IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2001 MTWCC 65

WCC No. 2000-0251

ROBERT CHEETHAM, JR.

Petitioner

vs.

LIBERTY NORTHWEST INSURANCE CORPORATION

Respondent/Insurer for

HAWKEYE CONSTRUCTION

Employer.

DECISION AND JUDGMENT

Summary: Claimant suffered a work-related aortic dissection on August 7, 1996. The insurer denied liability, however, this Court found it liable in a previous decision dated June 11, 1997. *Cheetham v. Liberty Northwest Ins. Corp.*, No. 9612-7675. In the first action, claimant asserted entitlement to temporary total and medical benefits. In 2000 he, for the first time, claimed entitlement to domiciliary care benefits for the year following his industrial accident. In October 2000 he also made a demand for domiciliary care for three months of care in 2000, all of it occurring prior to the demand. The insurer denies liability for all domiciliary care.

Held: Domiciliary care is governed by section 39-71-1107, MCA, which, among other things, limits liability for domiciliary care to periods on and after the insurer has notice or knowledge of the care. However, an insurer cannot insist on notice or knowledge at the same time it denies all liability for a claim. Therefore, claimant is entitled to benefits until the liability was adjudicated but not thereafter. The doctrine of res judicata does not bar his claim since the issue was not litigated in the prior proceeding. Laches does not apply because the insurer waived any right to knowledge or notice by denying liability.

Topics:

> **Statutes and Statutory Interpretation: Plain Meaning.** Where a statute is plain and unambiguous, it must be applied as written.

Constitutions, Statutes, Regulations and Rules: Montana Code Annotated: section 39-71-1107(1)(a), MCA (1997). Section 39-71-1107(1)(a), MCA, on its face limits liability for domiciliary care benefits to periods after the insurer has notice or knowledge of the need for domiciliary care.

Benefits: Domiciliary Care. Section 39-71-1107(1)(a), MCA, on its face limits liability for domiciliary care benefits to periods after the insurer has notice or knowledge of the need for domiciliary care.

Constitutions, Statutes, Regulations and Rules: Montana Code Annotated: section 39-71-1107(1)(a), MCA (1997). The knowledge requirement in section 39-71-1107(1)(a), MCA, has no application where the insurer denies all liability for a claim.

Benefits: Domiciliary Care. The knowledge requirement in section 39-71-1107(1)(a), MCA, has no application where the insurer denies all liability for a claim.

Judgments: Res Judicata. Where the only issue litigated in a prior proceeding was liability of the insurer, res judicata bars relitigation of the issue, however, under present rules and practice of the Workers' Compensation Court, it does not bar claimant from bringing a subsequent action seeking benefits for domiciliary care even though that care was rendered prior to and during the proceeding.

Defenses: Laches. The doctrine of laches is inapplicable to a claim for domiciliary care benefits for a period during which the insurer denied all liability.

¶1 The trial in this matter was held on March 22, 2001, in Kalispell, Montana, Petitioner, Robert Cheetham, Jr. (claimant), was present and represented by Mr. David W. Lauridsen. Respondent, Liberty Northwest Insurance Corporation (Liberty), was represented by Mr. Larry W. Jones. The parties filed post-trial briefs and the matter was submitted for decision on July 2, 2001.

¶2 Stipulations: At the time of trial, counsel for the parties entered into a series of stipulations, as follows:

¶2a Claimant's wife provided 24-hour domiciliary care to her husband from August 20, 1996 through September 16, 1996; September 24, 1996 through August 20, 1997; and May 24, 2000 through August 24, 2000.

¶2b Claimant's request for domiciliary benefits is pursuant to section 39-71-1107(3), MCA (1995), and is based upon the medicaid reimbursement rate. Counsel agree that if the Court finds that claimant is entitled to domiciliary care counsel should be able to compute amounts due, therefore it is unnecessary for the Court to make such determination.

¶2c The defenses raised by Liberty to the request for domiciliary benefits are legal defenses as set forth in the Pretrial Order.

¶2d The record was to remain open to allow claimant's attorney to review medical records from Michigan and submit some or all of those records for the purpose of determining whether Liberty had notice of claimant's need for domiciliary care. (None were ever submitted.)

¶2e If the Department of Labor and Industry has not adopted a rule prescribing the form contemplated in section 39-71-1107(3), MCA (1995), then Liberty waives any defense based on the lack of such form. (The parties were unable to find a rule.)

¶3 Exhibits: Exhibits 1 through 6 were admitted without objection.

¶4 Witnesses and Depositions: Depositions of the claimant and his wife, Inga Cheetham, were submitted for the Court's consideration. In light of stipulations made at the time of trial, the parties agreed that further testimony was unnecessary.

¶5 Issues Presented: The issues as set forth in the Pretrial Order are:

¶5a Whether Petitioner's spouse is entitled to domiciliary care benefits, and if so, the amount of such benefits owed by the respondent.

¶5b Whether Petitioner is entitled to an increase in award for unreasonable delay or refusal to pay proper workers' compensation benefits pursuant to §39-71-611 and/or 612, MCA.

(Pretrial Order at 3.)

FINDINGS OF FACT

¶6 The facts relevant to the present controversy are essentially undisputed.

¶7 Claimant suffered an ascending aortic dissection on August 7, 1996. In a prior proceeding I determined that the dissection was work related and ordered Liberty to pay benefits. *Robert Cheetham, Jr. v. Liberty Northwest Ins. Corp.*, No. 9612-7675, Findings of Fact, Conclusions of Law and Judgment (June 11, 1997) (Cheetham I). In this action the claimant seeks domiciliary care benefits. His request is based on 24-hour a day home care provided to him by his wife during the periods August 20, 1996 through September 16, 1996 (Period I); September 24, 1996 through August 20, 1997 (Period II); and May 24, 2000 through August 24, 2000 (Period III). Liberty does not dispute either the fact of domiciliary care or the dates of that care. Its defenses are legal ones.

¶8 Claimant's industrial injury was serious; death frequently follows aortic dissection. (*Cheetham I*, Finding of Fact 10.) The surgery he underwent immediately following his injury was major thoracic surgery, involving opening the chest and repairing the aorta. (*Id*. at

Finding of Fact 11.) The first period of domiciliary care (August 20, 1996 through September 16, 1996), occurred immediately following that first surgery.

¶9 On September 16, 1996, claimant was readmitted to the hospital for complications following his surgery. (Ex. 5 at 4.) He had developed a blood clot in the subclavian or superior vena cava. (Id. at 7.) Claimant was discharged from his second hospitalization on September 24, 1996, beginning the second period of domiciliary care, which extended to August 20, 1997.

¶10 In March 2000, surgeons at the University of Michigan determined that claimant needed additional surgery. (Id. at 52.) They noted that the claimant had a recurring aneurysm which was growing. (Id.)

¶11 On April 13, 2000, Dr. G. Michael Deeb operated on claimant. The surgery was major thoracic surgery involving the use of grafts in a portion of the aorta. (Id. at 54.) A post-operative note indicates that claimant was on a heart-lung bypass machine for 338 minutes, which is approximately five and a half hours, and needed nine units of blood. (Id. at 57.) The third period of domiciliary care began upon his discharge from the hospital on May 24, 2000.

¶12 Part of the domiciliary care provided in this case occurred during times that Liberty denied liability for the claimant's condition. The claimant submitted a claim for compensation on September 9, 1996. (*Cheetham I*, Finding of Fact 12.) On September 27, 1996, Liberty instituted benefits under a reservation of rights pursuant section 39-71-608, MCA (1995). (Ex. B to Brief in Support of Liberty's Affirmative Defenses; *Cheetham I* Pretrial Order, ¶ (C)(3).) Section 39-71-608, MCA, provides:

> **39-71-608. Payments within thirty days by insurer without admission of liability or waiver of defense authorized -- notice.** An insurer may, after written notice to the claimant and the department, make payment of compensation benefits within 30 days of receipt of a claim for compensation without such payments being construed as an admission of liability or a waiver of any right of defense.

The benefits were short lived: On October 15, 1996, Liberty denied liability outright.

¶13 On December 19, 1996, claimant filed his first Emergency Petition for Hearing with this Court, seeking a determination that he suffered an industrial injury and was entitled to temporary total disability and medical benefits, as well as attorney fees, a penalty, and costs. That petition was not finally resolved until June 11, 1997, when this Court issued its decision in Cheetham I. The time for Liberty to appeal the decision expired 30 days later on July 11, 1997.

¶14 Liberty did not have knowledge or notice of any need for domiciliary care until June 28, 2000. On that date, claimant's counsel sent a letter to Liberty regarding compensation for travel. That letter contained the following notice regarding domiciliary care:

> Further, Mr. Cheetham's wife had to provide domiciliary care for him for approximately three months following the initial surgery in August 1996, and she lost her job as a result. We will be getting verification of that situation and will be asking for payment for domiciliary care.

(Ex. 6.) While the letter mentioned claimant's "recent surgery in Michigan," it made no reference or claim with respect to domiciliary care following that surgery.

¶15 A second demand for domiciliary benefits followed on October 3, 2000, in a further letter from claimant's counsel. (Ex. 4.) That letter claimed a full year's domiciliary benefits following the first surgery (August 20, 1996). In addition, and for the first time, claimant also sought domiciliary care following his release from the hospital after his second surgery. However, the claim was for only one month of 24-hour care. (Id.)

Timetable

¶16 In considering the issues presented in this case, I find it helpful to set out a timetable of relevant events. The table is below:

Date	Event
8-7-1996	Claimant suffers an aortic dissection and undergoes surgery.
8-20-1996	Claimant discharged from the hospital. The first period of domiciliary care begins.
9-9-1996	Claimant submits his claim for compensation.
9-16-1996	Claimant is readmitted to the hospital for surgery-related complications. The first period of domiciliary care ends.
9-24-1996	Claimant is discharged from the hospital and the second period of domiciliary care begins.
9-27-1996	Liberty agrees to pay benefits under a reservation of rights, § 39-71-608, MCA (1995), while it investigates the claim.
10-15-1996	Liberty denies liability after investigating the claim and stops paying benefits.

12-19-1996	Claimant files his first petition in the Workers' Compensation Court asking that the Court find he suffered a work-related injury and is entitled to temporary total disability and medical benefits. (*Cheetham I*.)
6-11-1997	The Workers' Compensation Court issues its decision finding that the claimant's aortic dissection was work related and Liberty is liable for his condition and for benefits. The issue as phrased by the Court was the compensability of the claim. The Court did not separately consider the amounts due the claimant for compensation and medical benefits. (*Cheetham I*.)
7-11-1997	Time for appeal in *Cheetham I* expires without an appeal.
8-20-1997	Second period of domiciliary care ends.
4-13-2000	Claimant undergoes a second surgery.
5-24-2000	Third period of domiciliary care begins.
6-11-2000	Claimant for the first time notifies Liberty of a claim for domiciliary care. The notice claim was limited to "three months following the initial surgery in August 1996." No mention was made regarding any ongoing domiciliary care.
8-24-2000	Third period of domiciliary care ends.
10-3-2000	Claimant sends a second notice claiming domiciliary care for a full year following his first surgery and for one month following his release from the hospital after his second surgery.
12-12-2000	Claimant commences his present action seeking domiciliary care benefits.

CONCLUSIONS OF LAW

¶17 The injury in this case occurred in 1996, therefore the 1995 version of the Workers' Compensation Act applies. *Buckman v. Montana Deaconess Hospital*, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶18 Claimant bears the burden of proving his entitlement to domiciliary benefits. *Ricks v. Teslow Consolidated*, 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wicken Bros. Construction Co.*, 183 Mont. 190, 598 P.2d 1099 (1979). However, the facts in this case are essentially undisputed. Resolution of his claim is a question of law.

¶19 Liberty argues that claimant is not entitled to benefits because (1) it did not have knowledge of the need for benefits at the time they were provided, therefore the benefits are barred by section 39-71-1107(1)(a), MCA (1995); (2) the benefits are barred by this Court's prior decision in *Cheetham I*; and (3) the benefits are barred by the doctrine of laches. I address the contentions in that order.

¶20 Domiciliary care is governed by section 39-71-1107, MCA (1995), which provides as follows:

> **39-71-1107. Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:
> (a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;
> (b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;
> (c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;
> (d) when the services rendered are of the type beyond the scope of normal household duties; and
> (e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.
> (2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.
> (3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.
> (4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing hourly wage, and the insurer is not liable for more than 8 hours of care per day.

Subsection (a) is unequivocal and clear: an insurer is liable for domiciliary care only

> after learning of the need for such care, and not before. There can be no other reasonable reading of the section. Claimant's argument that he was unable to request domiciliary care until June 2000 because until that time he did not have physician verification of the need for the care is preposterous. He and his wife were aware the care was being given when it was given. They could have sought physician verification at that time, or at least notified Liberty that the care was being provided so that it could request further information as to the need and nature of the care. In any event, the subsection is clear and it must be applied as written. "When interpreting a statute, we look first to the plain meaning of its words. When the statute is plain, unambiguous, direct and certain, the statute speaks for itself and there is no need to resort to extrinsic means of interpretation." In *re Christian*, 1999 MT 189, ¶ 12, 295 Mont. 352, 983 P.2d 966 (1999).

¶21 Section 39-71-1107(1)(a), MCA, places the burden upon claimant to assure that Liberty was aware of his need for domiciliary care simultaneous with that need. It was his burden and duty to notify Liberty of his need, or to at least provide Liberty with information which would have made it aware of the need. Therefore, unless claimant is excused from the statutory requirement, his claim with respect to domiciliary care is barred in toto.

¶22 At trial I requested the parties to address whether claimant is excused from an application of section 39-71-1107(1)(a), MCA, on account of Liberty's denial of his claim. I noted, "My initial inclination is to see that Statute (§ 39-71-1107(1)(a)) as not applying where there's a denial of all liability, at least to the point where that [sic] is the adjudication that it is." (Trial Tr. at 16.) Neither party directly addressed the matter in post-trial briefs.

¶23 However, it is a maxim of jurisprudence that, "The law neither does nor requires idle acts." § 1-3-223, MCA. In its initial brief, Liberty points out that had claimant notified it of his need for domiciliary care contemporaneous with that need, the notice would have allowed the insurer to

> investigate the reasonableness of the request CONTEMPORANEOUSLY with the need. The notice provision under the domiciliary care section also allows the insurer to participate in the planning process and, in the event of disagreements, to obtain second opinions and to propose alternative courses of action.

(Brief in Support of Liberty's Affirmative Defenses at 5.) That argument presupposes that the insurer has accepted the claim. Where the insurer denies all liability, it gives notice that it is rejecting liability altogether: details pertaining to benefits are irrelevant. The claimant can submit information as to his or her wage loss, medical expenses, and domiciliary care expenses until the cows come home. When the cows are home the insurer still will not pay any benefits.

¶24 Section 39-71-1107, MCA (1995), cannot be construed in isolation: it must be construed together with other provisions relating to the subject matter. “A statute must be construed in a way that gives effect to all of its provisions.” *Taylor v. Matejovsky*, 261 Mont. 514, 520, 863 P.2d 1022, 1026 (1993). The duty and burden imposed under section 39-71-1107, MCA, applies only if the insurer is liable for the claim.

¶25 In *Hutchison v. General Host Corp*., 178 Mont. 81, 92, 582 P.2d 1203, 1209 (1978), the Supreme Court addressed a situation which is similar to that presented in the present case. In that case the Court considered a requirement that the insurer approve any change of physician by claimant. The insurer had denied liability for the claim. Secondarily, it asserted that it was not liable for the second physician’s bills because it had not approved the second physician. The Court rejected the insurer’s argument:

> Where an insurer refuses to recognize the compensability of a claim there is no duty on the claimant to obtain permission of the insurer to change doctors. In denying a claim an insurer is taking a chance that later it may be proven to be compensable. If so, the insurer, in denying liability for medical bills, cannot hide behind the regulation as a sanctuary against the payment of medical bills incurred by a claimant.

Id. The reasoning in *Hutchison* is persuasive in this case. I therefore conclude that the knowledge requirement of section 39-71-1107, MCA, has no application during the period Liberty denied liability for claimant’s industrial accident. That period ended upon the expiration of the time for appeal of this Court’s decision in *Cheetham I*. Therefore, claimant is entitled to domiciliary benefits through July 11, 1997, and not thereafter.

¶26 With respect to pre-July 12, 1997 domiciliary care, I must still consider Liberty’s res judicata and laches arguments.

¶27 Liberty argues that the claimant could and should have raised his entitlement to domiciliary benefits in his first petition to this Court. It cites decisions of both the Supreme Court and this Court holding that where a party could have raised a claim in a prior proceeding, but failed to do so, the party is barred from raising it in a subsequent proceeding. Liberty’s argument is not easily dismissed.

> ¶ 47 “[R]es judicata is a final judgment which, when rendered on the merits, is an absolute bar to a subsequent action between the same parties or those in privity with them, upon the same claim or demand." Scott v. Scott (1997), 283 Mont. 169, 175, 939 P.2d 998, 1001 (citing Fiscus v. Beartooth Electric Cooperative, Inc. (1979), 180 Mont. 434, 436, 591 P.2d 196, 197). The doctrine bars a party from re-litigating a matter that the party has already litigated and from re-litigating a matter that the party had the opportunity to litigate in an prior case. City of Bozeman v. AIU Ins. Co. (1995), 272 Mont. 349, 354, 900 P.2d 929, 932 (quoting State ex rel. Harlem Irrigation

> District v. Montana Seventeenth Judicial District Court (1995), 271 Mont. 129, 894 P.2d 943, 946). Res judicata is based on the policy that there [296 Mont. 68] must be some end to litigation. Glickman v. Whitefish Credit Union Ass'n, 1998 MT 8, ¶ 20, 287 Mont. 161, ¶ 20, 951 P.2d 1388, ¶ 20. A claim is res judicata if: (1) the parties or their privies are the same; (2) the subject matter of the claim is the same; (3) the issues are the same and relate to the same subject matter; and (4) the capacities of the persons are the same in reference to the subject matter and issues. Glickman, ¶ 20 (citing Loney v. Milodragovich, Dale & Dye, P.C. (1995), 273 Mont. 506, 510, 905 P.2d 158, 161).

In re Ramond W. George Trust, 1999 MT 223, ¶ 47, 296 Mont. 56, 986P.2d 427 (1999) (emphasis added).

¶28 The "opportunity to litigate" rule is discussed in Harlem Irrigation District, 271 Mont. 129, 894 P.2d 943 (1995). The discussion is quoted in the subsequent case of City of Bozeman v. AIU Insurance Co., 272 Mont. 349, 354, 900 P.2d 929, 932 (1995). That discussion is as follows:

> However, the doctrine of res judicata bars not only issues that were actually litigated, but also those that could have been litigated in a prior proceeding. *Mills v. Lincoln County*, (1993) 262 Mont. 283, 864 P.2d 1265, 1267. A party should not be able to litigate a matter that the party already had the opportunity to litigate; public policy dictates that there must be some end to litigation. [Citations omitted.] Once a party has had an opportunity to present a claim, the judgment in a previous case is final as to the issues that were raised, as well as those that could have been raised. *See Burgess v. Montana* (1989), 237 Mont. 364, 366, 772 P.2d 1272, 1273. This notion arises from public policy designed to prevent endless piecemeal attacks on previous judgments. *Wellman v. Wellman* (1982), 198 Mont. 42, 46, 643 P.2d 573, 575. We conclude that the theories of recovery alleged in this cause of action could have been litigated in the prior proceeding.

As set forth in the above quoted language, the "opportunity to litigate" rule is tied to the specific issues raised in the prior litigation. *Rafanelli v. Dale,* 1998 MT 331, ¶ 12, 292 Mont. 277, 971 P.2d 371. The doctrine prohibits a party in subsequent litigation from raising a new legal theory or ground with respect to the issues raised in the prior case. Consistent with that doctrine, I held in Miller v. State Compensation Fund, 2000 MTWCC 72, that where a claimant brought an action seeking to reopen a settlement agreement, the judgment rejecting his request barred a subsequent action again seeking to reopen the same settlement but on different grounds.

¶29 The difficulty in applying the "opportunity to litigate" doctrine to the present case arises from the practice of this Court. In cases where an insurer has denied liability, the Court typically considers only the issue of liability. In denied liability cases, the amount of

benefits due is typically an arithmetical computation not requiring judicial intervention. I rarely determine what benefits are due the claimant. If it appears that there may be an issue over amounts due I typically tell the parties to consult, reserving continuing jurisdiction to determine actual benefits in the event they are unable to agree. Indeed, I cannot remember the last time I determined a liability issue and was thereafter required to calculate the actual benefits due. Stated simply, once liability is determined the benefits fall into place. Thus, Workers' Compensation Court proceedings are very different from those in civil cases where both liability and damages are determined in a single action.

¶30 The claimant's petition in Cheetham I requested this Court to determine liability and award him temporary total disability and medical benefits. But the amounts due in benefits was never litigated and when I wrote my decision in Cheetham I, I narrowed the issues to the singular issue of whether the claimant suffered a compensable industrial accident. I never addressed his entitlement to specific benefits and it seemed unnecessary to do so at the time. Indeed, in denied liability cases, the parties almost invariably focus on the liability issue and rarely present evidence of the specific benefits due. It is the custom and practice of the Court to let the parties determine the amount of benefits due after liability is established, with the opportunity to return to the Court if they cannot agree.

¶31 In light of the custom and practice of this Court, and the limited nature of the dispute in Cheetham I, I find that the "opportunity to litigate" doctrine is inapplicable in this case. The sole issue actually litigated in the prior case was liability. Had Liberty prevailed on that issue, claimant could not request the Court to reconsider the matter based on other grounds or theories. However, he is not precluded from litigating his entitlement to specific benefits.

¶32 This Court previously adopted a rule requiring that requests for attorney fees and a penalty must be joined with the underlying claim. Rule 24.5.301(3). [1994 MAR p.27, Eff. 1/14/94.] That rule was adopted with the advice and consent of the Court's Rules Committee and precludes splitting of fees and penalty issues from the substantive claim. It thereby prevents two or three actions where one should suffice. It may well be that the time has come for a similar rule to be adopted as to benefits due at the time a petition is brought. The matter, however, is one which should be first submitted to and considered by the Rules Committee.

¶33 I still must consider Liberty's laches argument. The doctrine of laches is sum-marized in *Marriage of Hahn and Cladouhos*, 263 Mont. 315, 318, 868 P.2d 599, 601 (1994), as follows:

> Section 1-3-218, MCA, provides that "[t]he law protects the vigilant before those who sleep on their rights." Laches is a concept of equity that can apply when a person is negligent in asserting a right, and can apply where there has been an unexplained delay of such duration or character as to render the enforcement of the

asserted rights inequitable. *Fillner v. Richland* (1991), 247 Mont. 285, 290, 806 P.2d 537, 540. Each case must be determined on its own unique facts. Fillner, 806 P.2d at 540.

When a claim is filed within the time set by the statute of limitations, "the defendant bears the burden to show that extraordinary circumstances exist which require the application of laches." *Id.*, 263 Mont. at 319, 868 P.2d at 601. Liberty has not provided uncontroverted evidence of any extraordinary facts. It argues that had claimant given notice of his need for domiciliary care when that need arose, then it could have investigated the need. However, its denial of his claim effectively waived any right to contemporaneous notice. The doctrine of laches does not bar the present claim.

¶34 Claimant also requests attorney fees and a penalty. Both items require proof that Liberty acted unreasonably. §§ 39-79-611, -612, -2907, MCA (1995). On the basis of the uncontroverted record, Liberty's denial was not unreasonable. Its defenses raised significant and substantial questions and it has prevailed in part.

JUDGMENT

¶35 Liberty is liable for and shall pay domiciliary benefits up to and including July 11, 1997. It is not liable for domiciliary benefits after that date.

¶36 Claimant is not entitled to attorney fees or a penalty.

¶37 Claimant is entitled to his costs. He shall file his memorandum of costs in accordance with Court rules.

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

¶39 Any party to this dispute may have 20 days in which to request a rehearing from this Decision and Judgment.

DATED in Helena, Montana, this 18th day of December, 2001.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. David W. Lauridsen
Mr. Larry W. Jones
Submitted: July 2, 2001