IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

1994 MTWCC 61

WCC No. 9404-7039

STATE COMPENSATION INSURANCE FUND

Appellant

vs.

MARK ALLEN PETERSON

Respondent.

ORDER ON APPEAL

This appeal is from a March 29, 1994 Order on Motion for Continuation of Benefits entered by Stan Gerke, a hearing examiner for the Montana Department of Labor and Industry (DLI). The Order directed the insurer, State Compensation Insurance Fund (State Fund), to reinstate claimant's total rehabilitation benefits until the DLI issues a final order concerning rehabilitation options for claimant. On April 8, 1994, the State Fund appealed. The appeal is based on alleged errors of law arising out of the hearing examiner's interpretation of section 39-71-1023, MCA (1989). For the reasons set forth in this decision, the DLI Order is **reversed**.

Discussion

Based on the record below, which consists of the DLI file transmitted to the Court, the claimant suffered an industrial injury on January 22, 1990. The law in effect at the time of his injury, now repealed,[(1)] provided a specific procedure for determining rehabilitation options for injured workers. The procedure, which is administered by the DLI, initially requires the insurer to designate a rehabilitation provider. § 39-71-1014 (a), MCA (1989). The designated provider determines the first appropriate rehabilitation option for the injured worker. § 39-71-1015 (a), MCA (1989). Those options, in order, are:

> (a) return to the same position;
>
> (b) return to a modified position;
>
> (c) return to a related occupation suited to the claimant's education and marketable skills;
>
> (d) on-the-job training;

(e) short-term retraining program (less than 24 months);

(f) long-term retraining program (48 months maximum); or

(g) self-employment.

§ 39-71-1012 (2), MCA (1989). Where the worker in fact does not return to work, the DLI is then required to designate a rehabilitation panel to evaluate the worker and recommend a first appropriate rehabilitation option. § 39-71-1017, MCA (1989). Following the issuance of the panel's report, the DLI must consider the report and issue its own "initial order of determination" specifying the first appropriate option for the worker. § 39-71-1018 (1), MCA (1989). The initial order triggers the right to a hearing before the DLI. § 39-71-1018 (2), MCA (1989). After a hearing the DLI is required to issue a "final order," which in turn triggers the right of appeal to this Court. Section 39-71-1018 (3), (4), MCA (1989).

The process described in the previous paragraph has not been completed. The State Fund designated Montana Rehabilitation and Clinical Consultants to evaluate claimant. Claimant did not return to work following that evaluation, so a rehabilitation panel was designated by the DLI. The panel issued its report on January 6, 1992, more than two years ago, determining that option (c) was appropriate and that claimant could return to work in a related occupation. On January 16, 1994, the DLI issued its Initial Order of Determination adopting the panel's recommendation. On January 28, 1992, the DLI received a letter from claimant requesting a hearing. A prehearing conference was scheduled for May 11, 1992, but was continued to May 29, 1992 at the request of the claimant. On June 1, 1992, the hearing examiner filed an order continuing the prehearing conference indefinitely since the parties had agreed to an indefinite postponement. On July 3, 1992, claimant's attorney filed a status report indicating claimant had been allowed to see Dr. Johnson and was scheduled to see Dr. Lovitt.

Nothing else transpired until February 18, 1994, when claimant, through his attorney, filed a Motion to Continue Benefits pursuant to section 39-71-1023, MCA (1989), which governs payment of total rehabilitation benefits. According to the motion, claimant's benefits were cut off on March 13, 1992, reinstated on July 13, 1993 to allow for an independent medical examination by a psychologist, and again terminated on December 20, 1993. The State Fund did not dispute claimant's representations. While no documentation was presented to show that the terminated benefits were total rehabilitation benefits, the claimant's motion requested "an order **continuing** total rehab benefits and **reinstate** total rehab benefits." Lacking any further factual record, this Court must assume for purposes of this appeal that the benefits being paid at the time of initial termination on March 13, 1992, and reinstated during the period July 13 to December 19, 1993, were total rehabilitation benefits.

On March 29, 1994, the hearing examiner granted the claimant's motion. In his Order on Motion for Continuation of Benefits, the hearing examiner determined that claimant "is entitled to rehabilitation benefits until date [sic] of the issuance of a **Final Order of Determination** by the Department of Labor and Industry pursuant to Section 39-71-1023 (4)(b), MCA." (Emphasis in original.) The determination was based on the hearing examiner's reading of ***Higgenbotham v. Stoltze-Connor Lumber Co.,*** *248 Mont. 161, 810 P.2d 295 (1991),* the decision of this Court in ***Montana Health Network v. Katherine Nelson,*** *No. 9212-6649 (April 9, 1993) (decision withdrawn June 14, 1993),* and prior decisions of the DLI.

Section 39-71-1023, MCA (1989), provides for total rehabilitation benefits. The section was effective between July 1, 1987 and July 1, 1991, when it was repealed, 1991 Laws of Montana, ch. 574, § 14. The section provides:

> **39-71-1023. Total rehabilitation benefits during period of rehabilitation services -- limitation -- termination.** (1) A worker who no longer is temporarily totally disabled but meets the definition of a disabled worker may be eligible for total rehabilitation benefits.
>
> (2) Eligibility for total rehabilitation benefits begins on the date of maximum healing and continues for a period **not to exceed 26 weeks after the date notice is given to the department by the insurer that a rehabilitation provider has been designated.**
>
> (3) Benefits must be paid at the disabled worker's temporary total disability rate. **The department may extend the benefit period for good cause.** The insurer may extend the benefit period without department approval but must notify the department of the extension.
>
> (4) **Total rehabilitation benefits under this section terminate when:**
>
> (a) a worker returns to work;
>
> (b**) a worker is qualified to return to work under the priorities in 39-71-1012 pursuant to a department order; or**
>
> (c) an I.W.R.P. is submitted to the department by the department of social and rehabilitation services.
>
> (5) The insurer shall provide written notice to the worker and department that benefits have been terminated. [Emphasis added.]

In ***Higgenbotham*** the Supreme Court held that the insurer had improperly refused to pay claimant total rehabilitation benefits. The insurer in that case never paid total rehabilitation benefits. Rather, it terminated claimant's temporary total disability benefits on the date he

reached maximum healing and began paying permanent partial disability benefits, which were one-half of the amount of total rehabilitation benefits. The insurer did designate a rehabilitation provider but no rehabilitation panel was ever empaneled. On appeal, the Supreme Court broadly phrased the issue presented as:

> Under § 39-71-1023, MCA (1987), must an insurer pay total rehabilitation benefits to a worker during the review by the rehabilitation panel and the Department?

248 Mont. at 166. After discussing the issue, the Court concluded as follows:

> We conclude that claimant was denied the rehabilitation procedure required under the foregoing statutes. He did not receive a rehabilitation panel report or a Department order of determination. He did not receive the opportunity to have a hearing before the Department's final order of determination on the issue of rehabilitation.

Id. at 167.

The DLI hearing examiner misread ***Higgenbotham*** as **requiring** payment of rehabilitation benefits until the time a **final order** is issued by DLI. While the breadth of the issue phrased by the Supreme Court, as well as some of the language in the decision, might be construed as supporting that conclusion, a careful reading of the decision does not. The insurer in that case paid no total rehabilitation benefits whatsoever. That fact is important in light of the 26 week limitation on the benefits. Section 39-71-1023 (2), MCA. Since no benefits were paid, the 26 week limitation was not at issue, as it is in this case. In the paragraph preceding its conclusion, as quoted above, the Court made the following statement:

> Under the statutory provisions, after the insurer gave notice to the Department that Crawford had been designated as its rehabilitation provider, c**laimant was entitled to total rehabilitation benefits for a period not to exceed 26 weeks, unless extended by the Department.** [Emphasis added.]

Id. It further acknowledged the 26 week limitation in fashioning the relief for the insurer's failure to comply with the statute:

We further hold that the date of remand shall constitute the date notice is given to the Department by the insurer that a rehabilitation provider has been designated under the foregoing statutes, so that additional total rehabilitation **benefits shall be paid from that date as provided under the statutes for a period not to exceed 26 weeks unless otherwise extended by the Department under the statutory provisions.**

Id. at 167-8 (emphasis added). While the Court did not specifically explain why retroactive benefits were awarded in addition to the 26 weeks permitted by section 39-71-1023 (3), MCA,[(2)] the 26 week limitation was clearly and unequivocally acknowledged by the Court.

Section 39-71-1023 (3), MCA, expressly limits payment of total rehabilitation benefits to 26 weeks unless the DLI "extend[s] the benefit period **for good cause**" or the insurer voluntarily extends the benefits period. In light of this clear language, this Court will not impute to any intention on the part of the Supreme Court to abrogate the 26 week limitation or the good cause requirement.

In making his determination, the hearing examiner ignored the 26 week limitation on total rehabilitation benefits and the good cause requirement. The information furnished to the hearing examiner indicated that claimant had been paid at least 23 weeks of total rehabilitation benefits (July 13 to December 20, 1992), and probably 26 weeks or more since benefits were also paid prior to March 13, 1992. At least there is no factual basis for concluding that the insurer has paid less than 26 weeks of benefits. The hearing examiner never reached the issue of good cause. That issue is a substantial and troubling one since claimant chose not to vigorously pursue his request for hearing.

The hearing examiner also erred in interpreting section 39-71-1023 (4)(b), MCA (1989), which provides that total rehabilitation benefits terminate when "a worker is qualified to return to work under the priorities in 39-71-1012 **pursuant to a department order**." The hearing examiner construed the words "a department order" as meaning a "final order," citing a previous decision of this Court in ***Montana Health Network v. Katherine Nelson,*** *WCC No. 9212-6649 (April 9, 1993) (decision withdrawn on June 14, 1993).* In the withdrawn decision Judge Reardon concluded that language in section 39-71-1019 (1), MCA, "clearly indicates that **only a final order** relieves an insurer from the potential obligation to pay total rehabilitation benefits." Insofar as this holding might be considered precedent, it is overruled.

Section 39-71-1019 (1), MCA (1989), provides:

> **39-71-1019. Referral to department of social and rehabilitation services for retraining -- benefits -- appeals.** (1) If in its final order of determination the department considers a worker able to return to work in the worker's job pool, the insurer is not liable for **rehabilitation benefits**, even though the worker independently may pursue a training program of the worker's own choice or seek vocational rehabilitation services from the department of social and rehabilitation services. [Emphasis added.]

The quoted provision on-its-face concerns an insurer's liability, **after** a final order, where the worker independently pursues vocational training. It does not concern the insurer's liability for total rehabilitation benefits and does not nullify the 26 week limitation specified in section 39-71-1023 (2), MCA (1989). Section 39-71-1019 (1), MCA (1989) refers to "rehabilitation benefit**s**," not to "total rehabilitation benefits", and it is clear from the context of the quoted subsection, as well as the following subsections,[(3)] that the "rehabilitation benefits" referred to are those benefits available to workers determined in a final order to

be in need of retraining. Section 39-71-1024, MCA (1989), requires insurers to pay a "partial rehabilitation benefit" to workers in rehabilitation programs. Section 39-71-1025, MCA, provides an auxiliary rehabilitation benefit of up to $4,000 to aid the worker in relocating, searching for new employment and implementing a rehabilitation program.

A Court may not insert its own conditions or requirements into a statute. ***Russette v. State Compensation Insurance Fund,*** *51 St.Rptr. 414, 415 (1994).* It must apply a statute as written. Section 39-71-1023 (4)(b), MCA provides that an insurer may terminate total rehabilitation benefits where "a department order" determines that the worker is qualified to return to work. The legislature used the term "final order" in other parts of the rehabilitation statutes found in Chapter 10, Part 71, Title 39, but it did not do so in section 39-71-1023 (4)(b), MCA. We must assume that the omission of the word "final", and the use of the words "a department order" was deliberate; at least, the Court cannot insert the word "final" into the section. An "initial order of determination" **is** "a department order." Therefore, the State Fund cannot be required to pay total rehabilitation benefits after the issuance of its initial order on January 16, 1992.

Order

For the reasons set forth in the foregoing discussion, the DLI's Order on Motion for Continuation of Benefits is **reversed.** This matter is remanded to the DLI with instructions that the request be denied.

DATED in Helena, Montana, this 5th day of July, 1994.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Mr. Michael P. Heringer
Mr. Thomas J. Lynaugh

1. 1991 Laws of Montana, ch. 574, § 14.

2. The decision deemed the remand date as the date of notification to the DLI even though such notice had in fact been given on March 17, 1989. *248 Mont. at 161*. The date of notice is important since total rehabilitation benefits commence either on the date of maximum healing or the date of the notice, *whichever is later.* The Court may have considered the first notice void in light of the insurer's failure to pay any total rehabilitation benefits whatsoever.

3. The remaining subsections concern procedures which must be followed when the final order determines that the worker needs retraining. They provide:

(2) If in its final order of determination the department finds the worker needs retraining, the department shall determine the maximum duration for which funds under 39-71-1003 may be used for rehabilitation services under 39-71-1012(2)(d) through (2)(f) and shall refer the worker to the department of social and rehabilitation services for a determination of vocational handicap.

(3) If the department of social and rehabilitation services determines that a disabled worker has a vocational handicap, the worker is eligible for funds under 39-71-1003 up to the maximum duration established in the division's final order of determination.

(4) If a disabled worker seeks vocational rehabilitation services from the department of social and rehabilitation services without giving the insurer the opportunity to designate a rehabilitation provider or, subsequently, without giving the department the opportunity to designate a rehabilitation panel to provide a report, the insurer is not liable for rehabilitation benefits. The insurer may terminate rehabilitation and other benefits, if any, being received by the worker by following the procedure set forth in 39-71-1032.

(5) The department of social and rehabilitation services, in providing rehabilitation services to a worker referred to it by the department, shall consider but is not bound by the rehabilitation panel report.

(6) If the department of social and rehabilitation services has determined that all appropriate rehabilitation services have been provided to a disabled worker, the department shall document that determination to the department.

(7) The appeal process before the board of social and rehabilitation appeals provided for in 53-7-106 is the exclusive remedy for a person aggrieved in the receipt of services provided by the department of social and rehabilitation services.