IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2021 MTWCC 16

WCC No. 2020-4954

CANDIDA KREZELAK

Petitioner

vs.

INDEMNITY INS. CO. OF NORTH AMERICA

Respondent/Insurer.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND JUDGMENT

Summary: Petitioner was in a work-related MVA. Respondent accepted liability for strains/sprains to her entire back, including her neck and shoulders. Respondent denied liability for Petitioner's L4-5 condition, bilateral cubital tunnel syndrome, and left carpal tunnel syndrome, which were diagnosed months to years later. Petitioner argues that these later-diagnosed conditions were encompassed in Respondent's acceptance and that its denials were an attempt to "unaccept" liability without legal justification. Alternatively, Petitioner argues that she has met her burden of proof, that the MVA caused or permanently aggravated these conditions, with the opinions of her treating physicians. Petitioner also argues that Respondent's denials were unreasonable because its investigation was inadequate. Respondent argues that it did not attempt to "unaccept" liability for Petitioner's L4-5 condition, because it did not even know about, let alone accept, that condition in the first place. Respondent argues that Petitioner has failed to meet her burden of proof, that the MVA caused or permanently aggravated her L4-5 and arm conditions, based on the opinions of its IME physician. Respondent also argues that its denials were reasonable because its investigation was thorough.

Held: Respondent is not liable for Petitioner's conditions under the theory that its denials were an attempt to "unaccept" liability without legal justification. Respondent's denials were not an attempt to "unaccept" liability, because it did not even know about, let alone accept, those conditions in the first place. However, Respondent is liable for Petitioner's L4-5 condition and her left cubital tunnel syndrome because she met her burden of proof

with respect to those conditions. I.e., this Court was persuaded by Petitioner's treating physicians, who opined that the MVA caused or permanently aggravated her L4-5 condition and her left cubital tunnel syndrome. And, because Petitioner prevailed on these claims, Respondent is liable for her costs. Nevertheless, because Respondent's denials were reasonable, Respondent is not liable for Petitioner's attorney fees or a penalty. Respondent is not liable for Petitioner's right cubital tunnel syndrome or left carpal tunnel syndrome because Petitioner offered insufficient medical opinion evidence that the MVA caused or permanently aggravated those conditions.

¶ 1 The trial in this matter was held on October 20 and 21, 2020, in Helena, Montana. Matthew J. Murphy and Thomas M. Murphy represented Petitioner Candida Krezelak. Joe C. Maynard and Marina Tucker (f/k/a Marina Horsting) represented Respondent Indemnity Ins. Co. of North America (Indemnity).

¶ 2 Exhibits: This Court admitted Exhibits 1 through 78 without objection.

¶ 3 Witnesses and Depositions: This Court admitted the depositions of John VanGilder, MD; Emily Heid, MD; Kitrina Paddock; Laura LeBlanc; Stormy Flinders; Pat Anderson; Mike Anderson; Teri Bohnsack, CPCU; and Candida Krezelak into evidence. Candida Krezelak and Phillip M. Steele, MD, were sworn and testified at trial.

¶ 4 Issues Presented: This Court restates the issues set forth in the Pretrial Order as follows:

> Issue One: Was Krezelak's L4-5 condition caused or permanently aggravated by the motor vehicle accident?
>
> Issue Two: Was Krezelak's bilateral cubital tunnel syndrome caused or permanently aggravated by the motor vehicle accident?
>
> Issue Three: Was Krezelak's left carpal tunnel syndrome caused or permanently aggravated by the motor vehicle accident?
>
> Issue Four: Is Krezelak entitled to costs, attorney fees, and a penalty for this action?

FINDINGS OF FACT

¶ 5 This Court finds the following facts by a preponderance of the evidence.[1]

¶ 6 At all relevant times, Krezelak was a nurse and married mother of four.

[1] The claimant bears the burden of proving by a preponderance of the evidence that she is entitled to the benefits she seeks. *Dumont v. Wickens Bros. Constr. Co.*, 183 Mont. 190, 201, 598 P.2d 1099, 1105-06 (1979) (citations omitted).

¶ 7 Since around 2000, Krezelak has smoked on and off, anywhere from "socially" to a pack of cigarettes per day. During that period, she has quit smoking several times.

¶ 8 In September of 2009, Krezelak had no significant medical history other than depression.

¶ 9 On September 25, 2009, Krezelak suffered a low-back strain while trying to lift a patient in the operating room. A lumbar MRI around that time showed L4-5 degenerative disc disease with mild desiccation and no definite disc herniation, and some neuroforaminal narrowing at L5 on the left. Krezelak treated with physical therapy. By January of 2010, she was pain free and cleared to return to work full duty with no restrictions.

¶ 10 Between 2010 and 2016, Krezelak had intermittent flares of SI joint and bilateral hip pain, during which she felt like her hip was coming out of place. Nevertheless, she never sought treatment for this as she could relieve it with stretching.

¶ 11 In September of 2012, Krezelak began working as a nurse case manager for Coventry HC Workers Comp., Inc. (Coventry). Her job involved distance driving and long hours – up to 1,000 miles and 80 hours a week, respectively. She went to appointments with patients in different cities during the day and updated their charts at home after her kids went to bed.

¶ 12 During the first week of April 2016, Krezelak started an eight-week personal training program at the trainer's studio, which included running, doing exercises like planks and pushups, and lifting weights. Krezelak was faithful in attending her training sessions, which occurred three days a week. She also worked out at a gym and power-walked several miles a day, several days a week.

¶ 13 On April 28, 2016, Krezelak was in a high-speed, single car, motor vehicle accident (MVA) while coming home from an appointment for work. Her car hit slush and started spinning. Fearing a rollover, Krezelak tightened her grip on the steering wheel and locked her arms straight out in front of her. Her car eventually went off the road and crashed into a fence.

¶ 14 Krezelak was still in shock when she refused an ambulance ride and told a highway patrol officer she was okay and would ride home with her husband. But a few hours later, she started feeling sore everywhere, particularly in her left shoulder and mid back. Before the MVA, Krezelak had never had problems with or treatment for her neck or arms.

¶ 15 The evening of the MVA, Krezelak submitted an electronic First Report of Injury to Coventry, indicating that she was planning to seek medical treatment.

¶ 16 The next morning, Krezelak replied to an e-mail from Coventry, stating that she intended to seek treatment for the soreness in her "upper, middle, and lower back . . . as

well as both of [her] shoulders." That day, she also developed paresthesias in her left fourth and fifth fingers.

¶ 17 On May 2, 2016, Krezelak had an appointment with Abbey Barnhart, PA-C, for MVA-related pain. Prior to being examined, Krezelak filled out a symptom diagram, which read, in part: "Include all affected areas and be sure to mark radiating pain." She indicated burning in her left shoulder and numbness in her left-arm and -hand. Although she also had mid-back soreness, Krezelak made no indication of it on the diagram. Krezelak filled out at least seven more such diagrams over the next year and, likewise, made no indication of low-back or leg pain, despite having intermittent symptoms in both.

¶ 18 Once in the exam room, Krezelak told Barnhart that, notwithstanding some mid-back soreness, most of her discomfort was around her left shoulder. As is her tendency, Krezelak downplayed her symptoms, rating her pain at a 1.5 out of 10. Krezelak also reported that she had had some low-back pain that resolved on its own shortly after the MVA, although it ended up coming back soon after the MVA and then intermittently over the next year plus.

¶ 19 After examination, Barnhart assessed Krezelak as having a cervicothoracic strain. Barnhart was also concerned about a finding unrelated to the MVA, which took ultrasounds, x-rays, CT scans, and multiple appointments over several months for Krezelak to resolve.

¶ 20 After her initial appointment, Krezelak continued to treat with Barnhart into August of 2016. Her complaints included neck discomfort that went into her left shoulder, right-shoulder soreness, and numbness and tingling that went down her left arm and into her fourth and fifth fingers. Barnhart assessed her as having cervicothoracic strain, right myofascial shoulder pain, and cervicogenic left upper extremity radicular symptoms, including in an ulnar distribution in her left hand.

¶ 21 Because Krezelak's left-arm and -finger numbness was affecting her work — the placement of her arms while typing and driving made it worse[2] — she treated with a physical therapist during the same period. The physical therapist noted that Krezelak's symptoms appeared to stem from both her neck and a peripheral nerve irritation at her elbow. The physical therapist devised a treatment program, which made use of manual traction techniques and a home exercise program.

¶ 22 On May 6, 2016, the first time Krezelak spoke with an adjuster from Indemnity, she not only complained of pain in her neck but also pain in her back. Around the same time, Krezelak's husband noticed that her low back and hip were giving her trouble when she ran and, along with Krezelak's dad and several of her friends, that she was finding it hard to get comfortable in the bleachers during her kids' lacrosse games.

[2] Barnhart's notes intermittently and errantly describe Krezelak's problems as being right-sided.

¶ 23 At first, Krezelak's pain was a dull ache in her low back but, depending on what she was doing, it worsened and moved into different areas, including her SI joints, her hips, her buttocks, and her legs. When her hips hurt, it was not the dislocating sensation she had had before the MVA; it was a radicular pain. These symptoms got worse over time.

¶ 24 On the morning of May 9, 2016, Krezelak returned to the gym for the first time since the MVA. Her hip pain flared up while she was there jogging.

¶ 25 The same day, at an appointment with her primary care provider that was unrelated to the MVA, Krezelak also mentioned her hip pain, describing it as shooting down the front of her leg. After examination, her doctor opined that Krezelak had strained her hip flexor. Krezelak did not bring up the problems she was having with her neck, and left-shoulder and -arm, because she did not think she should mention injuries arising from her industrial accident.

¶ 26 Krezelak stopped going to the gym after that but tried to keep up with her personal training sessions. The trainer helped Krezelak modify the exercises to accommodate her arm and hip. However, around mid-May, noting a decline in Krezelak's attendance and performance, the trainer asked her to get medical clearance before resuming the program. Because she felt that her pain would not allow her to continue, Krezelak just stopped going to the studio.

¶ 27 Krezelak did, however, continue doing the physical therapist-prescribed home exercise program for her neck and left arm. She also lost weight to manage her SI joint and hip pain on her own.

¶ 28 Over the summer of 2016, Krezelak took walks with friends. One friend observed that Krezelak needed to stretch her low back and hip at or near the end of each walk to deal with her pain in those areas, and that, as Krezelak's pain worsened, their walks got slower and shorter.

¶ 29 Notwithstanding her months-long physical therapy treatment, Krezelak's left-arm symptoms persisted. When a cervical MRI failed to explain them, Barnhart referred her to the physician with whom she worked, Phillip M. Steele, MD.

¶ 30 At her first appointment of many with Dr. Steele on August 30, 2016, Krezelak complained of constant occipital headaches, in addition to "myofascial tenderness to the neck and radicular symptoms down the [left] arm to the fifth and fourth finger." As part of his examination, Dr. Steele palpated Krezelak's back. He noted that her thoracic and lumbar spine were nontender and that when he moved her neck, her lumbar spine and lower leg were "negative for radiculopathy neuropathy."

¶ 31 Dr. Steele performed a diagnostic ultrasound of Krezelak's neck, which, although it did not explain Krezelak's left-sided symptoms, revealed several variations of normal

anatomy in her neck, each of which, he opined, could cause pathology following an injury. Specifically, he noted that the "natural" state of Krezelak's neck was to have "a degree of neural tension" created by her C5 nerve root variation. He opined that the neck sprain Krezelak suffered in the MVA, which he later termed a brachial plexus stretch or whiplash, aggravated that preexisting state by damaging her scalene muscle fibers and creating swelling that impinged her C5-6 nerve roots. Dr. Steele further opined that Krezelak's left-shoulder pain was "most likely a referral pain pattern from the cervical spine or brachial plexus."

¶ 32 Dr. Steele diagnosed Krezelak with "[c]ervical spine pain, strain/sprain, [and] [s]pinal accessory . . . [and] [l]esser occipital nerve entrapment."

¶ 33 Notwithstanding that Krezelak never received a formal acceptance letter, her claim file indicates that on September 13, 2016, Indemnity determined her "[c]laim [was] compensable for strain/sprain to entire back, including neck and bilateral shoulders," and that her accepted diagnoses were "cervical spine pain, strain/sprain [and] spinal accessory . . . [and] lesser occipital nerve entrapment."

¶ 34 Although Krezelak's low-back pain bothered her more over time, and she saw Dr. Steele regularly, Krezelak did not seek treatment for it for nearly 16 months after the MVA. She delayed this treatment because she figured if she could manage her low-back pain on her own, whatever was causing it was not that serious.[3] She was also busy attending to other serious medical problems that were bothering her more. And she did not want to trouble Dr. Steele with issues for which she had not been referred. Indeed, Dr. Steele's office asked patients to make separate appointments for issues that were not on the schedule and would not treat workers' compensation and non-workers' compensation issues together.

¶ 35 On September 16, 2016, Dr. Steele injected Krezelak's left dorsal scapular and long thoracic nerves.

¶ 36 At her November 11, 2016, follow-up appointment with Dr. Steele, Krezelak reported that the injections had worked well for her left-shoulder pain but not her left fourth- and fifth-finger numbness. Dr. Steele opined that Krezelak's residual symptoms could be the result of a double-crush type phenomenon, i.e., an injury to her elbow in addition to her neck. Indeed, he observed "some compression [of her ulnar nerve] between the two heads of the flexor ulnar tendon" on ultrasound. Dr. Steele alternatively hypothesized that her symptoms could be related to an "older nerve issue" he did not know about that was exacerbated by the MVA. Dr. Steele recommended a night-time cubital tunnel brace and a topical pain reliever for her left arm to resolve her symptoms.

[3] Krezelak testified that, as a nurse, she thought that "if you could relieve your symptoms by simple things like stretching, or changing position, that it wasn't a significant injury."

¶ 37 Following that appointment, Indemnity accepted liability for Krezelak's "radicular symptoms leading to her left cubital tunnel," as a claim-related "exacerbation."

¶ 38 Dr. Steele noted that, in mid-December 2016, Krezelak was doing "extremely well" in terms of her left-arm symptoms, but he was "expecting one or two exacerbations per year." And, by the end of the year, Krezelak was again complaining of left cubital tunnel pain and left fourth-finger numbness and tingling. Dr. Steele noted that her left cubital tunnel was "tender on palpation of the ulna[r] nerve" and that the ultrasound he performed showed "evidence of ulna[r] nerve entrapment." Dr. Steele injected Krezelak's left ulnar nerve and diagnosed her with "[c]ubital tunnel/ulna[r] nerve neuropathy/radiculopathy."

¶ 39 By the end of the year, Krezelak had stopped walking with her friends due to low-back pain. While the pain was not affecting her on a day-to-day basis, she was starting to notice that prolonged standing, sitting, and walking would bring it on.

¶ 40 For the first several months of 2017, another serious, painful health condition, unrelated to the MVA, commanded much of Krezelak's focus. When she had surgery to address its symptoms in early April, Krezelak reported "SI joint [and] bilat[eral] hip pain occasionally," which she used "PT/stretching" to relieve.

¶ 41 By mid-February 2017, Dr. Steele noted that: Krezelak's neck symptoms had resolved; her chronic left-shoulder pain, which he continued to opine was caused by C5 nerve root "compression and swelling" from her whiplash, was significantly better; and her left cubital tunnel was no longer symptomatic on palpation. However, he documented that Krezelak still had some left-hand and -finger symptoms, which he opined were "[c]ertainly . . . exacerbated with this accident." Dr. Steele recommended a bilateral EMG.

¶ 42 Krezelak had the EMG-Nerve Conduction Study with John V. Stephens, MD, in early March 2017. Dr. Stephens found nerve conduction evidence for left ulnar nerve entrapment at the elbow. However, he found "no nerve conduction evidence for right ulnar nerve entrapment at the wrist or elbow," "no nerve conduction evidence for median nerve entrapment at wrists or elbows bilaterally," and "no EMG evidence to suggest a cervical radiculopathy, nor brachial plexopathy either right or left."

¶ 43 By the next time she saw Dr. Steele, on April 25, 2017, Krezelak was tired of going to doctors' appointments and having the extra stress in her life, and she just wanted to be done with her claim. Her left ulnar nerve neuropathy had resolved, and Dr. Steele noted, "At this time she is pain free with no other symptoms." Dr. Steele placed Krezelak at maximum medical improvement (MMI) and released her to return to work without restrictions or an impairment rating. He further noted that he did not anticipate needing to see Krezelak again unless she had a "re-injury or new injury."

¶ 44 Accordingly, on May 8, 2017, Teri Bohnsack, the claims adjuster assigned to Krezelak's case, notified her that she would have to seek preapproval for any future treatment.

¶ 45 Around this time, however, Krezelak's mother noticed that Krezelak "really started having problems" with her low back. She could just "see [it] in the way [her daughter] moved." Nevertheless, Krezelak continued with many of her recreational activities.

¶ 46 In late May and June of 2017, Krezelak took two trips of a personal nature. Both involved prolonged sitting and walking — though no injuries — and she suffered significant flareups of low-back, hip, and leg pain. She thought her SI joints were out of place.

¶ 47 But in August of 2017, after this pain had gotten to the point where it was affecting her everyday life, Krezelak sought treatment for the first time since the MVA. On August 10, 2017, Krezelak saw Bryan Hilborn, DC. Notwithstanding Bohnsack's earlier advisement, Krezelak did not seek her approval or Indemnity's payment for the treatment because she did not know what was generating the pain and thought "a couple manipulation treatments from a chiropractor" would take care of it.

¶ 48 On Dr. Hilborn's intake questionnaire, Krezelak indicated present back, hip, and leg pain, as well as general fatigue. She also indicated past neck, shoulder, arm, and hand pain. But she did not answer questions about any of her other health conditions. Krezelak wrote that she was seeking treatment for buttock/hip pain radiating down her leg, which was worse with prolonged walking and standing. She noted that she had had similar symptoms after her lifting injury but that her current symptoms had started "2 yrs ago" and were "getting worse."

¶ 49 Dr. Hilborn documented that prolonged sitting and walking "a couple of months ago" — during Krezelak's personal summer travel — had led to "dull/shooting pain" in her low back, which radiated into her hip and leg. He noted that her discomfort had gotten worse since then. On spinal examination, Dr. Hilborn observed segments with, among other characteristics, misalignment, restricted range of motion, inflamed soft tissue, muscle spasms, and active and latent trigger points. He diagnosed Krezelak with lumbago, right-sided sciatica, and lumbar, sacral/pelvic, and thoracic subluxation.

¶ 50 Krezelak saw Dr. Hilborn several more times. But she ended her treatment with him at the end of August because she found that his treatments were providing only temporary relief.

¶ 51 Krezelak sought no additional low-back treatment over the next eight months. In the interim, she dealt with a chronic health condition and a host of other painful health problems — unrelated to the MVA — that eventually led to another surgery in November of 2017. In her pre-operative paperwork for that surgery, Krezelak indicated she had back problems, including sciatica and bilateral hip pain.

¶ 52 Over the winter, Krezelak's back pain continued to be an issue for her; she was able to ski some, but the pain required her to take easy runs and frequent breaks. But

she was also plagued with a post-surgical infection that was difficult to treat and did not start to improve until the spring of 2018.

¶ 53 On May 3, 2018, Krezelak returned to see Dr. Hilborn. She reported that "she had slept wrong a few weeks prior," and that she had had pain in her low back that radiated across her lumbar sacral region ever since. She indicated that being in any position for too long increased her symptoms.

¶ 54 Over the summer of 2018, Krezelak had low-back pain with radiation down her leg; she was unable to hike or water ski as a result. The pain was worsening to the point where she was having trouble managing it.

¶ 55 At some point that summer, Krezelak also experienced a "re-exacerbation" of her C5-6 nerve root impingement. She had had significant relief from her last injections for more than a year, during which her left-upper extremity symptoms were only on and off. But with the re-exacerbation, which, according to Dr. Steele "can occur from time to time," her neck and left-arm symptoms, including pain and tingling and numbness, began coming back.

¶ 56 In late September and October of 2018, Krezelak treated with Sheridan Levi Jones, DC, for lumbar pain with sciatica, and neck and left-shoulder pain with radiating tingling and numbness in her fourth and fifth fingers.

¶ 57 As to her low back, Krezelak told Dr. Jones that she had had pain on and off for years. Although she mentioned her lifting injury and the MVA, she said she was not sure what caused it. Krezelak reported that her low-back pain was worse with prolonged walking and sitting. Dr. Jones noted that she wanted to start jogging again but that "even walking is horribly painful right now." Dr. Jones ordered lumbar spine x-rays, which showed disc narrowing at Krezelak's L4-5.

¶ 58 As to her neck and left-upper extremity symptoms, Krezelak ultimately stopped treating with Dr. Jones in October because "she did not feel it was helping"; although her pain improved, her tingling and numbness did not.

¶ 59 At Krezelak's request, Bohnsack approved a one-time appointment with Dr. Steele, on October 15, 2018, for possible injection after the return of her neck and left-arm pain and numbness. On physical examination, Dr. Steele noted "pain and tenderness in the distribution of the C5 nerve root[,] [and] [s]ome [left] shoulder tightness and pain with radicular arm symptoms." He found the examination of her right side to be "normal." With ultrasound guidance, Dr. Steele performed a C5-6 brachial plexus injection. The injection improved the cramping in Krezelak's left shoulder and the pain that went down her left arm but not her finger numbness.

¶ 60 On October 26, 2018, Krezelak had a follow-up lumbar MRI ordered by Dr. Jones. The radiologist's impression was that she had a subligamentous disc herniation at L4-5,

with compromise of the right nerve root recess and foramina and mild compromise of the left side.

¶ 61 It was only when Krezelak learned of the MRI findings that she put together in her own mind that: this was a significant low-back injury, it must have been caused by trauma, and that trauma was probably the MVA.

¶ 62 Krezelak asked for Dr. Jones's opinion as to whether her low-back pain could be related to the MVA, but he told her he did not have enough information to form an opinion. He referred her for bilateral L4-5 epidural steroid injections (ESI), which she underwent on November 6, 2018. Thereafter, her low-back pain and buttock/leg symptoms became constant.

¶ 63 Krezelak decided to seek Dr. Steele's opinion about the cause of her low-back pain. Despite its policy against combining office visits, Dr. Steele's office gave her permission to raise the issue at her next scheduled appointment, which was for her left arm, because her back was an "accepted" part of her claim.

¶ 64 At her appointment on November 15, 2018, Krezelak told Dr. Steele about her lumbar spine pain for the first time. She reported that the pain dated back to her lifting injury, but that, after resolving with physical therapy, it got progressively worse again with intermittent symptoms after the MVA.

¶ 65 Dr. Steele's physical exam included motor and muscle strength tests and was negative for radiculopathy. He compared Krezelak's 2009 and 2018 MRIs and noted "dramatic" changes; of the 2018 MRI, he noted that the L4-5 disc space was heavily damaged and had "Modic changes in progress." He ordered bloodwork and a bone mineral density study to exclude any "infectious etiology" or "autoimmune process." Dr. Steele then noted that the rest of the 2018 MRI was "fairly stable" and that it was "just the L4-L5 level which most likely clinically became unstable back with her original work place injury and was exacerbated by the motor vehicle accident." He diagnosed Krezelak with low-back pain, degenerative disc disease at L4-5, and a possible concurrence between her chronic health condition and a spine-related phenomenon.

¶ 66 Meeting with Dr. Steele and hearing his thoughts about her low back gave Krezelak confidence about the connection between the herniation and severe degeneration of her L4-5 disc (L4-5 condition) and the MVA.

¶ 67 After the appointment, Krezelak e-mailed Bohnsack, explaining for the first time that, after the MVA, she had had a recurrence and progressive worsening of low-back pain, which was originally from her lifting injury. She wrote that she had undergone various treatments and that her doctor opined her condition was a "permanent aggravation" of her lifting injury. Krezelak said that she did not mention this sooner because her primary concern had been her cervical spine and left-shoulder and -arm pain.

¶ 68 During a recorded statement on November 19, 2018, Krezelak told Bohnsack that since she had had sporadic hip and SI joint pain since her lifting injury, she had automatically attributed any low-back pain to that, even after the MVA.

¶ 69 On November 21, 2018, Krezelak saw neurosurgeon John VanGilder, MD, at Dr. Jones's request, complaining of constant low-back pain since her ESIs several weeks earlier. On his intake forms, Krezelak indicated that she had back pain and difficulty walking at times, but she also noted that she had health conditions unrelated to her low back. While she denied smoking at present, she indicated that she had previously smoked. Dr. VanGilder noted that Krezelak told him that she had been having intermittent symptoms since the MVA that were getting worse. He also noted that she could walk only about 1/8 of a mile before needing a break.

¶ 70 During physical examination, Dr. VanGilder documented a negative straight leg raise bilaterally, lower lumbar and paralumbar tenderness, decreased range of motion, and decreased sensation in the leg. He reviewed her 2018 MRI and noted, "She has a degenerative disc at the L4-5 level with a slight slip and a disc herniation causing compression of both L5 nerve roots, more so on the right." He then introduced different treatment options, including physical therapy, repeat injections, and surgery.

¶ 71 Krezelak moved ahead with physical therapy on December 5, 2018. The therapist noted that Krezelak had had low-back pain since her lifting injury and that it increased after the MVA. On examination, the therapist noted major movement loss in her lumbar spine, but no lower-extremity strength deficits. He diagnosed her with "[l]umbosacral dysfunction due to disc involvement, right pelvic up-slip, and anterior and left posterior innominates" and wanted Krezelak to come in several times a week for eight weeks.

¶ 72 On January 11, 2019, Krezelak saw Jamie E. Mashek, PA-C, for evaluation of her low back. Mashek noted that Krezelak's pain began with a lifting injury, where she bulged the disc at L4-5, eventually resolved, and began again after the MVA. She complained of constant low-back pain since her ESIs, as well as bilateral leg pain. Mashek reviewed Krezelak's 2018 lumbar MRI and referred her to Allen Weinert, MD, for repeat bilateral L4-5 transforaminal ESIs, which were scheduled for January 23, 2019.

¶ 73 On January 12, 2019, Krezelak was examined by Emily Heid, MD, pursuant to § 39-71-605, MCA.

¶ 74 On January 25, 2019, Krezelak had another MRI of her lumbar spine. The radiologist's impression was: "[d]egenerative disc disease . . . at L4-5 with stable appearing posterior disc osteophyte complex and neural foraminal narrowing. No spinal canal narrowing in the lumbar spine. Spondylolisthesis." Krezelak was diagnosed with lumbar radiculopathy.

¶ 75 On January 28, 2019, Krezelak returned to see Dr. Steele about her low-back pain. The medical assistant noted that Krezelak had constant pain with numbness and pins

and needles in one foot and shooting pain down the other. Dr. Steele reviewed the 2019 lumbar MRI and characterized it as showing "worsening disc herniation and worsening desiccation of the disc at L4-L5." He noted:

> Of importance is that the lumbar spine is showing rapid desiccation compared to her past study. I reviewed her older study. This rapid desiccation is suggestive of worsening injury from her motor vehicle accident, sprain/strain/tear of the ligament structure creating worsening instability and spondylosis and spondylolisthesis further breaking down the lumbar spine. For her relatively small size it is a pretty impressive lumbar scan in terms of the disc desiccation. The upper levels are beautiful. It is just incredibly well hydrated and completely normal. This would require some sort of trauma to create this amount of desiccation and injury.

Dr. Steele opined, "I do believe that the low back has been exacerbated by this motor vehicle accident and certainly breaking down rather quickly would certainly explain her worsening back pain." He diagnosed Krezelak with "chronic low back pain."

¶ 76 The same day, January 28, 2019, Krezelak returned to see Dr. VanGilder. Together, they "reviewed the MVA as the cause" of her hip and leg issues and that the 2019 lumbar MRI was "without much change" from the one in 2018. Notwithstanding, he noted that Krezelak's symptoms continued to worsen with nonsurgical management to the point of limiting her ambulation and affecting her quality of life. He presented the option of a surgical L4-5 decompression and fusion. Krezelak felt she had no other option than to proceed with surgery.

¶ 77 On February 4, 2019, Dr. Heid told Bohnsack by phone that, in her opinion, Krezelak's "lower back is not related" to the MVA. Bohnsack denied Dr. VanGilder's request for authorization for Krezelak's low-back surgery the same day. The factors she considered in making her decision included that: (a) Krezelak said her low-back pain had resolved at her May 2, 2016, appointment; (b) she sought no treatment for her low back in the first 16 months post-MVA; (c) she did not mark low-back pain on a year's worth of symptom diagrams; and (d) she first notified Bohnsack of a low-back claim on November 15, 2018, which was two and a half years post-MVA and one and a half years after she was pain-free at MMI.

¶ 78 The next day, February 5, 2019, Bohnsack denied Dr. Steele's request for authorization to refer Krezelak to a different surgeon to discuss another approach to lumbar spine fusion. While Bohnsack noted in her denial that Krezelak's "low back/lumbar spine [was] not an accepted body part for this claim," what she intended to convey was that: (a) the accepted condition was Krezelak's low-back strain/sprain; (b) Krezelak reached MMI on April 25, 2017; and (c) almost three years post-injury, Indemnity was not accepting whatever condition Krezelak had that required lumbar fusion surgery.

¶ 79 On February 12, 2019, Bohnsack received Dr. Heid's independent medical examination (IME) report.

¶ 80 In her report, Dr. Heid concluded that although Krezelak had an "[e]pisode" of "nonspecific neck pain/nonspecific left upper extremity pain without verifiable radiculopathy or myelopathy" after the MVA, it was "unrelated" to the MVA.[4] Still, she noted that the episode was completely resolved with 0% impairment about a year after the MVA, on April 25, 2017, and that there were no further documented neck/upper back/left upper extremity symptoms for another 17 months, until September 24, 2018. Dr. Heid also noted that Krezelak had a history of left ulnar nerve irritation at the elbow, which "Dr. Steele attributed . . . to the MVA of 4/2816 (sic) and documented resolution 4/25/17."

¶ 81 As to Krezelak's low back, Dr. Heid diagnosed her with "nonspecific low back pain with lumbar degenerative disc disease," and opined that because there was no temporal connection between the MVA and her symptoms, the MVA was neither the cause nor a substantial contributing factor. She opined that "there is not a credible injury model of low back pain" and that psychosocial factors, including "psychological distress," "disputed compensation issues," "other types of chronic pain," and "job dissatisfaction," "should be routinely assessed in patients with low back pain," including Krezelak.

¶ 82 Nor did Dr. Heid think that Krezelak's MVA aggravated or exacerbated any pre-existing conditions. She explained that "[m]inor trauma has not been demonstrated to result in degenerative changes of the spine becoming symptomatic" and "[e]ndplate changes, severe loss of disc height, and disc herniation have not been clearly associated with low back pain." Dr. Heid opined that because findings like Krezelak's "occur in pain-free individuals, it is not possible to state with medical certainty the L4-5 degenerative disc disease is the source of pain." She opined that "[t]he disc degeneration/protrusion is a result of aging and genetics on a more probable than not basis with genetics likely the dominant factor."

¶ 83 Bohnsack sent Dr. Heid's report to both Dr. Steele and Dr. VanGilder to see if they agreed.

¶ 84 At Krezelak's February 15, 2019, appointment, Dr. VanGilder noted that, although there were some differences between the history she had given him and what was in the IME report, "The history she has given to me has not changed with the visits we have had." Krezelak's lumbar spine surgery was scheduled for the following week.

¶ 85 On February 18, 2019, Krezelak had a bone density Dexa scan at Dr. Steele's request, which revealed she had osteopenia, or a mild decrease in bone mass.

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[4] Indemnity had, however, already accepted liability for "radicular symptoms leading to [Krezelak's] left cubital tunnel" as an exacerbation or temporary aggravation. See above at ¶ 37.

¶ 86 On February 21, 2019, Dr. VanGilder responded to Bohnsack's written questions. He indicated that he disagreed with Dr. Heid's conclusion that Krezelak's low-back pain was not caused by the MVA, explaining that "from pt. history her [signs and symptoms] began [with] MVA to the point of them being symptomatic causing back and leg pain issues."

¶ 87 On February 22, 2019, Dr. VanGilder performed Krezelak's L4-5 decompression and fusion surgery.

¶ 88 After recovering from the procedure, Krezelak was much more like her old self. She was in less pain and able to return to the things she used to do, like walking with friends and sitting in the bleachers to watch her kids' sporting events.

¶ 89 On March 27, 2019, Dr. Steele responded to Bohnsack's written questions. He disagreed with all of Dr. Heid's conclusions and opined that the MVA was the cause of Krezelak's low-back problems. He opined that Modic changes and disc herniation of her magnitude were "beyond . . . normal age-related finding[s]." He continued that "[t]he Modic changes . . . suggest[ed] significant instability of the lumbar spine contributing to her chronic pain symptoms." He concluded that it was "[o]bvious[ ]" that "the events of her past injury as well as the current motor vehicle accident have contributed to [this] significant lumbar spine instability."

¶ 90 Over the summer of 2019, Krezelak had a repeat C5-6 nerve root injection. At a follow-up appointment with Dr. Steele on August 23, 2019, however, she reported that it had not worked; she was still having neck and left-shoulder pain, as well as radicular symptoms. Dr. Steele diagnosed her with "[s]prain/strain/tear to the cervical spine" — muscle fascia and tendon — cervical radiculopathy and neuropathy and referred her to Dr. VanGilder for evaluation.

¶ 91 At Krezelak's appointment, on September 6, 2019, Dr. VanGilder noted that she had pain down her left arm into her hand, with numbness and tingling in her fourth and fifth fingers and cramping pain in the thumb and first finger. He also noted that her fine motor movement was a little off when she tried to open things with her left hand. Dr. VanGilder noted that she was not having any symptoms in her right upper extremity. After physical examination and review of various imaging and electrodiagnostic reports, he referred Krezelak for an ESI at C5-6 and for an orthopedic evaluation of her left ulnar nerve.

¶ 92 On September 16, 2019, Krezelak saw Matthew D. McLaren, MD, an interventional pain specialist and anesthesiologist, for a left-sided C5-6 ESI. At a follow-up appointment a few weeks later, Dr. McLaren noted that the injection had provided moderate relief for Krezelak's neck and left-shoulder pain, and some improvement to the pain and numbness in her first and second digits, but no improvement to the numbness in her fourth and fifth digits. He diagnosed Krezelak with cervicalgia, as well as cervical radiculopathy,

spondylosis, and disc degeneration. Dr. McLaren presented several treatment options, focusing on the ulnar distribution hand numbness, for her to discuss with Dr. VanGilder.

¶ 93 On October 15, 2019, Krezelak saw Joshua L. Hudgens, MD, an upper extremity specialist, for an evaluation to find out whether there might be some peripheral nerve etiology to her numbness and tingling. Dr. Hudgens noted that, on her left side, Krezelak had numbness and tingling in her fourth and fifth fingers, consistent with possible ulnar nerve compression at the elbow, and in her thumb and index finger, which could mean carpal tunnel syndrome. He opined that Krezelak may have had a double-crush situation along with her cervical spine issues. Dr. Hudgens also noted that, on her right side, Krezelak had numbness and tingling in her fourth and fifth fingers. Because she had right-sided symptoms, in addition to left, he recommended new bilateral upper extremity EMGs.

¶ 94 On November 4, 2019, Bohnsack wrote to Dr. Hudgens with three questions concerning his request for pre-authorization for the EMGs. Dr. Hudgens responded the following day, providing Bohnsack with: Krezelak's diagnosis, i.e., bilateral upper extremity numbness and tingling with a concern of peripheral nerve entrapment; and his opinion that the diagnosis was likely, and Krezelak's need for the EMGs probably, the direct result of the MVA.

¶ 95 On November 25, 2019, Krezelak returned to see Dr. Steele about her neck and left arm; she reported concerns about tingling in the fingers of her left hand. Dr. Steele performed an ultrasound and determined that Krezelak had a C5-6 small disc bulge, median nerve compression at the carpal tunnel, and ulnar nerve compression at the cubital tunnel. He recommended a "Left Ulnar & Median Nerve Injection."

¶ 96 On December 2, 2019, Krezelak saw William E. Henning, DO, for bilateral EMG/NCS testing. His assessment included that Krezelak had incomplete ulnar nerve lesions at both elbows and right C6 and C7 radiculopathy. After comparing her two most recent EMG/NCS reports, Dr. Henning concluded that Krezelak's right ulnar nerve compression and right C6 and C7 radiculopathy were new findings. Although he opined that all her abnormal findings were mild, he also considered them all to be chronic.

¶ 97 On December 17, 2019, Krezelak returned to see Dr. Hudgens. He noted that her clinical picture was confusing. He explained that different tests had yielded different results — e.g., Dr. Hudgens' provocative testing indicated left-sided cubital and carpal tunnel, whereas the EMG testing showed bilateral cubital tunnel — and that different doctors had different opinions as to the source of her numbness and tingling — e.g., Dr. Steele opined it was peripheral nerve compression, while Dr. VanGilder opined it was her cervical spine. Dr. Hudgens ultimately diagnosed Krezelak with bilateral cubital tunnel syndrome. He told her, however, that, given her clinical picture, he could not be confident that operative release of either her cubital or carpal tunnel would relieve her symptoms.

¶ 98 On February 20, 2020, Krezelak saw Dr. Steele. She reported no left ulnar nerve pain and numbness only in her left fifth finger. Because her symptoms had improved, Krezelak declined an ulnar nerve injection. Dr. Steele diagnosed her with ulnar and median nerve neuritis.

¶ 99 On February 26, 2020, Krezelak returned to see Dr. VanGilder. He noted that "her neck [wa]s tolerable at this time with minimal symptoms," and that she had some left upper extremity numbness, which was worst in her fifth finger. He released Krezelak to return as needed.

¶ 100 On April 10, 2020, Krezelak had a telemedicine exam with Dr. Steele for follow up. She reported that she was doing well with no pain in the left arm and just numbness of the left fourth and fifth fingers. Dr. Steele recommended an ulnar nerve injection, but Bohnsack declined to authorize the procedure on April 13, 2020, without explanation.

¶ 101 On August 26, 2020, Dr. Heid issued a written Causation Analysis, concluding that neither Krezelak's left- nor right-sided cubital tunnel syndrome had been caused by the MVA.

¶ 102 Indemnity denied liability for Krezelak's right cubital tunnel syndrome. Bohnsack testified that a significant factor in that decision was that the condition was first diagnosed three and a half years after the MVA.

¶ 103 Indemnity denied liability for Krezelak's left cubital tunnel syndrome. Bohnsack testified that, at MMI, Krezelak was "pain-free" and incorrectly asserted that she had never been diagnosed with left cubital tunnel syndrome.

¶ 104 Indemnity denied liability for Krezelak's left carpal tunnel syndrome, as well.

Medical Causation or Aggravation Opinions as to Krezelak's L4-5 Condition

Dr. Heid

¶ 105 Dr. Heid is an orthopedic surgeon. She practiced general orthopedics with an emphasis on foot and ankle for 20 years. However, during that time, she frequently saw spine patients. She estimated that she has performed approximately 50 spine surgeries in her career, but none since 2004. Dr. Heid testified that the spine is both part of the neurologic and orthopedic fields of medicine but agreed that a neurosurgeon has undergone more education and training than she has and has more experience in spine medicine than she does. She reviewed Krezelak's medical records, spanning from June of 2004 to January of 2019.

¶ 106 Dr. Heid opined that Krezelak's MVA did not cause or materially contribute to her low-back pain and ultimate surgery. The basis for that opinion is multifold.

¶ 107 First, Dr. Heid testified that she diagnosed Krezelak with "nonspecific" low-back pain because it was not clear what her pain generator was. Dr. Heid determined that Krezelak's pain presentation was "benign," meaning "non-cancer, non-fracture, non-serious neurologic trauma." But before she would attribute Krezelak's low-back pain to her disc herniation, Dr. Heid testified that she would require correlating clinical exam findings, e.g., radiculopathy, an MRI showing nerve compression on the L5 nerve root, inability to heel walk, weakness in the L5 nerves like DHL dorsiflexion, numbness, loss of reflex, or diminished patellar tendon reflex.

¶ 108 Second, Dr. Heid testified that there was no objective evidence of lower-back injury in Krezelak and that none of the providers for whom she reviewed records had noted any. She testified that "medically, I have a different opinion of what's objective"; "[o]bjective means it's things that we can see, we can measure." However, Dr. Heid agreed that an MRI is a form of objective medical evidence and acknowledged that Krezelak's 2018 lumbar MRI shows "a disc herniation causing nerve compression of both the L5 nerve roots," and that her "degenerative changes have progressed."

¶ 109 Third, Dr. Heid testified that "the overwhelming majority of herniated discs just occur spontaneously in the course of everyday normal life." While she acknowledged that trauma could cause a disc herniation, she testified that it was "[o]nly in extremely rare circumstances" and whiplash could not do it. She did, however, testify that spine trauma, depending on the type, could accelerate spine degeneration and that herniation is part of the "disc degeneration process."

¶ 110 Fourth, Dr. Heid testified that, based on the "overwhelming evidence" in the medical records that Krezelak did not mention low-back or leg complaints for almost a year and a half after the accident, there is no temporal association between them. She testified that "if [Krezelak] had had an acute traumatic injury to her low back at the time of the accident, I would have expected immediate pain that would have persisted and these findings, if related to the accident, would have been found much sooner than two and a half years after the accident." Nevertheless, Dr. Heid acknowledged that "[w]hether or not [Krezelak] would seek care would depend probably on the severity of symptoms" and that "we ask the patient usually to complete [diagrams] and mark where they're having symptoms at the time." Further, Dr. Heid acknowledged that she disregarded Krezelak's self-reported symptoms of pain after the MVA, testifying that patient "self-report is not reliable" because of the problem of recall.

Dr. Steele

¶ 111 Dr. Steele is a board-certified family practice physician with additional training and certification in sports medicine. Sixty percent of his practice is spine care; thirty percent is complex nerve care, focusing on the neck and brachial plexus; and ten percent is arthritis care, including knees, hips, and shoulders. His specialty is ultrasound-guided evaluation and treatment for nerve-related conditions. One such treatment is

hydrodissection, which is ultrasound-guided injection of the fluid around the restricted nerve to open up and push away scar tissue.

¶ 112 Dr. Steele opined that Krezelak's MVA caused trauma that permanently worsened her L4-5 disc by collapsing the disc space and herniating into the spinal canal. He testified that the basis for his opinion was the large amount of degeneration from 2009 to 2018, as well as its general confinement to L4-5 level.

¶ 113 As to the 2009 MRI study, Dr. Steele testified, "her original MRI didn't really show much. It didn't really show instability, didn't show the Modic changes, the endplate changes." He testified that at L4-5, "the endplate and the disc looked healthy at that point in time." He described what he saw as "age-related wear and tear at that point."

¶ 114 However, Dr. Steele testified that, compared to the 2009 MRI, the 2018 MRI "looked like a bomb had gone off" — i.e., the L4-5 disc was herniated and there was severe degeneration, including Modic changes to Krezelak's endplates. He testified that all the nerves are in the endplates and thus opined, contrary to Dr. Heid's opinion that "endplate changes, severe loss of disc height and disc herniation have not been clearly associated with low-back pain," that changes to her endplates were what was creating Krezelak's pain.

¶ 115 Dr. Steele testified that disc degeneration or shrinkage can be caused by multiple factors, including aging, trauma, genetics, obesity, hypothyroidism, heavy labor, osteoporosis/osteopenia, and infection.

¶ 116 Dr. Steele opined that Krezelak's level of degeneration was not consistent with mere aging for a person in her mid-30s. He testified that if Krezelak's degenerative disc disease had progressed on its own to the level shown on her 2018 MRI, the 2009 MRI would have produced significant findings, but the 2009 MRI was "completely normal."

¶ 117 Dr. Steele opined that, because he did not see any anatomical variation in Krezelak's spine that would predispose her to degenerative disc disease, genetics was not a factor in her case.

¶ 118 He further opined that Krezelak's disc changes were not related to her chronic health condition, osteoporosis/osteopenia, smoking, or something else wrong with her health, because if they were, "you would predict that more than one level would be involved." Dr. Steele testified that only one level of Krezelak's spine was unhealthy; the upper levels of Krezelak's spine were "beautiful," "incredibly well hydrated," and "completely normal."

¶ 119 Dr. Steele testified, "anytime you see single level disease where the disc is just completely blown apart, there's usually some sort of trauma that's related to it." He specifically testified that neither prolonged sitting nor prolonged walking would cause that type of trauma in Krezelak. Dr. Steele testified that "the only hypothesis I have at this

point in time is trauma. And the only trauma I'm aware of happened in that car accident." Contrary to Dr. Heid, Dr. Steele opined that it would be possible for a whiplash injury to herniate a spinal disc. However, he also testified that the trauma would not have to be severe; "a small ligamentous sprain to the low back can have consequences long term."

¶ 120 As to the timing of Krezelak's lumbar pain complaints, Dr. Steele testified that he was not surprised that Krezelak was doing okay weeks after her accident but had long-term issues. He opined that she may not have sought treatment sooner for several reasons.

¶ 121 First, Dr. Steele testified that when an injury causes "ligamentous instability or structural changes to the spine, [it] can take months or years for that to start to crop back up." Dr. Steele explained, "You have an insult to an area and it changes the dynamic relationship of the spine, and over time it starts to break down." He testified that "I see this all the time in my medical practice where somebody has a car accident, does well for a couple of years and then something crops up and starts really bothering them. And the only thing we can relate it to is an old motor-vehicle trauma."

¶ 122 Second, he testified that Krezelak's low-back symptoms may not have seemed that bad in comparison to the "significant neck and shoulder complaint[s]" she had right after the MVA. He explained that "[i]n the setting of severe neck pain, a small back ache gets put on the burner. Nobody really looks at it." Although Dr. Steele generally agreed that low-level pain like Krezelak reported for her neck and shoulder would not be severe enough to distract a person from low-back pain, he also testified that "one person's 1.5 is somebody else's 7."

¶ 123 Third, Dr. Steele testified that the only problems for which Barnhart referred Krezelak to him were neck and radicular arm pain. He testified that his patients commonly "only mark the pain symptoms they're there to see me about," even though his symptom diagrams ask about "all affected areas." Moreover, Dr. Steele testified that he typically treats only one area of the body at a time; in other words, there was no sense reporting low-back pain when treatment would have had to wait until her neck problems resolved anyway.

Dr. VanGilder

¶ 124 Dr. VanGilder is a board-certified neurosurgeon. He testified that, over the years, he has treated thousands of patients with spine issues and has performed thousands of lumber spine surgeries.

¶ 125 Dr. VanGilder testified that he disagreed with Dr. Heid that a whiplash injury could not herniate a spinal disc. Indeed, he testified that he thought that all of the pathology shown on the 2018 lumbar MRI was caused or materially aggravated by the MVA. He further opined that the MVA was "the episode that made [Krezelak's low-] back symptoms

occur" and "what caused her to ultimately need surgery." Dr. VanGilder testified that the basis for his opinion was twofold.

¶ 126 First, he testified that he based his opinion on the temporal association between the accident and the onset of Krezelak's low-back symptoms. Dr. VanGilder testified that the history Krezelak gave him included that her low-back symptoms started with the MVA and that he did not see any reason to doubt her reports of her own symptoms. He specifically disagreed with Dr. Heid that patient reports of their own symptoms should be disregarded for being "unreliable," testifying, "To disregard what the patient says" regarding their own symptoms is "nonsense."

¶ 127 Dr. VanGilder also testified that Krezelak's medical records document that she had low-back pain not long after the MVA. While acknowledging that some of the records referenced merely Krezelak's "back," he opined that, in his experience, such references are typically about the lumbar spine. Dr. VanGilder further opined that the early reference to Krezelak's hip-flexor strain after a gym workout could have been related to the MVA because, "if you have a problem somewhere and you end up doing increased activity that can cause that to be more symptomatic."

¶ 128 Moreover, contrary to Dr. Heid, Dr VanGilder opined that low-back pain is associated with "end plate changes, severe loss of disc height and disc herniation." Indeed, he testified that the fact that Krezelak's fusion surgery was successful supports the inference that her pre-surgical pain was generated by her L4-5 condition. In sum, Dr. VanGilder concluded that "the symptoms that she had and the findings that she had and the history of trauma that she had . . . all fit together."

¶ 129 Second, Dr. VanGilder testified that he based his opinion on the accelerated changes from Krezelak's 2009 to 2018 lumbar MRIs, which he opined "can certainly come from trauma." He opined that, although her back was not perfect before the accident, it was not causing her any major dysfunction as far as she told him. However, Dr. VanGilder testified that from the first MRI to the next, "the 4-5 level had clearly gotten significantly worse." While he acknowledged that younger people can sometimes have such findings, he testified that it is "unusual." Dr. VanGilder testified that Krezelak's spine was perfect except for the L4-5 level, where she had the spine of "a 60-year-old." He opined that, he "would be surprised, especially with everything else looking so normal, that this one level, I would be surprised if that's age related." Dr. VanGilder testified that the progression of Krezelak's L4-5 condition was more accelerated than he would normally expect.

¶ 130 Dr. VanGilder opined that accelerated degeneration can be caused by multiple factors. He opined that lifting light weights noncompetitively would not contribute to degenerative disc disease, but factors such as genetics, trauma, and the physicality of one's job could cause accelerated degeneration. He also opined that "[s]moking can contribute to lumbar disc degeneration, secondary to blood flow issues that occur with the disc," and "accelerate disc degeneration." Notwithstanding that he had notice of

Krezelak's smoking history, Dr. VanGilder testified that he "wouldn't be surprised if the trauma that occurred accelerated [Krezelak's] degeneration," opining, "the accident probably contributed to just the generalized arthritic changes noted on the MRI, made them become symptomatic for her."

¶ 131 As for the timing of Krezelak's low-back complaints, Dr. VanGilder testified that it did not concern him that she was seeing him for the first time more than two years after the MVA to which she attributed causation for her L4-5 condition. He testified that it is not uncommon for patients who suffer lumbar spine injuries to have slowly progressing symptoms. However, he also testified that just because Krezelak did not treat for low-back or radicular pain at all for 16 months does not mean that she had no pain during that time. Dr. VanGilder testified that he has patients, like Dr. Steele's, who fill out their pain diagrams according to the specific reason they are seeing him. Moreover, he testified, it would not be uncommon for a person with a mild lumbar spine injury or other injuries that take precedence to not treat for more than a year after an MVA.

Resolution of Causation or Permanent Aggravation as to Krezelak's L4-5 Condition

¶ 132 Krezelak argues that the opinions of Drs. Steele and VanGilder, that the MVA caused or permanently aggravated her L4-5 condition, are entitled to more weight than the opinions of Dr. Heid. Krezelak contends she gave them each the same history, but Drs. Steele and VanGilder have better credentials and more experience related to her condition, and they spent more time with her over a longer period. Moreover, she contends, their opinions advance a substantive theory of causation — trauma from the MVA — which is based on her findings.

¶ 133 Krezelak argues that Dr. Heid's opinions, that the MVA did not cause or permanently aggravate her conditions, are entitled to no weight or less weight. She contends that Dr. Heid lacked important information when she opined that there was no temporal association — which, according to Dr. Heid, is "the most essential part of causation" — between the MVA and Krezelak's L4-5 condition. Krezelak contends that Dr. Heid did not believe Krezelak's low-back pain started with the MVA based on her self-report, and that Indemnity never told Dr. Heid that Krezelak reported that symptom right after the MVA or that its acceptance of liability included her low back. Moreover, she argues, Dr. Heid's opinions are alternately based on the incorrect evidentiary standard of "medical certainty," and, in addition to clear financial bias, her report, in its exclusion of certain information favorable to Krezelak and inclusion of characterizations favorable to Indemnity, suggests examination bias. Further, Krezelak argues, Dr. Heid acknowledged that trauma is capable of herniating a disc "in extremely rare circumstances" or accelerating spine degeneration "[d]epend[ing] on the type of spine trauma," but opined that it did neither without much explanation as to why Drs. Steele and VanGilder were wrong or, ultimately, offering an alternative theory of causation.

¶ 134 Indemnity argues that although Dr. Heid is not a treating physician, her opinions, that the MVA did not cause or permanently aggravate Krezelak's conditions, are entitled

to more weight than those of Drs. VanGilder and Steele because they are supported by the credible evidence. Indemnity contends that if the MVA caused trauma to Krezelak's low back, there would have been a temporal relationship between the MVA and the onset of her symptoms. It contends, however, that since Krezelak's low-back symptoms started approximately 16 months after the MVA, there is no temporal or causal relationship between them.

¶ 135 Indemnity argues that Dr. VanGilder's opinions are entitled to no weight or less weight because they rely on a false history as to the onset of Krezelak's low-back symptoms and are inconsistent with a plethora of medical records. Indemnity contends that Krezelak's report to Dr. VanGilder, that her low-back symptoms started with the MVA and progressively worsened, is not credible because: she did not report those symptoms over the course of 49 post-MVA appointments, she would not have foregone treatment until August 2017 due to distraction from other injuries if her low-back pain was as bad as she claims starting around Christmas 2016 and again in June 2017, and she would not have waited until she was sure her condition was related to the MVA to seek treatment because, as a workers' compensation nurse case manager, she knew the importance of documenting any injury that could possibly be related to the MVA as early as possible. Moreover, Indemnity contends that Krezelak is not credible more generally, because she contradicted herself and her medical records several times, including as to whether she had low-back symptoms between 2009 and 2016, and as to how long she continued working out after the MVA.

¶ 136 Indemnity argues that Dr. Steele's opinions are entitled to no weight or less weight because they rely on a biomechanical model — that Krezelak's MVA-related injuries gradually led to her L4-5 condition — that is not supported by his own medical records, including a year's worth of pain diagrams that do not reflect low-back pain.

¶ 137 This Court's determination of which conditions, if any, were caused or permanently aggravated by Krezelak's MVA hangs on its evaluation of the medical opinions offered in this case and the facts upon which they rest. Although not conclusive, the opinion of a treating physician is generally afforded greater weight than the opinion of a competing expert.[5] When 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.[6] This Court may also consider other factors, including, for example: whether the opining physician reviewed the claimant's medical records before reaching his or her conclusions; the biases of the physician; the physician's specific analysis in the case; the physician's consideration and evaluation of other explanations for the claimant's condition; and medical and scientific literature

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

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

brought to the Court's attention which tends to support or contradict the physician's conclusions.[7]

¶ 138 Taking into account that the standard of proof is a preponderance of the evidence, this Court finds that Krezelak met her burden of proving that her L4-5 condition was caused or permanently aggravated by the MVA for two reasons.

¶ 139 First, this Court gives the opinions of Dr. VanGilder more weight than those of Dr. Heid. Dr. VanGilder is one of Krezelak's treating physicians, indeed, her surgeon, and therefore entitled to deference. But further, as Dr. Heid conceded, he also has the best credentials to opine as to the cause of Krezelak's L4-5 condition[8] and inspired this Court's confidence in his trustworthiness as he did so.

¶ 140 Second, this Court is persuaded by Dr. VanGilder's opinions — that the trauma from Krezelak's MVA contributed to the acceleration of her L4-5 condition and caused her back symptoms and need for surgery — because they have solid bases. To form his opinions, Dr. VanGilder relied in part on objective evidence of changes at Krezelak's L4-5 over time. I.e., when he compared her 2018 lumbar MRI to her 2009 lumbar MRI, he observed both "significant[ ]" and "accelerated" changes at that disc.

¶ 141 Dr. VanGilder also relied on Krezelak's subjective account of the onset and course of her low-back symptoms. This Court found Krezelak to be a credible witness and, between her testimony, several references to low-back problems in unrelated medical records, and multiple corroborating witness accounts, is likewise persuaded that the history she gave Dr. VanGilder was accurate. Notwithstanding that Krezelak's friends and family are inherently biased in her favor, this Court is not convinced that all eight — who signed declarations or gave depositions about either observing or talking with Krezelak about her low-back symptoms between the MVA and her first treatment —— were lying.

¶ 142 In this Court's view, Krezelak's credibility as to her low-back pain is not undermined by her failure to treat for it for 16 months following the MVA. Because she was dealing with other, serious health problems during that time, Krezelak's delay in seeking treatment for her low-back pain is understandable. Furthermore, Dr. VanGilder credibly testified that he was not concerned by the delay because those with lumbar spine injuries commonly have slowly progressing symptoms. Nor is Krezelak's credibility undermined, more generally, by the discrepancies Indemnity identified in her testimony and between

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[7] *Bain v. Liberty Mut. Fire Ins. Co.*, 2004 MTWCC 45, ¶ 135. Strict compliance with these factors is not a precondition to the admissibility of medical testimony or evidence. *Russell v. Watkins & Shepard Trucking Co.*, 2009 MT 217, ¶ 22.

[8] Moreover, Dr. Heid conceded that the correlating clinical exam findings she testified she would require before attributing Krezelak's low-back pain to her herniated L4-5 disc do, in fact, exist in this case in the form of Krezelak's 2018 lumbar spine MRI showing compression of her L5 nerve roots. See above at ¶¶ 107, 108.

her testimony and her medical records, because they were few, to be expected given the passage of time, and relatively minor.

Resolution of Indemnity's Reasonableness in Denying Liability for Krezelak's L4-5 Condition

¶ 143 Krezelak argues that Indemnity acted unreasonably by conducting an inadequate investigation and by attempting to "unaccept" liability for her L4-5 condition without proper justification.

¶ 144 The Montana Supreme Court has recognized that an adequate investigation includes a "reasoned review of all available evidence in the case . . . followed by an impartial evaluation of the evidence reviewed."[9]

¶ 145 This Court finds that Indemnity's investigation was sufficient. That investigation included taking a recorded statement, setting up an IME, and reviewing Dr. Heid's conclusions by phone. Notwithstanding the specific measures Indemnity took, however, the question of its liability for Krezelak's L4-5 condition came down to her credibility. And, although this Court is persuaded that Krezelak had intermittent low-back pain in the 16 months after the MVA, there was conflicting evidence, and it was a close case. Under these circumstances, Indemnity's denial of liability was not unreasonable for lack of an adequate investigation.[10]

¶ 146 This Court further finds that Indemnity did not attempt to "unaccept" liability for Krezelak's L4-5 condition. Indemnity's acceptance of liability included only those conditions that it knew about at the time of the acceptance. Here, that was a strain/sprain to Krezelak's entire back, not advanced-for-age degeneration and a herniated L4-5 disc requiring lumbar fusion surgery. This Court finds that because Indemnity did not accept liability for the latter condition in the first place, it could not "unaccept" it later on. Thus, although Indemnity could have communicated its reasoning more clearly,[11] Indemnity's denial of liability for Krezelak's L4-5 condition was reasonable.

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[9] *Marcott v. La. Pac. Corp.*, 275 Mont. 197, 209-11, 911 P.2d 1129, 1137-38 (citation omitted).

[10] *See, e.g.*, *Briese v. ACE Am. Ins. Co.*, 2005 MTWCC 50, ¶¶ 7, 22, 25 (insurer's denial not unreasonable where case rested on claimant's credibility and information provided by employer raised questions about whether claimant reported the incident when he said he did, and, thus, whether the incident happened as he alleged); *Stephenson III v. Cigna Ins. Co.*, 2001 MTWCC 12, ¶ 39 (insurer's denial not unreasonable where case rested on claimant's credibility and the facts raised serious questions as to his level of pain).

[11] See above at ¶ 78.

Medical Causation or Aggravation Opinions as to Krezelak's Bilateral Cubital Tunnel Syndrome

Dr. Hudgens

¶ 147 Prior to confirmation of Krezelak's diagnosis by EMGs, Dr. Hudgens opined that Krezelak's bilateral upper extremity numbness and tingling with a concern of peripheral nerve entrapment was "[l]ikely" a direct result of the MVA.

Dr. Heid

¶ 148 Dr. Heid testified that Krezelak's MVA did not cause or substantially and materially contribute to her bilateral cubital tunnel syndrome. Dr. Heid testified that the basis of that opinion was multifold.

¶ 149 First, Dr. Heid testified that holding the steering wheel with fully extended arms during a high-speed MVA is not an accepted mechanism of injury to the ulnar nerve at the elbow. She testified that traumatic injuries to the ulnar nerve have resulted from elbow fractures, dislocations, lacerations, and direct blunt force to or cutting of the nerve, none of which happened in Krezelak's MVA. She further testified that Krezelak's symptoms could be provoked by either prolonged elbow flexion or direct pressure on the ulnar nerve, and that her positioning in the MVA was not consistent with either.

¶ 150 Second, Dr. Heid opined that the onset of Krezelak's symptoms, the point at which her cubital tunnel syndrome was objectively verified, as well as the degree of findings on electrodiagnostic testing, weigh against trauma as the impetus of that condition. Dr. Heid opined that if Krezelak's arms and hands had been acutely injured, her symptoms would have appeared within a few hours of the MVA (rather than the next morning (left) and three and a half years later (right)) and been objectively verified sooner (rather than March 2017 EMG/NCS (left) and December 2019 EMG/NCS (right)). More specifically, Dr. Heid testified that if Krezelak's elbow had been hit, contusing or otherwise injuring her ulnar nerve, she would have had a sudden onset of symptoms (rather than no elbow pain or bruising and no swelling or symptoms when Barnhart tapped on her nerves). As Dr. Heid put it: "An acutely contused nerve would be irritable, it would hurt when you tapped on it." Dr. Heid testified that it is unlikely that "[Krezelak would] just hit it, it would go away and then later it would become a problem." Finally, Dr. Heid testified that Krezelak's electrodiagnostic nerve testing, resulting in mild, eventually bilateral, findings, was also inconsistent with a major injury to a nerve.

¶ 151 Third, Dr. Heid testified that there are other likely explanations for Krezelak's bilateral cubital tunnel syndrome. She opined that cubital tunnel syndrome is a common condition, affecting the left elbow more than the right regardless of hand dominance, and that it may go unnoticed for years because symptoms are typically intermittent. She testified that people frequently get cubital tunnel syndrome in both elbows because they

are using both arms in the same way, e.g., “they’re doing lots of push-ups, lots of bending activities, repetitive elbow flexion, pressure on the nerve.” Dr. Heid testified that aging, anatomy, and smoking could also be factors in developing bilateral cubital tunnel syndrome. She testified that a smoker is four times more likely to have cubital tunnel syndrome than a nonsmoker and that Krezelak smoked for many years.

¶ 152 Finally, Dr. Heid opined that Krezelak was not credible. She pointed out that Krezelak’s history included: inconsistent statements as to when she stopped working out post-MVA; reports that injections to her long thoracic and dorsal scapular nerves helped her left-arm pain and numbness even though “these nerves do not provide sensation to the arm or hand”; and some nonphysiologic findings on examination.

Dr. Steele

¶ 153 Dr. Steele testified that the cause of cubital tunnel syndrome, which occurs when the ulnar nerve is entrapped under the ligament between the two heads of the flexor carpi ulnaris muscle, is “multifactorial.”

¶ 154 He offered no opinion as to whether the MVA caused Krezelak’s right cubital tunnel syndrome; he only ever treated her for left-sided symptoms.

¶ 155 As to Krezelak’s left cubital tunnel syndrome, Dr. Steele testified that he has no way of proving or disproving the hypothesis that Krezelak’s ulnar nerve was injured in the MVA. He testified that all he knew was that it was irritated, and that “anytime if you’re in a car accident and your hands are locked on the steering wheel, lots of things get hurt.”

¶ 156 He did, however, opine that Krezelak’s MVA was the “inciting event” for her left upper extremity problems, including ulnar nerve neuritis. Dr. Steele testified that he uses the term “ulnar nerve neuritis” rather than “cubital tunnel syndrome,” because there can be inflammation of the ulnar nerve in more than one area, e.g., in the hand, not just at the cubital tunnel, which is at the elbow.

¶ 157 Dr. Steele testified that he did not believe that Krezelak’s ulnar neuropathy was more likely related to smoking than trauma from the MVA. He discounted the influence of push-ups — he had never seen it in 20 years — and planks — Krezelak did not have the required subluxed ulnar nerve. Dr. Steele opined that prolonged arm extension (driving), repetitive use (typing), and genetics were not factors in causing her ulnar nerve neuritis, although overuse could exacerbate it after the initial insult.

¶ 158 Dr. Steele opined that direct trauma, whether significant — e.g., a high-speed impact — or seemingly innocuous — e.g., hitting your funny bone — can cause cubital tunnel syndrome. But he also opined that a direct strike to the elbow is not required to injure an upper extremity nerve; there are many different ways — e.g., twisting your arm the wrong way — to stretch a nerve beyond where it is supposed to go.

¶ 159 When asked whether Krezelak keeping her arms on the steering wheel at "10 and 2" during the MVA, where there was no coming forward, hyperflexion or stretching of the ulnar nerve at the wrist, could cause cubital tunnel syndrome, Dr. Steele testified that it would depend on what was happening elsewhere along the ulnar nerve route:

> I mean, you've got to realize that nerve is connected all the way from the neuroforamen. As it exits out, it goes through the brachial plexus, goes through and underneath your clavicle, across the anterior shoulder, down and into your arm and all the way down to here (indicating). And anywhere in that chain that it's injured you can create neuritis of that ulnar nerve.

He testified that "If there's a severe strain between the flexor carpi ulnaris [in the forearm] to stabilize the wrist, that will cause a compression in the nerve at that level. So, a severe flexion, contracture type mechanism inferior, could cause ulnar nerve neuritis." Dr. Steele also testified that, in a car accident, if your hands remain on the steering wheel, you can injure the ulnar nerve at several places in the hand, and that, based on her symptoms, he was concerned about that in relation to Krezelak's accident.

¶ 160 As to the mechanism of Krezelak's injury, Dr. Steele opined that, as happens commonly in his car accident patients, she stretched her ulnar nerve more than 20%, which cut off its blood flow and created long-term issues. He further opined that both Krezelak's ulnar nerve and the "vascular nerve complex" that keeps the nerve healthy were injured in the MVA. He testified that both are "sensitive"; they get "irritated easily" after an injury and are "always susceptible to reinjury."

¶ 161 Dr. Steele testified that "if you develop neuritis and an inflammatory condition of the nerve, it's a process over time. The nerve is sensitized and it gradually gets inflamed and creates scar tissue." He testified that "the nerves after an insult can create a hypersensitization, which leads to an ever-evolving, gradually increasing neuritis that evolves over time."

¶ 162 Dr. Steele testified that 80% of his patients do not return once he has fixed their problem; 10% have waxing and waning symptoms that gradually go away; and 10% have a return of symptoms at some point: "They move wrong. They irritate it. They sleep on it wrong, whatever, and the symptoms return. . . . That nerve is never completely normal. It never completely seems to desensitize that sensitivity from the original injury." He testified that "the initial insult is what damages the nerve. And then the nerve its function for years to come is susceptible to reinjury or reaggravation."

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Resolution of Causation or Permanent Aggravation as to Krezelak's Bilateral Cubital Tunnel Syndrome

¶ 163 Both parties' arguments as to why the opinions of their medical expert are entitled to more weight than those of the opposing party are encompassed in the arguments set forth above.[12]

¶ 164 This Court finds that Krezelak met her burden of proving that the MVA caused or permanently aggravated her left cubital tunnel syndrome for two reasons.

¶ 165 First, this Court gives the opinions of Dr. Steele more weight than those of Dr. Heid. Although this Court was troubled by his demeanor and obvious bias against workers' compensation insurers, Dr. Steele is one of Krezelak's treating physicians and therefore entitled to deference, particularly because this Court was also troubled by Dr. Heid's bias. Dr. Steele is also more qualified than Dr. Heid to opine as to the cause or permanent aggravation of Krezelak's cubital tunnel syndrome.

¶ 166 And second, this Court is persuaded by Dr. Steele's opinion that, during the MVA, the placement of Krezelak's arm and hand, the use of her muscles to stabilize them, and the forces to which she was subjected caused an overstretch injury to her ulnar nerve. He testified that that injury cut off the blood flow to the ulnar nerve and created long-term issues, including neuritis. Dr. Steele explained that neuritis, even after an acute injury, is a condition that develops gradually over time. He also testified that Krezelak's ulnar nerve will, for years to come, be susceptible to reinjury or reaggravation from seemingly innocuous movements. Finally, Dr. Steele accounted for other possible causes of Krezelak's ulnar nerve neuritis, opining that exercises that put pressure on her forearm, prolonged extension (driving), repetitive use (typing), and genetics were either not factors or unlikely factors in her injury, and that smoking was not a more likely cause than her trauma.

¶ 167 However, this Court finds that Krezelak failed to meet her burden of proving that the MVA caused or permanently aggravated her right cubital tunnel syndrome because she offered insufficient medical opinion evidence on that issue. Dr. VanGilder did not opine on the cause of her cubital tunnel syndrome on either side. Dr. Steele did not opine on the cause of her cubital tunnel syndrome on the right side. And although Dr. Hudgens opined that there was likely a causal relationship between the MVA and Krezelak's bilateral upper extremity numbness and tingling with a concern of peripheral nerve entrapment, this Court finds that his opinion is entitled to no weight because the foundation for it is not known.[13]

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[12] See above at ¶¶ 132-36.

[13] Krezelak presented no evidence that Dr. Hudgens had any information about the mechanism of her injury. His only reference to the MVA is in his October 15, 2019, note, in which Krezelak's History of Present Illness includes "Injury: Motor vehicle crash in 2016."

Resolution of Indemnity's Reasonableness in Denying Liability for Krezelak's Bilateral Cubital Tunnel Syndrome

¶ 168 The details of Krezelak's arguments mirror those set forth above.[14]

¶ 169 With respect to Krezelak's left cubital tunnel syndrome, this Court finds that Indemnity's investigation was sufficient.[15] That investigation — which included setting up an IME with Dr. Heid, asking Dr. Steele to respond to the IME report, paying for Krezelak's related medical care for almost three years over two separate treatment periods, and having Dr. Heid prepare a causation analysis — revealed a legitimate medical dispute. Under these circumstances, Indemnity's denial of liability was not unreasonable for lack of an adequate investigation.

¶ 170 This Court further finds that Indemnity did not attempt to "unaccept" liability for Krezelak's left cubital tunnel syndrome. Indemnity's acceptance of liability shortly after the MVA did not include Krezelak's "bilateral upper extremities," or nerve problems at her elbows, as she argues. Rather, that acceptance included her "bilateral shoulders" and a "strain/sprain," which involves muscles/tendons and ligaments. Nor did Indemnity's later acceptance of liability for "radicular symptoms leading to her left cubital tunnel" as a temporary aggravation include acceptance of Krezelak's left cubital tunnel syndrome. While radicular symptoms can mimic those of cubital tunnel syndrome, each originates in a different part of the body. Because Indemnity never accepted liability for Krezelak's bilateral cubital tunnel syndrome in the first place, it could not "unaccept" it on her left side later on. Thus, Indemnity's denial of liability for Krezelak's left cubital tunnel syndrome was reasonable.

Medical Causation or Aggravation Opinions as to Krezelak's Left Carpal Tunnel Syndrome

Dr. Steele

¶ 171 Dr. Steele was the only physician to give an opinion as to the cause or permanent aggravation of Krezelak's left carpal tunnel syndrome. He testified that Krezelak had mild symptoms of carpal tunnel syndrome early on, which became more of an issue as time passed. He testified that, although he did not formally diagnose her with that condition, he thought "she [did, in fact,] develop[ ] some carpal tunnel."[16] However, Dr. Steele testified that he is "not convinced" that Krezelak's MVA caused it.

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[14] See above at ¶ 143.

[15] This Court does not address Indemnity's reasonableness with respect to Krezelak's right cubital tunnel syndrome since that claim is not compensable.

[16] Dr. Steele also testified that Krezelak's median nerve bifurcation "met the ultrasound criteria for a mild to moderate carpal tunnel, not requiring treatment, such as a carpal tunnel release."

Resolution of Causation or Aggravation as to Krezelak's Left Carpal Tunnel Syndrome

¶ 172 This Court need not apportion weight between competing experts as Dr. Steele is the only medical expert to offer an opinion as to the cause or permanent aggravation of Krezelak's left carpal tunnel syndrome. Nor does this Court need to determine whether Dr. Steele's opinion is entitled to weight, because the outcome would be the same either way.

¶ 173 This Court finds that Krezelak did not meet her burden of proof. Dr. Steele testified that he was not convinced that the MVA caused her left carpal tunnel syndrome.

Resolution of Indemnity's Reasonableness in Denying Liability for Krezelak's Left Carpal Tunnel Syndrome

¶ 174 The details of Krezelak's arguments mirror those set forth above.[17]

¶ 175 Indemnity argues that it acted reasonably in taking initial responsibility for Krezelak's injuries.

¶ 176 Because of its disposition of the issue of causation or aggravation of Krezelak's left carpal tunnel syndrome, Indemnity's denial of liability was reasonable.

CONCLUSIONS OF LAW

¶ 177 This case is governed by the 2015 version of the Montana Workers' Compensation Act since that was the law in effect at the time of Krezelak's industrial accident.[18]

Issue One: Was Krezelak's L4-5 condition caused or permanently aggravated by the motor vehicle accident?

¶ 178 Krezelak initially argued that she need not prove causation or permanent aggravation because her L4-5 condition was encompassed in the "entire back" Indemnity previously accepted as part of her claim. She contends that Indemnity's refusal to authorize her surgery constituted an attempt to "unaccept" liability that it had already accepted. Krezelak further argues that because Indemnity has not met its burden of proving the applicability of any of the exceptions to the general rule disfavoring "unacceptance" of liability, Indemnity's attempt to "unaccept" liability was without legal justification and it remains liable for her L4-5 condition.

¶ 179 In the alternative, Krezelak argues that she has affirmatively met her burden of proving that the MVA caused or permanently aggravated her L4-5 condition, and that

[17] See above at ¶ 143.

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

Indemnity has failed to offer substantive medical evidence to negate causation or propose an alternate theory of causation.

¶ 180 Indemnity argues that it did not attempt to "unaccept" liability for Krezelak's L4-5 condition, because it did not even know about, let alone accept, that condition in the first place.

¶ 181 Indemnity also argues that Krezelak failed to meet her burden of proving that the MVA caused or permanently aggravated her L4-5 condition. Specifically, it contends that her theory, that her upper extremity complaints distracted her from her low-back pain, was rejected by this Court in *Neisinger v. New Hampshire Ins. Co.*[19]

¶ 182 As to the "unacceptance" of liability, this Court reviewed Montana Supreme Court precedent in *Bouldin v. Liberty Northwest Ins. Corp.*, and based thereon, set forth the law in this area.[20] The general rule is that "once an insurer accepts liability it may not thereafter argue that the injury or condition for which liability has been accepted was not caused by the industrial accident or disease."[21] The exceptions to the general rule, which will relieve an insurer of accepted liability, include subsequent injury or aggravation, fraud, or mutual mistake of fact.[22]

¶ 183 As this Court found above,[23] Indemnity's acceptance of a strain/sprain of Krezelak's entire back did not include her L4-5 condition. Thus, Indemnity's refusal to authorize Krezelak's lumbar fusion surgery did not constitute an attempt to "unaccept" liability that it had already accepted.

¶ 184 As to permanent aggravation, this Court has previously set forth the applicable law as follows:

> Under § 39-71-407(3)(a)(ii), MCA, an insurer is liable for an injury if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that the claimed injury occurred and aggravated a pre-existing condition. The Montana Supreme Court has explained:

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[19] 2020 MTWCC 4, ¶ 42 (ruling that it was not credible for claimant to be so distracted by his quadricep pain that he waited 10 months to report his lumbar pain).

[20] 1996 MTWCC 61.

[21] *Bouldin*, 1996 MTWCC 61 (citing *Chaney v. U.S. Fidelity & Guar.*, 276 Mont. 513, 917 P.2d 912 (1996)); *see also Barnhart v. Liberty Nw. Ins. Corp.*, 2016 MTWCC 12, ¶ 50 (applying *Narum*, ¶ 42); *Narum v. Liberty Nw. Ins. Corp.*, 2008 MTWCC 30, ¶ 42 (*aff'd*, 2009 MT 127, 350 Mont. 252, 206 P.3d 964) ("Respondent cannot accept liability for a claim, settle the claim, and then un-accept the claim at a later date because it has changed its mind about whether it should have accepted liability in the first place.").

[22] *Bouldin*, 1996 MTWCC 61 (citations omitted); *see also Leys v. Liberty Mut. Ins.*, 2019 MTWCC 10, ¶ 164.

[23] See above at ¶ 146.

> The well established rule in Montana is that an employer takes his employee subject to the employee's physical condition at the time of employment. The fact that an employee is suffering from or afflicted with pre-existing disease or disability does not preclude compensation if the disease or disability is aggravated or accelerated by an industrial accident.
>
> If an industrial accident causes only a temporary aggravation to a pre-existing condition, the insurer at risk is liable for the injury only until the injured worker returns to baseline. In aggravation cases, this Court weighs the evidence to determine whether an industrial injury permanently aggravated a pre-existing condition. A claimant is required to establish injury and causation through objective medical findings. The claimant's burden to establish an accident, an injury or aggravation of a pre-existing condition, and a causal connection between the accident and the injury or aggravation is "more probable than not."[24]

¶ 185 As this Court found above,[25] Krezelak met her burden of proving that the MVA caused or permanently aggravated her L4-5 condition.

¶ 186 Indemnity's argument, that Krezelak did not meet her burden of proof because this Court rejected the "distraction theory" in *Neisinger*, is unavailing. While this Court did rule, in *Neisinger*, that the claimant did not meet his burden of proving that his industrial accident caused his lumbar spine condition because the onset of his symptoms was approximately ten months after his industrial accident,[26] each case must be decided on its own facts.

¶ 187 In *Neisinger*, the claimant claimed his quadriceps and knee injuries were distracting injuries in the months after his surgery.[27] However, this Court was not convinced because his medical records showed that those injuries gradually improved after the surgery, and because this Court could not reconcile the claimant's claim that they masked his lumbar spine pain after surgery with his claim that his lumbar spine pain was severe during the same period.[28] As this Court put it, "If he felt severe pain from his lumbar spine, the pain was not masked."[29]

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[24] *Barnhart*, ¶ 41 (internal citations omitted).

[25] See above at ¶ 138.

[26] *Neisinger*, ¶¶ 40, 43.

[27] *Neisinger*, ¶ 42.

[28] *Id*.

[29] *Id*.

¶ 188 Here, Krezelak did not claim that she had severe lumbar spine pain for 16 months following the MVA, which would obviously be difficult to mask. Rather, she claimed that she had intermittent lumbar spine pain that worsened over time and eventually became severe. And while her neck and left arm conditions did improve over the 16 months, her progress was slow. Nevertheless, those distractions could very well have been replaced by the onset of several new and serious health conditions unrelated to the MVA, which arose for Krezelak one after another during that time.

¶ 189 Moreover, Krezelak offered credible explanations as to why she did not treat for her low-back pain for 16 months following the MVA, of which being focused on health problems that were bothering her more was but one. And as explained above,[30] this Court specifically found that Krezelak's delay in seeking treatment for her low-back pain did not undermine her credibility as to her claim that she had symptoms during the period of delay.

¶ 190 As Krezelak met her burden of proof as to causation or permanent aggravation, Indemnity is liable for her L4-5 condition.

Issue Two: Was Krezelak's bilateral cubital tunnel syndrome caused or permanently aggravated by the motor vehicle accident?

¶ 191 Krezelak insinuates that she need not prove causation or permanent aggravation because her bilateral cubital tunnel syndrome was encompassed in the "bilateral upper extremities" Indemnity previously accepted as part of her claim. As evidence of acceptance, she points to Indemnity's payment of her treatment from the inception of her claim until April 13, 2020, i.e., even after she was diagnosed with left cubital tunnel syndrome in 2016, she reached MMI for left cubital tunnel syndrome in 2017, and she was diagnosed with bilateral cubital tunnel syndrome in 2019. Thus, Krezelak contends that Indemnity's denial of Dr. Steele's request for an ultrasound-guided left ulnar nerve injection on April 13, 2020, and its subsequent denial of all liability for her bilateral cubital tunnel, constituted an attempt to "unaccept" liability that it had already accepted. Krezelak argues that because Indemnity has not met its burden of proving the applicability of any of the exceptions to the general rule disfavoring "unacceptance" of liability, its attempt to "unaccept" liability was without legal justification and it remains liable for her bilateral cubital tunnel syndrome.

¶ 192 Indemnity argues that Krezelak's MVA did not cause or permanently aggravate her bilateral cubital tunnel syndrome. As to Krezelak's right-sided condition, Indemnity contends that there is no temporal connection between the MVA and the onset of her symptoms, which first appeared more than three years post-MVA. As to her left-sided condition, it acknowledges that Krezelak had post-MVA radiating pain from her neck and shoulder down her left arm that it accepted as a temporary aggravation. However,

[30] See above at ¶ 142.

Indemnity contends that the aggravation resolved, there was no permanent aggravation, and Krezelak was pain free by the time she reached MMI on April 25, 2017. It implies that any subsequent left cubital tunnel syndrome was unrelated to the MVA.

¶ 193 As this Court has found above, Indemnity's acceptance of a strain/sprain of Krezelak's bilateral shoulders did not encompass her bilateral cubital tunnel syndrome,[31] and its acceptance of "radicular symptoms leading to her left cubital tunnel" as a temporary aggravation did not include her left cubital tunnel syndrome.[32] Thus, neither Indemnity's denial of liability for Krezelak's cubital tunnel syndrome on the left or right constituted an attempt to "unaccept" liability that it had already accepted.

¶ 194 As a result, this Court must address whether Krezelak met her burden of proving causation or permanent aggravation. As this Court has found above, Krezelak met her burden of proving that the MVA caused or permanently aggravated her cubital tunnel syndrome on the left[33] but not the right.[34]

¶ 195 As Krezelak met her burden of proving causation or permanent aggravation, Indemnity is liable for her left cubital tunnel syndrome.

Issue Three: Was Krezelak's left carpal tunnel syndrome caused or permanently aggravated by the motor vehicle accident?

¶ 196 Krezelak again insinuates that she need not prove causation or permanent aggravation, because her left carpal tunnel syndrome was encompassed in the "bilateral upper extremities" Indemnity previously accepted as part of her claim. Thus, Krezelak contends that Indemnity's denial of liability for her left carpal tunnel syndrome constituted an attempt to "unaccept" liability that it had already accepted. Krezelak argues that because Indemnity has not met its burden of proving the applicability of any of the exceptions to the general rule disfavoring "unacceptance" of liability, its attempt to "unaccept" liability was without legal justification and it remains liable for her left carpal tunnel syndrome.

¶ 197 Indemnity contends that Krezelak has failed to prove a causal connection between the MVA and her alleged carpal tunnel symptoms, because she has not been definitively diagnosed with left carpal tunnel syndrome, EMGs have not confirmed the presence of left carpal tunnel syndrome, she has not established a mechanism of injury sufficient to cause left carpal tunnel syndrome, and there is no temporal connection between Krezelak's MVA and her left carpal tunnel syndrome.

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[31] See above at ¶ 170.

[32] See above at ¶ 170.

[33] See above at ¶¶ 164-66.

[34] See above at ¶ 167.

¶ 198 Indemnity's acceptance of a strain/sprain of Krezelak's bilateral shoulders did not include her left carpal tunnel syndrome because they are different conditions. A "strain/sprain" involves muscles/tendons and ligaments in the arm, whereas carpal tunnel syndrome involves a nerve at the wrist. Thus, Indemnity's denial of liability for Krezelak's left carpal tunnel syndrome did not constitute an attempt to "unaccept" liability that it had already accepted.

¶ 199 As this Court has found above,[35] Krezelak failed to meet her burden of proving that the MVA caused or permanently aggravated her left carpal tunnel syndrome.

¶ 200 As Krezelak did not meet her burden of proving causation or permanent aggravation, Indemnity is not liable for her left carpal tunnel syndrome.

Issue Four: Is Krezelak entitled to costs, attorney fees, and a penalty for this action?

¶ 201 Section 39-71-611, MCA, provides in pertinent part:

> (1) The insurer shall pay reasonable costs and attorney fees as established by the workers' compensation court if:
>
> (a) the insurer denies liability for a claim for compensation or terminates compensation benefits;
>
> (b) the claim is later adjudged compensable by the workers' compensation court; and
>
> (c) in the case of attorney fees, the workers' compensation court determines that the insurer's actions in denying liability or terminating benefits were unreasonable.

¶ 202 Section 39-71-2907, MCA, provides in pertinent part:

> (1) The workers' compensation judge may increase by 20% the full amount of benefits due a claimant during the period of delay or refusal to pay, when:
>
> (a) the insurer agrees to pay benefits but unreasonably delays or refuses to make the agreed-upon payments to the claimant; or
>
> (b) prior or subsequent to the issuance of an order by the workers' compensation judge granting a claimant benefits, the insurer unreasonably delays or refuses to make the payments.

[35] See above at ¶ 173.

> (2) The question of unreasonable delay or refusal shall be determined by the workers' compensation judge, and such a finding constitutes good cause to rescind, alter, or amend any order, decision, or award previously made in the cause for the purpose of making the increase provided herein.

¶ 203 Because this Court has found that Krezelak prevailed on her claims that her L4-5 condition and left cubital tunnel syndrome are compensable, she is entitled to her costs. However, since this Court has found that Indemnity's denials as to both were reasonable, Krezelak is not entitled to attorney fees or a penalty.

JUDGMENT

¶ 204 Indemnity is liable for Krezelak's L4-5 condition and left cubital tunnel syndrome because they were caused or permanently aggravated by the MVA.

¶ 205 Indemnity is not liable for Krezelak's right cubital tunnel syndrome nor left carpal tunnel syndrome because they were not caused or permanently aggravated by the MVA.

¶ 206 Because Krezelak prevailed as to two of her claims, Indemnity is liable for her costs under § 39-71-611, MCA.

¶ 207 However, because Indemnity's denials were reasonable, it is not liable for attorney fees under § 39-71-611, MCA, or a penalty under § 39-71-2907, MCA.

¶ 208 After awarding Krezelak her costs, this Court will certify this Judgment as final.

DATED this 16th day of September, 2021.

(SEAL)

/s/ DAVID M. SANDLER
JUDGE

c: Matthew J. Murphy/Thomas M. Murphy
Joe C. Maynard/Marina Tucker

Submitted: November 20, 2020