IN THE WORKERS' COMPENSATION COURT

OF THE STATE OF MONTANA

EULA MAE HIETT,

vs. WCC NO. 2001-0278

MSGIA/MONTANA STATE FUND

HONORABLE MIKE McCARTER, presiding

On the 11th day of May, 2005, beginning at 1:00 p.m., the above-referenced in-person conference was held at the Workers' Compensation Court, Helena, Montana, before Yvonne Madsen, Registered Professional Reporter, Certified Shorthand Reporter, Notary Public.

A P P E A R A N C E S

Honorable Mike McCarter, Judge

Clara Wilson, Deputy Clerk of Court

ATTORNEYS PRESENT:

David Sandler

James Donahue

Sydney McKenna

C.J. Tornabene

Larry Jones

Thomas Harrington

Thomas Martello

Oliver Goe

Ronald Thuesen

Diana Ferriter

Rick Davenport

Nancy Butler

Ronald Atwood (By phone)

Robert James (By phone)

WEDNESDAY, MAY 11, 2005

THE COURT: Okay. Well, let's start the conference. We're missing at least one attorney, Dave Sandler. And I think what I'll do to start out with is have everybody introduce themselves around the table.

And, Yvonne, you probably don't know everyone. There's a couple of new faces.

(Discussion held off the record.)

MS. McKENNA: Syd McKenna from Missoula, Montana. I represented Eula Mae Hiett.

MR. TORNABENE: C.J. Tornabene from Missoula, Montana. I'm Syd's partner and representing Eula Mae Hiett.

MR. MARTELLO: Tom Martello, Montana State Fund.

MR. HARRINGTON: Tom Harrington for the Montana State Fund.

MR. JONES: Larry Jones, Liberty Northwest and Liberty Mutual.

MS. FERRITER: Diana Ferriter with the Employment Relations Division.

MR. DONAHUE: Jim Donahue for Lumber Mutual Insurance.

MR. GOE: Oliver Goe on behalf of several

insurers.

MS. BUTLER: Nancy Butler for Montana State Fund.

MR. THUESEN: Ron Thuesen representing several insurance companies.

THE COURT: And then we have -- Mr. Atwood you're on the phone?

MR. ATWOOD: I am, thank you.

THE COURT: And Bob James on the phone?

MR. JAMES: Yes.

THE COURT: Okay. I think what we'll have to do is we'll have to try to have only one person speak at a time, and I guess I'll start out.

I think the primary purpose of this meeting is to identify what the outstanding legal issues are that we need to brief and to find out what other things we need to talk about. And, Syd, do you want to start, or do you want --

MS. McKENNA: Sure, I can start.

It seems to me, Judge, that the last time we were here, the one thing we talked about was what was the scope of the Hiett decision. And I have given that some thought since the last time we met, and I think that maybe it might be easy to

look at it in sort of two stages. I think if you take the stage from the time that the Work Comp decision came down until the time that the Supreme Court decision came down, which would be from September 6th, 2001 until August 14th, 2003, the files that might be implicated might be easier to identify. I think that in that stage, I know that there were sort of Hiett denial letters that went out. I'm fairly certain that Liberty Northwest was doing that. I think the State Fund has represented in the past that they did not do that. But that would be one way of identifying, you know, and sort of getting going maybe on identifying some of the claimants who are entitled to medical benefits as a result of the Hiett decision.

The second question was, Well, looking at the Supreme Court decision, what exactly -- you know, what kind of claimants are we looking at and whether we could get every potential claimant that might be implicated, whether or not the common fund would include all of the claimants that were denied medical benefits after they reached MMI or whether it would just involve a certain amount of claimants who, for instance, as Eula May Hiett,

could not return to work or whether the palliative and maintenance provisions were also included in defining the common fund.

THE COURT: Yeah, I mean --

MS. McKENNA: I remember that we did talk about that I had said that, you know, maybe we would need to limit the scope in the sense of only looking at those persons who, let's say, incurred a certain amount of medical bills or who had had medical treatment for a certain amount of time so that we wouldn't be getting into everyone who, let's say they, you know, went in to the doctor once or twice and then that was it, but we'd be looking at all those claimants who had reached MMI whose medical benefits were either terminated permanently or temporarily on the basis that they no longer met the definition of primary medical services. And I think that would be the broad definition of the common fund.

THE COURT: Okay. One of the questions I had, and still have, is how do we identify claimants who have reached MMI and who have been denied medical benefits based on the secondary medical services rule. And I think they have to be identifiable because if they're not

identifiable, then I don't think we have a class of claimants to basically certify the common fund.

MR. JAMES: I'm Ron James, I'm on the train.

THE COURT: The next question is where to. That's funny.

Have you thought about that at all? You know, how can we possibly identify these claimants without going through every single file? I mean, even if we could winnow it down to claimants that have reached MMI, assuming that we could do that, and I suppose to some extent we might be able to do it by looking at categories like permanent partially disabled or permanently totally disabled, that would tell us that they've reached MMI. But even then, how will we identify those people?

MS. McKENNA: Well, I'm not exactly sure how we're going to identify those people although I have seen letters that have been generated for me, they're the State Fund or Liberty Northwest where they would say to the person -- you know, this care that you're trying to get is chiropractic and it's maintenance care, it's not available to you because it's not helping you

return to work and so I believe that their -- you know, the adjusters were perhaps trained and there were form letters that were sent out to deny people who were still receiving medical benefits post MMI on the basis that they no longer met the definition of primary medical services. And sometimes the statutes were written into the letters. Sometimes there was, you know, other sorts of, like the 704 statute was written in, or the definition of primary medical services was written into the letters.

THE COURT: Okay. But the scope of our Hiett decision really deals with the secondary primary distinction, it really doesn't deal with palliative and maintenance care, so how do we work that in?

MR. MARTELLO: Well, Judge, I think there's also an additional problem. Even for those ones that potentially are identified as cases that were determined or a decision was made based upon the primary versus secondary medical care. And really, what is different about the Hiett type of case with all the other common fund cases is that it seems like each one has to -- a factual inquiry needs to be made as to whether the

criteria that was enunciated in the Hiett Supreme Court decision is either met or not. It seemed to be a very factually specific case as to whether the -- whether it's a medication or a certain type of treatment that is sustaining MMI. And that almost seems to me it would require, you know, some sort of medical testimony and a factual inquiry that we really don't have present in these other type of common fund cases.

So I think even if you identify the cases, then it's almost like you're going to have to have a mini trial on each one of them or at least a factual inquiry on each one of them.

MS. McKENNA: I guess the way that I look at that, though, is that these people were getting medical services and at some point they were -- the medical services would be terminated and that we should be able to figure out those people whose medical benefits were terminated after they reached MMI. And --

THE COURT: Well, that's a good question and maybe we ought to put that in. There's a question in my mind as to whether or not that could be readily ascertained other than by a file review. I don't know whether there's some sort of

computer field that you could run that would say medical benefits terminated or denied or something like that. And maybe that's a question we ought to pop to the insurers' attorneys and ask them if they know. I mean, I don't even know whether they'd know. It may take some IT people. That would be one question.

I mean, I think if we have to go through every single file and look at this thing, I'm skeptical that there's a class for common fund purposes. If there's some identifying criteria, then we may have it and that's where -- do you see the direction I'm going to, is to try to find out if there are identifiable criteria where we can readily identify these people, there's some sort of bright line to identify these people to even look at in the first instance.

MS. McKENNA: Again, I guess maybe I'm not quite following what your concern is. But my understanding is, is we'd be looking at people who are getting medical benefits whose medical benefits were terminated. And then there was apparently, generally, some reason given. So I don't necessarily agree that we'd be having to go back and adjust each and every claim because

generally there was a reason given to the claimant for the fact that their medical benefits were terminated.

MR. MARTELLO: But it has to be broader than that, simply because they're terminated, you still have to have the expert testimony of the doctor saying that by terminating either this medical procedure or this prescription that that somehow puts the person in a situation where they're no longer able to sustain MMI. That's what the whole key of Hiett is when you look at it. And you can't just make that determination by looking at the file and say, Okay, the causal connection is established simply because you terminate a service, that that somehow automatically translates to the fact that MMI is not now being sustained.

THE COURT: Well, let me ask this question. I haven't looked at the Hiett decision recently and you counsel probably have, or at least I hope you have. Does the Hiett decision do away with the secondary primary distinction entirely, or does it do away with it on a more limited basis only where the secondary services as defined in that section sustained maximum medical

improvement? What's your view of it?

MS. McKENNA: I suspect we're going to have different opinions in that regard. And mine is that I think that it basically obliterates the distinction of secondary medical services. I think it does away with it entirely.

THE COURT: Okay. Who has a different --

MR. HARRINGTON: Judge, I think now you need to evaluate secondary medical services in light of the Court's holding in Hiett that you don't have necessarily a specific point of MMI anymore. It could be an ongoing stage that, you know, a claimant finds himself in. I know prior to Hiett it used to be identifiable by a specific point in time where a doctor said, You are now at MMI as of such and such date. And as the Hiett decision indicates, there may now be a window of MMI where a claimant is in a state of MMI rather than just at MMI on Day One and then post MMI afterwards. And I think if you're evaluating secondary medical care, it needs to be done pursuant to Hiett's language, and I think that's all the decision really did.

Can I comment on this ascertainable class issue?

THE COURT: Uh-huh.

MR. HARRINGTON: This came up in our December conference. And as you recall, it was a significant concern that you had. We met with the State Fund people before that conference, and we were informed that there is no way to identify these people through a computer search like we've done in all the other common fund cases. And one of the issues that surfaced in December during the conference was that if we have to do a manual review unlike what's done in all the other cases, then this might be a situation where the claimant's counsel is going to have to pay for those significant costs and expenses associated with having an insurer manually review each file to determine if there are any Hiett-type claimants.

And that was an issue that really never was resolved. We had discussed it. It didn't really go anywhere. But that was one of the points that we made during that conference, was that this clearly is a different situation than the other common fund cases. This is more like the Wild case where it's very difficult to run a computer query to capture this ascertainable class

of beneficiaries. And even if we do define class, then we have significant problems in calculating how much they may be owed as a result of the Hiett decision but how do you quantify medical care that should have been given that wasn't. Are you going to pay claimants a certain amount of money? Or if you're just sending them back to a physician, then where is the fund?

THE COURT: Well, it could be a practical problem in that if they're denied initially, then they don't submit subsequent bills. So you may have subsequent bills out there. I don't know. I mean, this is sort of a --

MS. McKENNA: The same arguments were made in some of the class action stacking cases that I was involved in. And, you know, I think the question, first of all, is there probably are those people who did submit bills to private carriers, you know, continued to get their chiropractic treatment or their physical therapy treatment and submitted those bills to private carriers. And then there probably are those people that maybe paid out of their own pocket, and there might be people who just didn't seek the treatment, who then might get, might now seek

treatment.

So I would agree that there would be some different, you know, situations. But I think the question is, can the State Fund or Liberty or these other insurance companies identify claimants who were at MMI, then perhaps we limit our scope, had been getting treatment for at least six months and whose medical treatment was terminated. I find it difficult to believe that they can't identify those files or those persons. And I think once you make that identification, then you do have to go in. And it was like the same arguments were made in these class action stacking cases that, well, now, you're going to have to adjust each and every, you know, medical situation. Well, that's what adjusters do.

THE COURT: But in the first instance, you can identify where the insurance is stacked, and that's my first issue in this case, is can we identify these claimants so that we can even do a review, forget about getting down the road and actually looking at the individual files and figuring out what kind of problems we're going to have there and what kind of involvement there would be in order to do it.

I mean, my first question is, is how do we identify them? I mean, in a stacking case, you can go through and you can run the names of the insureds and you can identify those that have multiple policies and those who have paid the duplicate premiums for the same coverage, the UI coverage or the underinsured coverage. But, boy, I don't think we have that situation here.

And I guess one question, and I'm going to pop this back to the other side because I think this is one thing we're going to have to look at in the first place is, can we identify these people at all. When a claim gets denied, or when a medical request, a medical bill gets denied, what's generated in the computer with respect to that denial, if anything? Is there any entry made that goes into a computer database? And, if so, what is that entry? Can anybody representing any of the insurers answer that, at least for their people?

MR. DAVENPORT: Rick Davenport. I was identifying myself for her. I think you know who I am.

THE COURT: I do.

MR. DAVENPORT: There would be -- in our

system, there's nothing that would flag, you know, a case for benefits had been denied versus a case that had not been. In some of our systems, if a case had been denied at the outset and then later accepted, you would be able to see that at the very front. But if it's an accepted claim, that's how it shows is it's an accepted claim.

Denial of benefits is kind of a routine course of thing that happens, you make a decision on a daily basis on just about every different kind of thing that's identified, whether it's based on the Hiett decision or whether it's nonappropriate. There's just no flagging. There's no subjective way to slice and dice the data to see where it is.

THE COURT: So if you get a medical claim, a medical bill and you deny that, you don't go into the computer and say, got a medical bill and I denied it.

MR. DAVENPORT: Oh, you would, within the notes.

THE COURT: But it's in the notes.

MR. DAVENPORT: Right.

THE COURT: Okay. But that's not a searchable thing. You're talking about basically

like sort of a log or a journal?

MR. DAVENPORT: Right. Yes. The claims notes, whether it's the State Fund system or our system or anybody else, I don't know of any way to have searchable text within the system to go into the claims note and look for the word "denied" or the word "Hiett" or anything else. Maybe its conceivable, but I certainly don't know of any way to do it.

THE COURT: There is no coding that goes on?

MR. DAVENPORT: No.

MR. MARTELLO: The State Fund, and I can represent what we have on our computer system that way, but I would suspect it's similar to what Rick said. And we have additional things that I think come into play that would be a lot of red herrings to go in and say that medical bill is denied because we have managed care. And there are managed care issues that may come into play that have to do with why something is paid or not. And those sorts of issues, I think, just complicate it and make it even more difficult to refine it down to where it's just a denial and this is going to generate a population. I just don't think that

that's really feasible.

THE COURT: But the first question, though, is whether or not when a medical bill is denied whether or not there's anything that goes in the computer that you could search on through all these claimants that would identify these claimants that have had medical bills denied. And then the second question would be, even if you could do that, would it indicate the basis for the denial.

I mean, what happens when a State Fund adjuster denies a medical bill for whatever reason? Is there any entry into the computer, or is it sort of like -- okay, Nancy is going to see if we can get some computer expert.

Do you understand the journal type of thing that they're talking about?

MS. McKENNA: Yes, I do because I've seen the -- I generally, as a practice, get the claim file in advance of any case and so I ask for the notes so I know what they're talking about.

THE COURT: See, what I'm talking about here is if we did a computer search, for example, to try to find out whether people are being paid temporary total or permanent total disability

benefits, we could look at the first way it may be coded in the computer so we could run -- you know, ask the computer to identify every claimant who has ever received that. And even if we couldn't run that, we probably could run the amounts, there may be a way to run the amounts. And we sort of did that in the Broeker case, and I don't remember exactly how we did it.

But if we don't have anything in the computer that identifies this claimant has had medical benefits denied, then we don't even know that, and then we've got a real problem. And I don't know the answer to that. It sounds like as far as Rick is concerned, they don't do it for his clients, for the insurers he represents, other than make the entry in his notes.

MR. GOE: I can't speak for all the insurers I represent but, typically speaking, there's no entry in a computer data base that's going to tell you a particular bill has been denied because they never get into the data base. The bill shows up, the adjuster looks at it, may deny it because -- could have denied it because of a secondary medical service, but it may be denied for a whole host of other reasons as well, so you

aren't going to know that to begin with. But there is no particular entry in the system that's going to tell you, that's searchable, that a particular bill was denied.

MR. MARTELLO: And the volume is also another huge issue, and I'm just going off of my memory. But it's not unusual to get, you know, 10, 15, 20,000 medical bills a month. And if there was a way to go in and, let's say, find all of the ones that have been denied, I would venture to guess that well in excess of 95 percent of those things have virtually nothing to do with any sort of Hiett issues. And so you'd be generating just an inordinately large population of nonmembers.

MS. McKENNA: Again, Judge, one thing that I think would be important to keep in mind is that we aren't looking at all claimants, we are just looking at those claimants who had reached MMI and were either PPD or PTD and were still getting medical benefits. So I don't think it's a situation where we're looking, you know, right off the bat. And then I agree that when you then get down to, can you find whether the medical benefits were terminated, that gets to be an issue.

But I think the first thing you would look at is a search for how many people are we even talking about that were MMI, PTD, "P" partials and who were still getting medical benefits, say, you know, had had in excess of, you know. And maybe they don't keep track of how much they pay on each claim. But one of the reasons I was talking about limiting the search was to try to avoid hitting all of those, but maybe there's no way to limit that search.

THE COURT: Well, we could probably identify those who are classified as permanently partially disabled or permanently totally disabled, but that's going to be under-inclusive in the sense that there may be people who are neither who may still need some medical care, although that would probably become less likely, so being under-inclusive is better than having nothing.

But there's still a problem with -- you've probably got a pretty big universe still out there and then how do you know who is being denied benefits and why -- who is being denied medical benefits, that would be the question. I mean, you might be able to identify the paid

benefits. I assume that you probably can identify the paid benefits because you can run a computer search and find out if medical bills are being paid while they're in a category of permanent total or permanent partial disability benefits.

MR. DAVENPORT: Well, I can speak for our practice and that is if a person is classified or has, in fact, become permanently totally disabled, we have never restricted medical access. You know, our interpretation was that that person was entitled to unrestricted medicals so we never applied the terms of the Hiett.

Now, with respect to permanent partial, you know, they would be, you know, pretty much subject to the same standard that was almost made on a case-by-case basis depending on -- no case was the same and it was very difficult.

And Tom is right, you know. I mean, if a case is open six months, you know, people go to the pharmacy and they have other things going on in their lives. I mean, I can't tell how bills for Amoxicillin I've had to send back to a pharmacy because they weren't related to the injury.

MR. MARTELLO: Right. And that raises a

really big issue that you're constantly looking at, particularly with the perm totals where they may have a multitude of conditions that are unrelated to the injury and you have to go through and ferret out what is payable under the injury and what's not. And again, that has no Hiett implications. That's just simply managing the claim to pay those bills that are our liability.

And that occurs on perm partials, also, where you have someone who has pre-existing conditions that maybe aren't at all aggravated or involved with the work comp injury but nonetheless the medical providers will submit the bills to us for payment and you have to go through and determine whether that's paid or not. And that is probably the bulk of when you deny a medical bill.

THE COURT: Well, let me ask a "first" question. Shouldn't the first thing we do is cast out all insurers who are not using the secondary medical services as a basis for denying medical benefits?

MR. HARRINGTON: Yes.

MS. McKENNA: I would agree with that.

THE COURT: I mean, is there any reason to keep them in?

MS. McKENNA: No.

THE COURT: So if Rick's clients aren't using that distinction, his clients should go out. Is the State Fund using that distinction?

MR. HARRINGTON: They are not, Judge. And that was another issue that was brought up in December, is the State Fund did not have to change its adjusting practices after the Supreme Court's decision in Hiett, and we argued that we shouldn't be a part of this case.

MS. McKENNA: One of my concerns with the State Fund and that representation is that, again, then you get back to, I have letters from the State Fund denying medicals, you know, medical services based on palliative and maintenance that predated the Hiett decision.

THE COURT: Okay. But again, palliative and maintenance is a separate category and that doesn't really address the Hiett, does it?

MS. McKENNA: Yeah, I guess we're not communicating in terms of that. But my view on Hiett is that the Supreme Court said that you can have medical benefits to sustain medical stability and therefore you would not be able to deny on the basis of maintenance or palliative care.

MR. MARTELLO: But the Supreme Court specifically stated in the Hiett decision that those categories of maintenance and palliative care remain intact, that those were not thrown out as a basis for a denial of a medical service. And there's specific language in the decision to that effect.

MS. McKENNA: I don't agree with that interpretation.

MR. HARRINGTON: This was another issue.

THE COURT: Where is the case?

MS. McKENNA: I've got it.

MR. HARRINGTON: They talk about it in paragraph 34, Judge. And this was another issue we brought up in December, is what is the scope of the Hiett decision. Syd had suggested that the palliative and maintenance provisions were eliminated by Hiett. We, of course, took a different approach, and we even brought up the Hiett decision. You know, we feel that the palliative and maintenance provisions are wiped away.

THE COURT: So at least we've got an initial threshold issue as to the scope of Hiett and whether it essentially abrogates the

maintenance and palliative care provision or whether it's limited solely to denials based on the secondary medical services provision.

Tom, you said it's 34?

MR. HARRINGTON: I think so, Judge.

MR. ATWOOD: Your Honor, this is Ronald Atwood. And I think the sentence that he is talking about reads, "We find no tension or irreconcilability between the conclusion we reach here and the act reference to some maintenance for palliative care." And that is in paragraph 34.

THE COURT: All right. That's the last sentence.

MR. ATWOOD: That's the last sentence.

THE COURT: So it seems to me -- it looks to me like they're saying, you can deny it based on the fact that it's palliative or maintenance care and their decision isn't covering that sort of denial.

MS. McKENNA: Well, I don't necessarily agree with that interpretation, Judge, because if you look at paragraph 5, I think it just says -- what the Supreme Court is saying is that no matter what, you get to sustain medical stability. And so I think when you read paragraph 34 with

paragraph 35, you can come to a different conclusion.

THE COURT: Yeah, but wouldn't we have to have a fact -- I mean, they obviously see a distinction between a denial on the basis of secondary medical services and a denial based on maintenance care and palliative care because they say there's no tension between the two. If there's no tension between the two, you can deny it as maintenance care or palliative care without violating their decision, saying that it's necessary to sustain maximum medical improvement.

So, I mean, even if some palliative and maintenance care decisions would come under the -- to sustain medical care, to sustain maximum medical improvement, you could only determine that on a case-by-case almost trial basis.

MS. McKENNA: Well, what I think happened is that there were lots of people who reached MMI whose benefits were cut off because they had reached MMI and they were considered palliative or maintenance when those benefits would have helped them sustain medical stability. And to me, the Supreme Court was saying, you know, it's very simple, a work comp claimant who is injured gets

to sustain medical stability.

THE COURT: But not receive palliative or maintenance care, which they seem to indicate is valid.

MR. MARTELLO: But by definition, palliative or maintenance care is an optimum state of health, if you will, and improving someone's condition, but it doesn't sustain the condition, it brings them back, which is a different -- which is different than what the Supreme Court was saying in Hiett, which is that the prescriptions, if you will, that she was receiving, were needed to sustain maximum medical improvement. And that is --

I think when you look at the definition of palliative or maintenance care, it is a condition that it just improves it temporarily, but they return right back to the same state.

THE COURT: Well, palliative and maintenance care just stands independently, doesn't it? It's not dependent on their reaching MMI?

MR. MARTELLO: No, it's definitional, I think, under 118 or --

MS. McKENNA: Well, under sub (f), "The

insurer may not be required to furnish after the worker has achieved medical stability, palliative or maintenance care."

THE COURT: Let's see here. That's in 704?

MS. McKENNA: 704(f). And again, you know, I think in Hiett, we were certainly looking at her continuing employment as an issue, which was that 2(g).

THE COURT: The Hiett decision basically says you don't have to satisfy (g). All you have to show is that it's necessary to sustain maximum medical improvement so that you won't relapse into a non-MMI situation. And then in this paragraph 34, it seems to me that they're saying that that's different than palliative and maintenance care. And that palliative and maintenance care by definition would not meet the definition of care necessary to prevent a relapse.

So if it's denied on a palliative or a maintenance-care basis, it's not quite the same thing as a denial based on the fact that it's simply secondary medical services.

Well, okay. I think it sounds to me like the first thing we have to do is we have to get --

we have to address that threshold issue. And I guess as I'm reading the decision sitting here without the benefit of briefing, it looks to me like the Court has distinguished between palliative and maintenance care on the one hand and a denial of secondary medical services necessary to maintain or sustain maximum medical improvement on the other hand.

And if it's limited to that, then it seems to me that we need to identify insurers who have denied a basis -- on the basis of secondary medical services as opposed to palliative and maintenance care. And if they haven't denied on the basis of secondary services, if they don't use that criteria, then if my reading of Hiett is correct, my reading at this point of Hiett is correct, then we don't go any further with those insurers, I think, but I think we have to identify them. So I think, number one, we ought to brief that first issue.

MS. McKENNA: I agree.

THE COURT: And, number two, I think we need to ask the insurers to respond as to whether or not they ever have used the secondary medical services provision to deny benefits after

claimants have reached MMI.

MS. McKENNA: Judge, am I understanding that the second question would come after the first issue has been briefed?

THE COURT: Right, right, right.

MS. McKENNA: Because, again, if it's broader in regard to the palliative and maintenance, then we'd need to ask them that question as well.

THE COURT: Yeah. I mean, if I decide that my first inclination was wrong and that you're right, then they wouldn't go out on that basis --

MS. McKENNA: Right.

THE COURT -- so we wouldn't need to make that inquiry, so that would be a secondary inquiry.

MR. GOE: How would you propose to get that information from insurers that did not choose to participate, which is the vast majority?

MS. McKENNA: A really good order.

THE COURT: A really good order. "We're going to hang you by your thumbs" order. We could do that. And I suppose then a question would be whether or not just a simple response from them to

a court order would satisfy Syd or whether she'd want to do discovery.

MS. McKENNA: Yeah.

THE COURT: You know, that could be an inundating proposition to try to do discovery, so I guess, you know, you'd have to make that decision and tell me whether or not you thought you wanted to --

MS. McKENNA: Do that.

THE COURT -- put somebody under oath and ask him that sort of question. I suppose we could actually ask them, to compel them to answer it under oath. We could do that.

MS. McKENNA: One of the questions that I had, too, and maybe this is just too easy, but I think that there were Hiett denial letters. I mean, I think there were letters that went out from insurers that said, "Based on Hiett" --

THE COURT: In that interim period, I emboldened some insurers to use the secondary medical exclusion even though they weren't previously to that? It's possible.

MS. McKENNA: So I don't know if a computer search would --

THE COURT: We may have to survey their

claims adjusters and find out.

MR. HARRINGTON: Judge, do we even need to address these questions if this case is an inappropriate one to apply the common fund doctrine?

THE COURT: Well, I think we have to address these questions in order to figure out whether or not there's a common fund to start out with. I mean, firstly, sort of by process of elimination, if the insurer isn't using the secondary medical services rule to deny benefits, and my initial inclination to interpret Hiett as extending only to those insurers that do is correct, the correct one, then those insurers go out. Then we only have to worry about the rest.

Then the second question is, is do we have an identifiable class here. And, certainly, if you have an insurer who makes a computer entry when a medical benefit is denied and then has a list of reasons for the denial and one of those reasons is secondary medical services so that we could do a computer query and, bang, we've got a list of all of the medical benefits that have been denied because of the secondary services rule, then we may have a class, a common fund of those

particular claimants.

If we don't have any of that -- and that could be on an insurer-by-insurer basis -- if we don't have any of that, then the question becomes how do you identify any of those people, and that would be the next stage of trying to address that question. You see, it's sort of a filtering thing that I'm going through, at least in my own mind at this point. And I'm open to suggestions as to whether there's a better way to do this.

MR. HARRINGTON: Even if you get that far, though, and are able to identify an ascertainable class of nonparticipating beneficiaries, how are we going to go about figuring out damages? In analyzing the situation, it looks like you have to run through so many factual inquiries to determine what the damages are and you're likely going to have to either get a physician on the file to say, Well, these services would have helped the claimant sustain MMI, or you're going to have to gather up all the bills and figure out how much they spent in out-of-pocket damages.

This case is unlike the other ones where you had a framework like in Flynn and in Murer and

even in Broeker where you could do a computation and that was part of the reason why the common fund doctrine was applied after a class was identified was that at that point, I think in one of the hearings you referred to it as a ministerial act to just plug the figures in and let's get the damages cranked out. We do not have that in this case. Even if you could identify a class, you're going to have to run through mini trial after mini trail to figure out who is owed what.

THE COURT: Okay. So what you're saying is even if my scenario is correct that we've got an insurer who records the fact that they denied a claim and also records the basis of the denial being that it's a secondary medical services, that still doesn't give us our class because we still don't know whether or not the services that were denied were necessary to sustain maximum medical improvement. Are you following me?

MR. HARRINGTON: I am, yes.

THE COURT: Am I following you?

MR. HARRINGTON: Yes.

THE COURT: Okay. So you're saying we have to go through that next step and make an

individual inquiry as far as medical bills are concerned in order to identify whether or not they're benefited, in effect, or entitled to additional benefits, unless Hiett says that there's the complete obliteration of the rule.

MR. MARTELLO: Well, that was the point I was trying to make earlier, and you articulated it a lot better than I did. And once you get to that stage, then you have to have expert testimony. You're going to have a doctor saying, or some medical provider saying that whatever was denied was necessary to sustain MMI. And that language came about, if you will, in the Hiett decision. That is not language that a doctor is going to routinely say, that this is helping to sustain -- that's going to have to be elicited through a deposition or some sort of testimony. And it's factually specific to each individual case, which again, does not lend itself to a common fund or a class-action type of a case because it depends on the particular circumstance of that individual, and the doctor or medical provider's opinion as to the denied medical service as to what effect, if any, that has on sustaining MMI.

THE COURT: Okay, Syd, kick this back to

you. Are you contending that all secondary services are payable now under Hiett?

MS. McKENNA: No.

THE COURT: So we would have to do the exercise that the two Toms are talking about?

MS. McKENNA: Again, I make the analogy to these same arguments that I've heard in the class action stacking cases. The point is, is the insurance company decided at a certain point in time to terminate the services. In this case, arguably because they were secondary medical. The adjuster made that decision presumably with or without a doctor's opinion on that.

And then we are going to have to look at those situations. And some of those people -- you know, we are going to have to look at those situations and ask the question of whether this would have sustained medical stability.

THE COURT: But aren't you going to have to do that with just nearly every medical bill that's been denied, even if we can identify them as being denied on the basis of secondary services?

MS. McKENNA: I think that's possible, yes, that we are going to have to do that.

THE COURT: Are you willing to undertake that kind of review? Can you imagine what that would involve?

MS. McKENNA: Well, I think that unlike -- you know, similar to the stacking cases, I think that insurance companies are set up to do that kind of a review. If they denied the person's medical benefits and now the fund was supposed to be available to them, they have to revisit that and say the fund is available to you. And, perhaps, the claimant may or may not want to avail themselves of it.

But it's just like the stacking cases, and there's more coverage now and the claimants have to -- you know, the termination was made because the first coverage was exhausted and now the second coverage comes into play.

THE COURT: But that's easy. I mean, I don't buy your analogy to the stacking cases because the stacking cases you've exceeded the first limits, so you have to cut into the second limit. That is a mathematical, numerical computation.

In this particular case, you have to go back and you have to look at the medical

justification and figure out whether or not this is to sustain maximum medical improvement or not, and that probably is not going to appear in most of the files as to whether that's the case.

MS. McKENNA: Well, I think that the claimant was entitled to that inquiry being made. I think the claimants are entitled to that. They are entitled to receive medical benefits to sustain medical stability, and perhaps they were denied that. And so I think that inquiry has to be made for the claimant.

Just like some people who do exhaust, maybe they had another $1,000 and the same arguments were made by the insurance company, Well, we don't know if that was related to the car accident or if it was something else, but still the claimant was entitled to that money. And so because of that entitlement, and I think Hiett says they are entitled to it, the inquiry may have to be made. And it may be --

THE COURT: But with the stacking cases, you can identify those people. In this case, how do we identify those people without going through this bill-by-bill type of analysis?

MS. McKENNA: Well, again, my argument in

terms of how to identify the people is to say those claimants who reached MMI who were receiving medical benefits are either PPD or PTD and his medical benefits were terminated. You know, some of the insurers are saying, Well, we can't tell whose benefits were terminated. I may want to do some discovery on that in regard to whether their medical benefits -- I mean, whether or not they can identify the people whose medical benefits were terminated.

THE COURT: Well, even if they could, we're several steps short of identifying claimants who may be benefited by this, unlike the stacking case where you're pretty certain that they're going to be benefited unless they haven't spent that much money and then in which case they're going to be out of it, if their expenses have -- but in this case, you're several steps short. Number one, you don't know whether they've been denied because they're secondary medical benefits. And, number two, even more importantly, even if you know that and can figure that out, which you may not be able to except on by file-by-file review, even if you could figure it out, you still don't know whether or not it's necessary to

sustain -- to sustain maximum medical improvement so, I mean, you're two steps short. And those are two big steps, it seems to me. Do you see what I'm saying? I wonder how we get that --

MR. HARRINGTON: Judge, Syd's proposed approach to have the insurer review every medical bill in a case like this just underscores how expensive this common fund doctrine has become. This case, just step back and look at it, does not seem to be one that fits the parameters of the common fund doctrine. And if there are claimants out there who feel like they're entitled to additional benefits, there's nothing that prevents those claimants from bringing their situation to a particular insurer's attention to have them evaluate the medical situation, the benefits that they want to get and that evaluation can be done after Hiett. But there's no reason that an insurance company would have to review every single medical bill that's been denied and every claimant it's had to see if there are additional benefits owed under Hiett.

I mean, this is a not a case that needs to be managed under the common fund doctrine. There's too many factual problems in determining

damages, there's too many factual problems in identifying class. And the claimants still have an ability to bring a claim in front of an insurer, there's nothing that's stopping them from doing that. But to have us go out and look through every medical bill and identify every claimant to see who fits and who doesn't and who might and who shouldn't, that seems to me to be a little too big of an expansion of the common fund doctrine.

MR. TORNABENE: Your Honor, perhaps I could make a couple of comments. I find this kind of interesting. I don't do as much work comp as anyone else in this room, I'm sure, I haven't for years, and pardon me if I'm not real sympathetic with the insurance companies' position.

But what I've noticed here, first of all, is we took a case, a lady who was denied $1500 worth of medical bills. Now, to her it was the same as a million dollars. Now, from where we're sitting, we weren't going to see a big fee on this. We did it because we felt it was the right thing to do.

What we have is we have a whole bunch of other people that were probably in the same

position as our client, they're not going to go see an attorney and try to talk one into handling a $1500 claim, they're not going to call the insurance company and try to get their money because they don't know enough about the law to do that.

What I think we need is a procedure here to try to find as many of these people as we can. And one of the things that Syd has brought out is that we've come across a number of what we understand were called Hiett letters that denied these benefits, they denied them without a doctor saying they could deny them, they just simply denied them. So the idea that we should go get a doctor to come in and decide what's medically sustainable sort of goes against what apparently was okay from the claim adjuster's side in the past which was to deny the benefits without the benefit of a doctor telling them it was okay.

So to start with, I don't have a problem with somebody looking at each and every file in which they are able to delineate that there was a denial. And if you see a letter, like we have a couple of copies of, that indicate language that sounds like Hiett, then that file ought to be

looked at. And if it's going to take some time and some effort to do it, better they do that than have the person out there who should have got the money and never see it.

MR. MARTELLO: Judge, even if you took that sort of approach, let's say the adjuster goes through and looks at that file, who is going to be making that subjective analysis that that denial of that medical bill relates to sustaining or not sustaining MMI? That is not an objective criteria in which you can make a differentiation as to whether this is either in or out. The only one that can make that determination potentially is a medical doctor who's going to look at that particular individual's case and that particular medical procedure or prescription and make a determination as to whether that is, a denial of that is going to result in this person not being be able to sustain MMI.

THE COURT: Well, there possibly is a difference in treating cases in which you know you have basically a Hiett or the class that we were talking about where -- in between.

MR. MARTELLO: And I would agree with that.

THE COURT: And perhaps even a difference where if an insurer could, under my theoretical scenario, identify those cases where -- by computer -- identify all those cases in which they've issued a letter saying we deny on secondary medical benefits.

I think the argument can be made, and it's not off the wall, that the insurer ought to go back and take a look and forget about the -- you know, you look at it from the point of view, okay, now I have to look at it to see if it is necessary to sustain maximum medical improvement. And if I look at that, then I should make the payment if I determine it is.

The next question is, number one, can they do that, can you do that without asking for further information, which is a good question. I don't know the answer to that because you may have to ask for further information. And then the secondary thing is how do you do it with anybody else? I mean, assuming that we have a class where if these letters were issued, we've still got all of this other stuff, what do we do about them? Do we just exclude them or is this it, or are you going to argue that we should include everybody

and go through this whole thing, and how the heck are we going to do it?

MR. MARTELLO: Well, maybe I'm looking at it too simplistically, but I can't think of a case where this court has allowed an adjuster to make a determination without a doctor saying that someone is at maximum medical improvement. Say, you know, I've looked at this file and I've got enough stuff here to make the conclusion that this person is at maximum medical improvement, that's a medical determination. And as an insurer, we would never settle a case, other than on a disputed liability basis, where we didn't have a doctor saying that someone was at maximum medical improvement. I mean, that would be grounds to automatically reopen the settlement.

MS. McKENNA: That's interesting that in the Hiett case we never had a doctor talk about whether she -- there was no medical testimony in that regard.

THE COURT: I know, but we tried the case. And also, you can get that evidence in in other ways. For example, a doctor doesn't have to say MMI, the doctor could put in, you know, there isn't anything else I can do for this patient.

You know, there's some other ways to look at that, and I don't remember exactly what --

MS. McKENNA: Yeah. What basically came out in the Hiett case is she was denied because it wasn't helping her stay at work or work. She wasn't working.

THE COURT: Right.

MS. McKENNA: And basically, the Supreme Court said, "Look, she gets to keep on these antidepressants from her work-related injury to sustain medical stability," and there wasn't any medical testimony.

THE COURT: But there were medical records in the case.

MS. McKENNA: There were medical records that she was on the antidepressants and that it was a fact that she wasn't working.

THE COURT: Yeah. And one thing we could do is if a Hiett letter has issued or a denial is issued based on the secondary medical services, we could go back and look at that. And if the file clearly showed that it was necessary to sustain maximum medical improvement, then make the payment. But if it isn't, then you've got a contested case and you either have to go back and

you have to ask doctors questions. And if there's still disagreement, you have to have a trial over that, which is real different than the other common fund cases that we've had where, you know, basically we've got some sort of mathematical computation, or in most of the cases. Sometimes it's a little bit more complicated than that.

Well, how do we get these -- I guess the question I have in my mind is, you know, I think we see the problems and I think we see the kinds of things that we have to address, but how do we get them -- how do we bring them to a head so that we can address them and do we try to address all of them at one time. And I think -- I guess my druthers would be to address as many as we possibly could because my guess is this is a likely appeal either way. However I decide it, this case is probably going to get appealed. I think everybody is going to agree on that.

So I think the idea would be to try to get as much -- as many of the issues that we can envision decided and then let it go up and let the Supreme Court give us some direction as to how far is the common fund going to go, when do we have a common fund, when do we don't. And this may be a

good case for them to do that because of the kinds of problems. And they could tell us, okay, you can surmount these problems, but maybe you can't surmount these problems type of thing and we'll get a little bit better guidance.

And I guess part of what I need back from all of you right now is maybe some idea of evidentiary-wise. I mean, we could sit and talk about this and we sort of have some ideas about what can be done or what can't be done based on our experience in the field. But what kind of evidentiary record do we need to develop to make the arguments that are being made here?

MR. HARRINGTON: I think we need some factual information about the difficulties we'd encounter in identifying a class because that certainly is going to have a bearing on whether or not a common fund exists, if you want us to brief that issue, or else we're going to need to get factual information about the adjusting approaches that the insurance companies were taking. I know the State Fund has represented to you, although not in the form of a factual stipulation or an affidavit that it was in compliance with the Supreme Court's decision in Hiett before the

decision was even rendered.

Also some information on the difficulties we'd encounter in calculating damages and the mini trials that would be required, I think would need to be included in the evidence we're going to submit to you because that also has a bearing on the common fund and whether or not it's appropriate here. Retroactivity is also a concern. It goes hand in hand with --

THE COURT: Although, one of these days, we'll get a decision down in Stavenjord and Schmill and we'll have a pretty clear idea at that point on retroactivity.

MR. HARRINGTON: The hardships in this case are a little different than the hardships in the other cases because we can't get a feel for the monetary amount. But we do have a real good feel for how much, how many problems we would encounter in having people manually go through each file and review each medical bill that was denied. And certainly, that's maybe not quantifiable in terms of numbers, but we can present the evidence to show the difficulties we are experiencing in having to do that sort of thing and then has a bearing on the third Chevron

prong.

MS. McKENNA: It seems to me that maybe at the outset, Judge, we should resolve this issue about the scope of Hiett in regard to -- and that's a legal question that could be briefed and set up. And I think that that will certainly -- that's something that's got to be addressed and it would certainly clarify whether we're just talking about secondary medical and would involve all sorts of -- you know, would eliminate, obviously, a good portion of claimants if the scope isn't as broad as I'm suggesting.

THE COURT: Well, we've got two scope questions. The first scope question is whether it abrogates the maintenance and palliative care one. The secondary scope, although it sounds to me from your earlier response to my question, is whether or not Hiett abrogates all secondary services denial, and you indicated that it does not, so that's really not an issue. So that leaves us -- unless you want to rethink that -- but that leaves us with a case-by-case medical-bill-by-medical-bill inquiry, even if it was denied on the basis of secondary services, a medical-bill-by-medical-bill inquiry as to whether

or not the services are required to maintain maximum medical improvement.

So, I mean, we would have that scoped out if that's the position you're taking. The other position is basically that it abrogates the whole thing. And I mean you can take that position if you want to, that would narrow it down even further and make a clear bright line if that were the case, but I don't know whether you could justify it based on Hiett or not.

MS. McKENNA: Well, that's been my position.

THE COURT: So do you want to take a run at that?

MS. McKENNA: (Nodded in the affirmative.)

THE COURT: Okay. But then the question is, where do we go from there? I mean, do we wrap that into one package and send those two issues up to the Supreme Court, because it will be a year or two years before we get a decision back on that, and then we still have these other issues that are out there.

MR. MARTELLO: It seems to me that you have to do the -- you know, what does this cover?

You know, before you can ever get to the other issues, it seems to me that there are really three steps you'd have to go through. You'd have to do the scope and it may have subparts to it. And then you've got to determine once the scope is established whether it fits within a common fund given the scope that's been delineated. And it would seem, then, the third step would be the impediments if it does fit within the parameters of a common fund to the implementation and to the Chevron-type factors and things like that. And I don't know that you can package all of those things up because it seems that one may be the gateway to the other.

THE COURT: Yeah. I mean, my concern is -- I mean, we could do it from a filtering process and, you know, start and filter out one level and then go to the next level. And we could do that -- I mean, there's a couple ways we could do that. We could do that, first decide these two preliminary issues and then sit down with counsel again and decide should we go on to the next level and decide those issues with the first round of decisions governing what we do next and then filter on down until we've decided all of the

issues and then package that up and send it up to the Supreme Court. Or do we just take that first set of issues, which may well be very significant as to what follows and send that up to the Supreme Court, wait for them to decide that and then have that come back to us. Or the third possibility is do we try to address everything all at once. That's my question.

MR. SANDLER: Well, Judge, you said I haven't said a word. One thing I'll bring up is you've been talking about computer searches and everything and I know a lot of insurance companies here have the ability to do that. But I have one client that I know does not, just because of age and technology and stuff, does not have the ability to do that. And so for Rausch/Ruhd, they at the end after talking to the IT people and what it would take and their filtering and whatnot, and this isn't Rick, it's another adjustment firm, that they just finally said, you know, the only way we can do this is to send the adjuster to the warehouse and literally start going through files.

You probably know who it is because the first batch of materials I sent you said that after this adjuster worked for two-and-a-half

weeks straight reviewing physical files, this is what we got. And you'll get another batch here soon, so I just want to make the point that it's not possible for all insurers to sit and do computer searches.

THE COURT: Well, that raises the question that I raised before, is it possible that we can identify claimants for some insurers and not for others, you know, on the readily identifiable type of thing. And it comes back to also what can we require be done in order to identify these claimants. I mean, it just seems to me that you don't have a class if you have to go through manually every single file that you've got just in order to make a preliminary determination as to whether or not they might be eligible and not even be able to determine whether they are or not, you really don't have a class under a classical class action analysis or under a common fund analysis. I don't think it's there.

But the problem we have when we have 650 insurers, different insurers in the state of Montana, is that some insurers may be able to readily identify claimants, again going back to my examples that I gave earlier with the computer

criteria, and others we don't, which is sort of a -- I mean, that's why these common fund cases get so complicated and difficult. We're not dealing with a single -- you know, we're not dealing just with Allstate Insurance or State Farm Insurance, we're dealing with 650 different insurers who may have 650 different ways of doing things.

So I take your point and it's a valid point, and I think it's something that we'll have to address down the road. And we have to treat different ones differently. I don't know the answer to that at this point.

But I guess, let's go back to my question, and that is, is how do we handle this. You know, I'm amenable to handling it in any fashion that everybody wants me to if we can reach a consensus. If we can't reach a consensus on how to handle it, then I'll have to decide how to do it. And I need some help because I don't have any clear idea as to which is the best way to do it. Again, starting out answering one issue and then filter, go down to the next issue, make the decision at that level and then we have to go down to a third level and make that decision and keep

it all within the court and then bundle it up and go to the Supreme Court.

The second way would be to decide these two threshold issues, the scope of Hiett as to palliative and maintenance care, number one. And number two, whether or not it eradicates all secondary care denials altogether and basically nullifies the distinctions and send that up to the Supreme Court. Or number three, try to put all the questions together, identify them and get a factual basis for all of it and brief all of that, one decision, one appeal.

MR. HARRINGTON: If we go with briefing the first two issues you identified in terms of scope and whether or not it nullifies the distinctions, perhaps we should also add as a third issue what insurers were compliant with Hiett, because if an insurance company had as its practice and procedure to adjust claims in a manner compliant with the Supreme Court's decision in Hiett, it should not be a party to this common fund case.

THE COURT: But that may also depend upon the answers to those first two questions because an insurer could deny it based on palliative and

maintenance care. And if they're correct that that distinction is eradicated, then they still might not be compliant even though they didn't deny on a secondary care basis. Do you see what I'm saying?

MR. HARRINGTON: But what if it's limited and what if it only applies --

MR. ATWOOD: Your Honor, this is Ron Atwood.

THE COURT: Yes.

MR. ATWOOD: My preference would be to try to put together a briefing that we have a single bundle so that we only go up to the Supreme Court once on the issue and not jump back and forth. I think we'll resolve it sooner. It will be more work on the front end, but I think in the long run it will take less time.

THE COURT: Would you try to do that all in one shot rather than the two- or three-step process, the filtering process that I talked about?

MR. ATWOOD: I think I'd try to do your filtering process because you might want to set different dates because in some sense it's easier to brief the legal issues than to try to figure

out how to deal with the more practical problems of whether the carriers can actually identify the people. So I guess I wouldn't mind doing a two- or three-step process before you and then package everything up with a final decision.

THE COURT: Okay. All right. What are your thoughts, Syd?

MS. McKENNA: Well, my thoughts were that I guess I think it makes more sense to address the scope of Hiett at the outset because then I think we may end up not having to deal with a lot of questions whether the State Fund, for instance, can search for maintenance and palliative. If they're right and I'm wrong about the scope of Hiett then, really, all they're going to have to do is about -- do a search on the secondary services. So to me it makes more sense to do this initial threshold question. That would be my preference, but whatever the Court orders, we'll do. But I think it makes more sense to do this initial what-is-the-scope-of-Hiett question at the outset.

THE COURT: Okay. I hear that twice. Do I hear a third?

MR. JONES: I third it.

THE COURT: Anybody disagree with doing it that way?

MR. MARTELLO: I think it makes sense to find out what the scope is.

THE COURT: Okay.

MR. JONES: Judge, to preserve this issue for appeal, if necessary, you've already ruled on it in the Schmill case but it hasn't been ruled on by the Supreme Court, and that is whether you can have a common fund if you didn't plead it originally.

And correct me if I'm wrong, Syd, I don't think you pled originally.

MS. McKENNA: No.

MR. JONES: That's just to preserve the issues.

THE COURT: All right. So we've got the first two issues as far as scope, palliative and maintenance care, number one. And number two, whether or not the secondary medical services rule is eliminated entirely, eradicated. And number three, we'll put in a pleading, whether or not it's been pled. You know, I decided it did not have to be pled, but the Supreme Court conceivably could reverse me on that.

Are there any other threshold issues, legal issues that we can address at this time that make any sense?

MR. TORNABENE: If I could ask for clarification, Your Honor?

THE COURT: Certainly.

MR. TORNABENE: I understand you've already made a decision on whether a common fund has to be pled. So are we just packaging that to go to the Supreme Court if somebody wants to appeal, is that what we're saying, or do we actually brief that?

THE COURT: It's just to be preserved so Larry will just -- I'm not going to change my mind about it. It's pending on appeal. So I guess as a matter of record, Larry is preserving it. I don't think anybody has to brief it. Maybe if Larry just could put in his brief that he's raised it and understands that I've ruled on it already, but wishes to preserve it for this case and that will do it.

MS. McKENNA: Well, that would certainly get rid of our case if you reversed on that.

THE COURT: Well, you know, that's a possibility. I mean, these other decisions are

going to come along, and it may affect how we deal with that. But on the other hand, I don't think we can just twiddle our thumbs either and do nothing because I have no idea when those decisions will be coming down. It might be two weeks. Probably unlikely. When were the last briefs filed?

MR. HARRINGTON: The Stavenjord brief was April 25th. It's fully briefed now. Schmill --

MR. JONES: Was classified as -- it will go to argument by the seven-member panel.

THE COURT: Okay. Were they consolidated? Are they consolidated?

MR. HARRINGTON: No.

MR. MARTELLO: No.

THE COURT: And they asked a supplementary question in one or both of those cases.

MR. HARRINGTON: Just in Schmill, Your Honor, they asked us to address Dempsey because that case was decided after most of the briefing had been done in the Chevron case.

THE COURT: Okay. So you're not going to get a decision in two weeks. It might be two months, four months, who knows. Okay.

MR. HARRINGTON: So after these first couple of issues, then, we're going to address some common fund and retroactivity concerns?

THE COURT: Yeah. I think what we'll do is we'll reconvene and maybe we can read this transcript because -- of what we talked about, it may help us in clarifying things and then we can talk about the next part of it. And also talk about, you know, what we're going to do with however I rule on it, too. You know, how that affects it. I mean, there may be a consensus after I rule on it, who knows, and go from there. So what kind of time frame do we want?

MR. JONES: Well, who has the burden on that, Your Honor, those two scope issues?

THE COURT: Well, we could do it simultaneously, too. I mean, I think it's a question that everybody needs to address.

MR. JONES: I thought I understood you to say one might not be at issue depending on how Syd rethinks it or --

THE COURT: Well, I think she's going to take a crack at it, so --

MR. HARRINGTON: Should we do simultaneous briefing then?

THE COURT: Yeah, I think we could do simultaneous briefing. It's simply how we're going to construe the decision.

MR. JONES: I'll brief both sides of the Schmill issue, Your Honor.

THE COURT: Okay. So how much time?

MR. HARRINGTON: I'm thinking four weeks, but I'm not against a little longer stretch of time. There's lots of activity on these common cases.

MS. McKENNA: Yeah, 30 days is fine with me.

THE COURT: Would 30 days be enough or shall I give you six weeks?

MR. MARTELLO: Six weeks sounds better.

THE COURT: Six weeks and then, what, replies three weeks?

MR. HARRINGTON: Yes.

MR. ATWOOD: Judge, as you've memorialized, are you going to write out the question so that we have it in front of us and we're not relying upon our notes that we've taken today?

THE COURT: Yeah, I'll do that. I'll put it at least in the minute entry. And then if

anybody wants to try to rephrase the question, then let me know and we can try to do that.

MR. ATWOOD: Great.

THE COURT: This whole -- these kinds of cases become sort of a process that we go through, so we're always subject to doing a little bit of revision and recalculation as we go along.

Okay. Is there anything else we can do today?

MR. HARRINGTON: Just one issue we want to mention that we don't need to brief yet, but Syd's lien does extend beyond the date of the statutory prohibition on common fund fees. That would be one of the second steps in the briefing process, but we do want to identify that as an issue because I don't think it had previously been discussed with you, but it's becoming common in the current litigation, the lien dates are extending beyond April 21st, 2003.

MS. McKENNA: I'm not sure I'm following that, so --

THE COURT: Well, there's the statute in what, 2001?

MS. McKENNA: Oh.

THE COURT: Is it 2003? Okay. It did

away with the common fund liens as to injuries occurring after --

MS. McKENNA: Right. And one thing in this case, I believe we agreed not to request the lien prospectively from the date of the Supreme Court decision. I've sent, seen some denials that I thought were Hiett denials since then, but I think we've essentially stipulated that the lien would not go beyond that decision with the idea that the insurers would follow the law. And if they didn't, the claimants would hire counsel and do what they had to do, so maybe that eliminates that concern on the date.

THE COURT: It sounds like it probably does, although --

MS. McKENNA: The Supreme Court decision came down on August 14th, 2003, so maybe we're looking at a few months here, if it was April.

THE COURT: I think it was July.

MR. HARRINGTON: The effective date was April 21st.

THE COURT: Oh, okay, upon passage and approval, so there would be a few months there.

MR. HARRINGTON: And it likely may not have applicability here, we just didn't want to

waive it because the claimant would have to be injured April 22nd or later and hit MMI before August 14th, so --

MS. McKENNA: I probably would just agree to, you know --

THE COURT: That's a pretty small fish in this case.

MS. McKENNA: Yeah.

THE COURT: It is.

Okay. Anybody have anything else? All right, this is definitely the most difficult one we've dealt with to date, so --

MS. McKENNA: What's new, huh, Judge?

(Whereupon, the conference was concluded at 2:28 p.m.)

C E R T I F I C A T E

STATE OF MONTANA)
) ss.
COUNTY OF LEWIS & CLARK)

I, YVONNE MADSEN, RPR, CSR, Freelance Court Reporter and Notary Public in and for the County of Lewis and Clark, State of Montana, do hereby certify:

That the foregoing matter was taken before me at the time and place herein named; that the proceedings were reported and transcribed by me with a computer-aided transcription system, and that the foregoing pages contain a true record of the proceedings to the best of my ability.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on this 16th day of May, 2005.

Yvonne Madsen, RPR, CSR
Freelance Court Reporter
Notary Public, State of Montana
Residing in Helena, Montana.
My Commission expires: 8/6/2006