

IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2026 MTWCC 8

WCC No. MSF-2025-0000983-WCI

JOHN WHEELER

Petitioner

vs.

MONTANA STATE FUND

Respondent

**ORDER GRANTING IN PART AND DENYING IN PART RESPONDENT'S MOTION
FOR SUMMARY JUDGMENT, DENYING PETITIONER'S CROSS MOTION FOR
SUMMARY JUDGMENT, AND DENYING PETITIONER'S MOTION TO STRIKE**

Summary: Respondent moves for summary judgment, asserting that it correctly calculated Petitioner's wage-loss benefits under § 39-71-118(5)(d), MCA, based on the level of coverage the Petitioner elected. Respondent argues that, absent an ambiguity, Petitioner's reasonable expectations of the wage-loss benefits his workers' compensation policy would provide in the event of an industrial injury are irrelevant. Respondent also asserts that it correctly calculated Petitioner's domiciliary care benefits under § 39-71-1107, MCA, because there was never a basis for 24-hour care or an increase of five hours due to "needing transportation, more appointments." Petitioner opposes Respondent's motion because the wage-loss coverage Respondent seeks to provide is illusory or *de minimis* and violates public policy. Petitioner cross moves for summary judgment, asserting that the indemnity provision of the workers' compensation insurance policy he purchased is ambiguous and that he is entitled to the coverage he reasonably expected that he purchased. Petitioner also asserts that he is entitled to the balance of retroactive 24-hour domiciliary care between January 28, 2025, to April 10, 2025, based on the medical crises he experienced during this time period, and retroactive payment of five additional hours of domiciliary care for six months from October 22, 2025, forward based

on the opinions of his treating physician. Finally, Petitioner asserts that he is entitled to attorney fees under § 39-71-611, MCA, or § 39-71-612, MCA, and a penalty under § 39-71-2907, MCA, regarding the denied and delayed payment of Petitioner's domiciliary care benefits. Petitioner also moves to strike Respondent's supplemental brief for exceeding the scope of the issue on which this Court invited the parties to submit briefs.

Held: Respondent's motion for summary judgment on the issue of wage-loss benefits is granted. The policy language is clear, and Respondent calculated Petitioner's wage-loss benefits based on the level of coverage the Petitioner elected. Petitioner's cross motion for summary judgment on the issue of wage-loss benefits is denied. Both parties' motions on the issue of domiciliary care benefits are denied. There are disputed issues of material fact as to the number of hours of domiciliary care Petitioner needed at various points. Petitioner's motion on the issues of attorney fees and a penalty is denied, as well. Under WCC Rule 329(1)(a), these issues are better left for trial. Finally, Petitioner's motion to strike Respondent's supplemental brief is denied. The Court relies on both parties' supplemental briefs to the extent that they are relevant. To the extent that Respondent's supplemental brief addresses matters outside the issues the Court asked the parties to address, the Court does not consider it.

¶ 1 Respondent Montana State Fund (MSF) moves for summary judgment, asserting that it correctly calculated Petitioner John Wheeler's wage-loss and domiciliary care benefits.

¶ 2 Mr. Wheeler opposes MSF's motion and cross moves for summary judgment, asserting that, due to ambiguity, he should get the indemnity coverage he thought he purchased, and that he is entitled to additional domiciliary care benefits during certain periods, as well as attorney fees and a penalty for denied and delayed domiciliary care benefits.

¶ 3 The Court held a hearing on July 15, 2026.

¶ 4 The Court invited the parties to file supplemental briefing on or before July 31, 2026.

¶ 5 Mr. Wheeler moves to strike MSF's supplemental brief for exceeding the scope of the issue on which this Court invited the parties to submit briefs.

¶ 6 The parties' Cross Motions for Summary Judgment and Mr. Wheeler's Motion to Strike are now before the Court for decision.

¶ 7 For the following reasons, on the issue of wage-loss benefits, MSF's Motion for Summary Judgment is granted, and Mr. Wheeler's Cross Motion for Summary Judgment is denied. On the issue of domiciliary care benefits, both parties' motions are denied. Mr. Wheeler's Cross Motion for Summary Judgment on the issues of attorney fees, and a penalty, is denied. Mr. Wheeler's Motion to Strike the Respondent's Supplemental Brief is denied.

INTRODUCTION

¶ 8 Mr. Wheeler owned and operated a company called John Wheeler logging. He was badly injured in a logging truck accident on November 19, 2024. At issue are the weekly wage-loss benefits, the number of hours of domiciliary care to be provided under the policy, and whether any denial of or delay in payment of domiciliary care benefits results in a penalty.

FACTS

¶ 9 Mr. Wheeler is the owner of John Wheeler Logging, LLC.

¶ 10 Mr. Wheeler purchased an insurance policy from MSF, Policy No. 034813006 (Policy), that insured John Wheeler Logging, LLC, from April 1, 2024, to April 1, 2025.

¶ 11 John Wheeler Logging LLC, elected to cover Mr. Wheeler in his capacity as “LLC Manager” on the Policy. Specifically, John Wheeler Logging LLC, elected to cover Mr. Wheeler with a “Monthly Coverage Level” of “\$869.00.” The “Schedule of Corporate Officer(s) or LLC Manager(s)” stated that “Coverage is elected for this individual for the . . . elected level of coverage shown.” And the schedule further stated that “[w]age benefits are two-thirds of the elected level of coverage.”

¶ 12 In this case, the “level of coverage shown” for Mr. Wheeler was \$869.00 per month.

¶ 13 Based on Mr. Wheeler’s elected level of coverage of \$869.00 MSF computed Mr. Wheeler’s Temporary Total Disability (TTD) benefit rate to be \$133.33/week.

¶ 14 On November 19, 2024, Mr. Wheeler was involved in a serious accident while driving a logging truck. He suffered injuries to his left upper extremity, cervical spine, pelvis, low back, teeth, he sustained a concussion, had a bilateral pulmonary embolism, tinnitus, hearing loss, and PTSD.

¶ 15 On or about November 19, 2024, John Wheeler Logging, LLC, was enrolled under Plan No. III of the Workers’ Compensation Act and was insured by MSF.

¶ 16 From November 19, 2024, to December 3, 2024, Mr. Wheeler was admitted in-patient at St. Patrick’s Hospital.

¶ 17 From December 3, 2024, to December 17, 2024, Mr. Wheeler was discharged from hospital to inpatient rehabilitation care.

¶ 18 From December 17, 2024, to December 27, 2024, Mr. Wheeler was readmitted to the hospital.

¶ 19 On December 26, 2024, MSF accepted Mr. Wheeler’s claim for the following conditions: lower back, neck, hip (including pelvis area), left arm, left elbow and pulmonary embolisms and subsequently paid medical and indemnity benefits.

¶ 20 On December 27, 2024, Mr. Wheeler was discharged from hospital to inpatient rehabilitation care.

¶ 21 On January 18, 2025, MSF and/or its employees and/or agents prepared a discharge assessment. This assessment determined that domiciliary care would be required, and that a home assessment was needed.

¶ 22 On January 28, 2025, Mr. Wheeler was discharged home to Arlee, Montana, which is some distance to the closest emergency room. He was suffering from pain in his legs, pelvis, neck, back, left hand, and left elbow. Mr. Wheeler's wife Cindy began providing in-home care for Mr. Wheeler at this time. Mr. Wheeler is 5'10" and around 300 pounds, and Cindy is 60 years old, small in stature, and 4'11¾" tall. Among other things, Cindy's in-home care services included picking up multiple prescriptions at the pharmacy and preparing and placing them in a pill dispenser and driving Mr. Wheeler to and from his medical appointments and anywhere else he needed to go to help him get in and out of his vehicle.

¶ 23 On February 26, 2025, MSF scheduled an in-home domiciliary care assessment for mid-March.

¶ 24 On March 18, 2025, the in-home assessment was completed and sent to Richard Myers, MD, for approval.

¶ 25 On March 21, 2025, Mr. Wheeler retained counsel. Mr. Wheeler, through counsel, requested reimbursement for domiciliary care from the date of his discharge.

¶ 26 On April 10, 2025, Dr. Myers responded to the March 18, 2025, request, stating five hours of domiciliary care was needed per day for one year. Dr. Myers listed the types of activities needing domiciliary care assistance.

¶ 27 On April 15, 2025, MSF sent the first check to Mr. Wheeler covering the time from January 28 to April 14. This was never cashed.

¶ 28 On April 24, 2025, MSF sent the second check to Mr. Wheeler covering the time from April 15 to April 28. This was never cashed.

¶ 29 On May 12, 2025, MSF sent the third check to Mr. Wheeler covering the time from April 29 to June 15.

¶ 30 On June 6, 2025, Mr. Wheeler requested 24/7 skilled nursing care from the date of his discharge.

¶ 31 On June 13, 2025, MSF issued a replacement check for checks 1 and 2.

¶ 32 Effective July 1, 2025, the rate for unlicensed domiciliary care increased to \$15.22/hour, and State Fund has paid for care at the increased rate since.

¶ 33 On October 22, 2025, Dr. Myers stated domiciliary care at ten hours per day was required for six months.

¶ 34 On January 9, 2026, in response to MSF's request for more information supporting the five hour per day increase, Dr. Myers stated, "needing more transportation more appointments."

¶ 35 On March 13, 2026, True North completed a domiciliary in-home care assessment.

¶ 36 On April 13, 2026, the True North assessment was sent to Dr. Myers.

¶ 37 On May 12, 2026, Dr. Myers responded to the True North assessment but did not state that a specific number of hours was prescribed.

LAW AND ANALYSIS

¶ 38 The issues in the case are governed by the 2023 version of the Montana Workers' Compensation Act because that was the law in effect at the time of Mr. Wheeler's injury.¹

¶ 39 Summary judgment is appropriate when no genuine issue exists as to any material fact and the moving party is entitled to judgment as a matter of law.² The initial burden is on the moving party to establish no genuine issues of material facts exist, and the moving party is entitled to judgment based on controlling law.³ Once the moving party has met this burden, the burden then shifts to the responding party to establish disputed issues of material fact, or argue controlling law does not support judgment in favor of the moving party.⁴

Issue One: What is the Correct Amount of Mr. Wheeler's Weekly Wage-Loss Benefit?

¶ 40 An insurance policy is a contract. "When interpreting a written contract, the Court looks to the four corners of the document. If the language is clear, the duty of a Court is to apply the language as written."⁵

¶ 41 The policy states, "Wage benefits are two-thirds of the elected level of coverage. Wage benefits are calculated on a weekly basis using 40 hours per week to derive an hourly rate."

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

² ARM 24.5.329(2).

³ *Lindey's Inc., v. Professional Consultants, Inc.*, 244 Mont. 238, 244, 797 P.2d 920, 924 (1990).

⁴ *Id.*

⁵ *Van Hook v. Jennings*, 1999 MT 198, ¶ 11, 295 Mont. 409, 412, 983 P.2d 995, 997.

¶ 42 MSF moves for summary judgment, arguing that when the language of the insurance policy is unambiguous, the calculation of wage-loss benefits under § 39-71-118(5)(d), MCA, is solely based on the level of coverage the Petitioner elected, and his reasonable expectations are irrelevant. Here, MSF contends that the language of the insurance policy is unambiguous, Petitioner selected a monthly coverage level of \$869.00 when he purchased the policy, and that that figure is the assumed wages for the purpose of later determining wage loss benefits. This is the minimum amount of coverage allowed under the statute.⁶ \$869.00 per month is \$200.00 per week. Thus, MSF asserts that it correctly calculated Mr. Wheeler's wage loss benefits at 2/3 of \$200.00 or \$133.33/week.

¶ 43 Mr. Wheeler cross moves for summary judgment, asserting that, after reading the "Schedule of Corporate Officer(s) of LLC Manager(s)," Mr. Wheeler, a consumer of insurance products of average intelligence, had a good faith belief that if he was hurt and unable to work, the policy would pay him \$869.00/month or \$200.00/week, and that he is entitled to receive the coverage he believed and had reasonable expectations that he purchased. Or, in other words, Mr. Wheeler argues that elected coverage should be the wage loss benefit.

¶ 44 This interpretation is unsupported in, and contrary to, the plain language of the policy and the controlling statute. Section 39-71-701(3), MCA, provides: "Weekly compensation benefits for injury producing temporary total disability are 66 2/3% [also referred to as 2/3] of the wages received at the time of the injury."

¶ 45 The plain language of the policy and the statutes establish that wage-loss benefits are 2/3 of elected coverage. Mr. Wheeler elected coverage \$200.00/week. Wage-loss benefits are, therefore, \$133.33/week.

¶ 46 Next, Mr. Wheeler argues that coverage in an amount that small is so small as to be illusory. Mr. Wheeler argues the case of *Hardy v. Progressive Specialty Ins. Co.*⁷ for the proposition that insurance policies may not provide illusory coverage.

¶ 47 In the *Hardy* case, Ned Hardy was injured in a car accident and recovered \$50,000 from the at-fault driver's liability insurer, which didn't fully cover his injuries. He sought additional recovery by stacking three \$50,000 underinsured motorist (UIM) coverages on his Progressive policy, for which he had paid three separate premiums. Progressive denied coverage based on policy language defining "underinsured motor vehicle" as one whose liability limits are less than Hardy's UIM limit, an offset provision reducing UIM benefits by amounts recovered from the tortfeasor, and an anti-stacking clause barring

⁶ Section 39-71-118(5)(d), MCA, provides:

For the purposes of an election under this subsection (5), all weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than \$200 a week and not more than 1 ½ times the state's average weekly wage.

⁷ 2003 MT 85, 315 Mont. 107, 67 P.3d 892.

aggregation of the coverages. Since the tortfeasor's liability coverage equaled Hardy's UIM limit, these provisions combined to bar any recovery.

¶ 48 The Montana Supreme Court held the UIM definition and offset provision void as against public policy. Given Montana's mandatory minimum liability coverage, the \$50,000 UIM coverage would almost always be offset to zero whenever the tortfeasor carried at least equal coverage, rendering Progressive's promised coverage illusory in nearly all realistic scenarios and creating an ambiguity between the declarations page's stated \$50,000 and the policy's fine print — an ambiguity the Court determined must be resolved in favor of the insured's reasonable expectations.

¶ 49 This case is the opposite of *Hardy*. In *Hardy*, a premium was paid with no chance a benefit would ever be paid. In the instant case, a benefit is sought for which no premium was paid. To the extent the *Hardy* case is applicable, it actually supports MSF's position that the wage-loss benefits being paid are the same benefit that a premium was charged for.

¶ 50 Both parties discuss the case of *Major v. State Compensation Ins. Fund*.⁸ James Major was a self-employed window salesman and installer who elected workers' compensation coverage as a sole proprietor under § 39-71-118(2), MCA (1989), and selected the statutory minimum monthly wage of \$900.00 as his coverage level. After suffering a compensable injury, he returned to work but was no longer able to perform installation work and claimed that his business income had substantially declined. He sought wage supplement benefits based on his actual pre-injury business earnings rather than the \$900.00 monthly wage he had elected for coverage.

¶ 51 The issue presented to the Court in this case was, for purposes of calculating wage supplement benefits under § 39-71-703, MCA (1989), should a sole proprietor's "actual wages" be the claimant's actual business earnings at the time of injury or the amount of wages elected when obtaining workers' compensation coverage?

¶ 52 The Workers' Compensation Court (WCC) held that a sole proprietor's elected wage controls. Because § 39-71-118(2)(d), MCA (1989), provides that all weekly compensation benefits must be based on elected wages, wage supplement benefits must also be calculated using the elected wage rather than the claimant's actual business earnings. The court harmonized §§ 39-71-118 and 39-71-703, concluding that, for electing sole proprietors, the elected wage constitutes the claimant's "actual wages" for purposes of computing weekly benefits.

¶ 53 Here, as in the *Major* case, for purposes of calculating wage loss benefits, Mr. Wheeler is bound by the wages he elected when he obtained workers' compensation coverage. Premiums are based on that election. Benefits are paid at 2/3 of that amount.

⁸ 1996 MTWCC 70.

¶ 54 In conclusion, Mr. Wheeler elected coverage at the minimum allowed by statute, \$869.00 per month. The insurance policy and the statute both state the wage loss benefit is 2/3 of this amount. MSF correctly determined, and has been paying, a wage loss benefit of \$133.33 per week.

Issue Two: What is the Correct Amount of Mr. Wheeler's Weekly Domiciliary Care Benefit?

Recap of facts relating to the domiciliary care issue:

January 18, 2025	domiciliary care assessment prepared
January 27, 2025	Michele Giles, NCM (Genx Services, LLC) on behalf of MSF, inquires about home health care for Petitioner. Petitioner declined.
January 28, 2025	discharge
March 18, 2025	Giles prepares domiciliary care assessment.
March 18, 2025	domiciliary care assessment sent to Dr. Myers.
March 21, 2025	Petitioner retains counsel.
March 26, 2025	2 nd domiciliary care assessment sent to Dr. Myers. No response.
April 10, 2025	2 nd domiciliary care assessment again sent to Dr. Myers. He responds Petitioner will need in home assistance five hours per day for one year. This includes transportation.
April 15, 2025	Check for domiciliary care benefits sent to Petitioner, never cashed. Check covered 28 January to 14 April. This was 77 days post discharge.
April 24, 2025	Check for domiciliary care benefits sent to Petitioner for 15 April to 28 April. Never cashed.
June 13, 2025	Check for \$6433.70. This covered 28 January to 11 June 2025.
September 29, 2025	second request to Dr. Myers regarding domiciliary care.
October 22, 2025	Dr. Myers responds to MSF saying ten hours per day for six more months.
January 9, 2026	Dr. Myers confirmed five hours per day was appropriate at the time following discharge, but ten hours was now required.
March 13, 2026	Domiciliary Care assessment prepared by Anya Marie Jones, OTR (True North).

April 13, 2026	The True North assessment of 13 March was sent to Dr. Myers.
May 12, 2026	Dr. Myers responds to the True North assessment but does not state number of hours required. No response to additional inquiries by MSF agents.

¶ 55 Domiciliary care benefits are set by statute. Section 39-71-1107, MCA (2023) provides, in pertinent part:

- (1) Reasonable domiciliary care must be provided by the insurer:
 - (a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;
 - (b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;
 - (c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;
 - (d) when the services rendered are of the type beyond the scope of normal household duties; and
 - (e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.
- (2) . . .
- (3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.
- (4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the hourly mean wage by area for home health aides, as published by the department in the most recent edition of the Montana Informational Wage Rates by Occupation and adopted annually by the department prior to January 1. The insurer is not liable for more than 8 hours of care each day at the rate in effect at the time that the services are rendered.

¶ 56 Subpart (1) of the statute is conjunctive. All five elements, (a) through (e) must be met to establish a domiciliary care benefit.

(a) The insurer must know home care is needed;

(b) a **preponderance of credible medical evidence** establishes a need, and describes **with a reasonable degree of particularity** the nature and extent of duties to be performed;

(c) a physician must prescribe the care on a form provided by the department;

(d) the services must be beyond normal household duties;

(e) elements (c) and (d) must be established with reasonable certainty.

¶ 57 The leading case addressing the interpretation and application of this statute is *Skiff v. Montana State Fund*.⁹ In *Skiff*, the petitioner suffered an industrial injury on January 11, 2006, falling from a roof while working as a laborer for Clausen and Son's in Havre, Montana. He sustained an L1 burst fracture resulting in complete paraplegia (T10 level and below). MSF accepted liability and paid medical and wage-loss benefits. The petitioner's wife, Katie Skiff, provided in-home care.

¶ 58 The *Skiff* case presented in part the following issues: Whether respondent acted unreasonably in adjusting the claim. The court reasoned under § 39-71-1107(1), MCA, compensable domiciliary care requires, among other things, that (b) a preponderance of credible medical evidence establish the care is necessary and describe its nature and extent, and (c) the services be performed under the direction of the treating physician, following a nursing analysis, prescribed on a department form. Dr. Hinde, the treating physician, had prescribed only .5 to 1 hour of daily care; Dr. Gracey's broader 2-hour "homemaker assistance" estimate was not prescribed by a treating physician and therefore did not satisfy § 39-71-1107(1)(c). The Court further held that ordinary tasks the petitioner could perform himself with inconvenience (meal prep, basic housekeeping, taking out garbage) did not qualify as "beyond the scope of normal household duties" under § 39-71-1107(1)(d), and that home-maintenance services (e.g., yard work, vehicle maintenance) are not compensable under the statute at all, however sympathetic the facts.

¶ 59 Thus, the holding in *Skiff* requires a preponderance of credible medical evidence to establish the care is necessary and describe the nature and extent of care, and the physician must prescribe the care on a form provided by the Department.

¶ 60 The WCC also looked at the question of unreasonableness in the *Bustell v. AIG Claims Service, Inc.*¹⁰ case. In *Bustell*, the claimant suffered a catastrophic industrial injury on December 2, 1999, that left her quadriplegic and in need of 24-hour domiciliary

⁹ 2009 MTWCC 8.

¹⁰ 2002 MTWCC 26A.

care. The Insurer denied liability and delayed the payment of benefits, which this Court found unreasonable. In addition to other benefits, this Court ordered the Insurer to pay attorney fees and a penalty.¹¹

¶ 61 In a subsequent proceeding, the specific issue arose as to whether the delay in payment of domiciliary care benefits made the insurer liable for a penalty. The insurer did not pay domiciliary benefits for the period between October 11, 2000, and January 31, 2001, until February 28, 2001. The claimant did not specifically request domiciliary care benefits until December 22, 2000. Upon receipt of the claimant's request, the insurer promptly requested submission of a written prescription for domiciliary care and other required information. The WCC was unpersuaded that the delay was unreasonable, pointing out that "even though the claimant's need for 24-hour domiciliary care should have been obvious to the insurer, it ha[d] correctly pointed out that the care must be prescribed 'on a form provided by the department,' § 39-71-1107(1)(c), MCA (1999) Upon insurer's agreement to pay her benefits under a reservation of rights, claimant, who was represented by counsel, had some responsibility to establish her entitlement to domiciliary care benefits. Upon receiving the request for benefits, the insurer acted promptly to gather the documentation and information necessary to commence the benefits."¹²

¶ 62 Thus, the ruling in *Bustell* requires an insurer to provide reasonable domiciliary care when all five elements of § 39-71-1107, MCA are met, including § 39-71-1107(1)(c), MCA, which is a nursing analysis followed by the treating physician's prescription for domiciliary care services on a form provided by the department. That the claimant's need for domiciliary care benefits should have been obvious to the insurer was not sufficient in light of the statute's requirement of the treating physician's prescription on a form provided by the department.

¶ 63 MSF asserts that it correctly calculated and paid Mr. Wheeler's domiciliary care benefits (5 hours/day at the rate of \$14.14/hour from January 28, 2025, to June 30, 2025, and 5 hours/day at the rate of \$15.22/hour from July 1, 2025, to the present date) under § 39-71-1107, MCA.

¶ 64 Mr. Wheeler asserts that MSF should have to pay him the rate of skilled 24-hour nursing care from January 28, 2025, until April 10, 2025, the date of his first domiciliary care assessment, as Mr. Wheeler lived at least ½ hour from emergency medical care and suffered A-fib and pulmonary embolisms during this time. Mr. Wheeler also asserts that, under § 39-71-1107(1)(b), MCA, there is a basis to increase his domiciliary care benefits from 5 hours/day to 10 hours/day because his treating physician Dr. Myers says, he is "needing transportation, more appointments." And, if Dr. Myers' opinions were good enough to support his request for 5 hours/day, they should be good enough to support his request for 10 hours/day.

¹¹ 2002 MTWCC 26.

¹² 2002 MTWCC 26A, ¶ 9.

¶ 65 In response, MSF argues, there is no basis to award 24-hour domiciliary care from January 28, 2025, to April 10, 2025, when the prescribed level was 5 hours/day; there was no delay in paying domiciliary care benefits, but even if there were, awarding 24-hour care is not a type of penalty to be imposed for delays. MSF further argues that there is no basis to increase domiciliary care benefits from 5 hours/day to 10 hours/day because: credible medical evidence has not established, with a reasonable degree of particularity, that an increase in the extent of benefits is appropriate; transportation outside the home is a normal household duty, not a “home medical service,” which would trigger a need for domiciliary care services; and a forensic investigation showed that Mr. Wheeler’s medical appointments have decreased over time.

24-Hour Care

¶ 66 There is no basis to support Mr. Wheeler’s request for retroactive 24-hour domiciliary care from January 28, 2025, to April 10, 2025. No physician or any medical provider has indicated that this level of care was required during this timeframe. Mr. Wheeler cites no evidence supporting this conclusion. The undisputed facts, and Mr. Wheeler’s own physician contradict this assertion. This assertion lacks any supporting factual basis and is rejected.

Scope of Domiciliary Care Services

¶ 67 In *Skiff*, the court declined to award domiciliary care for “homemaking assistance” and “home maintenance assistance” and noted: “While Petitioner’s industrial injury has imposed severe limitations and it certainly makes sense for Petitioner to have [his wife] perform [those] tasks in light of [his] limitations, the domiciliary care statute only requires insurers to pay for services which meet the statutory criteria, and does not require insurers to pay for services which are within an injured worker’s capabilities or which do not constitute services beyond normal household duties.”¹³

¶ 68 Section 39-71-1107(1), MCA provides: “Reasonable domiciliary care must be provided by the insurer: . . . (d) when the services are of the type beyond the scope of normal household duties” MSF cites to § 39-71-704, MCA, for the proposition that driving a family member to medical appointments is a normal household duty.

¶ 69 Mr. Wheeler argues that driving an injured worker to and from medical appointments is not a normal household duty. Mr. Wheeler argues that he cannot drive, and therefore someone must take him to and from his medical appointments. In arguing for additional hours of domiciliary care, Petitioner argues that his wife Cindy must help with activities of daily living, manage his prescriptions, driving petitioner to and from appointments, and that this has taken a physical toll on her.

¶ 70 Normal household duties would obviously include washing dishes and taking out the trash. Normal duties that would be performed in the absence of the accident. Driving an injured worker to medical appointments is not done in the normal course of operating

¹³ *Skiff*, ¶ 96.

a household. The requirement only arises as a result of the accident. Transporting an injured worker to and from medical appointments is included within the scope of domiciliary care. Whether Mr. Wheeler actually needs someone to drive him is also a fact left for trial.

Dr. Myers' January 9, 2026, Statement

¶ 71 It may be that when Dr. Myers said Mr. Wheeler was “needing transportation, more appointments” on January 9, 2026, he thought, going forward, more time would be required to travel to and attend appointments. That may, or may not, be what Dr. Myers was trying to convey. It may also, as Mr. Wheeler argues, be a statement that the ongoing workload exceeds the initial estimate of 5 hours per day. It may be, as MSF argues, that Dr. Myers was mistaken about the decreasing number of appointments required and the time already allotted to this in the initial 5-hour prescription. This is a disputed issue of material fact and cannot be resolved in a summary judgment proceeding.

Issue Three: Are Attorney Fees and/or a Penalty Appropriate?

¶ 72 Mr. Wheeler asserts that he is entitled to attorney fees under § 39-71-611, MCA, or § 39-71-612, MCA, and a penalty under § 39-71-2907, MCA, regarding the denied and/or delayed payment of Mr. Wheeler’s domiciliary care benefits.

¶ 73 MSF argues that there is no basis for attorney fees under § 39-71-611, MCA, or § 39-71-612, MCA, and/or a penalty under § 39-71-2907, MCA, because: it only delayed accepting initial liability on his claim while it was awaiting a signed First Report of Injury and its acceptance was still timely; to the extent Mr. Wheeler received payment for domiciliary care benefits during the period from January 2025 through June 2025 late it was because he did not cash the first two checks MSF provided him; and while processing domiciliary care claims can take time, it followed the statutory procedures, began investigating before Mr. Wheeler retained counsel, and paid his benefits in a timely manner.

¶ 74 Section 39-71-611, MCA (2023) provides, in pertinent part:

(1) The insurer shall pay reasonable costs and attorney fees as established by the workers’ compensation court if:

(a) the insurer denies liability for a claim for compensation or terminates compensation benefits;

(b) the claim is later adjudged compensable by the workers’ compensation court; and

(c) in the case of attorney fees, the workers’ compensation court determines that the insurer’s actions in denying liability or terminating benefits were unreasonable.

To know whether MSF is liable for attorney fees under § 39-71-611, MCA, this Court must know whether the claim for which liability was denied is later adjudged compensable. Assuming the denial of a request to increase the number of domiciliary care benefits – in terms of hours – is the denial to which Mr. Wheeler refers, whether Mr. Wheeler is entitled to an increase in the number of domiciliary care benefits has yet to be decided. If that matter is best decided at trial, so must the matter of attorney fees under § 39-71-611, MCA.

¶ 75 Section 39-71-612, MCA (2023) provides, in pertinent part:

(1) If an insurer pays or submits a written offer of payment of compensation under this chapter but controversy relates to the amount of compensation due, the case is brought before the workers' compensation judge for adjudication of the controversy, and the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

(2) An award of attorney fees under subsection (1) may be made only if it is determined that the actions of the insurer were unreasonable. Any written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

Likewise, to know whether MSF is liable for attorney fees under § 39-71-612, MCA, this Court must know whether the award granted by the judge is greater than the amount paid by the insurer. Assuming the amount MSF paid in domiciliary care benefits – in terms of hours – is the controversial amount to which Mr. Wheeler refers, whether the award granted by the judge is greater has yet to be decided. As above, if that matter must wait until trial, so must the matter of attorney fees under § 39-71-612, MCA.

¶ 76 Section 39-71-2907, MCA (2023)¹⁴ provides, in pertinent part:

(1) The workers' compensation judge may increase by 20% the full amount of benefits due a claimant during the period of delay or refusal to pay, when:

(a) the insurer agrees to pay benefits but unreasonably delays or refuses to make the agreed-upon payments to the claimant; or

(b) prior or subsequent to the issuance of an order by the workers' compensation judge granting a claimant benefits, the insurer unreasonably delays or refuses to make the payments.

¹⁴ (Renumbered 3-9-112, MCA)

¶ 77 The issue here is whether the material facts surrounding the delay in initial payment are undisputed.

¶ 78 Mr. Wheeler argues the need for domiciliary care was undisputed on the day of discharge, and the delay in payment justifies a penalty.

¶ 79 MSF argues that meeting the domiciliary care statutory requirements takes time and it cannot pay and should not be required to pay contrary to the process set forth in the statute.

¶ 80 Mr. Wheeler was discharged home on January 28, 2025. On or before January 28, 2025, MSF determined that Mr. Wheeler would need domiciliary care.

¶ 81 Even though it was clear significant domiciliary care was needed immediately upon discharge, no funds were provided to this couple for over 77 days. In fact, almost two months passed between discharge and the request to Dr. Myers for a prescription for domiciliary care.

¶ 82 Mr. Wheeler was badly injured and had no income. Everyone agreed that Mr. Wheeler's wife would be providing care for at least 5 hours per day. Mr. Wheeler was discharged home on January 28, 2025. No payment was tendered until April 15, 2025. These facts may support a penalty of up to 20% for the delayed payments. This is an issue better addressed at trial. WCC Rule 329(1)(a) provides: "The court may decline to consider individual summary judgment motions if it concludes that it may resolve the issues as expeditiously by trial as by motion." The court denies the motion for summary judgment on this point without prejudice.

¶ 83 Accordingly, this Court enters the following:

ORDER

¶ 84 MSF's motion that weekly wage-loss benefits are properly set at \$133.33 per week is granted. To this extent, pursuant to ARM 24.5.348(2), this Order is certified as final and, for purposes of appeal, shall be considered as a notice of entry of judgment.

¶ 85 Mr. Wheeler's cross motion for summary judgment that the policy provides for a wage loss benefit of \$200.00 per week is denied.

¶ 86 Both parties' motions for summary judgment seeking to establish the domiciliary care benefit at a specific number of hours per day are denied without prejudice. What Dr. Myers meant when he changed his opinion on required domiciliary care, and when he increased the required domiciliary care are disputed issues of material fact. This issue cannot be resolved on summary judgment.

¶ 87 Mr. Wheeler's motion for attorney fees and/or a penalty for the denial of and/or delay in payment of the initial domiciliary care benefits is denied without prejudice. These issues will be decided at trial. (WCC Rule 329(1)(a)).

¶ 88 Mr. Wheeler's motion to strike MSF's supplemental brief is denied.

DATED this 15th day of September, 2026.

(SEAL)

/s/ Lee Bruner
Judge Lee Bruner

c: Eric Rasmusson
Mark Meyer, Jeffrey Doud, Nick Mazanec

Submitted: June 18, 2026 (Respondent's Motion for Summary Judgment)
July 31, 2026 (Petitioner's Cross Motion for Summary Judgment)