

IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

1994 MTWCC 22

WCC No. 9312-6975

BUD STRODE

Petitioner

vs.

STATE COMPENSATION INSURANCE FUND

Respondent/Insurer for

BLUE RIBBON BUILDERS

Employer.

ORDER GRANTING RECONSIDERATION; ORDER GRANTING MOTION TO DISMISS IN PART;
ORDER DENYING MOTION TO DISMISS IN PART

On February 22, 1994, the Court entered an Order Dismissing Petition. At the time of the Order we had not received any brief in opposition to respondent's motion to dismiss, and the time for filing an opposing brief had expired. In light of petitioner's failure to file an opposing brief, and the apparent merit of the motion, the Court dismissed the petition.

On the same day as dismissal, but after entry of the Order, the Court received a brief opposing the motion. A conference call was then held with counsel for both parties. Petitioner's counsel explained that in counting the days for his brief he had excluded weekends and holidays. The exclusion is permitted under the Montana Rules of Civil Procedure, Rule 6 (a). It is not permitted under the rules of this Court. ARM 24.5.303. However, the Court recently amended its rules to make it clear that the exclusion does **not** apply, thus eliminating any confusion that may have arisen within the bar. It is therefore sympathetic to counsel's oversight in this case. The Motion to Reconsider is **granted**. Counsel practicing before the Court are cautioned that they should familiarize themselves with the rule regarding computation of time. The rule expressly states that weekends and holidays **are included** in computing time, **even where** the time for action is 10 days or less.

Respondent, State Compensation Insurance Fund (State Fund), has been served with a copy of petitioner's opposing brief and has filed a reply brief. The Court now has the full benefit of arguments of both sides and will revisit the motion to dismiss.

Two petitions have actually been filed herein. The first is styled Claimant's Petition for Review of Final Impairment Rating and was filed on December 30, 1993. It consists of one sentence, as follows:

COMES NOW Claimant, by and through his attorney of record, and moves and petitions this Court for review of the final impairment rating rendered by Dr. Diggs pursuant to Section 39-71-711, MCA (1989).

The second Petition for Hearing, which will be deemed an amended petition, was filed on January 20, 1994. The second petition renews the challenge to Dr. Diggs' impairment rating and adds a request that the Court order rehabilitation benefits.

In the prior Order this Court dismissed both claims for relief. The challenge to Dr. Diggs' rating was dismissed because the rating was not a "final impairment rating" over which the Court has jurisdiction under section 39-71-711 (6), MCA (1989). The request for rehabilitation benefits was dismissed because it did not appear that the matter has been mediated.

There is no basis for retreating from the original conclusion regarding the claim for rehabilitation benefits. Except as otherwise provided within the Workers' Compensation Act, any dispute regarding benefits must first be mediated. Section 39-71-2401 and 2905, MCA (1989). A petition seeking benefits must affirmatively allege that mediation has taken place. ARM 24.5.301 (1)(e). The petition in this case does not do so and the State Fund expressly denies that the matter has been mediated. Thus, on its face the petition fails to set forth facts demonstrating that the mediation prerequisite has been satisfied. The claim for rehabilitation benefits is therefore dismissed without prejudice.

The matter of Dr. Digg's impairment rating is a different and more difficult matter. The injury in this case occurred on September 25, 1989. The parties have proceeded under the law in effect at that time, including section 39-71-711, MCA (1989), which provided an elaborate and since repealed procedure for impairment ratings. Under the section either the claimant or an insurer may request the Department of Labor and Industry (DLI) to designate a physician (a medical doctor or chiropractor) to "evaluate the claimant to determine the degree of impairment, if any, that exists due to the injury." If dissatisfied with the initial evaluator's rating, either party may request an evaluation by a second physician; however, the request automatically triggers appointment of yet a third physician, who must consult with the first two and render a "final impairment rating." All impairment ratings must be based on the "current edition of the Guides to Evaluation of Permanent Impairment." The "final impairment rating" may be appealed to the Worker's Compensation Court within 15 days, but is "presumed correct."⁽¹⁾ The full text of the statute is set out in an endnote.⁽²⁾

The statute has one additional feature: The party requesting the second evaluation is responsible for the costs of both the second and third evaluators. Section 39-71-711(5),

MCA. Those costs can be hundreds of dollars. Thus, there is penalty for disputing the first evaluation. That penalty is critical to the Court's analysis of petitioner's claim.

In his brief, the petitioner has set forth additional facts regarding the dispute over Dr. Digg's evaluation. A motion to dismiss ordinarily tests the facial sufficiency of the complaint ***Irving v. School Dist. No. 1-1A, Valley County***, 248 Mont. 460, 464, 813 P.2d 417 (1991). While this Court has not adopted a specific rule regarding such motions, it has often looked to the Montana Rules of Civil Procedure for guidance where its own rules are silent. ***See Murer v. State Compensation Mutual Insurance Fund***, 257 Mont. 434, 436, 849 P.2d 1036 (1993); ***Moen v. Peter Kiewit & Sons' Co.***, 201 Mont. 425, 434 655 P.2d 482 (1982). However, in light of this Court's expedited schedule for hearing petitions, and less formal pleading requirements, it will consider the factual representations made in petitioner's brief as supplementing and amending his petition. For purposes of the motion to dismiss, petitioner's contentions are accepted as true. ***Larson v. First Interstate Bank of Kalispell***, 241 Mont. 350, 352, 786 P.2d 1176 (1990).

According to Mr. Strode, he was injured in a job-related accident on September 25, 1989. On July 19, 1990, his treating physician rendered a two (2%) percent whole man impairment rating. On May 26, 1992, the State Fund declared him to be permanently totally disabled. On October 23, 1993, his physician rendered a new impairment rating of 32 percent based on the 3rd Edition of the Guides to Evaluation of Permanent Impairment. This latter impairment rating apparently triggered the State Fund's November 2, 1993 request to the Department of Labor and Industry (DLI) for appointment of an impairment evaluator pursuant to section 39-71-711, MCA (1989).

The DLI appointed Dr. Diggs to evaluate Mr. Strode. Dr. Diggs examined Strode on November 29, 1993, and reported a zero (0%) percent impairment. Dr. Diggs, however, refused to furnish either Mr. Strode or his attorney with a copy of his report. Strode's attorney therefore wrote to the DLI demanding a copy of the report. The report was furnished on December 17, 1993. On December 21, 1993, Strode's attorney faxed a letter to the DLI challenging the rating. The letter specifically alleged that the rating was not based on the "current" guides to impairment, as required by section 39-71-711, and was tainted by the DLI's informing Dr. Diggs that his evaluation had been requested by the State Fund. The time for requesting a second evaluator expired on December 31, 1993. Not having heard from the DLI, on December 30, 1993 Strode filed his petition with this Court. In his supporting brief, Strode states that he "will establish facts that show that Dr. Diggs' Impairment Rating did not meet the requirements of § 711 and consequently, forcing Mr. Strode to submit to a second evaluation" (Claimant's Brief in Opposition to Motion to Dismiss at 5.)

The first evaluation under section 39-71-711 is a critical one. No weight or effect whatsoever is given to any prior evaluation, including the evaluation of a treating physician.

The evaluation of the first evaluator designated by the DLI appears to be conclusive unless either the insurer or claimant requests a second evaluation, since it is only the "final evaluation" which may be appealed to the Workers' Compensation Court. The statute, however, extracts a price for challenging the first evaluation: the party requesting the second evaluation must pay not only for the second evaluator but also for a third evaluation, which is automatic under the statute. As already noted, those evaluations may cost hundreds of dollars. It is therefore important that the first evaluation be conducted fairly and in accordance with the "current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association. . . ." Section 39-71-711(1)(a), MCA (1989).

Respondent's motion to dismiss is rooted in the doctrine of exhaustion of administrative remedies. Section 39-71-711 provides an administrative process for determining impairment ratings and permits judicial review only upon the exhaustion of that process. While physicians are the instruments for making the administrative determination, and the scope of review of the Court is broader than that ordinarily prescribed,⁽³⁾ the process prescribed by the section is an administrative one which is mandatory and is subject only to judicial review. Therefore, we must determine if the failure of petitioner to request a second evaluation precludes intervention by this Court.

While the judicial review provisions of the Montana Administrative Procedure Act (Title 2, chap. 4, part 7, MCA) are not expressly applicable to the Workers' Compensation Court, they have been followed in previous decisions, e.g., ***State Compensation Insurance Fund v. Lee Rost Logging***, 252 Mont. 97, 102, 827 P.2d 85 (1992), and will be followed here. Section 2-4-701, MCA provides:

2-4-701. Immediate review of agency action. A preliminary, procedural, or intermediate agency action or ruling is immediately reviewable if review of the final agency decision would not provide an adequate remedy.

In light of the significant financial penalty imposed upon a party dissatisfied with an initial impairment rating rendered under section 39-71-711, and the statutorily mandated method for rendering the impairment rating, I conclude that Mr. Strode has properly invoked the Court's jurisdiction. The motion to dismiss that part of his petition regarding the impairment dispute therefore should be, and is, **denied**.

IT IS HEREBY ORDERED as follows:

1. That the petitioner's Motion to Reconsider is **granted**.
2. That the claim for rehabilitation benefits is **dismissed**, and,
3. That the motion to dismiss the portion of claimant's petition regarding the impairment dispute is **denied**.

DATED in Helena, Montana, this 9th day of March 1994.

(SEAL)

/S/ Mike McCarter

JUDGE

c: Mr. Thomas M. White

Ms. Ann E. Clark

1. The presumption is rebuttable. Section 39-71-711 (7), MCA.

2. **39-71-711. Impairment evaluation - ratings.** (1) An impairment rating:

(a) is purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum healing;

(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American Medical Association; and

(c) must be expressed as a percentage of the whole person.

(2) A claimant or insurer, or both, may obtain an impairment rating from a medical doctor or from a chiropractor if the claimant's treating physician is a chiropractor. If the claimant and insurer cannot agree upon the rating, the procedure in subsection (3) must be followed.

(3) (a) Upon request of the claimant or insurer, the department shall direct the claimant to an evaluator for a rating. The evaluator shall:

(i) evaluate the claimant to determine the degree of impairment, if any, that exists due to the injury; and

(ii) submit a report to the department, the claimant, and the insurer.

(b) Unless the following procedure is followed, the insurer shall begin paying the impairment award, if any, within 30 days of the evaluator's mailing of the report:

(i) Either the claimant or the insurer, within 15 days after the date of mailing of the report by the first evaluator, may request that the claimant be evaluated by a second evaluator. If a second evaluation is requested, the department shall direct the claimant to a second evaluator, who shall determine the degree of impairment, if any, that exists due to the injury.

(ii) The reports of both examinations must be submitted to a third evaluator, who may also examine the claimant or seek other consultation. The three evaluators shall consult with one another, and then the third evaluator shall submit a final

report to the department, the claimant, and the insurer. The final report must state the degree of impairment, if any, that exists due to the injury.

(iii) Unless either party disputes the rating in the final report as provided in subsection (6), the insurer shall begin paying the impairment award, if any, within 45 days of the date of mailing of the report by the third evaluator.

(4) The department shall appoint impairment evaluators to render ratings under subsection (1). The department shall adopt rules that set forth the qualifications of evaluators and the locations of examinations. An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12. The department may seek nominations from the board of medical examiners for evaluators licensed under Title 37, chapter 3, and from the board of chiropractors for evaluators licensed under Title 37, chapter 12.

(5) The cost of impairment evaluations is assessed to the insurer, except that the cost of an evaluation under subsection (3)(b)(i) or (3)(b)(ii) is assessed to the requesting party.

(6) A party may dispute a final impairment rating rendered under subsection (3)(b)(ii) by filing a petition with the workers' compensation court within 15 days of the evaluator's mailing of the report. Disputes over impairment ratings are not subject to 39-71-605 or to mandatory mediation.

(7) An impairment rating rendered under subsection (3) is presumed correct. This presumption is rebuttable.

3. Under the Montana Administrative Procedure Act courts exercise appellate jurisdiction over the decisions of administrative agencies and do not ordinarily make de novo determinations. See section 2-4-704, MCA. This Court's review under section 39-71-711 (6) is broader. The section provides that "[a] party may dispute a final impairment rating . . . by filing a *petition* with the workers' compensation court" Subsection (7) provides that the final rating "is presumed to be correct", but goes on to provide that the "presumption is rebuttable." Clearly, the section contemplates an evidentiary hearing before the Workers' Compensation Court.