Declaration of Public Policy [1]

It is an objective of the Montana workers' compensation system to provide, without regard to fault, wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist the injured worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

A worker's removal from the work force due to a work-related injury or disease has a negative impact on the injured worker, the injured worker's family, the employer, and the general public. Therefore, the main objective of the workers' compensation system is to return injured workers to work as soon as possible after suffering a work-related injury or disease.

Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to obtain benefits speedily and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

Title 39, chapters 71 and 72 (Workers' Compensation Act and the Occupational Disease Act), must be construed according to their terms and not liberally in favor of any party.

The legislature's intent regarding stress claims, often referred to as "mental-mental claims" and "mental-physical claims", does not allow for compensation under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to verify objectively and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, injuries such as repetitive injury claims are not compensable under the present system. The legislature has the authority to define the limits of the workers' compensation and occupational disease system.

[1] §39-71-105, MCA

Insurance - Who's Covered, Who's Not

If you are an employer or an employee, the Workers' Compensation Act applies to you. An employer who has an employee in service under any appointment or contract of hire, expressed or implied, oral or written, must elect to be bound by the provisions of compensation Plan 1 (self-insured), Plan 2 (privately insured), or Plan 3 (State Fund).

Employment Exempted[2]

The Workers' Compensation Act and the Occupational Disease Act do not apply to any of the following employments:

- Household and domestic employment
- Casual employment
- Dependent member of an employer's family for whom an exemption may be claimed by the employer under the federal Internal Revenue Code
- Sole proprietors, working members of a partnership, working members of a limited liability partnership, or working members of a member-managed limited liability company
- Real estate, securities or insurance salesperson paid solely by commission without a guarantee of minimum earnings
- A direct seller
- Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States
- A person performing services in return for aid or sustenance only except, employment of volunteers
- Employment with a railroad engaged in interstate commerce, except railroad construction work
- An official, including a timer, referee, umpire or judge, at a school amateur athletic event
- A person performing services as a newspaper carrier or freelance correspondent
- Cosmetologist's services and barber's services
- A person who is employed by an enrolled tribal member or an association, business, corporation, or other entity that is at least 51% owned by an enrolled tribal member or members, whose business is conducted solely within the reservation
- A jockey who is performing under a license issued by the Board of Horse Racing, from the time the jockey reports to the scale room prior to a race through the time weighed out and has acknowledged in writing that jockey is not covered while performing services as a jockey
- Trainer, assistant trainer, exercise person, or pony person who is providing services under the Board of Horseracing while on the grounds of a licensed race meet
- An employer's spouse
- A petroleum land professional
- An officer of a quasi-public or a private corporation or manager of a manager-managed limited liability company
- A person who is an officer or a manager of a ditch company
- Service performed by an ordained, commissioned, or licensed minister of a church
- Independent Contractors
- Providers of companionship services or respite care if the person providing care is a family member or legal guardian, effective 10/01/03.

[2] §39-71-401,MCA, effective July 1,2001, unless otherwise noted.

Life of a Claim[3]

Accidents do happen and when a Montana worker files a workers' compensation claim, the life of that claim is dictated primarily by statute. Progress of a typical workers' compensation claim in Montana is determined by the following guidelines:

- Once the injury occurs, the injured worker or their authorized representative has 30 days from the date of injury to notify the employer (employer, managing agent or superintendent in charge of the work) or the insurer. A covered employer who is injured has 30 days from the date of injury to notify the insurer. [§39-71-603, MCA]

- The employer then has six days from date of notification of an injury to report the injury to the insurer or the Department of Labor and Industry. [§39-71-307, MCA, and ARM 24.29.801]

- The claimant or the claimant's representative has 12 months from the date of injury to file a claim. [§39-71-601(1), MCA] The claim filing time can be extended up to an additional 24 months if it can be proven that the worker was somehow prevented from filing the claim because of something the employer said or did, or if the injury was latent or the worker lacked knowledge of disability. [§39-71-601(2), MCA]

- The signed claim form or First Report of Injury (FROI) (form ERD-991) can be submitted to the employer or sent directly to the insurer, the adjuster or the Department of Labor and Industry. [§39-71-601(1), MCA]

- The insurer/adjuster determines compensability based on descriptions of the accident provided by the employee and employer, and the time, place and circumstances of injury. This must be done within 30 days from date of receipt of the First Report of Injury. [§39-71-606, MCA]

- If further investigation is needed before the insurer accepts liability and the 30 day limitation for a decision on compensability is due to expire, the insurer/adjuster may pay wage loss and/or medical benefits without such payment being an indication of admission of liability or waiver of any right of defense. [§§39-71-608 and 39-71-615 MCA]

- The first 5 days or 40 hours (whichever is less) of total wage loss is not compensable but a claimant may use sick leave during this time. A claimant cannot use sick leave and receive wage loss benefits at the same time. [§39-71-736, MCA]. Effective 7/1/03, the first 4 days or 32 hours total wage loss is not compensable.

- In addition to using an emergency room or urgent care center, the claimant has the right to select the first treating physician (within the treating physician definition) but the insurer must then approve changes of treating physicians. The insurer has the right to deny payment for any unauthorized medical referrals and treatments. [§39-71-1101, MCA, and ARM 24.29.1510]

[3] MCA's effective July 1, 2001, unless otherwise noted.

- The physician bills the insurer/adjuster directly. Payment is made according to a fee schedule. [§39-71-704(2) and (3), MCA] The claimant is not responsible for any unpaid balance. Some insurers require that after the initial visit the claimant pay a co-payment of 20%, not to exceed $10, for a visit to a medical service provider, or $25 for an emergency room visit. [§39-71-704(7), MCA] The claimant is responsible for payment of any unauthorized treatment and for conditions not related to the industrial injury. [ARM 24.29.1401]. For treatment provided on or after 4/17/03, the claimant's co-payment for medical visits to medical providers is eliminated. The claimant is still responsible for a $25 co-pay, after the initial visit, to an emergency room unless the insurer requests the treatment.

- Temporary total disability (TTD) benefits are based on 66 ? % of the claimant's average gross wages subject to a maximum of the state's average weekly wage, and are paid bi-weekly until the claimant returns to work or has reached maximum medical improvement (MMI). [§§39-71-701 and 39-71-740, MCA] If the claimant is classified as permanently totally disabled (PTD), benefits can continue until they reach retirement age. [§39-71-710, MCA]

- If, prior to attaining maximum medical improvement and due to medical restrictions, the claimant returns to work at less than the wages received at the time of injury, they may be entitled to temporary partial disability (TPD) benefits to make up the difference. Temporary partial disability is limited to 26 weeks unless extended by the insurer/adjuster. [§39-71-712, MCA]

- If, after reaching maximum medical improvement, the claimant has a residual impairment, greater than zero, which is a percentage of medical impairment to the whole body, the insurer/adjuster is required to pay out the permanent partial disability (PPD) liability bi-weekly, unless the claimant requests a lump sum payment. All unaccrued lump sum payments must be approved by the Department of Labor and Industry and are subject to present value discount. [§§39-71-703 and 39-71-741, MCA]

- Other future permanent partial disability liability is typically based on age, education, loss of earning capacity, and work capacity restrictions. [§39-71-703, MCA]

- If the worker is precluded from returning to the job they held at the time of injury and suffers an actual wage loss or has an impairment of at least 15%, they are eligible for rehabilitation services. The insurer/adjuster selects a rehabilitation provider and a rehabilitation plan is established with the goal of returning the claimant to work as soon as possible. During retraining, the claimant may be eligible to receive monies for tuition, fees, books and other reasonable and necessary retraining expenses. They may also receive biweekly benefit payments based on their temporary total disability rate. [§39-71-1006, MCA] Financial assistance is also available for reasonable travel and relocation for training and job-related expenses, subject to a maximum amount of $4,000. [§39-71-1025, MCA]

- Unless medical benefits are closed as a condition of settlement, they may remain available for at least 60 months (5 years) from the last date of service. The insurer may not be required

[3] MCA's effective July 1, 2001, unless otherwise noted.

to furnish palliative or maintenance care after the claimant has achieved maximum medical improvement.[§39-71-704(1)(e), MCA]

How is Montana's Workers' Compensation System Administered?

The Employment Relations Division provides a wide variety of services and regulation related to workers' compensation and safety.

Workers' Compensation Regulation Bureau

The **Contractor Registration Unit** ensures businesses have complied with workers' compensation requirements. The law provides protection from liability for workers' compensation claims for contractors who use the service of other registered construction contractors.

The **Uninsured Employers Fund Unit** ensures employers and employees are protected under the Workers' Compensation and Occupational Disease Acts. The Unit enforces coverage requirements for all employers, pays benefits to injured workers whose employers did not have workers' compensation coverage, and manages the fund from which benefits are paid.

The **Subsequent Injury Fund Unit** administers the funds that are used to offset claim costs associated with injuries to workers with disabilities. This reduces claim liability and provides an incentive for employers to hire certified workers.

The **Medical Regulations Unit** administers a program that provides an effective and equitable method of health care cost containment. Medical fee schedules are established by the unit and utilized by insurers to reimburse medical providers.

The **Carrier Compliance Unit** monitors compliance of private workers’ compensation carriers. The unit also licenses professional employer organizations and processes extraterritorial agreements.

The **Independent Contractor Central Unit** issues decisions on employment relationships for the Department of Revenue, Labor Standards, Unemployment Insurance, and Workers' Compensation Compliance. The unit also issues Independent Contractor (IC) Exemptions.

Claims Assistance Bureau

The **Claims Unit** ensures compliance with the workers' compensation and occupational disease laws relating to benefits and claims. The unit also regulates attorney fees, administers the occupational disease panel process, and provides assistance to insurers, attorneys, and injured workers.

The **Data Management Unit** enters data on new claims, receives data on claims through electronic data interchange (EDI), tracks policy coverage, maintains the workers' compensation

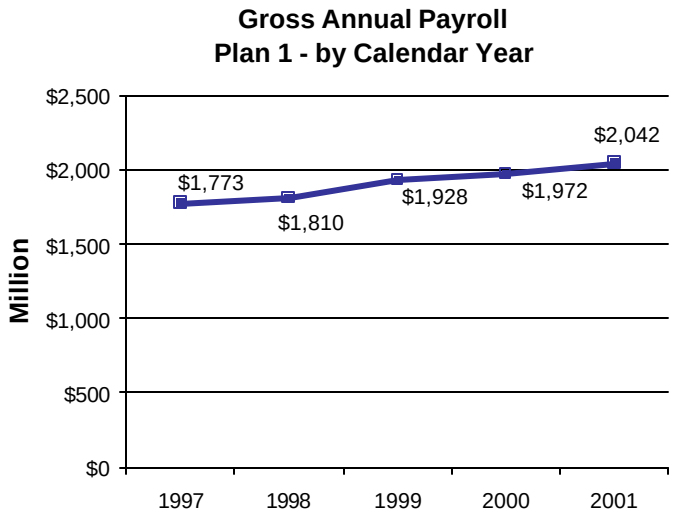
database system, and provides a comprehensive annual report on workers' compensation to the governor and the legislature.

The **Mediation Unit** provides an alternative method of resolving workers' compensation benefit disputes before the dispute goes to the Workers' Compensation Court. This is a mandatory non-binding process.

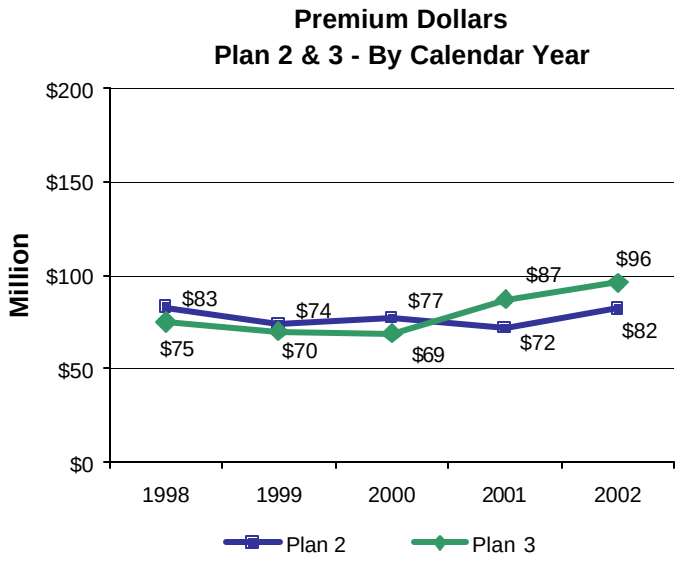
Occupational Safety & Health Bureau

The **Occupational Safety & Health Bureau** conducts inspections of public employers, performs on-site consultations for private employers, and inspects coal mines and sand and gravel operations throughout the state. The Bureau provides safety and occupational health training for both public and private employers.

Montana Workers' Compensation Market



Note:
Plan 1 employers pay no premium.



Montana employers have several options for obtaining workers' compensation coverage for their employees.

Employers with sufficient cash reserves may qualify as self-insured (Plan 1), either individually or by joining with other employers in their industry to form a self-insured group. Montana currently has 41 individual self-insured employers, four private groups (125 employers), and four public groups (378 employers).

Employers who do not self-insure have two options:

- They may obtain coverage with private insurance companies (Plan 2) in the voluntary market. 421 private insurance companies were authorized to write workers' compensation insurance in Montana in calendar year 2002.

- They can insure through Montana's State Fund (Plan 3). As the insurer of last resort, the State Fund assures all Montana employers can provide workers' compensation insurance for their employees.

The change in the Plan 1 and insurer's market share is reflected in the table below.

Distribution of Market Share
by Plan & by Calendar Year

Calendar Year	1998	1999	2000	2001	2002
Plan 1 – Payroll	$1,810,313,984	$1,927,960,055	$1,971,770,980	$2,042,192,981	*
Plan 2 – Premium	$83,274,441	$74,142,380	$77,129,965	$72,431,388	$81,725,533
Plan 3 – Premium	$75,177,196	$70,422,976	$69,411,843	$86,813,640	$95,558,150

Note: *Calendar year 2002 Gross Annual Payroll data was not available when this report was published.

Significant Court Cases

Case summaries are taken from the Workers' Compensation Court web site: http://wcc.dli.state.mt.us.

STEVE ROLAND vs LIBERTY NORTHWEST INSURANCE CORPORATION

2002 MTWCC 8

Summary: Claimant was one of several employees of a construction company crew working on building a house for the company's owner. The company owner gave permission to an adjacent property owner to use his crew, including claimant, to build a garage during times their services were not needed on his own house. The garage work was supervised, directed, and controlled by one of the construction company's supervisors. Claimant was injured while working on preparing the garage site for construction.

Held: Claimant was a loaned employee and his entitlement to compensation is governed by section 39-71-117(3), MCA (1999). Since the construction company controlled his work on the garage and had workers' compensation coverage for its crew, its insurer is liable for claimant's injury.

DANIELLE WHITLOCK vs. FREMONT INDUSTRIAL INDEMNITY COMPANY

2002 MTWCC 12

Summary: Claimant was involved in three incidents involving her lifting of 16 gallon beer kegs. In the first and second incidents, she felt a sting between her neck and right shoulder, however, the sting was transitory and she thereafter experienced a mild aching which did not indicate a need for medical care and did not interfere with her performing her job. However, a week after the second incident, she began to experience numbness in her arm and realized the need for and shortly thereafter sought medical care. She suffered a third incident which worsened her condition, which was ultimately diagnosed as a herniated cervical disk. She thereafter underwent surgery. The insurer denies liability based upon claimant's failure to report her injuries within 30 days as required by section 39-71-603, MCA (1999).

Held: Since the claimant had not reached maximum medical improvement with respect to the first injury, that claim is the one considered for purposes of determining liability. The first injury appeared insignificant at the time and the claimant did not experience symptoms which put her on notice that she might need medical care or be entitled to benefits. Therefore, the latent injury doctrine applied. *Killebrew v. Larson Cattle Co.*, 254 Mont. 513, 521, 839 P.2d 1260, 1265 (1992). Since she reported her initial injury within 30 days of when she began experiencing significant symptoms, her report was timely under section 39-71-603, MCA (1999).

EDNA HANKS vs LIBERTY NORTHWEST INSURANCE CORPORATION

2002 MTWCC 19

Summary: Claimant injured her back at work but did not report the injury to her employer for more than 60 days after it occurred. The insurer denied liability for failure to comply with the 30 day notice requirement in section 39-71-603(1), MCA (1999). She alleges that her back condition is nonetheless compensable either as an injury or occupational disease.

Held: The claim is barred by section 39-71-603(1), MCA (1999). The injury was not latent since she was aware within a few days of her need for medical care and in fact sought medical care. While she thought her increased symptoms were caused by arthritis, the lack of a prior history of back pain and the experiencing of pain due to a specific work-related incident put her on notice of the connection between her back condition and the incident. Moreover, she acknowledged thinking on a couple of occasions that it was related. Her occupational disease claim fails because the triggering event was singular and she offered no medical evidence that her preexisting back disease was occupationally caused. **Note: This case was affirme d by the Montana Supreme Court on 12/20/02**

ANN BUSTELL vs. THE INSURANCE COMPANY OF PENNSYLVANIA

2002 MTWCC 26

Summary: Claimant, a Montana resident who had driven for North American Van Lines (NAVL) and NAVL trucking firms for several years, and who had last driven for an NAVL firm just six months previous, sought employment with J-TABS. J-TABS was an interstate trucking firm and a large part of its business was hauling for NAVL. It agreed to hire claimant in November 1999, and purchased an airline ticket for her to fly from Billings, Montana, which was her home base, to Fort Wayne, Indiana, where she was to pick up her truck, update her NAVL training, and be dispatched on her first trip. Upon arriving in Fort Wayne, claimant signed a written contract with J-TABS. J-TABS' secretary, who had broad authority in J-TABS' affairs, including the authority to sign contracts, signed on behalf of J-TABS and turned over a Volvo truck to claimant to drive. Claimant completed her update class, loaded her personal gear into the truck, slept in the truck overnight, drove the truck to obtain repairs and detailing, fueled the truck using a J-TABS' credit card, and sought her first load from the NAVL dispatcher. After seeking her first load, claimant learned that NAVL required her to take a drug screening test despite the fact that she had taken four previous tests while working for NAVL, one as recently as eight months previous, and despite federal regulations which did not require retesting.

On December 2, 1999, claimant drove her truck to the drug testing laboratory and was returning to the NAVL complex in Fort Wayne to await her first load when she was broadsided by another truck, which ran a stop light. She suffered catastrophic injuries and is a quadriplegic.

At the time of the accident, J-TABS was insured by the same insurer as NAVL. NAVL personnel contacted the third-party administrator (TPA) of the insurer to report the accident. Based on information provided solely by NAVL and J-TABS, the TPA determined that Montana had jurisdiction over the claim and submitted a First Report in Montana. The insurer, however,

denied liability, asserting that claimant was not an employee of J-TABS at the time of the accident or was not in the course and scope of employment.

Claimant thereafter hired a Montana lawyer to pursue her claim and also accepted insurance monies from the other truck driver's insurer. Her Montana attorney requested mediation. The mediation took place in September 2000. At that time, and for the first time, the insurer challenged Montana jurisdiction over the claim. Mediation was unsuccessful and the claimant filed her petition with this Court. In this litigation the insurer asserts that Montana is not the proper forum for the claim and, secondarily, that the claimant was not an employee or was not in the course and scope of employment when she was injured.

Held: (1) There was an agreement of employment made orally while claimant was still in Montana and subsequently reduced to writing and signed by both J-TABS and claimant. The agreement was unconditional and contained no conditions precedent. Both parties reasonably expected that claimant would requalify to drive for NAVL; had she not qualified, then J-TABS remedy was to terminate the employment as provided in the agreement.

(2) Claimant was acting in the course and scope of her employment in taking possession of, preparing, and using the J-TABS' truck assigned to her. Since she had to qualify to drive for NAVL as a part of her employment, she was in the course and scope of her employment when driving to and from the medical laboratory for the drug screening test.

(3) Montana is the proper forum for her claim and the insurer is in any event estopped from asserting otherwise.

(4) The insurer's denial of benefits in this matter was unreasonable and entitles the claimant to attorney fees and a penalty. The insurer acted unreasonably in contesting Montana as the proper forum after it had determined, based solely on information provided by J-TABS and NAVL, that Montana was the proper forum. It also acted unreasonably in failing to properly focus on whether claimant had an agreement of employment with J-Tabs, instead it focused on whether she was qualified to drive for NAVL, which it also insured.

IN THE MATTER OF MICHAEL ABFALDER; TRAVELERS INDEMNITY COMPANY OF ILLINOIS vs. NATIONWIDE MUTUAL FIRE INSURANCE

WCC No. 2002 MTWCC 29

Summary: In 1994, the claimant was diagnosed as suffering an occupational back disease as a result of his continuous heavy lifting. His occupational disease claim was accepted by Nationwide. He continued working and suffered flareups from three specific incidents which were accepted as compensable aggravations by the employer's subsequent insurer, which was Travelers. Over the years, claimant also suffered flareups unrelated to specific incidents. After each flareup he returned to work with the same physical restrictions imposed in 1994. In December 1999, his employer imposed additional requirements on his work which were outside his restrictions, then laid him off because of his restrictions. Claimant's treating physician opined that claimant's post-1994 incidents were temporary aggravations but acknowledged that the subsequent incidents did to some degree worsen his condition. An IME physician also opined

initially that the incidents were temporary aggravations but during deposition testimony concluded that the incidents contributed to and worsened his condition. The insurer for the subsequent injuries seeks indemnification from the OD insurer.

Held: The OD insurer is liable. While the subsequent aggravations contributed to claimant's overall condition, the degree to which they contributed was neither material nor substantial. Claimant was laid off because of a change in the requirements of his job, not because of any change in his condition or restrictions. While he suffered numerous exacerbations over the years, he was motivated to work and would have continued working indefinitely but for the change in his job. **Note: This case has been appealed to the Montana Supreme Court. That decision is pending**

TRAVELERS PROPERTY CASUALTY vs. STEVEN M. MARTINI, M.D., P.C.

2002 MTWCC 31

Summary: The insurer appeals a determination by the Department of Labor and Industry finding that it is liable for services of a nurse practitioner who was employed by and working under the direct supervision of a medical doctor who had been approved to treat the claimant. It argues that the nurse practitioner is the *de facto* treating physician and that she is ineligible for reimbursement.
Held: The insurer's argument is without merit. Section 39-71-116(36), MCA, defines treating physician as the medical provider "primarily responsible for treatment of a worker's compensable injury." A medical doctor was primarily responsible for the treatment and maintained supervision and control over the nurse practitioner's services, therefore he was the treating physician and is entitled to reimbursement for the nurse practitioner's services.

JOHN MICHAEL HAMPSON vs. LIBERTY NORTHWEST INSURANCE CORPORATION

2002 MTWCC 57

Summary: Claimant, a registered nurse, provided home nursing care to clients of his employer. He served one client at a time. He was injured while traveling home from work and seeks workers' compensation benefits.

Held: Claimant is not entitled to benefits since he was going home from work. He was not paid for his travel and his going to and from work was not part of his employment, therefore section 39-71-407(3), MCA (1999), precludes him from receiving benefits.

CAROLYN McCOY vs. BENEFIS HEALTHCARE

2002 MTWCC 59

Summary: Claimant and insurer disagree as to claimant's entitlement to rehabilitation benefits during semester breaks and auxiliary benefits for commuting to and from school. They submit the disputes to the Court for resolution.

Held: A claimant who is continuously attending school pursuant to a rehabilitation plan is entitled to rehabilitation benefits during semester breaks and is entitled to auxiliary benefits for commuting to and from school.

KATE J. OSWALD vs. HORIZON CMS HEALTHCARE CORPORATION

2002 MTWCC 62

Summary: The 48-year old claimant suffering from Hepatitis C, an infectious disease obtained through exposure to infected blood or bodily fluids, worked as a nurse's aide at the Butte Convalescent Center from 1988 through 1994, where she provided direct patient care including exposure to blood and bodily fluids through changing patients' clothes, sheets, and bandages. Claimant credibly testified that she frequently worked with open cuts on her knuckles and hands, which she attributed to frequent hand washing at work. The Center did not provide gloves or other protective clothing and she did not use gloves or other protective clothing. Claimant also credibly testified that her other employments over the years did not involve direct contact with blood or bodily fluids. In 2001, claimant was diagnosed with Hepatitis C and currently suffers from numerous symptoms of the disease. Though now single, claimant was married from 1980 through 1996. Her ex-husband, to her knowledge, has not been tested for Hepatitis C but does not have symptoms of the disease. Claimant's treating physician, Dr. Florian Cortese, concluded that since claimant does not have other risk factors, it is highly probably she contracted Hepatitis C at the Butte Convalescent Center. While she would not conclude that claimant more probably than not acquired her disease through this work exposure, Dr. Dana Headapohl, who conducted an IME of claimant, opined that the two most probable means by which claimant obtained the disease were through the work exposure or through her husband. Dr. Headapohl also credibly and unequivocally testified that Hepatitis C is acquired through a single exposure. The self-insured entity that was the final employer of claimant while she worked at the Butte Convalescent Center, Horizon CMS Healthcare Corporation, denies liability on the ground that claimant cannot prove her exposure was through employment at the facility. It also argues claimant does not suffer from an occupational disease. Both parties agreed that whether claimant's hepatitis is the result of an industrial injury within the meaning of the Workers' Compensation Act is not currently an issue before the Court.

Held: Crediting claimant's testimony about the frequency with which she was exposed to patients' bodily fluids or blood while having open cuts on her hands, and her testimony that her ex-husband to her knowledge does not have symptoms of Hepatitis C, the Court finds claimant to have proven she more likely than not acquired Hepatitis C through working at the Butte Convalescent Center. Because the uncontroverted medical evidence establishes that Hepatitis C is acquired through a single exposure, claimant does not meet the criteria of the Occupational Disease Act and is not entitled to occupational disease benefits.

Recent Important Montana Supreme Court Decisions on Workers' Compensation & Occupational Disease

These decisions can be found at the State Law Library Website: www.lawlibrary.state.mt.us

RAUSCH, FISCH, FROST vs. STATE FUND

Supreme Court no. 2002 MT 203
Decision Date 09/05/02

The Supreme Court reversed the Workers' Compensation Court by finding that permanently totally disabled claimants are legally entitled to an impairment award for the loss of physical function resulting from a work related injury. The Court found that the impairment award is due to a permanently totally disabled claimant upon receipt of the undisputed impairment rating. Further, the impairment award in such cases should be classified as a permanent total disability benefit. The court also awarded "common-fund" attorney fees.

FLIEHLER vs. UNINSURED EMPLOYERS FUND

Supreme Court no. 2002 MT 125
Decision Date 06/11/02

The Supreme Court affirmed the decision of the Workers' Compensation Court finding that this claimant met the definition of an "employee" of an "employer" in Montana and was entitled to benefits. The Supreme Court decision found that "when faced with multiple locations where the owner controlled the claimant's employment duties, the court was correct in comparing all of the owner's activities at these various locations and concluding that the primary, principal and ultimate control over the claimant's work took place in Montana. For these reasons, the court was correct in concluding that the claimant's employment duties were primarily controlled in Montana."

STAVENJORD vs. MONTANA STATE FUND

Supreme Court no. 2003 MT 67
Decision Date 04/01/03

The Supreme Court affirmed the decision of the Workers' Compensation Court in finding the $10,000 limitation under the Occupational Disease Act is unconstitutional and the claimant is entitled to the same benefits she would receive if the condition arose under the Workers' Compensation Act.

SCHMILL vs. LIBERTY NORTHWEST INSURANCE CORP.

Supreme Court no. 2003 MT 83
Decision Date 04/10/03

The Supreme Court affirmed the decision of the Workers' Compensation Court in finding the apportioning of wage loss benefits pursuant to Section 39-72-706, MCA, of the Occupational Disease Act is unconstitutional and the claimant is entitled to the same benefits she would receive if the condition arose under the Workers' Compensation Act.

WILD vs. MONTANA STATE FUND

Supreme Court no. 2003 MT 115
Decision Date 04/29/03

The Supreme Court reversed the decision of the Workers' Compensation Court finding the existence of a Certificate of Independent Contractor Exemption was not conclusive evidence of whether Wild was an independent contractor (IC) or an employee. The Supreme Court Decision found that "Nothing in Section 39-71-401, MCA, precludes a factual inquiry into whether an employer/employee relationship exists at the time a worker is hired. On the contrary, we agree that an employer has clear obligation to make at least a cursory determination of whether the worker is an IC in fact, as opposed to merely in name, before the employer can reasonably rely upon the exemption. An employer who fails to do so, with knowledge of the facts, should not be allowed to hide behind the exemption."