IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2019 MTWCC 11

WCC No. 2017-4168

DANIEL WARD

Petitioner

vs.

VICTORY INSURANCE CO.

Respondent/Insurer.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND JUDGMENT

Summary: Petitioner asserts that he has CRPS in his left ankle as a result of an industrial accident. Petitioner relies on his current treating physician who, like many other medical providers who examined him, observed some of the objective signs of CRPS per the Budapest criteria, which are included in the Montana Utilization and Treatment Guidelines. Respondent denied liability, relying on the opinions of the physicians who examined him under § 39-71-605, MCA, and one of his treating physicians, who opined that Petitioner does not have CRPS. The psychiatrist who examined Petitioner under § 39-71-605, MCA, concluded that Petitioner has Somatic Symptom Disorder, a psychological condition.

Held: Petitioner proved by a preponderance of the evidence that he suffers from CRPS and that it was caused by an industrial accident. This Court gives greater weight to Petitioner's current treating physician's diagnosis of CRPS under the criteria in the Montana Utilization and Treatment Guidelines primarily because his opinion was supported by the other medical evidence in this case while the opinions of the physicians who examined Petitioner under § 39-71-605, MCA, and the treating physician who agreed with them, were not.

¶ 1 The trial in this matter was held on June 19, 20, and 22, 2018, in Helena. Petitioner Daniel Ward was present and represented by Matthew J. Murphy and Thomas J. Murphy. Respondent Victory Insurance Co. (Victory) was represented by Jon T. Dyre.

¶ 2 Exhibits: The Court admitted Exhibits 1 through 3, 9, 12 through 31, 33 through 65, 67 through 79, 81, and 82 without objection. The Court admitted Exhibits 4, 8, 11, and 66 over Ward's objections. Exhibits 5 and 7 were withdrawn. The Court sustained Victory's objections and Exhibits 6-1 through 6-3, 6-5, 6-7 through 6-14, and 6-17 were not admitted. During the trial, the Court admitted Exhibits 6-4, 6-6, 6-15, and 32. The Court admits Exhibit 10, a written statement of Tyler Brenner, because although a determination in an unemployment insurance case is not admissible under § 39-51-110, MCA, evidence submitted in an unemployment insurance case can be admitted in other cases. Moreover, the parties deposed Brenner and Ward cross examined him on the subject matter of the statement. The Court admits Exhibit 80 for the reasons set forth in footnote 7. This Court excluded Exhibit 83 under ARM 24.29.1595(5)(c).[1] This Court admits Exhibit 84 because Victory cited no authority supporting its claim that this Court may not admit copyrighted materials.

¶ 3 Witnesses and Depositions: This Court admitted the depositions of Ward, Riley Silvernail, Tyler Brenner, Jon Robinson, MD, and Bradley L. Aylor, MD, into evidence. This Court overrules Ward's objections to the questions on pages 25 and 28 in Dr. Aylor's deposition because the questions, while technically compound, were not confusing. This Court overrules Ward's objections to the questioning of Tyler Brenner on trial Exhibit 10 because Exhibit 10 is admissible. This Court overrules Ward's objections to the questions on page 18 of Silvernail's deposition because, given the context, the questions were not asking Silvernail to speculate. Daniel Ward, Angel Ward, Ashley Burch, William D. Stratford, MD, Emily Heid, MD, and Michael Schabacker, MD, were sworn and testified at trial.

Issues Presented: The Pretrial Order sets forth the following issues:

Issue One: Whether Petitioner is entitled to acceptance of liability for his February 15, 2016, claim?

Issue Two: Whether Petitioner is entitled to acceptance of liability for his December 13, 2016, claim?

Issue Three: Whether Respondent is liable for Petitioner's alleged Complex Regional Pain Syndrome, or a similar condition, which Respondent disputes exists?

Issue Four: Whether Petitioner is entitled to payment of incurred medical treatment costs?

Issue Five: Whether Petitioner is entitled to any further medical benefits at this time?

[1] ARM 24.29.1595(5)(c) was transferred to ARM 24.29.1641 effective 01/01/19.

Issue Six: Whether Petitioner is entitled to any further indemnity benefits at this time?

Issue Seven: Whether Petitioner is entitled to his attorney fees, costs, and/or a penalty?

INTRODUCTION

¶ 4 The primary issue in this case is whether Ward has Complex Regional Pain Syndrome (CRPS) from his industrial accident on December 13, 2016. There is some controversy with CRPS, as it is not currently well-understood. The Montana Utilization and Treatment (U&T) Guidelines explain:

> Complex Regional Pain Syndrome (CRPS Types I and II) describes painful syndromes, which were formerly referred to as Reflex Sympathetic Dystrophy (RSD) and causalgia. CRPS conditions usually follow injury that appears regionally and have a distal predominance of abnormal findings, exceeding the expected clinical course of the inciting event in both magnitude and duration and often resulting in significant impairment of limb function.
>
> CRPS I (RSD) is a syndrome that usually develops after an initiating noxious event, is not limited to the distribution of a single peripheral nerve and appears to be disproportionate to the inciting event. It is associated at some point with evidence of edema, changes in skin, blood flow, abnormal sudomotor activity in the region of the pain, allodynia, or hyperalgesia. The site is usually in the distal aspect of an affected extremity or with a distal to proximal gradient. The peripheral nervous system and possibly the central nervous system are involved.
>
> CRPS II (Causalgia) is the presence of burning pain, allodynia, and hyperpathia usually in the hand or foot after partial injury to a nerve or one of its major branches. Pain is within the distribution of the damaged nerve but not generally confined to a single nerve.
>
> Historically, three stages were thought to occur. These stages include: Stage 1 - Acute (Hyperemic), Stage 2 - Dystrophic (Ischemic), and Stage 3 - Atrophic. However, the stages in CRPS I are not absolute and in fact, may not all be observed in any single patient. Signs and symptoms fluctuate over time and are reflective of ongoing dynamic changes in both the peripheral and central nervous systems.
>
> Although there has been some debate regarding both the existence and pathophysiologic basis of CRPS, as with all chronic pain, psychological

issues should always be addressed, but there are a number of studies identifying pathological findings.[2]

¶ 5 CRPS is diagnosed clinically, meaning that there is not a specific test upon which a physician can make a definitive diagnosis. Rather, physicians rely upon a collection of subjective symptoms and objective signs to make the diagnosis. CRPS is diagnosed under what have become known as the Budapest criteria, established by the International Association for the Study of Pain in 1993. The U&T Guidelines have adopted the Budapest criteria to diagnose CRPS.[3] They are:

1. Continuing pain, which is disproportionate to any inciting event.

2. At least one symptom in *three of the four* following categories:

- *Sensory:* reports of hyperesthesia and/or allodynia.
- *Vasomotor:* reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry.
- *Sudomotor/edema:* reports of edema and/or sweating changes and/or sweating asymmetry.
- *Motor/trophic:* reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

3. At least one sign at time of evaluation in *two or more* of the following categories:

- *Sensory:* evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement).
- *Vasomotor:* evidence of temperature asymmetry and/or skin color changes and/or asymmetry. Temperature asymmetry should ideally be established by infrared thermometer measurements showing at least a 1°C difference between the affected and unaffected extremities.
- *Sudomotor/edema:* evidence of edema and/or sweating changes and/or sweating asymmetry. Upper extremity volumetrics may be performed by therapists that have been trained in the technique to assess edema.

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[2] Department of Labor and Industry, Employment Relations Division, State of Montana, Complex Regional Pain Syndrome and/Reflex Sympathetic Dystrophy, Montana Utilization and Treatment Guidelines (2019), p. 10.

[3] *Id*., pp. 21-22. *See also* R. Rondinelli, M.D., Ph.D., *et al*. (eds.), *American Medical Association Guides to the Evaluation of Permanent Impairment*, 6th ed., AMA Press, p. 453, Table 15-24, 2008.

- *Motor/trophic:* evidence of decreased range-of-motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

4. No other diagnosis that better explains the signs and symptoms.

¶ 6 A person diagnosed under these criteria can obtain an impairment rating under the 6th Edition of the *Guides to the Evaluation of Permanent Impairment*.[4]

FINDINGS OF FACT

¶ 7 The following facts have been proven by a preponderance of the evidence.

¶ 8 During the winter of 2016, Ward worked as a laborer for Little Bear Construction (LB), a company that installs siding on houses. Tyler Brenner and his wife Angel own LB.

¶ 9 On February 15, 2016, Ward suffered an injury to his left ankle in the course of his employment. At the time of his injury, Ward was making $18 per hour.

¶ 10 Ward initially saw a physician's assistant, who thought that Ward had a sprained ankle. However, because Ward's ankle did not materially improve, on April 4, 2016, the physician's assistant ordered an MRI and referred Ward to Jon F. Robinson, MD, an orthopedic surgeon.

¶ 11 Victory initially paid benefits under § 39-71-608, MCA, and then obtained an extension from the Department of Labor & Industry. It thereafter accepted liability.

¶ 12 On May 10, 2016, Ward saw Dr. Robinson, who specializes in ankle injuries. Dr. Robinson reviewed Ward's left-ankle MRI, which the radiologist read as normal. However, Dr. Robinson noted instability in Ward's ankle. Dr. Robinson explained that when a ligament is stretched and lengthened, it can appear normal on an MRI. Thus, he clinically diagnosed Ward with injuries to the lateral ligaments and tendons of his ankle. Dr. Robinson recommended surgical repair.

¶ 13 On May 18, 2016, Dr. Robinson surgically repaired Ward's left ankle, which included reattaching a ligament that had torn off the bone. At the time, Dr. Robinson expected Ward to fully recover in approximately 12 weeks, as more than 90% of his patients with such injuries return to full unrestricted activity with "basically a normal ankle."

¶ 14 On July 12, 2016, Ward saw Dr. Robinson. Dr. Robinson noted that Ward was making "good progress." Dr. Robinson advised Ward to transition from a post-surgery walking boot to a regular shoe. Dr. Robinson released Ward to "full unrestricted activity as long as he wears a lace up boot . . . ."

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[4] *See generally*, AMA Guides, 6th Ed., pp. 450-54.

¶ 15 On August 15, 2016, Ward resumed working for LB. Ward's ankle remained painful and did not feel stable.

¶ 16 Thereafter, LB promoted Ward to a lead installer, a position in which Ward was the person on a ladder or lift taking measurements, telling the laborer what was needed, and installing the siding, soffit, and fascia. Following this promotion, Ward made $19 per hour. Ward's work performance was generally satisfactory.

¶ 17 Ward returned to Dr. Robinson on October 6, 2016. Dr. Robinson noted increased pain and swelling, and tenderness over his lateral ankle, all of which was unusual to have five months after ankle ligament reconstruction. Dr. Robinson gave Ward several options and Ward decided to try an ankle brace.

¶ 18 Ward returned to Dr. Robinson on December 7, 2016. Ward continued to wear the brace but continued to have ankle pain.

¶ 19 On December 13, 2016, Ward reinjured his left ankle while working when his foot slipped off the second rung of a ladder and he landed flat-footed. Ward told Brenner that he reinjured his ankle. Ward worked the rest of the day. However, while Ward was driving home, Brenner called and fired him because of his ankle injury.

¶ 20 Victory did not reinstate Ward's temporary total disability (TTD) benefits because Brenner falsely told Ashley Burch, the claims examiner, that he fired Ward for poor work performance.

¶ 21 On December 20, 2016, Burch spoke with Ward. Ward did not mention his December 13, 2016, fall.

¶ 22 On January 5, 2017, Burch and Ward spoke again. Ward told Burch he slipped off the bottom rung of his ladder on or around December 19, 2016, and he was experiencing an increased pain in his left ankle after the fall. Although Ward was not originally scheduled to see Dr. Robinson until March, Ward told Burch that he had rescheduled the appointment for January 11, 2017, because of pain from his December fall.

¶ 23 On January 11, 2017, Ward returned to Dr. Robinson, noting increased pain following his fall from the ladder. Dr. Robinson diagnosed Ward with a sprained left ankle from his fall from the ladder.

¶ 24 Dr. Robinson monitored the progress of Ward's ankle at appointments on January 31 and February 7 and 16, 2017. Dr. Robinson referred Ward for an MRI, which did not show anything unusual. Dr. Robinson noted that Ward was not just sore over his lateral ligaments, but sore throughout his ankle, which was unusual. On February 16, 2017, Dr. Robinson restricted Ward to "[d]esk, sedentary duty for 6 weeks until next follow up."

¶ 25 On February 20, 2017, Ward saw KJ Schretenthaler, PT, at Yellowstone Physical Therapy. PT Schretenthaler wrote that "Dan reports he had left ankle MRI and saw Dr. Robinson. MRI reported to show no significant findings. States Dr. Robinson thinks he has CRPS." PT Schretenthaler noted limited motion in Ward's left ankle and wrote that Ward reported "notable pain and burning with even light touch to left ankle/foot, particularly over lateral aspect. No notable edema. Temperature of left foot does feel slightly colder than right to touch." Lastly, PT Schretenthaler concluded that Ward appeared "to have [signs and symptoms] consistent with CRPS."

¶ 26 Dr. Robinson agreed that based on his examinations to that point, he thought that Ward might have CRPS. However, Dr. Robinson did not diagnose CRPS, which he deemed a "serious diagnosis," because it is outside the scope of his practice.

¶ 27 On March 8, 2017, Susanne Crane, PA-C, examined Ward at Community Health Partners. PA-C Crane assessed Ward's left ankle, noting that it had a "[s]lightly duskier hue compared to R foot but towards end of visit skin appears similar." Moreover, PA-C Crane wrote that Ward's left foot was "generally tender, hypersensitive" and that the toes on the left foot were redder than the right foot. PA-C Crane referred Ward to Bradley L. Aylor, MD, "for further evaluation and management of chronic left ankle pain, possible CRPS."

¶ 28 On March 15, 2017, Ward saw Dr. Aylor. Dr. Aylor noted that Ward had an "odd complex of symptoms" with his left foot and ankle pain, and numbness. Dr. Aylor reported that Ward had a limited range of motion in his ankle, and noted Ward's intense ankle pain, his antalgic gait, and his sensitivity to manipulation of his left foot. Dr. Aylor noted variable pain response to palpation. Dr. Aylor did not find atrophy in Ward's calves. Dr. Aylor noted that his "[p]sychiatric assessment" of Ward was normal. Dr. Aylor ordered a triple phase bone scan "to evaluate the left lower leg for RSD and local inflammatory changes at the joints."

¶ 29 On March 27, 2017, Victory reinstated Ward's TTD benefits, retroactive to February 17, 2017, when Dr. Robinson restricted Ward to sedentary duty, a restriction that LB could not accommodate.

¶ 30 On March 28, 2017, Ward returned to Dr. Robinson. Dr. Robinson noted:

> Clinical findings from today are consistent with persistent pain of the left lateral ankle after a Brostrom ligament reconstruction. We discussed further treatment options for his symptoms. At this time, I have no further surgical options and from an orthopedic standpoint, we need to proceed with [an] FCE and impairment rating. He will follow up with Dr. Bradley Aylor for management of his pain. He will follow up as needed.

¶ 31 On April 3, 2017, Ward underwent a three-phase nuclear bone scan. The radiologist reported:

> There is asymmetric, greater on the right, blood flow, pool, and delayed uptake in the lower extremities. Given that the left is the presumed symptomatic side, I presume that the flow, pool, and delayed uptake is decreased on the left and normal on the right. Decreased radiotracer uptake can be seen with disuse. No focal increased left-side radiotracer uptake to suggest trauma or infection.

¶ 32 On April 6, 2017, Victory denied liability for any injury Ward suffered on December 13, 2016, on the grounds that Ward did not give timely notice of his industrial accident.

¶ 33 On April 12, 2017, Dr. Aylor met with Ward. Dr. Aylor noted that Ward's "left foot is generally cooler than that on the right." Dr. Aylor also noted that the bone scan revealed that Ward's blood pool was diminished on his left ankle. Dr. Aylor concluded that "This could be a pattern that would be consistent with a sympathetically mediated type pain syndrome . . . ." Dr. Aylor scheduled a series of lumbar sympathetic blocks for Ward's left foot.

¶ 34 On April 26, 2017, Ward underwent a Functional Capacity Evaluation (FCE) with Angie Kolar, PT. Based on the results, PT Kolar restricted Ward to light-duty work. Ward reported to PT Kolar that his pain was worsening, and described a burning, stabbing sensation. Ward began using crutches, taking the weight off his ankle. Ward reported that even gentle physical therapy exercises caused excruciating pain.

¶ 35 Ward underwent a series of three lumbar sympathetic nerve blocks by Dr. Aylor. Following each injection Ward's pain levels reduced, and the color of his left foot returned to normal. However, within 24 to 36 hours, Ward reported increased back pain and a return of foot and ankle pain.

¶ 36 On May 12, 2017, Victory accepted liability for Ward's December 13, 2016, claim, as Burch recognized that because he had reported the injury directly to her within 30 days, he had met the notice requirement. Because Ward was not at maximum medical improvement (MMI) from his original February 2016 injury, Victory opted to continue his treatment under that claim.

¶ 37 On June 6, 2017, the Department of Labor & Industry approved a settlement over the dispute over Ward's entitlement to TTD benefits for the period of December 13, 2016, to February 16, 2017.

¶ 38 On June 12, 2017, Ward returned to Dr. Aylor for a follow up visit and reported no significant improvement. Dr. Aylor opined that additional lumbar injections would not resolve his symptoms and that there was "no definitive diagnosis." Dr. Aylor injected Ward's ankle with anesthetics to see if "blocking" Ward's nerves would eliminate his pain.

¶ 39 On June 19, 2017, Ward returned to Dr. Aylor. Ward reported that after the numbing medication wore off, his symptoms were worse for three days. Ward complained of aching, numbness, pins and needles with stabbing and burning, and itching. Dr. Aylor could not explain Ward's symptoms or his pain. Because Ward did not respond to the sympathetic nerve blocks, Dr. Aylor did not think Ward had RSD. Dr. Aylor stated that he could not provide any additional treatment. Thus, Dr. Aylor referred Ward back to Dr. Robinson.

¶ 40 Dr. Robinson declined to see Ward, also stating that there was nothing more he could provide in terms of treatment.

¶ 41 On July 24, 2017, Ward saw Rebecca Hintze, PA-C, complaining of left ankle and foot pain. Ward inquired if anyone else could administer lumbar injections since Dr. Aylor refused to see him. PA Hintze suggested Kraig A. Ward, MD. PA Hintze determined Ward was suffering from CRPS.

¶ 42 On July 29, 2017, Ward went to the ER at Livingston HealthCare, complaining of intense left foot and ankle pain. Benjamin N. Flook, MD, recorded that Ward's left leg was "clearly cool from about the mid calf down into the foot." Dr. Flook observed Ward's forefoot "turns from a purplish color to a more normal pinkish color." Dr. Flook also found delayed capillary refill of Ward's left foot. Dr. Flook's assessment was, "[s]evere complex regional pain syndrome affecting the left leg."

¶ 43 Following Dr. Aylor's and Dr. Robinson's conclusions that Ward was at MMI, Burch scheduled Ward for an impairment rating examination with Royce Pyette, MD.

¶ 44 Dr. Pyette thoroughly reviewed Ward's medical records and, on August 2, 2017, examined Ward. Dr. Pyette recorded that Ward reported a pain level of "8/10 with intermittent flares rated at a 10/10." Dr. Pyette's physical examination was limited by Ward's pain sensitivity. Dr. Pyette noted Ward's left foot was "slight [sic] cool to the touch when compared to the contralateral extremity." Dr. Pyette rated Ward with a 2% whole person impairment for his "tendon injury only." Dr. Pyette did not provide an impairment rating for CRPS because Dr. Aylor had determined that Ward did not have CRPS. However, it is apparent that Dr. Pyette was not convinced that Ward was at MMI as Dr. Pyette indicated that Ward should see Dr. Ward. Dr. Pyette also stated that it "may be reasonable to consider a panel IME including an orthopedist, neurologist and/or a neuropsychologist . . . ."

Kraig A. Ward, MD and Gregg W. Schellack, DO

¶ 45 On August 11, 2017, Ward saw Dr. Ward, a pain medicine physician. Dr. Ward noted that the, "skin and the dorsum of the left foot is noticeably discolored in comparison to the right and there is slower capillary refill. On palpation it is noticeably cooler in the left foot than the right." Dr. Ward diagnosed Ward with CRPS. Dr. Ward recommended Ward try a Quell unit, an electrical stimulator similar to a TENS unit, for pain relief therapy and a spinal cord stimulator.

¶ 46 On December 8, 2017, Ward returned to Dr. Ward. Dr. Ward noted that Ward had tried a Quell unit, and it had provided some pain relief. Dr. Ward continued to think that Ward had CRPS but stated:

> I don't think based upon the Quell response that the CRPS is the entire pain issue, and that he appears to have further pain from nociception sources of the left ankle joint.
>
> I can followup, but don't have other things to offer. As such, I don't think the spinal cord stim[ulator] would be expected to exceed the Quell response.

Dr. Ward recommended that Ward be seen by an experienced surgeon to consider surgical revision or a fusion.

¶ 47 On December 13, 2017, Ward saw Gregg Schellack, DO, an orthopedic surgeon, on referral from Dr. Ward. In the "[p]sychiatric" part of his records, Dr. Schellack noted that Ward was "[c]ooperative," and had "[a]ppropriate mood & affect," and "[n]ormal judgment." Dr. Schellack observed that Ward's left foot was "dusky red" when compared to Ward's right foot and ankle. At his December 29, 2019, visit, Dr. Schellack thought that a gastrocnemius release was a treatment option but that "performing this surgery during CRPS is not an option."

¶ 48 Ward returned to Dr. Ward on March 9, 2018. Dr. Ward noted a "dusky dark red appearance to entire left foot distal to ankles" and "delayed capillary refill observed in comparison to right." Dr. Ward repeated his CRPS diagnosis. Ward told Dr. Ward that he was interested in other treatments. However, Dr. Ward stated that the only other treatments would be invasive and that he would not be "comfortable doing interventional procedures with him, given the distance involved."

¶ 49 On January 22, 2018, Ward saw Dr. Schellack. Dr. Schellack observed that Ward's left foot and ankle were mildly red when compared to his right. Dr. Schellack noted a gastric contracture but again stated that Ward was "not [a] surgical [candidate] while being treated for CRPS."

Rachel Jergenson, PsyD

¶ 50 Between October 2017 and April 2018, Dr. Jergenson provided psychological treatment for Ward, who saw her on his own accord because he was having problems coping with the sequalae of his ankle pain and the stress of his claim.

Victory's § 39-71-605, MCA, Examination

¶ 51 On November 10 and 14, 2017, Ward underwent an examination under § 39-71-605, MCA, with Dr. Heid and Dr. Stratford.

¶ 52 Dr. Heid is an orthopedist. Dr. Heid no longer treats patients and does not have admitting privileges at any hospital. She only conducts independent medical examinations (IME).

¶ 53 In the late 1980s and early 1990s, Dr. Heid worked at the Cleveland Clinic under some of the country's experts on what is now known as CRPS. During her 25 years as a practicing orthopedist, Dr. Heid saw CRPS or CRPS-like presentations a couple of times per year. Dr. Heid has diagnosed CRPS, and would diagnose it based on the Budapest criteria, but thinks it is over diagnosed. Dr. Heid testified that the Budapest criteria is "the only diagnostic criteria that we have" for CRPS.

¶ 54 In her report, Dr. Heid noted that Ward's feet were "symmetrically callused." She noted an abnormal gait but opined that it was not physiological because it was different when walking forward when compared to walking backward. Dr. Heid noted that Ward had pain behaviors when she touched the area around his left ankle. However, she asserts that he did not have such behaviors when distracted:

> Behavioral findings—Positive for: Overreaction such as heavy breathing, sighing, gasping, wincing, jumping, withdrawal. Pain around left ankle not reproducible with distraction: I was able to touch the areas of reported hypersensitivity multiple times with light and heavy touch when he was distracted without pain reports (when focused on the ankle, the slightest touch in various locations would cause him to withdraw or even jump before he was touched).

Dr. Heid also noted: "Good capillary refill. Skin temperature symmetric to touch. No discoloration. Hair growth on toes symmetric. The skin was not shiny on left foot. Toe nails symmetric."

¶ 55 Dr. Heid determined that there were "no physical signs of CRPS" and "no evidence of CRPS" and that Ward's ankle was "stable." At trial, Dr. Heid clarified that her comments regarding evidence of CRPS were based exclusively on her examination, not on Ward's medical records. Dr. Heid concluded:

> Mr. Ward's physical exam is not consistent with CRPS. There is no allodynia and no trophic changes. His palpatory exam is inconsistent with distraction. His gait is not antalgic, and is not explainable based on anatomic pathology (this is a nonphysiologic gait). There is no evidence of atrophy that would be expected for someone with reported severe pain and limp for close to 2 years.

¶ 56 Before issuing her report, Dr. Heid spoke to Dr. Stratford, who told her that he thought that Ward's problems were psychological. Thus, in her report, Dr. Heid agreed that "psychosocial issues provide a more credible explanation for the disproportionate pain than a diagnosis of CRPS." When asked what supported her opinion that Ward suffered from psychological problems and not CRPS, Dr. Heid circularly reasoned it was because, "he doesn't have CRPS."

¶ 57 Dr. Heid concluded that Ward was at MMI and did not have impairment. Dr. Heid found that Ward required no further medical treatment and that he could return to work.

¶ 58 Dr. Stratford is a forensic psychiatrist and has been practicing in Montana since 1974. Dr. Stratford explained that a forensic psychiatrist interfaces between the medical and legal communities, offering evaluations of patients. He has frequently testified as an expert witness, dating back to the early 1980s.

¶ 59 Dr. Stratford thinks that, "more than likely," CRPS does not exist and that he does not "believe in CRPS." To the extent it exists, Dr. Stratford thinks it is "vastly overstated" and that there are psychogenic factors in it.

¶ 60 Before issuing his report, Dr. Stratford conferred with Dr. Heid and reviewed her report, noting that Dr. Heid opined, "There is no evidence of CRPS."

¶ 61 Dr. Stratford reviewed some of Ward's medical records and interviewed Ward via videoconference. In the "mental status evaluation" section of his report, Dr. Stratford recorded that Ward's presentation was mostly normal. However, Dr. Stratford noted that Ward stated, "he is always worrying about what is wrong with his leg, and he is anxious and focused on his leg." Dr. Stratford also noted, "He often worries that he may have a serious physical illness, and it is hard to stop worrying at times." From this, Dr. Stratford concluded, "He exhibits chronic symptoms of somatic symptom disorder" (SSD). SSD is a psychological illness wherein a person devotes an excessive amount of attention and time to a perceived or actual physical condition. Dr. Stratford described SSD as "the focus on physical complaints with excessive thoughts, anxiety, worry, and time spent on his disability and physical condition." Dr. Stratford agreed that it is normal for a person with an injury and pain to worry, but that SSD is "a matter of degree." He explained, "It's an extreme focus on physical symptoms."

¶ 62 Dr. Stratford had Ward take a battery of psychological tests and inventories to "test his hypothesis" that Ward had SSD. These tests produced wide ranging results when

compared to the average. Ward's results were in the normal or moderate ranges on the Beck Anxiety Inventory, Patient Health Questionnaire, and World Health Organization Disability Assessment Schedule 2.0. Ward tested in the extreme range for disability conviction on the Pain Disability Questionnaire. Ward tested in the severe range on the Beck Hopelessness Scale. Ward tested in the high ranges on the functional complaints scale, the hostility scale, and the doctor dissatisfaction scale on the Million Clinical Multiaxial Inventory-III. Ward's test results on the Minnesota Multiphasic Personality Inventory-2 and the Personality Assessment Inventory revealed that he has "a number of concerns about his physical health" and "some concerns about physical functioning and health matters in general." On the Battery for Health Improvement (BHI-2), Ward scored "moderately high" on the somatic complaints scale, "very high" on the functional complaints scale, "high" on the hostility scale, "moderately high" on the chronic maladjustment scale, and "high" on the doctor dissatisfaction scale.[5] However, these scales are based on the average person and not on a person who actually has an injury. For example, for the somatic complaints scale, Dr. Stratford stated, "[h]e reported a level of somatic symptoms that is higher than that of community subjects but is commonly found in patients." Likewise, Dr. Stratford stated, "Patients with this high level of functional complaints tend to perceive themselves as disabled, which may be true depending on the severity of their physical injury or illness."

¶ 63 Dr. Stratford diagnosed Ward with SSD. Dr. Stratford explained that it is his opinion that Ward's SSD "results from pre-existing personality issues–with excessive thoughts, anxiety, worry, and feelings about his physical condition/disability."[6] *Inter alia*, Dr. Stratford also diagnosed panic attacks, depressive disorder, and "severe disability conviction." Dr. Stratford testified that none of the tests he administered can individually diagnose SSD and that his diagnosis of SSD is "the totality of all his testing that he pulls this together."

Victory's Denial of Liability for CRPS

¶ 64 Upon receiving Dr. Heid's and Dr. Stratford's reports, Burch sent Dr. Heid's report to Dr. Aylor with a letter asking if he agreed that Ward was at MMI for his left-ankle injury, if he agreed with Dr. Heid's and Dr. Stratford's conclusion that Ward did not have CRPS, and if he agreed that Ward could return to work. Dr. Aylor did not read Dr. Heid's report in its entirety, but checked the boxes stating that he agreed because he read the last pages and agreed that Ward did not have CRPS, that he was at MMI, and that he could return to work.

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[5] At trial, the parties spent a significant amount of time on a discrepancy between the history Ward gave to Dr. Stratford and his testimony versus an answer Ward gave on the BHI-2. Ward told Dr. Stratford that he had never been sexually assaulted and testified the same way. But, Ward indicated on one multiple choice question on the BHI-2 that he had been sexually assaulted at some point in his life. This Court finds that Ward's answer on the BHI-2 was a mistake. Moreover, it turned out that Ward's answer on the BHI-2 was inconsequential. While Dr. Stratford testified that victims of abuse are susceptible to SSD, he testified that Ward's answer on the BHI-2 did not affect his opinion.

[6] (Emphasis in original.)

¶ 65 Victory denied liability for Ward's CRPS claim. Because Dr. Heid and Dr. Stratford had released Ward to return to work, Victory terminated Ward's TTD benefits on January 26, 2018.

¶ 66 Based on the information Victory had, its denial of Ward's CRPS claim was reasonable.

¶ 67 In March 2018, Burch denied payment of Ward's medical appointments with Dr. Ward and Dr. Schellack.

Testimony of Bradley L. Aylor, MD

¶ 68 Dr. Aylor's practice includes pain management. However, he acknowledged that he focuses on other areas of pain management and does not "emphasize at this time . . . staying current on CRPS." At the time of his deposition, he had "only recently" heard of the Budapest criteria. After reviewing information on the Budapest criteria from Ward's attorneys, Dr. Aylor thinks they are overly broad; he utilizes an approach that focuses more on "objective measures" and his experience. Dr. Aylor acknowledged that what he defines as CRPS "may not fit everybody else's criteria." Dr. Aylor also explained that he considers RSD to be broader than what the Budapest criteria labels as CRPS I. Dr. Aylor also focuses more on treating his patients' symptoms rather than attaching a "label" to their conditions.[7]

¶ 69 Dr. Aylor testified that he based his opinion that Ward did not have RSD primarily on the results of the sympathetic blocks. Dr. Aylor explained that if Ward had RSD, the sympathetic blocks would have significantly alleviated Ward's pain for at least a short while.

[7] Ward moved to exclude Dr. Aylor's opinion testimony on CRPS on the grounds that it did not meet the standard in M.R.Evid. 702, which permits "a witness qualified as an expert by knowledge, skill, experience, training, or education" to testify "in the form of an opinion or otherwise" if "scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." Ward argued that because Dr. Aylor was not aware of the Budapest criteria when he first opined that Ward did not have CRPS, he was not qualified to testify as an expert, and because he used his own criteria to determine if a patient had CRPS, his testimony is not scientific. While Dr. Aylor has not kept current on CRPS, he has sufficient expertise to give the opinion that Ward does not have what Dr. Aylor calls RSD because the Budapest criteria are generally accepted but not infallible. In fact, the U&T Guidelines state, "Diagnosis of CRPS continues to be controversial. The clinical criteria used by the International Association for the Study of Pain is thought to be overly sensitive and unable to differentiate well between those patients with other pain complaints and those with actual CRPS." Moreover, Dr. Aylor's testimony regarding the sympathetic nerve blocks is relevant to the issue of whether Ward has sympathetically mediated pain, which the U&T Guidelines recognize as a differential diagnosis of CRPS. Accordingly, as this Court has done in the past, this Court denies Ward's Motion to Exclude Opinion Testimony of Dr. Aylor Regarding CRPS and will give Dr. Aylor's opinion testimony regarding CRPS the weight it deserves. *See, e.g.*, *Petritz v. Mont. State Fund*, 2010 MTWCC 17, ¶ 22 (ruling that objections to a physician's medical opinions on the grounds that the physician was not qualified to give the particular medical opinions "go to the weight and not the admissibility of his testimony and medical opinions").

Michael Schabacker, MD

¶ 70 Dr. Schabacker practices in the areas of physical rehabilitation and pain management. Throughout his medical career, Dr. Schabacker has diagnosed CRPS approximately 40 times. Dr. Schabacker has consulted several times with one of the physicians who Dr. Heid worked under at the Cleveland Clinic, a recognized expert in CRPS. Dr. Schabacker estimates that he is currently providing treatment for 15 to 20 patients with CRPS.

¶ 71 Dr. Schabacker examined Ward for the first time on April 24, 2018, without the benefit of Ward's prior medical records. Ward reported a persistent burning pain and pressure in his left foot and ankle. Dr. Schabacker observed that the "[l]eft foot is distinctly different in appearance when compared to the right" and that while the right foot was unremarkable, the left foot was red and there was "[n]otable temperature variation . . . on palpation." Dr. Schabacker used a thermometer to measure the temperature of Ward's feet and found "in different locations on the left foot or to that on the right shows left foot to be consistently 4°C cooler than the right." Ward's left foot was also swollen. Dr. Schabacker also noted Ward's sensitivity to touch around the ankle and that Ward's left ankle's range of motion was limited. Dr. Schabacker concluded that Ward suffered from CRPS. Dr. Schabacker prescribed Lyrica and discussed a spinal cord stimulator. Dr. Schabacker was critical of the IME reports produced by Dr. Heid and Dr. Stratford, writing that Victory's benefits denial was "a self-serving conclusion not supported by any fact that is [sic] been presented to me in clinic today."

¶ 72 On June 11, 2018, Dr. Schabacker conducted a follow-up examination of Ward. Dr. Schabacker noted that Ward was experiencing "persistent swelling, tingling, and stabbing pain at times." Dr. Schabacker also noted that Ward reported paresthesia, which is an unusual sensation such as itching or crawling. Dr. Schabacker documented atrophy in Ward's left-ankle muscles, verified by measurement. Dr. Schabacker also observed that Ward's left foot was red, Ward's left ankle's range of motion was decreased, and that Ward's left ankle had a "[d]usky, bluish appearance" around the area of his surgery. Dr. Schabacker measured Ward's left ankle at 5.5°F cooler than Ward's right ankle, which is a "significant variation." Dr. Schabacker again concluded that Ward was suffering from CRPS. Dr. Schabacker wrote that additional treatment through spinal cord stimulation "deserves additional consideration." Summarizing his findings, Dr. Schabacker wrote that "Clearly, the indication for the CRPS relates directly and solely to his work-related injury and as such, that issue needs to be addressed once issues with his Worker's Compensation carrier are resolved."

¶ 73 At trial, Dr. Schabacker confirmed that his diagnosis of CRPS satisfied the Budapest criteria. Dr. Schabacker testified that Ward satisfied the first criteria because Ward consistently reported pain that was disproportionate to the inciting event, the sprained ankle that Ward suffered on December 13, 2016, when he slipped off the ladder. Dr. Schabacker testified that Ward satisfied the second criteria because Ward reported

allodynia, skin color changes and color asymmetry, edema, atrophy, and decreased range of motion. Dr. Schabacker explained that the third criteria was established because when he examined Ward, he personally saw and verified hyperalgesia, allodynia, skin color and texture changes, edema, temperature variation, and limited range of motion. When asked whether these symptoms and signs can be caused by disuse, Dr. Schabacker agreed, but also pointed out that a CRPS patient will not use the affected extremity because of pain, which is what he thought was happening with Ward. Finally, Dr. Schabacker opined that Ward met the fourth criteria because lastly there was no other diagnosis that better explained Ward's symptoms and signs. Dr. Schabacker explained that while he considered several differential diagnoses, he did not spend considerable time doing so because it was "clear cut" that Ward has CRPS. As to Ward's psychological state, Dr. Schabacker noted that it is common for patients with CRPS to have accompanying psychological distress and opined that Ward's CRPS was the cause. Dr. Schabacker testified that he has never thought that Ward was malingering, had a factitious disorder, or a somatoform disorder.

¶ 74 Dr. Schabacker testified that Ward should continue taking Lyrica and seeing a psychologist, and have a spinal cord stimulator. Dr. Schabacker explained that when a spinal cord stimulator was approved, he would refer Ward for a psychological examination. Dr. Schabacker explained that Dr. Stratford's evaluation would not qualify as the required psychological evaluation for a spinal cord stimulator and that he would not rely on Dr. Stratford's opinions in IME evaluations because he has "had the opportunity to review enough of them and see some consistency in the conclusions that are drawn to cause me some concern about accepting any of them . . . ." Because additional treatments may improve Ward's condition, Dr. Schabacker did not think Ward was at MMI.

Todd A. Anderson, MD

¶ 75 Ward saw Todd A. Anderson, MD, on May 9, 2018. Dr. Anderson noted that Ward's left foot had "some irregular skin discoloration." Dr. Anderson noted that Ward had CRPS.

Ward's Return to Work

¶ 76 On May 30, 2018, Ward accepted an apprentice position with Wilson Boots making $9.00 per hour. Ward cuts out boot patterns and is learning to be a cobbler. Ward's ankle continues to hurt but Wilson Boots is accommodating. Ward's position is classified as light duty.

Resolution

¶ 77 Although not conclusive, the opinion of a treating physician is generally afforded greater weight than the opinion of a competing expert.[8] In weighing medical opinions, this Court considers such factors as the relative credentials of the physicians and the quality of evidence upon which the physicians base their respective opinions.[9]

¶ 78 This Court finds that Dr. Schabacker and Dr. Heid have comparable credentials to diagnose CRPS, and that each has better credentials than Dr. Aylor, who was not current on the Budapest criteria, and the other physicians who assessed CRPS on a general understanding of the condition. However, this Court gives greater weight to Dr. Schabacker's opinion than Dr. Heid's, and finds that Ward has CRPS, for several reasons.

¶ 79 First, Dr. Schabacker's opinion is supported by the other medical evidence in this case whereas Dr. Heid's is not. Most of the medical providers who physically examined Ward noted some of the objective signs of CRPS per the Budapest criteria, including: (1) PT Schretenthaler, who noted that Ward's left ankle was slightly cooler than his right; (2) PA-C Crane, who noted that Ward's left ankle had a "[s]lightly duskier hue" when compared to his right; (3) Dr. Aylor, who noted that Ward's left foot was cooler than his right and that Ward's left ankle had limited range of motion; (4) Dr. Flook, who noted color and temperature differences and delayed capillary refill; (5) Dr. Pyette, who noted that Ward's left foot was slightly cooler than his right; (6) Dr. Ward, who noted that Ward's left foot was "discolored," that Ward's left foot was cooler than his right, and that Ward had slow capillary refill; (7) Dr. Schellack, who observed Ward's left foot was "dusky red"; and (8) Dr. Anderson, who noted "irregular skin coloration." Dr. Schabacker's physical examination of Ward was consistent with the observations of these medical providers; he credibly testified that he observed that Ward's left ankle area was discolored, that he measured Ward's left ankle to be more than 1°C cooler than Ward's right, that he saw edema, and that his examination revealed decreased range of motion.

¶ 80 In contrast, Dr. Heid — who was the only medical provider who physically examined Ward who did not see a sign or symptom of CRPS — glossed over and downplayed the other medical providers' observations of the objective signs of CRPS. In her report, Dr. Heid randomly picked an objective sign of CRPS and would note that the provider's record did not contain that sign but omitted that the physician had noted another objective sign of CRPS. As one example, in the part of her report labeled, "Summation of History," Dr. Heid noted that Dr. Pyette "did not document any trophic changes," but omitted that Dr. Pyette noted that Ward's left foot was cooler than his right. As another example, in that same section, Dr. Heid noted that Dr. Ward "did not note any atrophy," but omitted that Dr. Ward noted color and temperature variation and slow capillary refill.

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[8] *Ford v. Sentry Cas. Co.*, 2012 MT 156, ¶ 27, 365 Mont. 405, 282 P.3d 687 (citation omitted).

[9] *See, e.g.*, *Floyd v. Zurich Am. Ins. Co. of Ill.*, 2017 MTWCC 4, ¶ 47 (citation omitted).

Because Dr. Heid knew that she was evaluating Ward to determine if he had CRPS, this Court was not persuaded by Dr. Heid's explanation that she omitted other medical providers' reports of an objective sign of CRPS to keep her report short. At trial, Dr. Heid acknowledged some of the signs of CRPS were "variably documented" in Ward's medical records, which was an understatement. While she attributed the presence of the objective signs of CRPS to Ward's "nonuse" of his left ankle, her opinion as to the cause of these objective signs cannot be reconciled with her emphasis on the lack of atrophy, which she said meant that Ward was actually using his left foot.

¶ 81 Second, this Court agrees with Dr. Schabacker that Dr. Heid's report unfairly painted Ward in a negative light, which shows a lack of objectivity. For example, Dr. Heid emphasized that the first MRI of Ward's ankle was normal and at least implied that she did not think he suffered any ankle injury. However, Dr. Robinson explained that MRIs are not perfect, that a ligament that is stretched and lengthened can appear normal on an MRI, that he felt instability in Ward's ankle during his physical examination, and that he had to reattach a ligament that had torn off the bone during surgery, which did not appear on the MRI. This Court is convinced that Dr. Robinson accurately diagnosed Ward's ankle injury.

¶ 82 Third, Dr. Heid heavily relied on Dr. Stratford's diagnosis of SSD. However, this Court gives no weight to Dr. Stratford's differential diagnosis of SSD for two reasons.

¶ 83 First, like Dr. Heid, Dr. Stratford disregarded the objective signs of CRPS in Ward's medical records. Dr. Stratford admitted that he relied exclusively on Dr. Heid's examination and "questioned" the other medical providers' observations of some of the objective signs of CRPS, which shows a lack of objectivity. Dr. Stratford offered no legitimate basis for questioning the observations of the other medical providers. This Court is convinced that the other medical providers accurately and honestly documented what they saw. Dr. Stratford also conceded that SSD is a psychiatric condition and is <u>not</u> the cause of physical symptoms including color variation between limbs, temperature variation between limbs, swelling, delayed blood flow, or a loss of range of motion. Dr. Stratford did not offer a plausible explanation as to the cause of these objective signs.

¶ 84 Second, Dr. Stratford admitted a bias against CRPS. This Court is convinced that due to Dr. Stratford's belief that CRPS does not exist, his diagnosis of SSD from "pre-existing personality issues" was not an impartial diagnosis based on his examination and testing; rather, his diagnosis of SSD was a result of confirmation bias. I.e., because of his belief that Ward did not have a physical problem, Dr. Stratford compared his test results to the average and concluded that Ward's levels of functional complaints, worry, and disability perception were "excessive." However, Dr. Stratford acknowledged in his report and at trial that it would be normal for a person who actually has an ongoing physical problem to complain, to worry, and to perceive himself as disabled. This Court is convinced that Ward suffers from the symptoms and signs of CRPS; thus, there is no evidence from which this Court could find that Ward's psychological response was

excessive. In fact, this Court is persuaded by Dr. Schabacker's testimony that Ward's psychological response is typical of a CRPS patient.

¶ 85 Taken together, Dr. Heid and Dr. Stratford reached their respective opinions based upon collaborative circular reasoning. Dr. Heid relied on Dr. Stratford's opinion that Ward had SSD to conclude that Ward did not have CRPS under the Budapest criteria because she thought SSD better explained Ward's symptoms. However, at the same time, Dr. Stratford relied upon Dr. Heid's opinion that Ward did not have CRPS to determine that Ward had SSD. In short, they each worked backwards; i.e., they started with the conclusion that Ward had a psychological condition and not CRPS and looked for evidence to support a diagnosis of a psychological condition, while ignoring the evidence supporting the other physicians' diagnoses of CRPS. While it is important for physicians to consider differential diagnoses, this Court is not persuaded by an approach in which the differential diagnosis is a foregone conclusion.

¶ 86 Accordingly, this Court finds that Ward has CRPS, caused by his December 13, 2016, industrial accident.

CONCLUSIONS OF LAW

¶ 87 This case is governed by the 2015 version of the Workers' Compensation Act since that was the law in effect at the time of Ward's industrial injury.[10]

Issue One: Whether Petitioner is entitled to acceptance of liability for his February 15, 2016, claim?

¶ 88 Ward takes issue with Victory's adjusting because it paid benefits under § 39-71-608, MCA, beyond the time allowed by Montana law. However, this issue is moot because this Court has found that Victory ultimately accepted liability for Ward's February 15, 2016, claim.

Issue Two: Whether Petitioner is entitled to acceptance of liability for his December 13, 2016, claim?

¶ 89 This issue is moot because this Court has found that Victory accepted liability for Ward's December 13, 2016, claim on May 12, 2017.

Issue Three: Whether Respondent is liable for Petitioner's alleged Complex Regional Pain Syndrome, or a similar condition, which Respondent disputes exists?

[10] *Ford*, ¶ 32 (citation omitted); § 1-2-201, MCA.

¶ 90 Because this Court has found that Ward has CRPS arising out of the course of his employment on December 13, 2016, Victory is liable for Ward's CRPS under § 39-71-407, MCA.

Issue Four: Whether Petitioner is entitled to payment of incurred medical treatment costs?

¶ 91 Because this Court has found that Ward has CRPS arising out of the course of his employment on December 13, 2016, Ward is entitled to payment of medical benefits under § 39-71-704, MCA. This includes the medical benefits for Ward's appointments with Dr. Ward and Dr. Schellack, to whom Ward was referred for treatment of CRPS.

Issue Five: Whether Petitioner is entitled to any further medical benefits at this time?

¶ 92 Because this Court has found that Ward has CRPS arising out of the course of his employment on December 13, 2016, Victory is liable for Ward's future medical benefits under § 39-71-704, MCA.

Issue Six: Whether Petitioner is entitled to any further indemnity benefits at this time?

¶ 93 The parties settled the dispute over Ward's entitlement to TTD benefits from December 13, 2016, to February 16, 2017. Victory paid TTD benefits from February 17, 2017, to January 26, 2018. Ward resumed working on May 30, 2018.

¶ 94 Victory terminated Ward's TTD benefits on January 26, 2018, on the basis of Dr. Heid's, Dr. Stratford's, and Dr. Aylor's opinions that Ward did not have CRPS, was at MMI, and could return to work. However, because this Court has found that Ward has CRPS arising out of the course of his employment, was not at MMI at that time, and there is no persuasive evidence that Ward was released to physically return to the work in which he was engaged at the time of injury, Victory is liable for TTD benefits from January 27, 2018, to May 29, 2018, under § 39-71-701, MCA.

Issue Seven: Whether Petitioner is entitled to his attorney fees, costs, and/or a penalty?

¶ 95 Since Ward is the prevailing party, he is entitled to his costs under § 39-71-611, MCA.

¶ 96 Ward is not entitled to his attorney fees under § 39-71-611, MCA, nor a penalty under § 39-71-2907, MCA, because this Court has found that Victory's denial of liability for Ward's CRPS was reasonable.

JUDGMENT

¶ 97 Ward sustained a compensable left-ankle injury on February 15, 2016.

¶ 98 Ward sustained another compensable left-ankle injury on December 13, 2016, that being CRPS.

¶ 99 Victory is liable for past and future medical benefits for Ward's CRPS under § 39-71-704, MCA.

¶ 100 Victory is liable for TTD benefits from December 27, 2017, to May 29, 2018, under § 39-71-701, MCA.

¶ 101 Ward is entitled to his costs pursuant to § 39-71-611, MCA.

¶ 102 Ward is not entitled to his attorney fees under § 39-71-611, MCA, nor a penalty under § 39-71-2907, MCA.

¶ 103 After awarding Ward his costs, this Court will certify this Judgment as final.

DATED this 7th day of August, 2019.

(SEAL)

/s/ DAVID M. SANDLER
JUDGE

c: Thomas J. Murphy and Matthew J. Murphy
Jon T. Dyre

Submitted: July 11, 2018