IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2007 MTWCC 16

WCC No. 2006-1558

ROBERT MACK

Petitioner

vs.

TRANSPORTATION INSURANCE COMPANY

Respondent/Insurer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: Petitioner petitioned the Court for an increase in his impairment award based on the opinion of his treating physician.

Held: Petitioner is entitled to an increased impairment award.

¶ 1 The trial in this matter was held on October 6, 2006, in Kalispell, Montana, and December 11, 2006, in Helena, Montana. Petitioner Robert Mack, who was not present, was represented by Laurie Wallace and Jon L. Heberling.[1] Respondent Transportation Insurance Company was represented by Todd A. Hammer.

¶ 2 Exhibits: Exhibits 1 through 8 were admitted without objection. Exhibits 1C-K were submitted for demonstrative purposes. Petitioner objected to portions of Exhibit 9 for lack of foundation (specifically, pages 6-10, the bottom of page 10 through the top of page 12, and page 23). Petitioner was allowed an opportunity to *voir dire* at the time of Dr. Dana Headapohl's testimony, at which time Petitioner withdrew his objections. Exhibit 10 was admitted without objection. Exhibit 11 was withdrawn by Respondent. Exhibit 12 was admitted over Petitioner's relevancy objection. Petitioner's objection to Exhibit 13 was withdrawn and Exhibit 13 was admitted.

---

[1] Ms. Wallace was not present for the conclusion of the trial on December 11, 2006.

¶ 3 Witnesses and Depositions: Drs. Alan C. Whitehouse and Dana Headapohl testified at trial. Petitioner testified by videotape. The depositions of Petitioner, Sandy Mayernik, and Dr. Whitehouse were submitted to the Court.

¶ 4 Issues Presented: The Court restates the following contested issues as set forth in the Pretrial Order:

¶ 4a Whether Petitioner is entitled to additional impairment benefits.

¶ 4b Whether Respondent has been unreasonable in paying benefits entitling Petitioner to a 20% increased award.

¶ 4c Whether Petitioner is entitled to reasonable costs and attorney fees.[2]

FINDINGS OF FACT

¶ 5 Petitioner is 73 years old. He was born on March 14, 1934.[3] Petitioner worked for W.R. Grace & Co. (W.R. Grace) at its mine in Libby, Montana, from approximately May 1, 1969, through September 25, 1990.[4]

¶ 6 Respondent has admitted liability for Petitioner's occupational disease claim.[5]

¶ 7 Dr. Whitehouse was a credible witness and the Court finds his testimony by deposition and at trial credible.

¶ 8 Dr. Headapohl was a credible witness and the Court finds her testimony at trial credible.

¶ 9 Petitioner's jobs at the mine consisted of working as a laborer, Euclid driver, oiler, shovel operator, front-end loader, water truck driver, and sand truck driver.[6]

---

[2] Pretrial Order at 3-4.

[3] Mack Dep. 8:19.

[4] Pretrial Order at 2.

[5] *Id*.

[6] Mack Dep. 19:10-15; 20:13-16; 21:9-13; 24:17-19; 24:25 - 25:1; 28:18-25.

¶ 10 After Petitioner left W.R. Grace he went to Elko, Nevada, and began working for Newmont Gold, Inc. (Newmont) on October 29, 1990.[7] He worked as a truck driver for 11 years before retiring in February of 2002.[8] Petitioner took Social Security retirement benefits from the date he first became eligible for them, and he has received such benefits since that time.[9]

¶ 11 Petitioner had trouble with his breathing during the last two years he worked for Newmont.[10] Specifically, Petitioner had difficulty walking 150 yards from the time shack to his truck and performing the visual inspection of his truck at the start of each shift.[11] On April 4, 2000, Petitioner reported to Dr. Whitehouse that if he had to climb into his truck cab at Newmont more than one time, he would have to sit in the cab and rest.[12]

¶ 12 After he left employment with Newmont, Petitioner's breathing problems worsened.[13] For example, in the winter of 2004 it took Petitioner two days to shovel 1½ feet of snow off a 16'x35' slab of concrete.[14]

¶ 13 On January 20, 2005, Petitioner began using oxygen due to his breathing difficulties.[15]

¶ 14 As of the date of his deposition, April 25, 2006, Petitioner described his ability to do household chores as follows:

> I can't do chores around the house anymore. It's all I can do to get to the bathroom. And I can do my own showers. I have to sit on the stool. I can't stand up and do it. I've got to sit down and shower.
>
> . . . .

---

[7] Mack Dep. 30:3-4.

[8] Mack Dep. 57:17 - 58:3.

[9] Mack Dep. 92:11 - 93:9.

[10] Mack Dep. 132:25 - 133:4.

[11] Mack Dep 59:7 - 60:1.

[12] Ex. 1(a) at 13.

[13] Mack Dep. 64:12-19.

[14] Mack Dep. 67:22 - 68:20.

[15] Mack Dep. 68:21-24.

> Well, like I go from my bedroom to the bathroom. By the time I go into the bathroom, I've got to stand there and get my wind back. That's probably about 25-30 feet. I run out of -- out of oxygen.[16]

Medical Evidence

¶ 15 "Asbestos is a mineral fiber. There are two kinds, serpentine (chrysotile) and asbestiform amphiboles. Chrysotile asbestos is the kind used commercially in building products. Chrysotile asbestos is more curly, or more club-like, whereas amphibole asbestos is like tiny needles or spears."[17] The asbestos found in Libby is an amphibole. "It is generally referred to as tremolite, and variously referred to as winchite, richterite or tremolite-actinolite, all of which are amphiboles."[18]

¶ 16 "In relative terms of their length to width (aspect ratio), tremolite fibers are long and sharp, like needles. The fibers are microscopic, as are the alveoli (tiny air sacs) in the lungs when breathed in. When breathed in, the fibers lodge in the structure around the alveoli, and are too small to be expelled. With each breath, they irritate and inflame the lung tissue structure around the air sacs (the interstitia). Scarring in the interstitia is interstitial disease. When the interstitia are significantly scarred, they can no long[er] expand or contract, and breathing is restricted."[19]

¶ 17 "The amphibole fibers also migrate through the air sacs to the outside portion of the lung, where they scar and inflame the pleura (the lung lining) and cause pleural disease."[20] "Pleural disease seems particularly pronounced with tremolite fibers."[21]

¶ 18 The normal pleura is a very thin membrane and can expand like a balloon. "Asbestos fiber scarring causes the pleura to look much like the orange portion of an orange rind, and can be just as thick. When surgeons peel it off the pleura, they call it a rind. When the lung lining becomes as thick as an orange rind, it can no longer expand

---

[16] Mack Dep. 74:8-11; 76:2-5.

[17] General Affidavit of Dr. Alan C. Whitehouse, ¶ 10.

[18] *Id*.

[19] General Affidavit of Dr. Alan C. Whitehouse, ¶ 11.

[20] General Affidavit of Dr. Alan C. Whitehouse, ¶ 12, *citing* R. Frazer, et al., *Frazer and Pare's Diagnosis and Diseases of the Chest*, 4th ed., 1999, p. 2809.

[21] General Affidavit of Dr. Alan C. Whitehouse, ¶ 12.

freely and breathing is restricted. Asbestos disease is generally a restrictive lung disease."[22]

¶ 19 Dr. Whitehouse is a board-certified pulmonologist licensed in the states of Montana and Washington.[23] Dr. Whitehouse had a full-time practice for 36 years in Spokane, Washington, treating pulmonary disease, and has been associated with the Center for Asbestos-Related Disease (CARD) Clinic since 2005.[24] Over the course of his career, Dr. Whitehouse has treated over 700 cases of asbestos disease caused by exposure to Libby tremolite asbestos.[25]

¶ 20 Petitioner first saw Dr. Whitehouse on November 28, 1988. At that time, Petitioner wanted to be evaluated to see if he had an industrial illness due to concerns about his lungs. Dr. Whitehouse did not find any evidence of asbestosis or any industrial illness, but did diagnose Petitioner with bronchial asthma probably superimposed on some underlying mild bullous emphysema.[26]

¶ 21 When Petitioner returned to see Dr. Whitehouse on July 28, 1998, he was complaining of increased shortness of breath, especially with climbing the ten stairs needed to get into his ore truck. Petitioner was diagnosed with asbestosis based upon chest x-ray changes and his pulmonary function studies.[27]

¶ 22 In later appointments with Dr. Whitehouse in July 2002, April 2004, and March 2005, Petitioner described difficulties with shortness of breath while walking on level ground,[28] shortness of breath when getting onto the exam table and walking from room to room at the doctor's office,[29] and dyspneic at rest.[30] On March 14, 2005, Petitioner completed a respiratory questionnaire in which he stated that his breathing made it difficult for him to do

---

[22] General Affidavit of Dr. Alan C. Whitehouse, ¶ 13.

[23] Trial Test.; Ex. 1 of General Affidavit of Dr. Alan C. Whitehouse.

[24] *Id.*

[25] Trial Test.; General Affidavit of Dr. Alan C. Whitehouse, ¶ 5.

[26] Ex. 1(a) at 3.

[27] Ex. 1(a) at 5.

[28] Ex. 1(a) at 27.

[29] Ex. 1(a) at 28.

[30] Ex. 1(a) at 44.

such things as walk up hills, carry things up stairs, light gardening, housework, and everything he would like to do.[31]

¶ 23 When Petitioner saw Dr. Rick Almaguer, his local physician in Elko, Nevada, on January 20, 2005, he stated that shortness of breath required him to rest for approximately twenty minutes to catch his breath between short periods of walking.[32] On January 21, 2005, Petitioner was admitted to the hospital for a right pleural effusion, which is an accumulation of fluid between the two layers of the pleura in the chest cavity. The pleural effusion was most likely secondary to Petitioner's asbestos exposure.[33]

¶ 24 The fluid in Petitioner's chest was surgically drained.[34] Upon discharge, Petitioner was placed on supplemental oxygen and advised to continue with nebulizer treatments.[35]

¶ 25 On February 28, 2005, Petitioner told Dr. Almaguer that he could not do regular chores without shortness of breath.[36] By August 1, 2005, Petitioner was "extremely SOB most of the time."[37]

¶ 26 Due to increasing shortness of breath and a chest x-ray showing an enlarged heart, Dr. Almaguer had Petitioner undergo an echocardiogram on April 28, 2005.[38] The results of the echocardiogram showed "[m]ild left atrial enlargement with normal appearing mitral valve and diastolic dysfunction, manifested as elevated left ventricular filling pressure," and a trace of tricuspid insufficiency.[39]

¶ 27 The cardiologist, Dr. David M. Hogle, who did the echocardiogram (echo) reported that the study was a technically limited study based on grainy 2-D views due to lung

---

[31] Ex. 1(a) at 36.

[32] Ex. 3 at 48.

[33] Ex. 2 at 369.

[34] *Id*.

[35] *Id*.

[36] Ex. 3 at 49.

[37] Ex. 3 at 58.

[38] Ex. 3 at 54-55.

[39] Ex. 3 at 55.

disease.[40] Echos use ultrasound (high frequency sound waves) to image the heart. The procedure is noninvasive.[41] Dr. Whitehouse testified that good echos are more difficult to obtain in patients with lung disease because the diseased lung is between the chest wall and the heart.[42]

¶ 28 Dr. Whitehouse testified at trial that cor pulmonale is right-sided heart failure. In his deposition, Dr. Whitehouse testified that Petitioner has pulmonary hypertension and cor pulmonale.[43] The indicia for pulmonary hypertension is as follows:

> He's on continuous oxygen, he has chronic edema, he was so short of breath in the office on oxygen that he could barely get up on to a table, and then had to sit for awhile before he could even talk because he was so short of breath. He was very tachypneic at that point in time. So he falls also into the category of pulmonary hypertension of a class 4.[44]

¶ 29 Petitioner is without significant heart disease to otherwise explain the edema.[45] The echo of April 28, 2005, shows "a trace of tricuspid insufficiency."[46] At trial, Dr. Whitehouse referred to *Fishman's Pulmonary Diseases and Disorders* as an authoritative text on pulmonary disease. At page 1267, it states "tricuspid insufficiency . . . is often delayed until pulmonary hypertension is severe and has led to heart failure. . . . In sustained severe pulmonary hypertension, tricuspid insufficiency is commonly seen."[47]

¶ 30 Dr. Whitehouse explained the mechanism for this, and how it is a factor in the diagnosis of Petitioner's cor pulmonale and pulmonary hypertension. The hallmarks of cor pulmonale are pulmonary hypertension, low oxygen levels in the blood, and edema. Dr. Whitehouse testified that cor pulmonale is almost always related to lung disease and pulmonary hypertension. According to Dr. Whitehouse, in Libby asbestos cases, pulmonary hypertension

---

[40] *Id*.

[41] Trial Test.

[42] Trial Test.

[43] Whitehouse Dep. 48:16-17.

[44] Whitehouse Dep. 49:12-19.

[45] Trial Test.

[46] Ex. 3 at 55.

[47] A. Fishman, M.D., *Fishman's Pulmonary Diseases and Disorders*, 3rd ed., McGraw-Hill, 1998, Chap. 83, "Pulmonary Hypertension and Cor Pulmonale", p. 1267.

and cor pulmonale are due to the heart pumping against increased pressure due to the asbestos disease.[48]

¶ 31 On July 23, 2002, Dr. Whitehouse noted that Petitioner had 2+ edema and encouraged Petitioner to take Lasix.[49] Despite remaining on Lasix, Petitioner was again noted to have 1+ bilateral edema on September 11, 2003,[50] and continuing trace bilateral edema on January 24 and January 25, 2005.[51] At his last exam with Dr. Whitehouse on June 5, 2006, the doctor again noted 1+ edema.[52]

¶ 32 In May of 2005, Dr. Whitehouse completed a form entitled "Doctor's Estimate of Pulmonary Residual Functional Capacity."[53] The doctor noted that Petitioner was basically "wheelchair bound"[54] at that time and "could barely walk into [the] clinic."[55] The doctor found that Petitioner could stand a total of one-half hour during the course of a day, and the remaining time he would need to be sitting or reclining. Dr. Whitehouse noted that from a functional standpoint, Petitioner could not walk, could only stand for a half hour at a time, could only lift up to five pounds, was required to rest 15 minutes between activities, and was prohibited from doing any reaching and/or using foot controls. Dr. Whitehouse characterized Petitioner's asbestos disease as severe both radiographically and in terms of pulmonary function test results. The physical symptoms of Petitioner's functional limitations included shortness of breath, edema, pleural pain, rales, rhonchi, fatigue, coughing, and chest tightness.[56]

¶ 33 Dr. Whitehouse explained that lung function test results vary with the individual. "Total lung capacity (TLC) may be in the severe range, whereas forced vital capacity (FVC) and diffusion capacity (DLCO) may not, yet the patient may have severe impairment of function."[57]

---

[48] Trial Test.

[49] Ex. 1(a) at 27.

[50] Ex. 2 at 296.

[51] Ex. 2 at 384-85.

[52] Ex. 1(a) at 46.

[53] Ex. 1(b).

[54] Ex. 1(b) at 3.

[55] Ex. 1(b) at 9.

[56] Ex. 1(b) at 1.

[57] General Affidavit of Dr. Alan C. Whitehouse, ¶ 48.

In such cases, page 107 of the *American Medical Association Guides to the Evaluation of Permanent Impairment*[58] call for the use of clinical judgment in assigning an impairment rating.[59]

¶ 34 Dr. Whitehouse further explained that the AMA Guides, Table 5-12, require that FVC be in the 40s or DLCO be in the 30s before the individual is considered impaired greater than 50%. In his experience with patients with asbestos disease from Libby tremolite asbestos exposure, Dr. Whitehouse testified that many are dead before they reach this point.[60]

¶ 35 Incorporating the foregoing principles, Dr. Whitehouse began to calculate Petitioner's impairment rating by first noting that he had a DLCO of 34%.[61] According to the AMA Guides, that would place Petitioner into a Class 4, which means that his impairment is somewhere between 51 and 100%.[62]

¶ 36 Dr. Whitehouse then considered Petitioner's FVC of 52%. He explained the significance of this result as follows:

> You know, class 4 says he has to be less than 50 percent of predicted. I don't know if anybody can really imagine how bad a 50 percent vital capacity is . . . . When you get down anywhere near 50 percent, you can hardly do anything.[63]

¶ 37 Based upon his knowledge of not only the severity of Petitioner's disease, but also taking into account the severe limitations Petitioner was experiencing in his activities of daily living and the pulmonary function results as required by the AMA Guides, Dr. Whitehouse opined that Petitioner's impairment from respiratory disorder was 85%.[64]

---

[58] L. Cocchiarella, *et al*. (eds.), *American Medical Association Guides to the Evaluation of Permanent Impairment*, 5th ed., AMA Press, 2005 (AMA Guides).

[59] General Affidavit of Dr. Alan C. Whitehouse, ¶ 48.

[60] Trial Test.; General Affidavit of Dr. Alan C. Whitehouse, ¶ 50.

[61] Trial Test.

[62] Whitehouse Dep. 47:19 - 48:4.

[63] Whitehouse Dep. 51:8-16.

[64] Trial Test.; Whitehouse Dep. 55:9-15.

¶ 38 Dr. Whitehouse also assessed an impairment for pulmonary hypertension.[65] Based upon Petitioner's use of continuous oxygen, his chronic edema, his severe shortness of breath, the fact that he was very tachypneic (increased rate of respiration), the hypoxia, the tricuspid insufficiency, and his severe limitation in activities of daily living, Dr. Whitehouse felt Petitioner met the classification of Class 4 in the category of pulmonary hypertension.[66] Tables 4-6 of the AMA Guides requires for Class 4 "symptoms of severe limitation (class 3 or 4) with any degree of pulmonary hypertension."[67] Based upon his physical symptoms and evidence of pulmonary hypertension with chronic edema and some tricuspid insufficiency, Dr. Whitehouse estimated Petitioner's pulmonary hypertension impairment to be 51%.[68]

¶ 39 Using the Combined Values Chart at page 604 of the AMA Guides, Petitioner has a total impairment of 93%, according to Dr. Whitehouse.[69]

¶ 40 Dr. Headapohl is a physician practicing medicine at St. Patrick Hospital and Health Sciences Center (St. Patrick's) in Missoula, Montana. She is the medical director of Occupational and Environmental Healthcare Services, which focuses on the evaluation, prevention, and treatment of occupational and environmental illnesses. She has done hundreds of impairment ratings as part of her practice.[70]

¶ 41 Dr. Headapohl graduated from Stanford with a B.A. in human biology, she has a master's degree in public health from the University of Wisconsin, and she has a medical degree from the University of Washington. She is board certified in occupational medicine, and she is also board certified as an independent medical evaluator with the American Board of Independent Medical Evaluators. She uses AMA Guides frequently to give impairment ratings in her practice.[71]

---

[65] Trial Test.; Ex. 1(b) at 8-10.

[66] Trial Test.; Whitehouse Dep. 49:2-23.

[67] AMA Guides at 79.

[68] Trial Test.; Ex. 1(b) at 9.

[69] Trial Test.; Ex. 1(b) at 10.

[70] Trial Test.

[71] Trial Test.

¶ 42 Respondent retained Dr. Headapohl to perform an independent medical examination of Petitioner and to give him an impairment rating. Dr. Headapohl evaluated Petitioner on March 13, 2006.[72]

¶ 43 Dr. Headapohl agreed with Dr. Whitehouse that Petitioner's pulmonary function testing showed a severe restrictive component consistent with interstitial disease.[73] Dr. Headapohl also agreed that Petitioner's pulmonary function studies indicated a Class 4 impairment rating somewhere between 51 to 100%.[74]

¶ 44 Dr. Headapohl then calculated an impairment rating based upon a range of viable DLCO numbers from 10 (assumed minimum for patient viability) to 40% (maximum for Class 4, AMA Guides).[75] This is a 30-point spread. Using a DLCO of 36%, Dr. Headapohl determined that a 4% reduction in the DLCO below 40% equated to a 7% increase in the impairment rating. Adding 7% to the Class 4 threshold of 51%, Dr. Headapohl arrived at an impairment rating of 58%.[76] Dr. Headapohl did not find evidence of pulmonary hypertension or cor pulmonale and thus did not increase Petitioner's impairment rating for that condition.[77]

¶ 45 Dr. Headapohl discussed the appropriateness of this methodology for calculating Class 4 respiratory impairment. She testified the appropriateness of the methodology has been confirmed by the author of "The Respiratory System" chapter of the current edition of the AMA Guides, Paul E. Epstein, M.D., Clinical Professor of Medicine and Chief of Pulmonary and Critical Care Medicine, Penn Medicine at Radnor, University of Pennsylvania.[78] She was not aware, however, whether any other practitioner employed such a method.[79]

¶ 46 Both Drs. Whitehouse and Headapohl agreed that they exercised their own clinical judgment in arriving at Petitioner's impairment rating.[80] Both doctors agreed that clinical

---

[72] Ex. 9 at 1-25.

[73] Ex. 9 at 24.

[74] Ex. 9 at 25.

[75] Trial Test.

[76] Trial Test.; Ex. 9 at 25.

[77] Trial Test.; Ex. 9 at 24.

[78] Trial Test.

[79] *Id*.

[80] *Id*.

judgment goes into arriving at an impairment rating and the AMA Guides specifically provide for the exercise of such judgment.[81]

¶ 47 Drs. Headapohl and Whitehouse disagreed as to what constituted the lowest viable DLCO number. No specific study has been conducted on what constitutes the minimum viable DLCO number. Dr. Headapohl opined that 10% was the lowest viable DLCO number. She arrived at this number by calling several hospitals around the country and inquiring as to the lowest DLCO level they had observed in their patients. Dr. Whitehouse disputed Dr. Headapohl's use of 10% as the lowest viable DLCO number. Dr. Whitehouse testified that, based on his experience treating diagnosed asbestos patients in Libby, the lowest DLCO he has observed in a Libby asbestos sufferer is 26%.[82]

CONCLUSIONS OF LAW

¶ 48 Petitioner's last day of work was September 25, 1990, and thus 1989 law applies to this claim.[83]

¶ 49 Petitioner bears the burden of proving by a preponderance of the evidence that he is entitled to the benefits he seeks.[84]

Impairment Award

¶ 50 Respondent has raised the issue of whether or not Petitioner is entitled to an impairment award pursuant to the Montana Supreme Court's holding in *Rausch v. State Compensation Ins. Fund*.[85] In *Rausch*, the Court held that the 1987 and 1989 version of § 39-71-703, MCA, "specifically prohibits any claimant who is eligible for PTD benefits from receiving an impairment award."[86]

¶ 51 The Court determines Respondent's reliance on *Rausch* in the present case is misplaced. Petitioner was first declared permanently and totally disabled on October 15,

---

[81] *Id*.

[82] *Id*.

[83] *Grenz v. Fire & Cas. of Conn.*, 278 Mont. 268, 271, 924 P.2d 264, 266 (1996).

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

[85] Rausch, 2005 MT 140, 327 Mont. 272, 114 P.3d 192.

[86] *Id.*, ¶ 14.

2004.[87] Although this declaration may have otherwise rendered Petitioner eligible for PTD benefits – thereby rendering him ineligible from receiving an impairment award under the 1987 and 1989 versions of § 39-71-703, MCA – Petitioner was already retired at the time he was declared PTD. Therefore, Petitioner was not eligible to receive PTD benefits pursuant to § 39-71-710, MCA. Since Petitioner was not eligible to receive PTD benefits, the prohibition set forth in *Rausch* does not apply. The Court notes that the constitutionality of § 39-71-710, MCA, has been challenged and this Court's ruling upholding the constitutionality of this statute is presently on appeal before the Montana Supreme Court. As matters presently stand, however, this Court has upheld the constitutionality of that statute.[88] Therefore, since Petitioner was at no time eligible to receive PTD benefits, the holding in *Rausch* does not deprive him of his eligibility for an impairment award.

¶ 52 Both Drs. Headapohl and Whitehouse agree that Petitioner is properly placed in Class 4 due to his respiratory disorder.[89] Dr. Whitehouse further found Petitioner was entitled to an impairment rating for pulmonary hypertension. As Dr. Headapohl testified, both she and Dr. Whitehouse believe that Petitioner falls within the severe range.[90] Class 4 is a broad range, allowing for impairment ratings of anywhere between 51 and 100%. The dispute in this case is where within this broad range Petitioner's impairment properly lies.

¶ 53 The methodologies employed by both doctors relied, to a certain degree, on both subjective and objective information. Likewise, they both employed, to a degree, anecdotal information. Their conclusions also employed a certain amount of clinical judgment. In the case of Dr. Whitehouse, the information upon which he relied and the clinical judgment he exercised included his first-hand experience and treatment of over 700 asbestos patients in Libby and his first-hand treatment of Petitioner. Dr. Headapohl's opinion was premised, in part, on her experience as an occupational medicine specialist and her training and experience in the AMA Guides.

¶ 54 With respect to Dr. Headapohl's determination of the lowest viable DLCO number – a critical component in her ultimate calculation of Petitioner's impairment – she arrived at this figure by making phone calls to six hospitals around the country. These facilities included the Mayo Clinic, St. Patrick's in Missoula, Kalispell Regional Medical Center, National Jewish Hospital, the University of Utah, and another medical facility on the east coast that she could not recall. Most of these facilities had observed patients with DLCO numbers as low as 10%.

---

[87] Ex. 4 at 4.

[88] *Satterlee v. Lumberman's Mut. Casualty Co.*, 2006 MTWCC 36.

[89] Trial Test.

[90] *Id*.

Dr. Headapohl testified, however, that St. Patrick's had not observed a patient with a DLCO number below 15%. With respect to the DLCO norms being used by the hospitals Dr. Headapohl called, she believed they were all using Crapo norms.[91] She testified that although some facilities use Knudson norms, she did not think any of the facilities she contacted did.[92]

¶ 55 In determining which doctor's opinion carries the most weight, the Court ultimately finds Dr. Whitehouse's testimony to be more persuasive. Both doctors were credible witnesses and both employed their own clinical judgment in arriving at their conclusions. However, Dr. Whitehouse has had extensive experience specifically treating asbestos patients in Libby over a number of years. He has also treated Petitioner for a considerable length of time. As a general rule, the testimony of the treating physician, although not conclusive, is entitled to greater weight.[93] Finally, although I find Dr. Headapohl's overall methodology to be reasonable, I find the methodology she used in determining what constitutes a minimum viable DLCO number to be less persuasive. In his years of experience treating hundreds of asbestos patients in Libby, Dr. Whitehouse had never observed a patient who survived for an appreciable length of time with a DLCO number below the high 20s.[94] Conversely, Dr. Headapohl noted that, with the exception of St. Patrick's, the other medical facilities reported to her that they had observed patients who recorded DLCO numbers as low as 10. However, she could neither testify to the number of these patients whose DLCO number was as low as 10 nor to the number of total patients in the sampling.[95] Moreover, although she believed all the facilities she contacted were reporting numbers based on Crapo norms, she could not testify with certainty to this fact and, indeed, she acknowledged that some facilities use Knudson norms.[96] This may be a fair assumption but it calls into question the reliability of these numbers since a conversion between these norms may skew the numbers by several points.[97]

---

[91] The testimony revealed that there are two different sets of norms, Crapo and Knudson, which are used when determining an individual's DLCO percentage. Depending on which norms are used, an individual's DLCO number can be impacted significantly. The AMA Guides use the Crapo norms.

[92] Trial Test.

[93] *EBI/Orion Group v. Blythe,* 281 Mont. 50, 56, 931 P.2d 38, 42 (1997).

[94] Trial Test.

[95] *Id*.

[96] *Id*.

[97] *Id*.

¶ 56 Dr. Headapohl did not represent that this was a scientific study and, in the absence of any such study, her methods may have been reasonable, albeit anecdotal. When compared to Dr. Whitehouse's extensive experience and his role as treating physician, however, the Court ultimately finds his opinion on this matter more persuasive. The Court therefore concludes that Petitioner's combined impairment rating is 93%.

Penalty and Attorney Fees

¶ 57 Section 39-71-2907, MCA, allows for an increase in award when an insurer unreasonably refuses payment of benefits.

¶ 58 In this case, the difference between Dr. Headapohl's and Dr. Whitehouse's impairment ratings was substantial. Dr. Headapohl's rating was near the bottom of the range, while Dr. Whitehouse's was near the top. The doctors disagreed whether Petitioner met the criteria necessary for pulmonary hypertension and they used different methodologies to arrive at their respective impairment ratings. Although the Court ultimately finds Dr. Whitehouse's conclusions more persuasive, the Court has also found both methodologies employed a certain amount of subjective and objective information and clinical judgment. The Court also has found Dr. Headapohl to be credible. Accordingly, the Court does not conclude that Respondent's conduct in this claim was unreasonable and that an award of a penalty or attorney fees is warranted.

Costs

¶ 59 Petitioner is entitled to costs pursuant to § 39-71-612, MCA. Since the controversy is related to the amount of compensation due Petitioner, and by order of this Court, Petitioner has become entitled to additional compensation benefits, Petitioner is entitled to reasonable costs.

JUDGMENT

¶ 60 Petitioner is entitled to an additional 35% in impairment benefits.

¶ 61 Petitioner is entitled to reasonable costs relative to the award of the impairment benefits pursuant to § 39-71-612, MCA.

¶ 62 This JUDGMENT is certified as final for purposes of appeal.

///

¶ 63 Any party to this dispute may have twenty days in which to request reconsideration from these FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT.

DATED in Helena, Montana, this 22nd day of May, 2007.

(SEAL)

/s/ JAMES JEREMIAH SHEA
JUDGE

c: Laurie Wallace
Jon L. Heberling
Todd A. Hammer
Submitted: February 21, 2007