IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2001 MTWCC 21

WCC No. 2000-0059

MICHAEL L. MILLER

Petitioner

vs.

STATE COMPENSATION INSURANCE FUND

Respondent/Insurer for

JACK GALT

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: Pro sé claimant, who previously litigated a claim to reopen his 1988 settlement with State Fund, filed a new petition seeking to "settle my Medical Benefits," "get a decision from the Court on the Reduction to Present Value that was done on my settlement in error," and "have the Court look at how State Fund has treated me." In a second new petition, claimant sought a jacuzzi tub, handicapped bathroom facilities, and a computer as medical benefits. After a discovery order indicating claimant could not re-litigate claims that were raised or could have been raised in the earlier case, claimant alleged that the Clerk of the Workers' Compensation Court had told him to limit his presentation in the prior proceeding. *That* factual allegation was referred to District Court Judge Jeffrey M. Sherlock for resolution. After hearing, Judge Sherlock found the Clerk had *not* in fact advised claimant to limit his case. Because claimant's various narrative filings made numerous allegations, the Court reviewed whether those allegations stated claims for relief and set out those claims which would proceed to trial in an Order Governing Further Proceedings, ruling other claims not proper.

Held: Arguments to reopen the 1988 settlement are barred by *res judicata*. Where Judge Sherlock found claimant had not in fact been advised to limit his presentation, he may not avoid application of that doctrine. To permit appellate review of the underlying claims to reopen, however, the Court also finds that even if claimant were permitted to reargue opening of his 1988 settlement, he has not presented evidence to prove mistake of fact or law to warrant reopening. Claimant's allegation that the parties erroneously reduced his

lump-sum settlement to present value is not supported by the record, which indicates that State Fund initially disputed whether claimant was in fact permanently totally disabled and then negotiated a specific dollar settlement with claimant's attorney. While reference was made to "present value" of a payout of permanent total disability benefits, that reference, in context, was part of State Fund's evaluation of the case for settlement. Claimant also did not prove that the parties erroneously failed to consider his "concurrent" earnings from self-employment, where such earnings would not have been considered under 1983 law and the settlement, in any event, was for payment of specific funds to allow claimant to operate a business. With regard to claimant's demand for lump-sum settlement of his future entitlement to medical benefits, the Court does not have jurisdiction to order State Fund to settle such benefits. While claimant has convinced the Court that from *his* perspective his relationship with State Fund is unworkable, State Fund's positions on medical benefits and refusal to settle medical benefits is objectively reasonable. In those circumstances, while the Court would probably approve a reasonable settlement of medical benefits negotiated between the parties, it cannot order State Fund to settle against the insurer's judgment. The Court rejected claims for past expenses for back treatment as previously settled and rejected claimant's demand that the insurer pay him for travel expenses in a yearly lump-sum amount prior to the occurrence of the travel. The Court also rejected demands for coverage of foot fungus medication and purchase of a computer as a medical benefit. The Court ordered coverage of handicapped bathroom facilities installed in claimant's home (which the insurer had recently authorized), as well as expenses associated with installing a tub in claimant's home for hydrotherapy.

Topics:

Benefits: Medical Benefits: Mileage. Claimant is not entitled to a yearly pre-travel lump-sum payment of mileage.

Benefits: Medical Benefits: Primary Medical Services. Claimant is not entitled to reimbursement for chiropractic and massage expenses incurred prior to insurer's acceptance of back condition as related to injury where credible evidence demonstrated his claim for those services had been previously settled. Claimant is not entitled to payment for foot fungus medication where prescribing physician opined condition was not related to industrial injury.

Benefits: Medical Benefits: Secondary Medical Services. Claimant with brain-damage and related back problems entitled to compensation for installation of handicapped bathroom facilities and tub for hydrotherapy based on recommendations from physician and chiropractor. Claimant is not entitled to a computer despite past adjuster's testimony that computers assist brain damaged individuals in communications and is therapeutic, where the record contains no medical opinion advising purchase of a computer for a therapeutic purpose but

rather suggests claimant's desire to have a computer for operation of a family business.

Defenses: Res Judicata. Arguments for reopening settlement which could have been made in prior proceeding asking for reopening of settlement could not be made in new case.

Settlements: Reopening. Arguments for reopening settlement which could have been made in prior proceeding barred by *res judicata*.

Settlements: Medical Benefits. While the Court may approve under appropriate conditions a reasonable agreement to settle medical benefits negotiated between the parties, it does not have jurisdiction to order an insurer to settle claimant's entitlement to future medical benefits with a lump-sum payment.

Settlements: Reopening: Mistake of Law. Claimant failed to convince the Court that the insurer erroneously reduced settlement, made under 1983 law, to present-value where the record demonstrated insurer disputed liability for permanent total disability and negotiated a settlement for specific monetary payment for claimant to operate a ranch. I find no evidence that the parties agreed to a lump-sum payout of permanent total disability benefits, which they then erroneously reduced to present value.

Introduction

¶1 During 1998, claimant Michael L. Miller (Miller) brought an action in this Court to reopen a 1988 full and final settlement with the State Compensation Insurance Fund. I found his claim to reopen barred by the applicable statute of limitations and the Supreme Court affirmed. (*Miller v. State Compensation Insurance Fund*, 1999 MTWCC 21, aff'd, 2000 MT 19N.) In March 2000, claimant filed a new petition in this Court asking to "settle my medical benefits," "get a decision from the Court on the Reduction to Present Value that was done on my settlement in error," and "have the court look at how State Fund has treated me." As explained fully in my Order Governing Further Proceedings filed as *Miller v. State Compensation Insurance Fund*, 2000 MTWCC 72, claimant's allegations were expanded and supplemented through various other filings.

¶2 During June 2000, State Fund filed a Motion for Protective Order in response to discovery requests served by claimant. Most of the discovery requests sought information related to grounds for reopening the settlement, the very matter litigated in the prior case. In my Order Limiting Discovery, filed June 17, 2000, I found that the only issues properly before the Court on the 2000 petition were claimant's request for a settlement of his medical benefits and the reasonableness of State Fund's failure to agree to his request. I explained:

> The prior decision of this Court is *res judicata* as to all issues and facts which were raised, or which could have been raised, in connection with Miller's request to reopen. "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 [sic] prior case." *In re Raymond W. George Trust*, 296 Mont. 56, 67, 986 P.2d 427, 435 (1999). In this case, Miller requests the Court to determine whether the State Fund improperly discounted his settlement and directs a number of his interrogatories to the manner in which the settlement was calculated. This argument could have been raised as a ground for reopening when claimant petitioned the Court in 1998. It is not an issue which arose subsequent to the Court's prior decision, hence it is barred under the *res judicata* doctrine.

(Order Limiting Discovery ¶ 3.)

¶3 As detailed in my November 17, 2000 Order Governing Further Proceedings, *Miller v. State Compensation Ins. Fund*, 2000 MTWCC 72, Miller then alleged he had been told by Ms. Patricia J. Kessner, the Clerk of the Workers' Compensation Court, that he could only argue his back problems as a ground for reopening the settlement. He claimed the advice prevented him from raising arguments for reopening that he now wanted to make. I determined Miller's allegation required a factual hearing. That determination was based upon my conclusion that had Miller been told by Court staff that he could not litigate certain issues, then the doctrine of *res judicata* did not apply to those issues since he was denied an "opportunity" to litigate the claims in the prior case. (*See Miller v. State Compensation Insurance Fund*, 2000 MTWCC 72, ¶ 12.)

¶4 Because Miller's allegation involved a member of my staff, I called in a district court judge to determine whether claimant had been deterred from prosecuting certain claims in his first action. A hearing was held before Judge Jeffrey M. Sherlock on January 2, 2001. In his Findings of Fact, Conclusions of Law and Order, filed February 5, 2001, Judge Sherlock found Ms. Kessner "had no conversation with Miller on whether to litigate any particular theory with respect to reopening his settlement." (Findings of Fact, Conclusions of Law and Order at 6.) Judge Sherlock observed that "[b]ased on the Court's Findings of Fact, no grounds exist for Miller to avoid *res judicata* on issues that were or could have been litigated previously as a result of alleged conversations with Kessner." (*Id* at 7.)

¶5 In my Order Governing Further Proceedings, I ruled that I would take evidence on the merits of all matters raised by claimant which state claims, regardless of whether *res judicata* is applicable, so that a complete record is made.

¶6 So that the parties would know which issues could be litigated at trial, my Order Governing Further Proceedings identified those claims alleged by Miller which may state claims for relief cognizable in this Court if not barred by *res judicata*. I rejected allegations which did not state claims for relief (e.g., "State Fund has never treated me like a human

being."). Given Judge Sherlock's factual findings, I reaffirm my conclusion and ruling that claimant is barred from relitigating matters relating to reopening of his settlement which could have been raised in the prior case. Nevertheless, for the reasons noted above, this opinion resolves those specific claims which *would* state claims for relief if not barred.

¶7 This opinion also resolves those new issues raised by claimant in the 2000 petition and in a separate petition filed January 11, 2001, but consolidated into this proceeding. These new issues center upon specific medical benefits and settlement of medical benefits.

¶8 Trial: Trial was held on Friday March 2, 2001, in Helena, Montana. Miller represented himself. In light of his brain injury, I allowed his wife, Amy Miller, to assist with his communication. Respondent, State Compensation Insurance Fund, was represented by Mr. Thomas E. Martello. A trial transcript has not been prepared.

¶9 Exhibits: Exhibits 2, 16 through 21, 23 through 25, 27, and 28 were admitted without objection. Exhibit 30, an expert estimate of future medical expenses prepared on behalf of claimant but not provided to State Fund prior to this Court's exchange date, was refused at the time of trial, however, it is included in the exhibit book for purposes of review. At trial, the Court reserved ruling on the admissibility of Exhibits 1, 3 through 15, 22, 26, 29, and 31, and now rules as follows: Exhibit 1 is refused because it consists of written argument, copies of statutes, and calculations which are insufficiently explained and not supported by expert testimony. Exhibits 3 through15, 22, 26, 29, and 31 are admitted. The State Fund's primary objections to those exhibits involved relevancy given the application of *res judicata* to claimant's attempt to reopen the settlement. I have received and considered those exhibits primarily for the purpose of entering my alternative rulings. Some aspects of these exhibits are also relevant to issues which are properly before the Court. This will be clear from the text of the opinion.

¶10 Witnesses: Claimant was sworn and testified by reading a factual statement into the record and providing additional information in narrative form. Samantha Heigh, Mike Welsh, Bob Silberling, and Bill Galt were sworn and testified.

¶11 Issues presented: The following issues were stated in the Pretrial Order. Issues 1 and 2 are barred by *res judicata,* but are considered for the reasons noted above.

> 1. Whether the 1988 Full and Final Compromise Settlement between Miller and the State Fund was based on a mistake of law which entitles Miller to rescind the settlement.
>
> 2. Whether the 1988 Full and Final Compromise Settlement between Miller and the State Fund was based on a mistake of fact with respect to wages from concurrent employment.

3. Whether Petitioner is entitled to a lump-sum conversation [sic] of his future medical benefits.

4. Whether Petitioner is entitled to attorney fees and a penalty.

5. Whether the State Fund is liable for unpaid medical bills identified by Petitioner.

6. Whether the State Fund should purchase a Jacuzzi tub for Petitioner.

7. Whether the State Fund should purchase a handicapped toilet for Petitioner.

8. Whether the State Fund should purchase a computer for Petitioner.

¶12 Having considered the Pretrial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the exhibits, and the arguments of the parties, the Court makes the following:

FINDINGS OF FACT

¶13 The findings of fact filed by Judge Sherlock on February 5, 2001, are incorporated by reference into this decision.

I.

Facts Relating to Re-Opening Settlement

¶14 As noted, I make the following findings *only* to permit consolidated review should claimant appeal this decision.

A.

Alleged Mistaken Reduction to Present Value

¶15 Claimant contends his 1988 settlement was based upon calculations which mistakenly included discount to present value, not proper under 1983 law. In my Order Governing Further Proceedings, I noted that if not barred by *res judicata*, this allegation might have merit, depending on facts proven and application of case law concerning setting aside settlement based on mistake. Specifically, on the factual issues, I noted:

> As there has been no evidentiary hearing concerning the calculation of the settlement amount, it is unknown whether the parties were relying on the 1983 version of section 39-71-741, MCA, and using an annuity or discounted amount as a compromise, or whether they were relying on the 1985 or 1987 version of the Act. Moreover, lacking a factual record, it is unknown whether either or both parties were laboring under a mistake of law.

(Order Governing Further Proceedings at ¶ 28.)

¶16 Neither party presented testimony from participants to the settlement process. Based on review of exhibits, I find that claimant was represented in the settlement process by attorney Richard J. Pinsoneault (Pinsoneault). (Ex. 6, at 1-3; Ex. 11 at 4; Ex. 12 at 9; Ex. 13 at 2-4, 6-8.) Claimant testified to the effect that Pinsoneault was a family friend and only helped "with the paperwork." I find, however, that Pinsoneault actively negotiated settlement of the case, successfully putting forth claimant's desire for a lump-sum settlement to fund a ranch operation. State Fund was represented by various claims adjusters in the settlement process, including Ed Eberly, Brenda Lillie, P.J. Strizich, and Bill Visser.

¶17 Determining the parties' assumptions and reasoning in the settlement process requires me to draw inferences from documents. The exhibits presented convince me that claimant and State Fund entered into a compromise settlement for a negotiated specific amount of money, to be distributed in stipulated fashion to set up a ranching business for claimant. I find no evidence that the parties agreed to a lump-sum payout of permanent total disability benefits, which they then erroneously reduced to present value.

¶18 The history of negotiations indicate that State Fund's initial position was that claimant was **not** permanently totally disabled. On September 17, 1987, claims adjuster Ed Eberly wrote to claimant that "State Fund would be willing to settle your case for 500 weeks of permanent **partial** benefits," but wanted claimant to first "consult your attorney or your family's attorney to set up a conservatorship" in order "that your future interest be protected." (Ex. 13 at 1, emphasis added.) Pinsoneault then began representing claimant.

¶19 On February 25, 1988, Bill Visser, a claims adjuster supervisor with State Fund, wrote to Mr. Pinsoneault, as follows:

> This is to acknowledge our telephone conversation of February 25, 1988 in which we discussed possible settlement of this case.
>
> It is presently the State Compensation Insurance Fund's position that the claimant cannot be considered totally disabled and that his ability to run a ranching operation points in that direction. As such, we have no alternative but to consider this a permanent partial disability case, which has a maximum value of $69,250.00. We are fully aware of the fact that your client has considerable difficulty competing in the open labor market and his prospective loss of earning capacity justifies settlement of the maximum. We are, therefore, offering to settle this case for the above mentioned amount.
>
> It is also understood that you and your client have a different opinion and that you would like to settle this case on the basis of permanent total disability. You indicated that you would discuss this case with your client and make a formal settlement demand to us.

> In order to obtain a settlement based on permanent total disability benefits, you will have to show that the claimant is unable to make ends meet in his present situation and that a lump sum conversion would provide sufficient income to him to sustain himself financially.

(Ex. 13 at 2.)

¶20 Further negotiations took place over a period of months. Exhibits suggest State Fund looked to various calculations in evaluating the settlement. Exhibit 15 is a printout of the computation of the number of weeks of permanent total and permanent partial disability benefits to which claimant would be entitled, the total payments that would be made, and the "present value @ 7%" of those payments.[(1)] The "date of calculation" was June 17, 1988, within the period the parties were negotiating settlement. The stated present value of permanent total disability payments was $132,568.65, a figure close to what State Fund eventually agreed to pay, $132,145.10. (*See* Ex. 6 at 1.)

¶21 On August 8, 1988, claims adjuster Brenda Lillie wrote to Pinsoneault, forwarding a copy of an "Annuity Quote." She wrote: "As I stated to you on the phone, Mr. Visser has calculated the annuity plus 20% to be $132,145.10. This would be the full value of the case." (Ex. 29 at 1.) Nothing in the record explains this comment. In the context of ongoing settlement discussions, it makes most sense to me as a means of discussing the "cost" of the case to State Fund.

¶22 Contrary to claimant's assertion, I do not read such references as indication that State Fund erroneously reduced a settlement to present value. If State Fund had conceded claimant was permanently totally disabled, agreed to make a lump-sum payout of benefits, and *then* reduced that agreed-upon lump-sum to present value, claimant's argument on "mistake of law" may have some weight. But this is not what happened. From the record, it is clear that State Fund began with the position that claimant was not permanently totally disabled (supported by the fact that he wanted to operate a ranch), received specific monetary demands from Pinsoneault, and negotiated a final settlement.

¶23 A lump-sum payment is by no means a right, even if claimant were able to prove permanent total disability. In *Byrd v. Ramsey Engineering*, 217 Mont. 18, 21, 701 P.2d 1385, 1387 (1985), the Supreme Court explained:

> The general rule concerning the award or denial of lump sum settlements under the Workers' Compensation Act is well settled in this state. Lump sum settlements are only granted in exceptional circumstances. Where the best interests of the claimant are generally served by paying compensation in regular periodic installments, the conversion of benefits to a lump sum settlement has been recognized as the exception rather than the rule.

¶24 The record indicates that State Fund shared information with Pinsoneault about matters such as "cost of annuity" in order to persuade Pinsoneault that State Fund would not agree to pay the amount of money Pinsoneault initially demanded. The Settlement Recap Memorandum notes in part: "Mr. Pinsoneault initially provided a proposal that required $201,751.00. At the time, **he was told there was not this kind of money in the case.** He has since revised his proposal and also gone about the creation of a conservator for Mr. Miller." (Ex. 6 at 2, emphasis added.) The agreement to settle for a specific amount of money followed. In this context, reference to present-value and cost of annuity simply flowed from negotiation of a disputed case, not mistaken reduction of agreed-upon benefits to present value.

¶25 When the agreement to settle was finally reached, it was processed as a "total disability" compromise settlement. A "Petition For Full And Final Compromise Settlement of Total Disability Benefits" was signed on September 20, 1988, by claimant and by his mother as conservator. (Ex. 6 at 1, capitalized in original.) That petition stated that the parties were settling a "controversy [which] exists between the claimant and insurer over the amount and duration of compensation benefits" and "have agreed to fully and finally conclude all compensation payments due the claimant under the Workers' Compensation Act" for the payment of $132,145.10 to claimant. (Ex. 6 at 1.)

¶26 As a basis for settlement, the petition did recite that claimant appeared "to be totally disabled from finding regular employment of any kind in the normal labor market." (Ex. 6 at 1.) It also recited that settlement was "based on the claimant's total disability benefit rate after the rate has been reduced as a result of the offset taken against the claimant's social security disability benefits," thus amounting "to approximately 644 weeks of total disability payments." (*Id.*) In context, however, these recitals indicate the form into which the parties placed the negotiated settlement for purposes of processing, not an agreed lump-sum payout reduced to present value.

¶27 This becomes more clear with the "Recap Memorandum for Full and Final Compromise Settlement Total Disability (Recap)," which sets out the following "Settlement Rationale":

> The claimant is represented by R. J. Pinsoneault. Mr. Pinsoneault has had extensive meetings with Brenda Lillie, Bill Visser and Pete Strizich. The case is being settled on a total disability basis for $132,145.10. We received an annuity quote in the amount of $110,120.92 plus 20% would equal the full value of the case at $132,145.10.
>
> Mr. Pinsoneault initially provided a proposal that required $201,751.00. At the time, he was told there was not this kind of money in the case. He has since revised his proposal and also gone about the creation of a conservator for Mr. Miller.

> The business proposal is attached in detail. There have been several reviews by qualified personnel from Montana State University regarding this business venture. It would appear this settlement is in the best interest of the claimant as it will return him to some type of regular work situation.

(*Id.* at 2.)

¶28 The Recap specifies in detail how the $132,145.10 will be disbursed. The nature of the payments confirms what is not disputed: that a ranching business was being created for claimant. (*Id.* at 3.) Settlement based on creation of a ranching business for claimant -- "some type of regular work situation" in the words of the Recap -- is inconsistent with claimant's argument that settlement was simply a lump-sum payout of undisputed total disability benefits erroneously reduced to present value. The fact that the settlement contemplates claimant operating and working in a business demonstrates claimant's case was not a clear cut total disability case which the parties "mistakenly" reduced to present value.

¶29 Miller has presented no evidence to convince me that Pinsoneault and State Fund did anything more than negotiate a specific monetary settlement of his claim for total disability benefits. He has not presented any evidence showing that either the State Fund or his attorney were mistaken about the law concerning discounts of permanent total disability benefits. Claimant's attorney at the time did not testify as to any such mistake, indeed he did not testify at all. No State Fund employee testified that such a mistake was made. Thus, even if relitigation of reopening were proper, claimant has not produced facts to warrant setting aside the settlement on his assertion of mistaken reduction to present value of a lump-sum award.

B.

Mistake of Fact Regarding

Wages from Concurrent Employment

¶30 In my Order Governing Further Proceedings, I noted that "if Miller was denied the opportunity to present evidence of a mistake of fact concerning concurrent employment, he should be allowed to do so in this action." (Order Governing Further Proceedings ¶ 30.)

¶31 At trial, claimant presented the testimony of Bill Galt (Galt), his employer at his time of injury. Galt testified that claimant had been self-employed in 1983 working his own cattle, as well as working for Galt's ranch. Galt testified that wages he paid claimant were not claimant's sole source of income.

¶32 A State Fund file memo, dated November 10, 1983, reflects conversations with Galt around the time of claimant's injury. Galt stated "that Michael had leased a ranch of his own but works for them whenever they need him." (Ex. 3 at 1.) Other information in the

memo paints a somewhat different picture. Galt is quoted as stating that "Michael would have worked for them every day, seven days a work [sic], through the rest of this year." (*Id.*) Nevertheless, from Galt's testimony, and consideration of the memo as a whole, I am persuaded that claimant was in fact "working" his own cattle at the time he was employed by Galt. While he might have earned some income from that cattle, I am not convinced that the income would have been substantial. There is nothing in the record to suggest how much claimant would have made from this "concurrent" work.

¶33 State Fund argues, and I agree, that under 1983 law, "wages" for purposes of calculating benefit rate did not include earnings from self-employment. Under the 1983 Act, wages were defined in 39-71-116(20), MCA, which provides:

> "Wages" means the average gross earnings received by the employee at the time of the injury for the usual hours of employment in a week, and overtime is not to be considered. Sick leave benefits accrued by employees of public corporations, as defined in subsection (16) of this section, are considered wages.

Subsequent enactments added "concurrent earnings" to wages, but have not included earnings from self-employment which are not covered by a workers' compensation policy. *See* 39-71-123(4), MCA (1989) - (1999). Where the law did not require consideration of claimant's potential earnings from self-employment, there was obviously no "mistake" on the part of the parties in failing to "add" such to claimant's wages when settling the case.

II.

Lump Sum Settlement of

Future Medical Benefits

¶34 For the reasons explained fully in the following conclusions of law, I have concluded I do not have jurisdiction to enter an order compelling settlement of claimant's medical benefits. Nevertheless, I will enter findings of fact relating to settlement of medical benefits as relevant to claimant's request for a penalty against State Fund and to permit review by the Supreme Court, if necessary.

¶35 The thrust of claimant's presentation at trial to support his request for lump summing of medical benefits was his vehement dissatisfaction with State Fund. Claimant testified and argued that he does not trust State Fund, suffers mental distress from continued dealings with State Fund, and wants to sever all ties with State Fund. He did not present expert evidence on the impact of his perceived battle with State Fund on his psychological and physical state. Even without expert opinion, however, it is clear to me that State Fund has become an enemy of large proportion in claimant's mind.

¶36 I am persuaded that claimant honestly believes State Fund has wronged him on numerous occasions. His litany of complaints and accusations spans fifteen years and

countless disagreements. There is some evidence in the record suggesting claimant's viewpoint is the product of his injury and/or his pre-existing personality traits. (*See* Ex. 22 at 5; Ex. 23 at 21-25, and 25 in particular.) On the present record, I am not in the position to reach conclusions about claimant's psychology, but I have observed his difficulty accepting State Fund's explanations and his ready transformation of any denial into perceived harassment. It is entirely possible that if State Fund were removed from claimant's life some other entity or individual would take its place as claimant's adversary in his mind. Nevertheless, I am convinced that from claimant's perspective, he would gain peace of mind from severing his relationship with State Fund through settlement of his medical benefits.

¶37 On the other hand, claimant has **not** convinced me that, objectively, State Fund has unreasonably denied or delayed any medical benefits due him or has unreasonably refused to settle his medical benefits. While claimant has numerous complaints against State Fund, when each matter is examined, it becomes clear that State Fund has taken reasonable positions based on the evidence before it. Several specific disputes over medical benefits are at issue in this case and will be discussed below. At this point, however, some review of State Fund's handling of claimant's case in recent years is appropriate.

¶38 Samantha Heigh (Heigh), one of the adjusters involved in the case, was called as a witness by claimant. Claimant asked Heigh why he was paid compensation for only twenty miles travel for certain treatments when the travel involved thirty miles. Heigh explained that claimant had chosen to travel for treatment outside his area, when treatment was available in his locale, and that State Fund had agreed to pay twenty miles as a compromise. Claimant did not refute her testimony. He had either forgotten the compromise or refused to accept it.

¶39 Claimant asked Heigh why State Fund had not told him prior to mediation that he could receive compensation for certain medication. Heigh testified the issue had not come up prior to the mediation. Claimant again had no response. Heigh was credible, indeed patient, in her explanations.

¶40 Bob Silberling (Silberling), another adjuster, testified. Claimant asked why Silberling did not authorize chiropractic treatment. Silberling explained that chiropractic treatment was authorized only when recommended by a physician. Claimant then asked why Silberling would not pay travel reimbursement on a yearly basis, a practice followed by an earlier adjuster, Mike Welsh. Silberling testified he considered yearly reimbursement unworkable. He offered to reimburse claimant based on e-mails from claimant after a travel expense was incurred. Claimant's questioning suggested he believed Silberling's positions were designed to harass him. I do not share that perception. Rather, Silberling convinced me he has tried to handle claimant's case in as fair and diplomatic a fashion as

possible. I credited his testimony that he tried to be respectful, to listen, and to advise claimant what benefits he believed were owed to him.

Records made by Silberling corroborate my impression:

> [6/22/00.] The claimant called numerous times and left several messages. P/C to his home and was able to t/w his wife. He was not available. . . . The claimant and I were finally able to connect after 5PM. We reviewed his concerns and again reviewed his same issues and frustrations about the work comp system and his belief that he has been cheated. The best at this time was to listen to his concerns and to continue to support that we can only procede [sic] with what he is eligible for not what we think or he may think he is deserving of. Advised him that the issues he wanted to address could only be resolved with the court and if they choose not to proceed or rule contrary to his belief we could not take any different path…we are also bound by the laws.
>
> [10/18/00.] Claimant continues to call three to four times a day to discuss his claim. He expresses anger over the settlement of his indemnity portion of the claim. He cotinues [sic] to pursue this in litigation. We have advised him verbally and in writting [sic] that we can not discuss any issues related to his litigation…he chooses to ignore this. He advises that the SF attorney has authorized payment for a whirlpool tub. He also maintains that we have authorized payment of RX's for fungus on his feet. The claim notes do not support this. The claimant continues to push for these issues by phoning the adjuster, the SF attorney, and members of Claims Management. The issues have bee [sic] referred to our attorney for review and comment. POA is to f/up with another letter to the claimant for response to these issues.

(Ex. 17 at 38, 48.)

¶41 Mike Welsh (Welsh), the one adjuster claimant liked, also testified. Welsh no longer works for State Fund and appeared through claimant's subpoena. Welsh testified he had prior experience working with individuals with disabilities similar to claimant's and developed a rapport with claimant. This rapport seemed to follow from devoting considerable time to claimant's case. Welsh testified he sometimes took calls from claimant as many as two or three times a day, with claimant often repeating the same question several times. Welsh testified that claimant had in fact taken "a lot" of his time. A sampling of memorandum made by Welsh indicates:

> [5/08/00.] I told the clmnt again (this is after many no [sic] notable calls) I have no authority and more importantly, no reason, to send him any sum of money. I encouraged him to speak with Tom Martello, but he won't. I explained that I could not discuss the merits of his case, pro & con, and I could make no comment on any

assertions he makes regarding the State Fund's handling of his case. I empathize with the claimant's condition after his closed head injury, but he really has no reason, under our law and procedures to receive any more benefits than he has.

[5/17/00.] I fielded another phone call from clmt today. He is insistent he will get some sort of settlement of his settlement. I told him the Supreme Court is our court of last resort. He asked that I speak with Tom Martello and/or Sam to see what they say. I finally told him it is imperative that I work on my other cases. He was annoyed. I spoke briefly with Sam. Her inclination is the same as mine. We don't, in truth, owe the clmnt any further benefits. Spoke also with Tom and he said he will send us an e-mail outlining his opinion.

[5/25/00.] Mike, the claimant, has called twice this week for extended periods of time. His insistence that he be paid a hefty sum of money and get an apology from WC is unabated. The second time he called, I told him upfront that I had some urgent items to take care of and I couldn't spend much time with him. He became angry with me and told me he couldn't talk any more for now because he is angry.

Sam, Tom Martello and I sat down to discuss this case. Mike is monopolizing Tom's time and mine. Sam said she will review the file with an eye to seeing if there is any way the medicals might be settled if I would get them for her, which I did.

(Ex. 17 at 31-33.)

¶42 Claimant evidently produced Welsh's testimony to demonstrate that other adjusters reneged on positions taken by Welsh or simply did not treat him as well as Welsh. Specific issues of medical benefits are discussed below. In general, Welsh's testimony did not suggest to me that other adjusters took unreasonable or unfair positions with claimant, only that Welsh showed remarkable patience in working with claimant and managed to win his confidence.

¶43 Given the nature of claimant's perception of the State Fund and its adjusters, I would seriously consider a fair settlement of medical benefits negotiated between the parties should that question come before me. However, no settlement is presented. (See Ex. 13 at 11-12; and argument.)[(2)]

¶44 Finally, even if I did have jurisdiction to *order* the parties to settle or order a lump sum, claimant has not created a record which would support an order of a lump-sum settlement in any particular amount.

IV.

Specific Medical lssues

A.

Past Expenses for Back Treatment

¶45 Exhibit 26 contains copies of checks paid by claimant to Larry Pitts (a massage therapist), the Garden Wall Clinic, and the Medicine Tree between 1990 and 1996. According to claimant, these records relate to treatment for his back prior to State Fund's acceptance of liability for that condition.

¶46 Heigh testified that in 1997, State Fund paid claimant $2,000 in settlement of his claim for reimbursement for past medical expenses related to his back. Exhibit 14 contains a State Fund memorandum reflecting payment of $2,000 to claimant as "compromise agreement for past medicals for low back problem." (Ex. 14 at 2.) A more detailed memo by Heigh, dated May 28, 1997, reflects the same agreement, describing the positions taken by each side, the negotiations, and the settlement. (Ex. 3 at 9.) That memo described negotiations to resolve any past medical issues, which is consistent with Heigh's trial testimony. While Heigh had not seen the particular checks reproduced as Exhibit 26, and recalled that claimant had not in fact been able to document expenses at the time settlement was negotiated, she believed State Fund settled all outstanding medical expenses relating to claimant's back.

¶47 At trial, claimant's wife asserted on his behalf that payment of massage therapy costs had not been settled, but noted that this was not one of claimant's primary contentions at this point.

¶48 Claimant has not convinced me State Fund owes anything for past medical expenses relating to his back. Both the State Fund records, and Heigh's recollection, convince me that around May, 1997, the parties settled all claims for past medical expenses relating to claimant's low back.

B.

Yearly Mileage Reimbursement.

¶49 Claimant argues State Fund is bound to pay him mileage reimbursement on a yearly basis because Mike Welsh followed that practice. An October 2, 1997 memo written by Welsh states: "I told clmnt, because he finds it difficult to recall and record all of his visits when they occur, I will pay him $93.00 for the year's travel in a single warrant after January 1, 1998." (Ex. 17 at 1.) Welsh's practice evidently endured over two or three years. On January 5, 1999, Welsh recorded:

> Clmnt called and subsequently faxed a request for 24 chiro visits for 1999 @ 30 miles a trip for a total of $226.80. Since the clmnt has has [sic] trouble remembering isolated events, we pay him for travel **in advance,** in a lump. That way he only has one payment to keep track of instead of several. I authorized payment today and handcarried it to Med Pay.

(*Id.* at 4, emphasis added.) The record also contains the letter claimant apparently faxed, with Welsh's handwritten note to "Pls pay to clmnt $226.80 in travel - for 1999." (Ex. 24 at 1.)

¶50 Silberling testified that he has refused to pay claimant in advance for travel related to chiropractic care. Rather, he requires evidence of actual miles traveled to support reimbursement after the expense has occurred. Silberling offered to accept e-mails from claimant indicating mileage traveled. This position is reasonable. Welsh's decision to pay in advance, while enjoyed by claimant, was unusual in that the insurer was paying for travel that had not yet occurred and might not, for various reasons, in fact take place.

¶51 Claimant obviously knows how to contact State Fund when he wants to. I find there is no right on behalf of claimant to a yearly advance.

C.

Lamisal

¶52 Lamisal is a medication for toenail fungus. On April 5, 2000, Dr. Dean E. Ross, one of claimant's physicians, wrote to State Fund, including the following:

Mike desired medication for fungal infection of his toenails (onychomycosis). I provided prescription for Lamisal 250 mgs QD for the necessary 12 week course, but made clear to Mike that this does **not** stem from his industrial accident.

(Ex. 22 at 6, emphasis added.)

¶53 Claimant's position on Lamisal is stated in the written Argument he filed pretrial, which paralleled his testimony in Court:

> Mike Welsh authorized me to see Dr. Biehgle, a Podiatrist, in April 2000. Dr. Biehgle prescribed Lamisil [sic] for a foot fungus and Mike Welsh authorized it. When Mike Welsh was on a leave of absence from State Fund in July, August Bob Silberling came on as my Claims Adjuster and all of a sudden there was no record of Mike having authorized the Lamisil [sic], so it was cut off.

(Argument filed February 23, 2001 at 2.)

¶54 According to State Fund "notepad" records of day-to-day contact with claimant, Carol Morris (Morris), evidently filling in for Silberling, talked with claimant about Lamisal on June 22, 2000. Morris reviewed Dr. Ross's April 5th letter and explained it to claimant. She then recorded:

> The call today centered on a bill for approximately $700 for Lamisil [sic], a medication for toenail fungus and he stated we had agreed to pay for that (I believe he said Mike Welsh had approved it) but there is nothing in notepad re approval and there is a 4/5/00 medical report from Dr. Dean Ross clearly indicating that he did

> indeed prescribe the Lamisil [sic] for him but made it clear the problem was not related to his industrial injury. I shared that info with Mr. Miller and he was upset but did not get abusive. . . . I told Mr. Miller I would bring Bob [Silberling] current and one of us would call him back tomorrow, June 23rd. He was pleasant and grateful at that point although determined "somebody was going to pay for the Lamisil [sic] as he can't afford it."

(Ex. 17 at 37.)

¶55 This information evidently did not reach Silberling. In a memo dated August 15, 2000, Silberling wrote:

> The claimant has had several ongoing issues on this claim. He has requested medication for fungus on his feet. I was unable to confirm with any medical on the file. I placed a call to the doctor's office to t/w the nurse for f/up on this request. The doctor's nurse advised that there was no supporting medical documentation for the fungus RX relating to claimant's injury. She will f/up with the doctor and request any subjective medical that would support the relationship.

(*Id*. at 42.)

¶56 On August 16, Silberling noted he had been having long and detailed discussions with claimant, which included the Lamisal issue. He noted:

> The claimant has been made aware that we do not have documentation from his physician that supports that the prescription is related to the injury. We have contacted his doctor's office requesting supporting documentation for the prescription and have been advised by the nurse that the notes do not relate and that she could not see any subjective relationship noted. She stated that she would review the file and contact us if there was any additional information. We have to date not received any further information. The claimant states that he never can talk with the doctor and that all he gets is the nurse that says the same. I have suggested that he send a letter if he is not satisfied with the answers that he is getting; his response is that it will just be thrown into a pile and never answered. I have reviewed this same information with his spouse and have not been successful in resolving any direction of resolution. They have also reviewed this with both the Unit Supervisor and with the legal department. I have requested the assistance of the MCM to address the issue of the prescription and will ask them to write to the physician and seek the medical documentation needed to either accept liability of confirm our denial.

(*Id*. at 43.) These records suggest to me that Silberling was talking with Dr. *Ross'* office, although that is not made explicit.

¶57 The task of writing to the doctor was assigned to State Fund employee Patricia Boege (Boege) on August 17, 2000. (*Id.* at 44.) Subsequent notes, from November and December of 2000, indicate Boege wrote to Dr. *Beighle*, perhaps because claimant had told her *that* doctor wrote the prescription, as he asserts in argument to this Court. There are no records of Dr. Beihgle in evidence and no indication, other than claimant's recollection, that Dr. Beihgle prescribed the Lamisal.

¶58 Boege's November and December notes indicate Dr. Beighle's office did not respond to her inquiries. (*Id.* at 49, 52.) In the absence of evidence that Dr. Beighle *also* wrote a prescription for Lamisal in the spring of 2000, it seems highly likely that it was Dr. Ross's prescription that was at issue. This would explain why Dr. Beighle's office offered no response to Boege's communications.

¶59 Adding to the confusion, Welsh testified he *had* authorized Lamisal and that documentation should exist to that effect. When asked why no such documentation was produced by State Fund, Welsh had no explanation. On cross-examination, Welsh reviewed a notepad entry stating that he told claimant on August 30, 2000, that he would look at approving Lamisal **only** with a doctor's opinion relating the prescription to the injury. (Ex. 31; Ex. 17 at 46.) Although there was some confusion around that entry, Welsh conceded he had probably written the following:

> Clmnt calls with his distinctive style looking for authorization on Lamisil [sic], additional psychological testing and authorization for a hot tub. We discussed these items at length and I explained to Mike my recollection of our conversations on Lamisil [sic] I had simply told him if he had a medical provider (i.e., Dr. Ross or Dr. Stone) relate the need for the antifungal to his 1983 industrial injury, I would look at approving it. He said he kinda remembers that, but thought I had authorized it for him later. I told him that was not my recollection. I explained to Mike it's out of our hands now, because the MCM is making the necessary inquiries.

(Ex. 31; Ex. 17 at 46.)[(3)] On cross-examination, Welsh also noted that he did recall authorizing payment for Lamisal, although he said he could be wrong in his recollection.

¶60 From review of the above-referenced exhibits, from observing Welsh's testimony in Court, and from review of this case as a whole, I am persuaded that State Fund did *not* authorize Lamisal treatment or agree to pay for those prescriptions. Welsh was not certain in his recollection that he had approved Lamisal. His testimony as a whole indicated to me he was trying to give claimant the benefit of the doubt on many issues. I find the notepad entries more reliable than Welsh's recollection.

¶61 In summary, I am persuaded that Dr. Ross told claimant during April 2000 that the fungal condition was not related to his industrial injury and that this opinion was repeated to claimant by Morris during June of that same year.

D.

Jacuzzi and Handicapped Bathroom Facilities.

¶62 On January 19, 2000, chiropractor Paul J. Miller wrote to Welsh, recommending purchase of a hot water spa for claimant. He noted:

> The brain injury he suffered left Mr. Miller with an ataxic gait that causes frequent musculoskeletal problems including pain, muscle spasm and decreased ranges of motion, particularly in his lumbar spine. Fortunately, the continued care authorized by State Fund allows us to provide a modicum of relief to Mr. Miller.
>
> I am writing today to ask you to consider authorizing the purchase of a hot water spa of some sort for Mr. Miller. I feel that the therapeutic benefit from regular warm hydrotherapy would be great in this case. I am sure the cost of such a purchase would be less than having him travel for regular visits to a physical therapist's office for supervised hydrotherapy.

(Ex. 9 at 2.)

¶63 A notepad entry dated February 4, 2000, reflects a conversation between Welsh and claimant's wife concerning a "small hot tub arrangement" to assist with claimant's back problems. (Ex. 17 at 18.) Welsh recorded that the Millers did not have a bathtub, but only a shower. (*Id.*) Welsh asked for legal counsel's input and was told "to leave the door open on the hot tub." (*Id.*) At trial, Welsh testified that counsel had recommended leaving the issue open because Mrs. Miller had also conveyed her concern that claimant was suicidal following the Supreme Court's decision against him.

¶64 On August 15, 2000, Silberling recorded that claimant "has also requested a hot tub which we have denied as reasonable medical." (*Id.* at 42.) Claimant then asked for a "jacuzi [sic] tub." (*Id.*) Silberling "advised that we would evaluate a unit that would go into his current tub." (*Id.*) Claimant was not satisfied with this as "he doesn't feel it would do the job that he needs." (*Id.*) Silberling noted: "I will continue to work with the claimant and explore his requests/ I have continued to request medical documentation to review/ but have not received any supporting information." (*Id.*)

¶65 On February 14, 2001, Dr. Dean Ross mentioned hydrotherapy in a letter to State Fund. Noting claimant's continued back problems, he recommended that some means be found for claimant to exercise and receive hydrotherapy closer to his home, rather than through the YMCA membership in Missoula which State Fund had approved. (Ex. 28 at 1-2.) Dr. Ross wrote: "Mr. Miller reports good response to the hydrotherapy as from a home whirlpool spa, and on a cost-effectiveness basis, that may even be a wise investment for his home use." (*Id.* at 2.)

¶66 Welsh testified that he did *not* consider a hot tub out of the "realm of feasibility" for someone in claimant's situation. If he were still adjusting the case, he would consider a hot tub in lieu of covering therapy away from home. On cross-examination, Welsh testified that State Fund had paid for "hot tubs" for claimants, though he conceded this was not routine. Based on Welsh's testimony, I believe Welsh told claimant it was possible State Fund would pay for a hot tub, but did not commit to that purchase.

¶67 In its trial brief, State Fund contends it already authorized either a whirlpool insert into an existing tub or "the cost of the jacuzzi tub." (State Fund Trial Brief at 5.) At trial, there was some confusion regarding what State Fund had offered and whether that offer had in fact been conveyed to claimant. Mr. Martello stated State Fund had offered to pay $800 toward the purchase and installation of a hot tub, but problems arose when claimant went ahead with more extensive bathroom renovations and wanted full reimbursement. Exhibit 16 contains receipts related to the bathroom renovation, including a receipt showing purchase of a "bathtub" from Mountain Spring Spas.

¶68 Mr. Martello represented that State Fund had released funds to reimburse claimant for various aspects of the renovations (a toilet and grab bars) but that those funds were still being processed. After these points of clarification, Mr. Martello reverted to the position that hot water treatment at home was not related to claimant's work injury.

¶69 The record indicates State Fund has paid for treatments claimant received in Missoula, including hydrotherapy. I view this as a concession by State Fund that hot water treatment for claimant's back is related to the industrial injury. Moreover, Dr. Ross and chiropractor Miller have both recommended home hydrotherapy. I find the purchase and installation of the "bathtub" reflected on the Mountain Spring Spas receipt a reasonable and necessary medical expense. (Ex. 16 at 2.) Reasonable and necessary medical expenses, however, do **not** include upgrades. However, the State Fund is free to reimburse claimant for whatever upgrades it chooses to cover.

E.

Computer

¶70 On June 19, 2000, claimant wrote to Silberling that "[a]fter going to Mon [sic] Tech during rehab at Community Bridges, they recommended that I use a computer" with certain specified accessories. (Ex. 25 at 1.) Claimant wrote:

> If I had a computer I could help with the Malt Shop business and it will give me something to do during my leisure time. Also, I intend to enroll in a Basic Computer training course at Adult Education.
>
> I would like State Fund to purchase the computer and accessories for me in order to give me back some good feelings about myself.

(*Id*. at 2.)

¶71 On July 5, 2000, Silberling recorded as follows:

> Claimant has requested purchase of a computer for assistance in development of a career change. He has not presented any particulars or an itemization of costs. This claim has been settled and re-employment issues have been closed. The potential for some participation might possibly be there with auxiliary funds. This would need to be evaluated and addressed with the unit supervisor because the funds technically should be accessed for relocation. Once I have a clearer idea of the costs we can give further evaluation to this request.

(Ex. 17 at 39.)

¶72 Welsh testified a computer was neither authorized nor denied while he was adjusting the claim. He believed it was "not out of the realm" for State Fund to purchase a computer for a claimant. If he were still adjusting the claim, he would consider a computer for the purpose of helping claimant with communication skills. He believes disabled adults benefit from communicating with other similarly situated people over the Internet. He considers this therapeutic, with the potential of reducing the need for psychotherapy. Welsh maintained that State Fund has purchased computers for such purposes in other cases, rejecting the suggestion that computers had only been purchased as part of work rehabilitation plans.

¶73 Welsh was asked to review the Community Bridges discharge summary, relating to in-patient treatment claimant had received between May and August 2000. (Ex. 23 at 21-26.) The "Discharge Setting" summary notes that "Mr. Miller plans to play a more active role in the family business and is seeking further training in use of computers to achieve this goal." (*Id*. at 21.) The "Vocational plan" portion of the report's "Community Resources" section states: "Mr. Miller was interested in learning computer skills so that he could assist with bookkeeping at their family business, 'The Malt Shop.'" (*Id*. at 24.) After reviewing these materials, Welsh conceded he was aware that Miller wanted money to put toward operation of the Malt Shop. The implication was that claimant may in fact intend to use a computer for the Malt Shop, rather than for the therapeutic purposes Welsh envisioned.

¶74 While claimant and Welsh have suggested a computer might assist claimant with psychological issues resulting from his work injury, the record contains no clear medical opinion recommending a computer for that purpose. The Community Bridges report contains recommendations related to claimant's psychological well-being, but mention a computer in the context of vocational rehabilitation and claimant's desire to help with the family business. (*Id*. at 21, 24.) In the absence of an unequivocal medical recommendation of a computer for therapeutic value, the record does not support an order from this Court that State Fund purchase a computer for claimant.

CONCLUSIONS OF LAW

¶75 Because claimant was injured October 23, 1983, the 1983 version of the Workers' Compensation Act is applicable in this case. *Buckman v. Deaconess Hospital*, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶76 Claimant bears the burden of proving by a preponderance of the evidence that he is entitled to the additional benefits he seeks. *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).

I.

Reopening

¶77 For the reasons fully explained in my November 17, 2000 Order Governing Further Proceedings, *Miller v. State Compensation Ins. Fund*, 2000 MTWCC 72, ¶ 9-13, the doctrine of *res judicata* bars claimant from relitigating all claims relating to reopening settlement which could have been asserted in the 1998 proceeding. Given Judge Sherlock's findings, claimant has not avoided that doctrine through his allegations regarding Ms. Kessner. Thus, the claims for reopening on the ground of mistake of law (application of present-value discount) and mistake of fact (failure to consider wages from concurrent employment) are barred by *res judicata*.

¶78 Even if those claims were not barred, claimant has failed to carry his burden of proving that he and State Fund settled his claim in 1988 on the basis of mistaken application of a present-value discount not authorized by 1983 law. I am persuaded the parties negotiated settlement for a particular dollar amount, with references to "present value discount" and "annuity" simply involving State Fund's assessment of its risk in not settling the case. Moreover, claimant has failed to present evidence that his attorney or the State Fund were in fact operating under a mistake of law when they settled his case.

¶79 Similarly, because claimant has not convinced me that failure to consider "concurrent earnings" represented a material mistake of fact leading to the settlement, that alleged ground for reopening is also rejected.

II.

Settlement of Medical Benefits

¶80 While I have found this Court to have jurisdiction to approve settlements of workers' compensation medical benefits negotiated by the parties, (*Tucker v. State Compensation Ins. Fund*, WCC No. 9706-7764 (11/14/97); *Valance v. State Compensation Ins. Fund*, 1998 MTWCC 23), the question whether I can order an insurer to settle medical benefits

presents an entirely different situation. I conclude I do not have jurisdiction to enter such an order.

¶81 Section 39-71-2905, MCA (1983), provides:

> **Petition to workers' compensation judge.** A claimant or an insurer who has a dispute concerning any benefits under chapter 71 of this title may petition the workers' compensation judge for a determination of the dispute. The judge, after a hearing, shall make a determination of the dispute in accordance with the law as set forth in chapter 71 of this title. If the dispute relates to benefits due a claimant under chapter 71, the judge shall fix and determine any benefits to be paid and specify the manner of payment. The workers' compensation judge has exclusive jurisdiction to make determinations concerning disputes under chapter 71. The penalties and assessments allowed against an insurer under chapter 71 are the exclusive penalties and assessments that can be assessed against an insurer for disputes arising under chapter 71.

¶82 While section 39-71-2905, MCA (1983), confers jurisdiction on this Court to resolve any disputes concerning benefits under chapter 71, there must be some basis within that chapter for the assertion of the right to particular benefits. State Fund argues, and I agree, that neither section 39-71-704, MCA (1983)[(4)], governing medical benefits, nor section 39-71-741, MCA (1983)[(5)], governing lump-sum payments, provides for lump-sum settlement of medical benefits. Section 39-71-704, MCA (1983), contemplates coverage of medical costs "without limitation as to length of time," making no mention of settling medical benefits. Section 39-71-741, MCA (1983), regarding lump-sum settlement, contemplates settlement of bi-weekly benefits, which are different from medical benefits.

¶83 Since there is nothing in the 1983 statutes to suggest a right by claimant to a settlement of medical benefits, I do not find authority to order the insurer to settle medical benefits.

III.

Disputes over Medical Benefits

¶84 Section 39-71-704, MCA (1983), provides that the insurer shall furnish "reasonable services by a physician or surgeon, reasonable hospital services and medicines when needed, and such other treatment as may be approved by the division for the injuries sustained." Neither party has argued "division approval" as a ground for acceptance or denial of the particular medical benefit issues. Given the Court's jurisdiction over the entitlement to specific medical benefits, I consider the issues raised without regard to any action or opinion by the Department of Labor.

¶85 Based on the findings made above, the only medical service due claimant at this point is reimbursement for the "hot tub" installation in his bathroom and related expenses, as well as the reimbursement for handicapped bathroom facilities State Fund represents are already being processed. Claimant has not proved entitlement to past expenses for back treatment, yearly mileage reimbursement, Lamisal prescription expenses, or a computer as reasonable medical expenses.

IV.

Attorneys Fees and Penalty

¶86 Having found no unreasonable denial or delay on the part of State Fund, claimant is not entitled to a penalty under section 39-71-2907, MCA (1983).

¶87 The only claim found compensable in this proceeding is claimant's request for a "hot tub" for treatment of his back. While negotiations existed between the parties for that expense, the final position taken by State Fund at trial was that a "hot tub" was not a reasonable medical expense for claimant. Even though the attorney fee provision in effect in 1983, §§39-71-611 -612, MCA (1983), does not require proof of unreasonable conduct, claimant is not entitled to attorney fees since he did not employ an attorney.

¶88 Claimant is entitled to costs only associated with the one claim on which he prevailed. (*See* ¶ 85.)

JUDGMENT

¶89 Claimant is not entitled to reopen his 1988 settlement.

¶90 This Court does not have jurisdiction to order the insurer to lump sum claimant's future entitlement to medical benefits and in any event the claimant failed to provide an evidentiary basis for a lump sum.

¶91 The insurer shall reimburse claimant for reasonable costs associated with installation of a "hot tub" in his home and for handicapped improvements to his bathroom.

¶92 Claimant is not entitled to other medical benefits claimed in this proceeding.

¶93 Claimant is not entitled to attorney fees.

¶94 Any party to this dispute may have 20 days in which to request a rehearing from these Findings of Fact, Conclusions of Law and Judgment.

¶95 This JUDGMENT is certified as final for purposes of appeal pursuant to ARM 24.5.348.

DATED in Helena, Montana, this 14th day of May, 2001.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. Michael L. Miller
Mr. Thomas E. Martello
Submitted: March 2, 2001

1. State Fund objects to the admission of this document on grounds of "foundation and authentication" in addition to relevance and *res judicata*. Other than claimant's suggestion that the document was provided to him by State Fund, it was not identified or explained by any witness. Nevertheless, I am satisfied that the document contains sufficient distinctive characteristics to convince me it is what it purports to be, at least to warrant the use I make of it in this proceeding. *See* M.R.Evid. 901(a)(4). In any event, I do not find the document inconsistent with State Fund's position in this case.

2. The record indicates that during the spring of 2000, State Fund took preliminary steps toward considering settlement of medical benefits. In addition to the review by Samantha Heigh referenced above, an earlier memo indicates Welsh had been asked by legal counsel to "workup some figures based upon the last two years of medical and the normal life expectancy of the claimant." (Ex. 17 at 30.) When Silberling received the file in June of 2000, he also noted "[t]his claim may have potential for settlement." (*Id*. at 35.) Whether State Fund decided against negotiating settlement for the reasons now offered, or because claimant's demands were simply too high, is not clear from the record. In April 2000, Welsh recorded that claimant's settlement demands "are in the six figures." (*Id*. at 30; see also, Ex. 14 at 1.)

3. Confusion arose at trial over two pages containing the paragraph reproduced above. Review of the two pages leads me to the following conclusion. Ex. 31 reflects a notepad entry made by Welsh on August 30, 2000, after the conversation reflected in the paragraph. The entry was mistakenly posted to the file of another claimant (Doris Pederson). Around October 5, 2000, Jacqui Garcia, identified by Welsh as a State Fund adjuster having nothing to do with the Miller case, evidently came across the mistakenly posted entry and posted it to the Miller file. The document at Ex. 17, page 46, is an October 5, 2000 notepad entry bearing Garcia's name, repeating the paragraph, but also containing the following additional sentences: "This notepad was put on file 3-82-15076-1 by Mike Welsh. Transferred to Mike miller [sic] claim." I read those sentences to mean that Garcia herself transferred the note to the Miller file and has noted what she has done. This conclusion is supported by Welsh's testimony that there had been problems around that time with posting to the wrong files. Nothing else makes sense to the Court. I reject claimant's suggestion of some misconduct on the part of State Fund surrounding this confusion. If someone at State Fund had decided to fabricate the August 30 Welsh note, I believe a document without the "Doris Pederson" confusion would have been created.

4. **39-71-704. Payment of medical, hospital, and related services.** (1) In addition to the compensation provided by this chapter and as an additional benefit separate and apart from compensation, the following shall be furnished:

(a) After the happening of the injury, the employer or insurer shall furnish, without limitation as to length of time or dollar amount, reasonable services by a physician or surgeon, reasonable hospital services and medicines when needed, and such other treatment as may be approved by the division for the injuries sustained.

(b) The employer or insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(2) Fees and charges for medical, chiropractic, and paramedical services provided for in this chapter, excluding hospital services, shall be established by the workers' compensation division based on the 90th percentile of usual and customary charges of the medical speciality involved based upon the most recent 6-months data as determined in January and July of each year.

5. **Compromise settlements and lump-sum payments - division approval required.** The biweekly payments provided for in this chapter may be converted, in whole or in part, into a lump-sum payment. Such conversion can only be made upon the written application of the injured worker or the worker's beneficiary, with the concurrence of the insurer, and shall rest in the discretion of the division, both as to the amount of such lump-sum payment and the advisability of such conversion. The division is hereby vested with full power, authority, and jurisdiction to allow and approve compromises of claims under this chapter. All settlements and compromises of compensation provided in this chapter are void without the approval of the division. Approval of the division must be in writing. The division shall directly notify every claimant of any division order approving or denying a claimant's settlement or compromise of a claim. A controversy between a claimant and an insurer regarding the conversion of biweekly payments into a lump sum is considered a dispute for which the workers' compensation judge has jurisdiction to make a determination.