IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2018 MTWCC 14

WCC No. 2017-4074

TROY W. WESTRE

Petitioner

vs.

LIBERTY NORTHWEST INS. CORP.

Respondent/Insurer.

ORDER DENYING RESPONDENT'S MOTION FOR SUMMARY JUDGMENT AND GRANTING PETITIONER'S MOTION FOR SUMMARY JUDGMENT

Summary: Respondent moved for summary judgment, asserting that Petitioner's medical benefits terminated under the 60-month rule at § 39-71-704(1)(f), MCA (2005). It is undisputed that Petitioner saw his treating physician within the 60-month period, but his physician's office made a mistake and did not bill Respondent for the appointment within the 60-month period. Because Petitioner's physician did not send Respondent the bill, Respondent asserts that the appointment does not constitute use of medical benefits. Petitioner moved for summary judgment, arguing that he used his medical benefits within the 60-month period by obtaining treatment from his physician, and that he cannot suffer a consequence because of his physician's office's mistake in failing to bill Respondent for the appointment.

Held: Respondent's Motion for Summary Judgment is denied, and Petitioner's Motion for Summary Judgment is granted. Petitioner used his medical benefits within the 60-month period when he saw his treating physician for treatment. As a matter of law, the physician's office had the duty to bill Respondent, and Petitioner cannot suffer a consequence because of his physician's office's mistake in failing to bill Respondent.

¶ 1 Respondent Liberty Northwest Insurance Corporation (Liberty) and Petitioner Troy Westre dispute the legal significance of Westre's treating physician's office's mistake in failing to bill Liberty for an appointment at which Westre received treatment. Liberty

maintains that because it did not receive a bill for the appointment, Westre did not use his medical benefits and such benefits terminated under § 39-71-704(f), MCA (2005), which provides that medical benefits terminate if not used for 60 consecutive months. Westre argues that he used his medical benefits within the 60-month period by obtaining treatment from Chriss A. Mack, MD, and that he cannot suffer a consequence because Dr. Mack's office made a mistake and did not bill Liberty within the 60-month period. He further seeks costs, attorney fees, and a penalty.

FACTS

¶ 2 The following facts are undisputed.

¶ 3 On September 12, 2005, Westre suffered an injury to his back within the course and scope of his employment for Johnson Brothers Construction.

¶ 4 Liberty accepted liability for his claim.

¶ 5 In 2006, Westre underwent a discectomy at L5-S1. Thereafter, Westre followed up with his surgeon, Dr. Mack, who prescribed low-dose narcotic medicine, anti-inflammatories, and muscle relaxants.

¶ 6 The parties settled Westre's indemnity and vocational rehabilitation benefits and reserved his medical benefits.

¶ 7 On October 24, 2007, Dr. Mack informed Liberty's life care planner that Westre would require annual lifelong follow-up visits; that Westre would need ongoing medications when necessary; and that it was probable Westre would need a fusion or placement of the DIAM device on his lumbar spine in the future.

¶ 8 On February 6, 2012, Westre saw Dr. Mack for back pain. Liberty received the bill from this appointment, and the bill from the x-ray that Westre received at the appointment, within 30 days. On February 10, 2012, Westre filled a prescription from Dr. Mack. Liberty received the bill within 30 days.

¶ 9 On May 10, 2013, Liberty wrote Westre and attempted to settle his medical benefits for $8,500. Liberty stated that it would continue to handle Westre's claim if he preferred to keep it open.

¶ 10 On July 2, 2013, a Liberty claims adjustor wrote in the claim file "if claimant resumes treatment, file will remain open indefinitely." On January 21, 2014, a Liberty supervisor wrote in the claim file: "Montana claim assigned to pension desk for oversight of lifetime medical benefits."

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¶ 11 On March 11, 2016, Westre returned to Dr. Mack for treatment of his residual back pain and intermittent right-leg pain. Dr. Mack's impression following his examination was that Westre "is suffering from degenerative disc disease at L5-S1 subsequent [to] a microsurgical discectomy for a largely well-managed right leg pain" and that his "progressive symptoms of back pain are most likely related to aggressive degenerative changes." Dr. Mack prescribed Lortab and Robaxin and noted that Westre was taking over-the-counter anti-inflammatories.

¶ 12 On May 1, 2017, Dr. Mack's office sent a Provider Request Authorization Form, requesting that Liberty authorize Westre to see Dr. Mack. Dr. Mack's office had not scheduled the appointment, explaining on the form that Westre "was told his claim was closed for LNW not having rec'd this 2009 note (the bill for that visit was paid – so not sure how claim was closed. Here is the note again[])."

¶ 13 On May 2, 2017, a Liberty claims adjustor wrote Dr. Mack's office stating that Westre's medical benefits terminated under § 39-71-704(1)(f), MCA, because he had not been "treated since 2/6/12." Liberty also explained, "The last treatment that we paid for was 2/6/12. Therefore, Mr. Westre's benefits closed 2/6/2017."

¶ 14 At her deposition, Liberty's adjuster testified that it was Liberty's position that Westre had not had medical treatment for 60 consecutive months:

> Q. What was your reasoning for terminating Troy's medical benefits?
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> A. Per the statute, he had gone 60 months without medical treatment or submitting treatment and bills to us for treatment.

¶ 15 On May 8, 2017, Dr. Mack's office notified Liberty that Liberty's statement that Westre had not been treated since February 6, 2012, was false. Dr. Mack's office told Liberty that Dr. Mack treated Westre on March 11, 2016. Dr. Mack's office explained that it made a mistake in not billing Liberty for Westre's appointment: "Mr. Westre had a visit added on 3/11/16 (the day of appt). The billing office was never told about this schedule change, therefore, it was never billed along with the dictation."

¶ 16 At her deposition, Liberty's adjuster — an experienced adjuster who handles 125 to 130 claims at any one time — acknowledged that medical providers send their bills directly to Liberty for payment:

> Q. And [in the workers' compensation claims that you handle], do the doctors' offices send Liberty the bills?
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> A. If they want to be paid for the services they do, yes.

¶ 17 As of October 2017, Dr. Mack's office had not billed Liberty for Westre's appointment with Dr. Mack on March 11, 2016.

LAW AND ANALYSIS

¶ 18 This case is governed by the 2005 version of the Montana Workers' Compensation Act (WCA) because that was the law in effect at the time of Westre's injury.[1]

¶ 19 Summary judgment is only appropriate when the moving party establishes no genuine issue of material fact, and that the moving party is entitled to judgment as a matter of law.[2]

¶ 20 Section 39-71-704, MCA (2005), is the statute under which insurers are liable for medical benefits following a compensable injury. However, it provides in relevant part:

> (f) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive months.

¶ 21 Although it acknowledges that Westre treated with Dr. Mack before the 60-month period ran, Liberty argues that treatment, by itself, does not constitute use of medical benefits. Liberty cites *Schellinger v. St. Patrick Hospital and Health Sciences Center*,[3] and claims that this Court created a two-part test to determine if a claimant has used his medical benefits: (1) a claimant must have received treatment for his injury before the expiration of 60 months; and (2) he or his representative must request payment for that treatment before the expiration of the 60-month period. Liberty also cites the part of § 39-71-604(1), MCA, providing that "the worker shall file with the insurer all reasonable information needed by the insurer to determine compensability" and asserts that it is the claimant's duty to send the medical record and bill to the insurer during the 60-month period. Thus, although Dr. Mack's office made the mistake in not billing Liberty, Liberty argues that Westre is ultimately to blame. Moreover, Liberty asserts that the 60-month rule was enacted to ensure insurers are timely notified of a claimant's efforts to use his benefits and that this purpose will be undercut if this Court does not rule in its favor.

¶ 22 Westre maintains that he used his medical benefits within the 60-month period because he saw Dr. Mack for treatment on March 11, 2016, approximately 49 months since he last used his medical benefits on February 6, 2012. Westre argues that obtaining treatment is using medical benefits under § 39-71-704(1)(f), MCA, and that there is no requirement that a claimant obtain treatment *and* provide the medical record and bill to the insurer, which is normally done by the physician's office with a demand for payment. Westre argues that his medical benefits cannot terminate because Dr. Mack's office made a mistake and did not bill Liberty for the appointment.

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[1] *Ford v. Sentry Cas. Co.*, 2012 MT 156, ¶ 32, 365 Mont. 405, 282 P.3d 687 (citation omitted); § 1-2-201, MCA.

[2] ARM 24.5.329; *Farmers Union Mut. Ins. Co. v. Horton*, 2003 MT 79, ¶ 10, 315 Mont. 43, 67 P.3d 285.

[3] 2012 MTWCC 10.

¶ 23 Here, Westre is correct that he used his medical benefits within the 60-month period by seeing Dr. Mack for treatment on March 11, 2016. The benefits provided for in § 39-71-704, MCA, include "reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires." Section 39-71-116(26), MCA, defines "primary medical services" as "treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability." In short, treatment is a benefit under § 39-71-704, MCA. Westre availed himself of Dr. Mack's treatment on March 11, 2016; therefore, he used his medical benefits within the 60-month period.

¶ 24 For three reasons, this Court rejects Liberty's arguments.

¶ 25 First, the case law on which Liberty relies does not support its position. To the contrary, the case law supports Westre's.

¶ 26 Liberty takes more from *Schellinger* than is there. Schellinger suffered a back injury in the course of her employment.[4] The insurer accepted liability and paid medical benefits on her claim from November 1997 to February 2003.[5] Thereafter, Schellinger asserted psychological and cognitive impairment stemming from her industrial injury.[6] After this Court ruled that the insurer was liable for Schellinger's cognitive and psychological impairments in 2007, the insurer argued that it was not liable for her medical bills, claiming that she had not used her medical benefits for 60-consecutive months.[7] This Court ruled that Schellinger had used her medical benefits during the 60-month period, noting that: she sought treatment despite the insurer's denial of liability; obtained treatment on her own; and that after this Court ruled in her favor, sent demands that the insurer pay her medical bills.[8] While those were the facts of the case, this Court did not rule that a demand for payment was a necessary element to use medical benefits.

¶ 27 Indeed, in *Dauenhauer v. Montana State Fund*,[9] this Court ruled that all that was required to use medical benefits was to request authorization to see the treating physician. Dauenhauer suffered an industrial injury in 1994 and underwent a surgery which included a cervical fusion.[10] In late 2010, Dauenhauer's wife called State Fund, seeking authorization to see his surgeon, as he had not had a follow-up since 2006.[11]

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[4] *Schellinger*, ¶ 4.

[5] *Schellinger*, ¶ 5.

[6] *Schellinger*, ¶ 6.

[7] *Schellinger*, ¶¶ 10, 16.

[8] *Schellinger*, ¶ 17.

[9] 2012 MTWCC 22.

[10] *Dauenhauer*, ¶ 8.

[11] *Dauenhauer*, ¶ 15.

State Fund denied the request, asserting that the appointment was for palliative or maintenance care and not treatment, and then asserted that Dauenhauer's medical benefits terminated under the 60-month rule.[12] After ruling that the requested appointment was for treatment, this Court explained that the case was similar to *Schellinger*, and ruled that Dauenhauer's "request for authorization to be seen by a physician is 'use' under [the 60-month rule] since any other conclusion would lead to an absurd result. If an insurer denies authorization and a claimant cannot afford the treatment out of his or her own pocket, an insurer could evade the payment of medical benefits until the 60 months had run, and then simply close its file."[13]

¶ 28 Here, Westre went a step beyond requesting authorization to see his treating physician for treatment; he actually went to Dr. Mack, his treating physician, for treatment within the 60-month period. Thus, under *Dauenhauer*, he used his medical benefits when he saw Dr. Mack for treatment.

¶ 29 Second, there is no merit to Liberty's argument that Westre had the duty under § 39-71-604(1), MCA, to submit to Liberty his medical record and bill from his March 11, 2016, appointment with Dr. Mack, and demand payment. Liberty takes the phrase on which it relies out of context and ignores the rest of the statute, which requires the physician to provide information to the insurer as required by the Department of Labor & Industry. It states:

> **Application for compensation -- disclosure and communication without prior notice of health care information.** (1) If a worker is entitled to benefits under this chapter, the worker shall file with the insurer all reasonable information needed by the insurer to determine compensability. It is the duty of the worker's attending physician to lend all necessary assistance in making application for compensation and proof of other matters that may be required by the rules of the department without charge to the worker. The filing of forms or other documentation by the attending physician does not constitute a claim for compensation.

The Department of Labor & Industry's rules, in turn, reflect that the information that physicians are required to provide include the medical bills. ARM 24.29.1402 states, in relevant part, that "charges *submitted by providers* must be the usual and customary charge billed for nonworkers' compensation patients," and that an insurer shall timely pay medical claims, and, "The insurer must document receipt date of the bill(s) or the receipt date will be three days after the bill(s) was *sent by the provider*."[14] Indeed, Liberty's adjuster — an experienced adjuster who handles between 125 and 130 claims at a time — acknowledged that it is the physicians' office that sends Liberty the medical bills.

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[12] *Dauenhauer*, ¶¶ 23, 34–39.

[13] *Dauenhauer*, ¶¶ 35, 37.

[14] (Emphasis added.)

¶ 30 Here, Liberty accepted liability for Westre's claim — i.e., it determined the claim was compensable — and there is no evidence that Liberty requested any additional information to determine the compensability of his claim. Westre therefore satisfied his duty under § 39-71-604(1), MCA. Although Dr. Mack's office made a mistake and did not bill Liberty for Westre's March 11, 2016, appointment, Westre used his medical benefits when he attended the appointment and had no duty to submit the medical record and bill to Liberty and cannot suffer a consequence as a result of Dr. Mack's office's mistake.[15]

¶ 31 Third, there is no merit to Liberty's argument that the purpose of the 60-month rule would be undercut if this Court rules that Westre used his medical benefits on March 11, 2016. In *Schellinger*, this Court stated that the "purpose of the statute of repose is to protect insurers by providing them with timely notice that a claimant is making a claim for benefits."[16] Notwithstanding, the facts of this case establish that Liberty has known since the fall of 2007 that Westre was going to require lifelong medical care, including yearly appointments with Dr. Mack. Liberty cannot credibly claim it was surprised that Westre saw Dr. Mack for treatment on March 11, 2016.

¶ 32 As a final point, although Liberty's arguments failed to carry the day, this Court finds that Liberty's overall position was reasonable because the issue had not been squarely decided; therefore, it will not assess a penalty against Liberty under § 39-71-2907, MCA, nor award Westre his attorney fees under § 39-71-611, MCA.

¶ 33 In *Marcott v. Louisiana Pacific Corp*, the Montana Supreme Court explained that "with regard to an insurer's decision to contest compensability based on its interpretation of case law, the Workers' Compensation Court's reasonableness finding remains a question of fact subject to the substantial evidence standard of review."[17] The court further explained that an insurer is reasonable when there is a "genuine doubt, from a legal standpoint, that any liability exists,"[18] which is to be determined on whether the issue has been clearly decided. The court stated:

> [A]s a general rule, where a court of competent jurisdiction has clearly decided an issue regarding compensability in advance of an insurer's decision to contest compensability, the clear applicability of the earlier decision constitutes substantial evidence supporting a finding by the Workers' Compensation Court that the contest over compensability is unreasonable. Conversely, where the issue upon which an insurer bases its legal interpretation has not been clearly decided, the lack of clear decision may constitute substantial evidence supporting a finding by the

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[15] *See* § 1-3-211, MCA ("No one should suffer for the act of another.").

[16] *Schellinger*, ¶ 18.

[17] 275 Mont. 197, 205, 911 P.2d 1129, 1134 (1996) (citation omitted).

[18] *Id.*

> Workers' Compensation Court that the insurer's legal interpretation is not unreasonable.[19]

¶ 34 This issue in this case was not clearly decided in *Schellinger* nor *Dauenhauer*. Thus, under the standard set forth in *Marcott*, this Court finds that Liberty's position was reasonable.

¶ 35 In sum, Westre used his medical benefits during the 60-month period on March 11, 2016, by visiting Dr. Mack and obtaining treatment. Thus, Westre's medical benefits did not terminate under § 39-71-704(f), MCA. Accordingly, this Court makes the following:

ORDER

¶ 36 Westre's Motion for Summary Judgment is **granted** and Liberty's Motion for Summary Judgment is **denied**.

¶ 37 Because he prevailed, Westre is entitled to his costs under § 39-71-611, MCA.

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

DATED this 14th day of August, 2018.

(SEAL)

/s/ DAVID M. SANDLER
JUDGE

c: Sydney E. McKenna
Larry W. Jones

Submitted: November 2, 2017 (Respondent's Motion for Summary Judgment)
November 13, 2017 (Petitioner's Motion for Summary Judgment)

[19] *Id.* (internal citations omitted).