

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

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| PATRICK W. WILLIAMS, |) | filed February 3, 2010 |
| |) | |
| Petitioner, |) | |
| |) | IC 2006-509079 |
| v. |) | (15-000089) |
| |) | |
| BLUE CROSS OF IDAHO, |) | DECISION AND ORDER |
| |) | ON PETITION FOR |
| Respondent. |) | DECLARATORY RELIEF |
| _____ |) | |

In an Order filed August 5, 2009, the Commission ruled that it has jurisdiction to consider the question of whether or not the proceeds of a previous Lump Sum Settlement are subject to the claims of Blue Cross of Idaho (Blue Cross), a third party medical insurer who paid some portion of the medical bills incurred by Claimant in connection with his disputed work injury. Specifically, the Commission concluded that it does have jurisdiction to consider whether or not the provisions of Idaho Code § 72-802 prohibit Blue Cross, or an entity similarly situated, from asserting a claim against the proceeds of a Lump Sum Settlement.

Following that decision, the Commission held a telephonic status conference with the parties on September 28, 2009, at which time the parties stipulated to certain facts, and agreed to a briefing schedule. The parties also agreed that Blue Cross would be allowed to submit additional evidence by way of affidavit. For that reason, the Commission's Order reversed the usual briefing schedule, in order to allow Petitioner an opportunity to fully respond to any new facts that might be set forth in the supporting Affidavits accompanying the Blue Cross brief. From review of Petitioner's brief, it appears that no issue is taken with the factual averments made by Blue Cross in its brief, nor with

the facts set forth in the supporting Affidavits of Tim Walton and Debbie Lowe. In its August 5, 2009 decision, the Commission assumed certain facts to be true, even though not all those assumptions were supported by evidence that had been adduced as of the date of August 5, 2009 decision. Since that time, additional evidence has been forthcoming, which allows the Commission to make specific findings of fact.

FINDINGS OF FACTS

1. At all times relevant hereto, Petitioner was employed by Paul Crossingham, dba AAA Plumbing. On April 11, 2006, Petitioner suffered a work related injury to his left shoulder. On April 24, 2007, Petitioner suffered a work related injury to his left hand. Petitioner suffered a second work related injury to his left shoulder on June 28, 2007. At all times relevant hereto, Employer's liability under the Workers' Compensation Laws of the state was insured by the State Insurance Fund (SIF).

2. Although the SIF initially accepted responsibility for the aforementioned claims, it appears at some point following the accident of April 24, 2007, the SIF took the position that Claimant's need for further medical/surgical treatment for his left shoulder injury was not related to any of the industrial accidents, but was, instead, related to a left shoulder condition which pre-dated the subject claims.

On September 5, 2006, Claimant underwent a left shoulder acromioclavicular reconstruction procedure performed by Michael R. DiBenedetto, M.D. On March 20, 2007, Dr. DiBenedetto performed his second surgery on Claimant's left shoulder, this time involving a biceps tenotomy and biceps tenodesis. Surety denied responsibility for all benefits related to Claimant's surgeries of September 5, 2006 and March 20, 2007.

3. As an incident of his employment by AAA Plumbing, Claimant was insured under a non-occupational group health care policy issued by Blue Cross. From the Affidavit of Debbie Lowe, it appears that coverage under this policy was initiated in 1999, and remained in effect until 2008, when the policy was cancelled for nonpayment of premium. At the time of the accident giving rise to this claim, Patrick Williams was insured under the Blue Cross policy.

4. At all times relevant hereto, AAA Plumbing paid the premiums, or some portion thereof, for Petitioner's non-occupational group health insurance.

5. The Blue Cross policy contains a number of subrogation provisions:

The benefits of this Policy will be available to an Insured when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured's death, to the rights of his or her heirs, estate, and/or personal representative.

....

Subrogation is taking over the Insured's right to receive payments from other parties. The Insured or his or her legal representative will transfer to Blue Cross of Idaho any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho may initiate litigation at its sole discretion, in the name of the Insured, against any third party or parties. Furthermore, the Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho's subrogation rights and efforts. Blue Cross of Idaho will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

....

To the extent that Blue Cross of Idaho provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any right the Insured has to recover from the Insured's insurer, or under the Insured's

“Medical Payments” coverage or any “Uninsured Motorist,” “Underinsured Motorist,” or other similar coverage provisions, and workers’ compensation benefits.

Blue Cross of Idaho shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Insured, the Insured’s personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Insured including the Insured’s attorney.

6. Following the SIF’s denial of responsibility for the payment of medical benefits associated with Petitioner’s left shoulder treatment, Petitioner applied to Blue Cross for the payment of these medical expenses. From the documents attached to the Affidavits of Tim Walton and Debbie Lowe, it appears that the medical bills subject to payment under the Blue Cross policy totaled \$31,195.14. Although various documents submitted by Petitioner in connection with the resolution of his claim against the SIF reflect that the medical bills incurred by Petitioner for treatment of his left shoulder had a considerably higher invoiced amount, it does not appear that Petitioner takes any issue, at present, with the \$31,195.14, figure supported by Blue Cross documents. Although Blue Cross accepted responsibility for payment of the aforementioned medical bills, because of various contractual adjustments with Petitioner’s providers, Blue Cross was able to satisfy those bills for the sum of \$11,181.08.

7. The record reflects that both before and after the eventual Lump Sum Settlement of the underlying Workers’ Compensation claim, Blue Cross communicated its intention to enforce its right of subrogation to Petitioner’s counsel. At no point did Petitioner’s counsel acknowledge the validity of the contractual right of subrogation.

8. As noted, the SIF denied responsibility for medical treatment incurred subsequent to the April 11, 2006 left shoulder injury. The SIF’s denial was premised on its belief that Claimant’s

left shoulder condition was not referable to the subject April 11, 2006 accident, but was, instead, related to a pre-existing left shoulder condition documented in Claimant's medical records. Following the SIF's denial of responsibility for this medical treatment, Petitioner filed his Complaint against Employer/Surety. That Complaint sought, *inter alia*, the payment of medical expenses incurred by Petitioner in connection with his two left shoulder surgeries. That Petitioner asserted an entitlement to the payment of the disputed medical expenses is made clear by counsel's January 29, 2008 demand letter to David Skinner, attorney for the SIF. In that letter, Petitioner clearly asserted that his need for medical treatment following the industrial accident of April 11, 2006 was a product of that accident, and that he was entitled to the payment of medical expenses incurred in connection with his treatment, totaling, in his estimation, \$59,060.83. As noted, the actual amount of invoiced medical expenses appears to be \$31,195.14.

9. On or about February 20, 2008, Petitioner and the SIF reached a mediated settlement of the underlying Workers' Compensation claims. That Settlement is memorialized in a Lump Sum Settlement Agreement approved by the Industrial Commission on or about March 21, 2008. Pursuant to the terms of that Agreement, Claimant accepted the "new money" sum of \$70,000.00 in compromise of all claims arising out of the subject accidents. In consideration of its payment of that new money sum, the SIF was released from any and all liability, of any type whatsoever, arising from the subject accidents. Specifically, the Lump Sum Settlement released the SIF from any and all responsibility for the payment of the disputed medical bills incurred by Petitioner in connection with the medical/surgical treatment of his left shoulder. Concerning the disputed medical bills incurred by Petitioner following the industrial accidents, the Lump Sum contains the following language:

"There are genuine and substantial disputes and differences between the parties as to

the degree, if any, of claimant's impairment and the disability, the need for retraining benefits, the need for the surgeries of September 5, 2006 and March 20, 2007, which defendants assert are due to pre-existing conditions, and the need for future medical benefits....

It is further understood between the parties that the claimant agrees to pay all outstanding medical bills not listed in the fourth section of this agreement and the employer and surety will not be responsible for, nor do they assume a liability for, any other medical bills whatsoever..."

10. In that portion of the Lump Sum Settlement Agreement which accounts for the distribution of the monies received pursuant to that Settlement, the following entry is found:

ITEMIZED LIST OF OUTSTANDING MEDICALS TO BE PAID BY CLAIMANT FROM LUMP SUM SETTLEMENT BALANCE: (List provider and amounts.)

None

From this language, which is the only language in the Lump Sum Settlement Agreement that treats the issue of outstanding disputed medical bills, it is impossible to ascertain whether there were, in fact, outstanding disputed medical bills, and if so, whether any claim for the payment of such bills had been waived by Blue Cross, previously satisfied by Petitioner, or rejected by Petitioner.

11. Following the approval of the Lump Sum Settlement Agreement by the Industrial Commission on March 21, 2008, the SIF discharged its obligation under the Agreement by the payment of the new money sum of \$70,000.00. Neither the Agreement, nor the Commission's Order approving the same, resolves the question of whether or not the medical care Claimant received following the SIF's denial of responsibility was causally related to the subject accident. The Lump Sum Settlement Agreement only memorializes the parties' compromise of that disputed issue.

12. The consideration paid pursuant to the Lump Sum Settlement Agreement is unapportioned. Nothing in the Agreement reflects how much, if any, of the Settlement proceeds

were assigned by the parties to the resolution of the issue of Claimant's entitlement to payment of disputed medical bills.

CONCLUSIONS OF LAW

I

The narrow issue before the Industrial Commission is whether Idaho Code § 72-802 prohibits Blue Cross from pursuing its contractual right subrogation against the proceeds of the Lump Sum Settlement.

Idaho Code § 72-802 provides:

72-802. Compensation not assignable – Exempt from execution.

No claims for compensation under this law, including compensation payable to a resident of this state under the worker's compensation laws of any other state, shall be assignable, and all compensation and claims therefor shall be exempt from all claims of creditors, except the restrictions under this section shall not apply to enforcement of an order of any court for the support of any person by execution, garnishment or wage withholding under chapter 12, title 7, Idaho Code.

A plain reading of the statute demonstrates that two types of actions are prohibited:

1. Assignment of claims for compensation; and,
2. The claims of creditors against compensation, and all claims therefor.

Turning first to the prohibition against assignments, Blue Cross argues that no assignment of the claim has been made in this case, and that this portion of the statute does not prohibit its claim, which arises out of a contractual right of subrogation. Blue Cross relies on the case of Rinehart v. Farm Bureau Mutual Insurance Company of Idaho, 96 Idaho 115, 524 P.2d 1343 (1974) in support of its position that the facts of this case do not implicate a prohibited assignment.

In that case, Rinehart was injured in an automobile/motorcycle collision. He incurred medical expenses in the amount of \$2,589.00. He made demands upon the driver of the automobile

involved in the accident, and eventually reached a settlement, under the terms of which he received \$11,500.00 in consideration of his full and final release of all claims and rights against the driver of the other vehicle. Thereafter, Rinehart demanded the payment of \$2,000.00 under the medical expense provisions of his own automobile insurance policy. That policy contained the following subrogation provisions:

“Subrogation: (a) In the event of any payment under Section III, the Company shall be subrogated to all the insured’s rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights.

‘(b) In the event of any payment under the medical expense coverage of this policy the Company shall be subrogated to all the rights of recovery therefor which the injured person or anyone receiving such payment may have against any person or organization and such person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. Such person shall do nothing after loss to prejudice such rights.’”

Farm Bureau refused to make payment, on the grounds that Rinehart had breached the terms of the policy by executing a general release which destroyed the right of subrogation retained by Farm Bureau under the policy. In defense of his position, Rinehart argued that the subrogation clause was nothing more than an attempted assignment of a claim for personal injuries. Asserting that such assignments are not favored at common law, Rinehart argued that the release of claim could not alter Farm Bureau’s right of subrogation to its detriment, since no such right actually existed in the first place. The Idaho Supreme Court rejected the assertion that the subrogation clause of the contract constituted an assignment, relying on the following language from Imel v. Travelers Indemnity Company, 281 N.E.2d, 919 (Ill.App.Ct. 1972):

“subrogation secures contribution and indemnity, whereas assignment transfers the entire claim; the consideration in subrogation moves from subrogor (insureds) to

sobrogee (insurer), whereas in an assignment the consideration flows from assignee to assignor; assignment contemplates the assignee being a volunteer, whereas subrogation rests on a contractual duty to pay; assignment normally covers but a single claim, whereas subrogation may include a number of claims over a specific period of time; subrogation entails a substitution, whereas assignment is an outright transfer.’”

The same reasoning should apply in the instant matter. The subrogation clause at issue in Rinehart, *supra*, is similar to that at issue in the case at hand. The Blue Cross policy contains no language suggesting that what was contemplated was a prohibited assignment of the entire claim. Rather, the policy language contemplates that Blue Cross will be substituted for Petitioner, up to the amount of benefits that Blue Cross has paid on Petitioner’s behalf.

While we agree with Blue Cross that the contract at issue does not constitute a prohibited assignment of a claim, this conclusion, standing alone, does not support the proposition that Blue Cross may proceed unimpeded against the proceeds of the Lump Sum Settlement. In addition to prohibiting the “assignment” of claims, Idaho Code § 72-802 also specifies that all compensation, and claims therefore, are exempt from the claims of “creditors.” In other words, notwithstanding that the policy makes no prohibited assignment, does it nevertheless memorialize the claim of a “creditor?”

However, just as the Blue Cross policy fails to create a prohibited assignment, neither is it in derogation of the statutory exemption of compensation from the claims of creditors. Case law draws a clear distinction between “creditors” and “subrogees.” Kenneth F. White, Chtd v. St. Alphonsus Regional Medical Center, 136 Idaho 238, 31 P.3d 926 (2001).

In White, Krivanec was injured as a result of a motor vehicle accident. Following the accident, Krivanec was hospitalized, and incurred medical expenses totaling \$131,677.23. St.

Alphonsus' recorded a hospital lien pursuant to the hospital lien statute. White represented the Krivanec's in their claim against the negligent driver of the other vehicle involved in the collision, and eventually obtained for the Krivanecs a settlement in the amount \$25,000.00.

In connection with its discussion of the applicability of the Common Fund Doctrine to the facts of the case, the Court of Appeals noted the importance of ascertaining whether St. Alphonsus was a "creditor" or a "subrogee." The hospital argued that it was not asserting a subrogation claim to the settlement, but was, rather, a creditor of Ms. Krivanec. The Court agreed, noting that the hospital did not stand in the shoes of the injured party as a subrogee, but was, instead, a creditor, who possessed a lien on the tort recovery to secure payment of its charges for services rendered. Unlike a true subrogee, the hospital was entitled to payment regardless whether or not Krivanec made any recovery against the negligent third party, and was therefore, a true "creditor."

As applied to the facts of the instant matter, it is clear that Blue Cross is not a "creditor" within the meaning of the statute, but is, rather, a subrogee, against whom the prohibitions of the statute do not specifically apply.

Having found that the provisions of Idaho Code § 72-802 do not apply to prohibit the claim of a subrogated medical insurer who has made payments on disputed medical bills, it is necessary to consider how next to proceed in the instant matter. It is important to recall that this matter comes to us on Petitioner's claim for a declaratory ruling that the provisions of Idaho Code § 72-802 prohibit any claim to the proceeds of the Lump Sum Settlement. However, to date, Blue Cross has not attempted to pursue its subrogation claim before the Industrial Commission. Although we have found that the Industrial Commission does have jurisdiction to consider the applicability of Idaho Code § 72-802 to these facts, we do not believe that the Commission has jurisdiction to consider any

claim that Blue Cross might be inclined to pursue against Petitioner.

In its August 5, 2009 Decision, the Commission did not feel that Owsley v. Idaho Industrial Commission, 141 Idaho 129, 106 P.3d 455 (2005) prohibited the Commission from considering an injured worker's petition for interpretation of the provisions of Idaho Code § 72-802. However, we do feel that that case does auger against the Commission accepting jurisdiction over any claim that Blue Cross might attempt to bring before the Commission to pursue its right of subrogation against the proceeds of settlement. Per Owsley, Supra, "an action by a worker against any entity besides a surety or employer does not generally fall within the purview of the Commission." Here, any cause of action owned by Blue Cross arises out of a contract between Blue Cross and Petitioner, a contract that is not governed by, and arose outside of, the Workers' Compensation Laws of this state. Moreover, Blue Cross is neither an injured worker nor an Employer/Surety. For these reasons, we conclude that Blue Cross must pursue its remedy in some venue other than the Idaho Industrial Commission.

The Commission recognizes that this case is complicated by the fact that there has been no adjudication of the question of whether or not the disputed care is causally related to the subject accidents. The parties agreed to compromise this dispute before it could be heard by the Industrial Commission, and that compromise is memorialized in the Lump Sum Settlement Agreement. However, since Blue Cross is only subrogated to the rights of the Petitioner to recover workers' compensation benefits, it might well be argued that before any right of subrogation can be said to exist, it must be determined that Petitioner is entitled, under the Workers' Compensation Laws of this state, to the payment of medical expenses he incurred following the SIF's denial of responsibility for further medical treatment. Although this determination has not been made by the

Industrial Commission, there is no reason that this issue could not be adjudicated in the court in which Petitioner pursues its subrogation claim.

The order approving the Lump Sum Settlement Agreement at issue in this case is a decision of the Industrial Commission from which no appeal has been taken. As such, it is final and conclusive as to all matters adjudicated therein. *See*, Idaho Code § 72-718; Woodvine v. Triangle Dairy, Inc., 106 Idaho 716, 682 P.2d 1263 (1984). However, as noted above, the Lump Sum Settlement Agreement does not adjudicate the question of whether or not the Claimant's medical treatment at issue is causally related to the subject accident. Since the Lump Sum Settlement Agreement is only final and conclusive as to matters actually adjudicated, the Agreement does not prohibit the downstream adjudication of this question by the state or federal court in which Blue Cross pursues its contractual right of subrogation.¹ Of course, a determination on this issue would in no wise impact Employer and Surety, who have bought their peace by the payment of the Lump Sum Settlement.

Finally, although Blue Cross has argued that employer's non-occupational group insurance policy is an ERISA Plan governed by Federal law, because we have determined that the provisions of Idaho Code § 72-802 do not prohibit Blue Cross' subrogation claim, we need not determine whether the insurance contract in question is an "ERISA Plan," much less whether ERISA preempts the provisions of Idaho Code § 72-802.

II

The instant matter can be narrowly decided on the basis that the provisions of Idaho Code §

¹ Moreover, since Blue Cross is not a party to the Lump Sum Settlement, any "adjudication" of issues therein would not bind it.

72-802 do not prohibit the claim of a medical insurer who has paid benefits to an injured worker subject to a contractual right of subrogation. In reaching this conclusion, the Commission need not reach the different, but closely related question, of whether or not the provisions of Idaho Code § 72-802 exempt the proceeds of an award or settlement from the claim of a medical provider who has contracted with a claimant for the provision of medical services, an entity that is assuredly a “creditor” within the meaning of Idaho Code § 72-802. Therefore, we decline to make any ruling on this issue at this time. However, for purposes of guidance only, it seems doubtful that Idaho Code § 72-802 should be strictly read to exempt the proceeds of an award or settlement from the claim of a medical provider who provided disputed care.

The recent case of Neel v. Western Construction, 147 Idaho 146, 206 P.3d 852 (2009), and a plethora of similar Industrial Commission cases, stands for the proposition that where a surety denies responsibility for certain medical treatment required by claimant following an industrial injury, thus forcing claimant to independently contract with a medical provider for the provision of the required care, a subsequent ruling by the Industrial Commission finding the care in question to be compensable requires the surety to pay to the claimant 100% of the medical bills as originally invoiced to the claimant.

Implicit in this decision is the recognition that the award of disputed medical benefits is payable to Claimant because it is he who has obligated himself to the medical provider outside the workers’ compensation system. Absent a recognition that an injured worker has such an obligation, it is impossible to justify a decision ordering surety to pay to the injured worker the invoiced amount of the bills incurred. To interpret Idaho Code § 72-802 in the manner favored by Petitioner would seem to give rise to an irreducible conundrum: In a contested case, why should an injured worker be

awarded the value of disputed medical expenses he incurred outside the workers' compensation system, if he has no corresponding obligation to repay those providers from the proceeds of the award? In other words, if the award is not intended to satisfy the injured worker's obligation to the medical provider, then what is the justification for making the award in the first place? Construing Idaho Code § 72-802 in the manner urged by Petitioner would seem to result in the payment of a benefit to the injured worker of a type not recognized by our Workers' Compensation Law.

In light of Neel, *supra*, it would seem that Idaho Code § 72-802 is not intended to exempt the proceeds of an award made following hearing from the claim of a medical provider, where it is shown that in such award the injured worker was awarded payment of the disputed medical bills at issue. To do otherwise would grant a windfall to claimant to which he is not entitled, and would make pointless our many orders awarding medical benefits to injured workers for care received in connection with a disputed claim that has been decided following hearing before the Industrial Commission. To the criticism that this interpretation appears to be in direct contravention of the plain language of the statute, we believe that this construction may necessarily be implied in the Court's decision in Neel, and, further, that this construction underlies all awards of medical benefits payable to an injured worker in a disputed case.

III

As a practical matter, it is in the interest of the workers' compensation system to encourage medical insurers and medical providers to continue to provide care where there is an initial dispute between the injured worker and employer/surety over the compensability of the claim. In such circumstances, if the employer/surety, reasonably or not, denies responsibility for a particular claim, it may be a matter of many months before a decision is eventually rendered on the compensability of

the accident/injury or occupational disease. During the pendency of such a decision, it is in the interest of the injured worker for medical providers to provide the needed care, against the chance that they may be able to eventually recover payment for services rendered. However, if medical providers receive the message that even if the Industrial Commission awards the injured worker a sum of money in payment of medical expenses incurred in connection with a compensable injury, the claimant has no obligation whatsoever to pay his provider from the proceeds of that award, they will likely be disinclined to treat injured workers where there is a threshold dispute concerning the compensability of a claim.

We recognize that our ruling subjects an injured worker to the possibility of litigation in federal or state court following an award or settlement in a disputed case. However, it is the experience of the Commission that most members of the claimant's bar recognize the importance of resolving the claims of medical providers and third party insurers contemporaneous with the settlement of a disputed claim. As Blue Cross has aptly noted, the process of resolving a disputed workers' compensation case provides the perfect opportunity to likewise resolve the claim of a medical insurer who has paid medical bills on a disputed claim. If compensability is doubtful, and the medical insurer/provider can be persuaded to this point of view, then it is likely that the insurer/provider will be willing to resolve its claim for something substantially less than 100 cents on the dollar.

Even though we have decided that the Industrial Commission does not have jurisdiction over the claims of medical insurers, Practitioners are advised to attempt to resolve such claims contemporaneous with the settlement of the underlying workers' compensation case, since failure to do so may produce anomalous results. If, when considering a proposed lump sum settlement

agreement such as that at issue in this case, it becomes clear to the Commission that there are disputed unpaid medical bills for which Claimant is to receive some compensation, and that the claims of medical insurers and medical providers have not been resolved contemporaneous with the proposed settlement, it may be difficult for the Industrial Commission to conclude that the proposed lump sum settlement is in the best interest of all parties under Idaho Code § 72-404. It may not be in the best interest of the injured worker to subject him or her to further litigation subsequent to the settlement of a workers' compensation claim, and it may not be in the long term best interest of an employer/surety for monies paid in compromise of disputed medical expenses to be applied to something other than resolution of the outstanding claims of medical providers/medical insurers.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED, ADJUDGED and DECREED that Idaho Code § 72-802 does not prohibit the claim of a subrogated medical insurer against the proceeds of an award following hearing, where it is shown that in such award, the injured worker received payment for the disputed medical bills at issue. In the case of a lump sum settlement reached prior to hearing, where it is shown that the claimant received some consideration for disputed medical bills he claimed were incurred in connection with the work injury, Idaho Code § 72-802 does not prohibit the claim of a medical insurer who has a valid right of subrogation.

This decision does not address whether there are exemptions created by other law which might exempt the proceeds of such an award or settlement from execution.

DATED this __3rd__ day of __February____, 2010.

INDUSTRIAL COMMISSION

_____/s/_____
R.D. Maynard, Chairman

_____/s/_____
Thomas E. Limbaugh, Commissioner

_____/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of February, 2010 a true and correct copy of the foregoing **Decision and Order on Petition for Declaratory Relief** was served by regular United States Mail upon each of the following persons:

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cjh

_____/s/_____
