head and losing consciousness for one or two hours. As set forth above, I did not find Sherwood credible as to this industrial accident.

¶ 189 Sherwood argues that he is "totally disabled" and therefore should be entitled to benefits from either Watkins & Shepard or Great West. To be entitled to permanent total disability (PTD) benefits under § 39-71-702, MCA, Sherwood must meet the definition of PTD found at § 39-71-116(25), MCA:

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[315] *Buckman v. Montana Deaconess Hosp.*, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

[316] *Ricks v. Teslow Consol.,* 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wickens Bros. Constr. Co.*, 183 Mont. 190, 598 P.2d 1099 (1979).

> "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum healing, in which a worker does not have a reasonable prospect of physically performing regular employment. . . .

As a threshhold issue, Sherwood must be at maximum healing in order to be permanently totally disabled. Sherwood has not proven that he is at maximum healing. I therefore conclude he is not permanently totally disabled as defined in § 39-71-116(25), MCA.

¶ 190 Under § 39-71-701(1), MCA, a worker is eligible for temporary total disability (TTD) benefits when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing, or until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.

¶ 191 Sherwood is not yet at maximum healing. However, Sherwood lost his job at Hoovestol for performance issues and not because of his industrial injuries. His total loss of wages occurred when he was terminated for disappearing with a company truck for several hours. While Sherwood later attempted to account for this absence by reporting that he had actually fallen and suffered a head injury the previous day, I found Sherwood's story to be completely lacking in credibility.

¶ 192 Sherwood further argues that he cannot return to his time-of-injury occupation. Under § 39-71-701(1)(b), MCA, Sherwood could potentially be eligible for TTD benefits until he has been released to return to the employment in which he was engaged at the time of his injury, or to employment with similar physical restrictions. The difficulty in determining whether Sherwood is eligible for TTD benefits is that his treating physician never took him off work. Throughout the latter period of his treatment with Dr. Schabacker, including three weeks after Sherwood was fired by Hoovestol, Dr. Schabacker expressed reservations about Sherwood's future as a truck driver, encouraged him to seek other employment, and cautioned Sherwood not to drive while taking certain prescription medications. However, Dr. Schabacker stopped short of taking Sherwood off work.

¶ 193 Since ceasing to treat with Dr. Schabacker, Sherwood has attended an IME with Dr. Capps, who opined during her August 27, 2009, deposition that she would not clear Sherwood to drive given his current prescriptions. Dr. Rosen, who asserted that narcotic tolerance is poorly studied, initially opined that whether Sherwood was capable driving

under his current prescription regimen was unclear. However, on September 28, 2009, Dr. Rosen testified that Sherwood's prescriptions had increased and that he would no longer approve him to drive commercially. Sherwood was apparently receiving pain management via medical providers in Utah while considering transferring his care to Dr. Rosen at the time of trial. Not present among the massive volume of medical records submitted in this case is an opinion from the Utah medical providers as to whether Sherwood is capable of returning to work.

¶ 194 I am persuaded by the weight of the medical evidence presented that Sherwood was no longer released to return to his time-of-injury employment on September 28, 2009. He is therefore entitled to TTD benefits from that date. Since I have further determined that Sherwood has failed to prove that his alleged April 1, 2008, and June 4, 2008, industrial accidents occurred, liability for his workers' compensation benefits remains with Watkins & Shepard.

## JUDGMENT

¶ 195 Petitioner is entitled to temporary total disability benefits against Watkins & Shepard Trucking from September 28, 2009.

¶ 196 Pursuant to ARM 24.5.348(2), this Judgment is certified as final and, for purposes of appeal, shall be considered as a notice of entry of judgment.

DATED in Helena, Montana, this 30th day of June, 2010.

(SEAL)

/s/ JAMES JEREMIAH SHEA
JUDGE

c: Norman H. Grosfield
Leo S. Ward
Geoffrey R. Keller

Submitted: November 12, 2009