OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-787-172

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable right shoulder injury on February 16, 2009, in the course and scope of his employment with Respondent-Employer.

2. Whether Claimant has established by a preponderance of the evidence that he is entitled to any and all reasonable and necessary medical benefits for his February 16, 2009, right shoulder condition.

3. Whether Claimant established by a preponderance of the evidence that he is entitled to temporary total disability benefits for the February 16, 2009, right shoulder injury from June 10, 2009 and ongoing.

4. Whether Respondents have established by a preponderance of the evidence that Claimant was terminated for cause.

FINDINGS OF FACT

1. On January 9, 2009, Claimant began work for B in Pueblo, Colorado. Claimant was assigned to the Pueblo Chemical Depot, which is a large-scale industrial project. Claimant was attached to a welding crew under

the direct supervision of Alvin Buffalo. Claimant was required to carry and move welding equipment weighing approximately 100 pounds or more, hammer for long periods of time, move and carry gang boxes weighing approximately 100 pounds or more, carry heavy pieces of steal, use a grinder for long periods and numerous other forms of heavy industrial labor. The job requirements are extremely physical and impossible to perform unless one is in excellent physical condition. From January 9, 2009 to February 15, 2009, Claimant fully performed his job duties without incident and without injury.

2. On February 16, 2009, Claimant, in the course of his employment, was required to spend a large portion of the morning hammering washers into place so that they could be welded. Claimant was also required to string out a significant amount of welding equipment and move numerous gang boxes. Somewhere around 2:00 p.m., Claimant began to feel what he described as a cramp in his bicep and pain up into the shoulder. Consistent with B policy, Claimant reported the injury to his supervisor, Alvin Buffalo.

3. Alvin Buffalo accompanied Claimant to B's onsite medical personnel and informed medical that Claimant needed treatment. Claimant was examined and treated by Christine Segala. Ms. Segala examined Claimant's right upper extremity and noted that there was a knot in the bicep area. Ms. Segala massaged the knot and applied Biofreeze cream. After the visit to medical, Claimant returned to work but essentially in a light duty capacity.

4. Claimant continued to treat with B's medical staff on February 17th and 18th. On February 18, 2009, Claimant saw Dr. Paul Smith who is a staff doctor at B's onsite medical facility. Dr. Smith essentially treated the injury as a bicep strain and provided conservative treatment. Claimant saw

Dr. Smith again on February 23rd and 24th. On February 24, 2009, Dr. Smith began to suspect Claimant needed an MRI of the shoulder and recommended that Claimant have this done through Claimant's private insurance carrier.

5. At this point, Claimant contacted his union steward, Kevin Thomson, in order to sort out the confusion about the nature of the February 16, 2009, injury. On February 25, 2009, subsequent to a meeting between Kevin Thomson, Claimant and B management, an accident report was created consistent with the above-stated facts.

6. B personnel referred Claimant to Dr. Suzanne Malis. Claimant was examined and treated by Dr. Malis on February 25, 2009. Claimant provided a report of the injury and his course of treatment to Dr. Malis. Dr. Malis asked Claimant is he had ever had any prior shoulder injures. Claimant informed Dr. Malis about the 2007 shoulder problem but indicated that it was short lived and long since resolved. Dr. Malis charted that Claimant had no significant prior shoulder injuries. Dr. Malis examined Claimant and provided a work related diagnosis of right shoulder impingement. Dr. Malis recommended physical therapy and medications. Claimant was put on temporary physical restrictions and referred for an MRI of the right shoulder.

7. Shortly after February 25, 2009, Claimant began working light duty for B in what essentially amounted to an office job. Although Claimant was told he would be reviewing plans and checking numbers he was never provided the materials he needed to perform these tasks. He was never brought any plans. Claimant was required simply sit in a job trailer 10 hours a day with nothing to do.

8. The MRI was performed on March 3, 2009 at Southwest

Diagnostic Centers. The MRI showed a "focal superficial articular sided partial tear at the supraspinatus footprint" and "mild acromioclavicular arthrosis."

9. Claimant returned to Dr. Malis on March 6, 2009. At that time, Dr. Malis reviewed the MRI and felt that it supported her initial diagnosis of work-related right shoulder impingement. Dr. Malis referred Claimant for a general consult with an orthopedic surgeon. Dr. Malis continued Claimant's temporary physical restrictions.

10. On March 10, 2009, Dr. Wiley Jinkins examined Claimant as part of a general orthopedic consult. Dr. Jinkins' assessment was "strain/sprain of the right shoulder with MRI evidence of partial thickness rotator cuff tear." Dr. Jinkins did not recommend surgery at that point, as Claimant's injury was fairly recent. Dr. Jinkins recommended conservative therapy, which he carried out.

11. On March 10, 2009, Respondents issued a Notice of Contest denying the claim and indicating that they wanted to investigate the matter further.

12. Claimant returned to see Dr. Jinkins on May 12, 2009. At that time, Dr. Jinkins noted no significant improvement and recommended an "arthroscopic subacromial decompression with rotator cuff repair." Dr. Jinkins requested preauthorization for the recommended surgical procedure but Respondents denied the request.

13. Claimant continued to work light duty until June 9, 2009. On that date Claimant was terminated because his cell phone rang during a meeting. Although Claimant did not answer his cell phone, B management considered this use of a cell phone and a violation of the Employee Handbook. According to the

termination slip issued by B, Claimant received a verbal warning on June 4, 2009, for excessive absenteeism, and written warning on June 8, 2009, for not wearing steel toed boots on the job site and the June 9, 2009, written warning for use of a cell phone outside of the change area.

14. The ALJ infers from the timing of events, and other credible evidence, such as a prior attempt to discipline Claimant for cell phone use when he did not have a cell phone in his possession, that the termination of Claimant was a subterfuge and that Claimant was not responsible for his termination.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

2. A claimant must show that the injury was sustained in the course of his employment and that the injury arose out of his employment. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical

condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. See H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990); see also Subsequent Injury Fund v. Thompson, 793 P.2d 579. A work-related injury is compensable if it "aggravates, accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. See H & H Warehouse v. Vicory, supra.

3. Whether there is a sufficient "nexus" or relationship between the Claimant's employment and his injury is one of fact for resolution by the ALJ based on the totality of the circumstances. In re Question Submitted by the United States Court of Appeals, 759 P.2d 17 (Colo. 1988). The question of whether a claimant has proven that a particular disease, or aggravation of a particular disease, was caused by a work-related hazard is one of fact for determination by the ALJ. Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office, 989 P.2d 251 (Colo.App. 1999).

4. Claimant has established, by a preponderance of the evidence, that Claimant suffered a compensable right upper extremity injury arising out of and in the course of his employment with Respondent-Employer on February 16, 2009.

5. Once a claimant has established a compensable work injury, the claimant is entitled to a general award of medical benefits and respondents are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. Section 8-42-101, C.R.S.; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988); Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo.App. 1990).

6. As found above, Claimant has established by a preponderance of the evidence that he suffered a compensable injury. As such, Claimant is entitled to a general award of any and all reasonable and necessary medical benefits.

7. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), supra, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. PDM Molding, Inc. v. Stanberg, supra. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. Culver v. Ace Electric, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. Lymburn v. Symbios Logic, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. Ortiz v. Charles J. Murphy & Co., 964 P.2d 595 (Colo.App. 1998).

8. Claimant established by a preponderance of the evidence that he is entitled to temporary total disability benefits for the February 16, 2009,

right shoulder injury from June 10, 2009 and ongoing.

9. In Gilmore v. Industrial Claim Appeals Office, 187 P.3d 1129, 1131 (Colo.App. 2008), the court stated:

The Workers' Compensation Act (Act) prohibits a claimant from receiving temporary disability benefits if the claimant is responsible for the termination of the employment relationship. “In cases where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury.” ßß 8-42-103(1)(g), 8-42-105(4), C.R.S.2007.

Under the termination statutes, sections 8-42-103(1)(g) and 8-42-105(4), an employer bears the burden of establishing by a preponderance of the evidence that a claimant was terminated for cause or was responsible for the separation from employment. Cf. City & County of Denver v. Indus. Claim Appeals Office, 58 P.3d 1162, 1164-65 (Colo.App.2002) (the employer bears the burden of establishing its entitlement to an overpayment); Cowin & Co. v. Medina, 860 P.2d 535, 538 (Colo.App.1992) (”[g]enerally, the party relying upon a statutory exception has the burden of establishing the factual predicate for its application”). The termination statutes cannot be applied to cease payment of TTD benefits unless and until the ALJ makes a factual determination that a claimant was responsible for the termination of employment. See Padilla, 902 P.2d at 416.

10. As found above, Respondents have failed to establish by a preponderance of the evidence that Claimant was terminated for cause.

ORDER

It is therefore ordered that:

1. Claimant suffered a compensable right shoulder injury on February 16, 2009 and is entitled to whatever benefits may accrue under the Workers' Compensation Act of Colorado (WCA).

2. Respondent-Insurer is responsible for payment of benefits to Claimant for his February 16, 2009 work-related injury.

3. Respondent-Insurer shall provide and pay for any and all reasonable, necessary and related medical benefits for Claimant's February 16, 2009, right shoulder injury.

4. Respondent-Insurer shall pay Claimant temporary total disability benefits for the February 16, 2009, right shoulder injury beginning June 10, 2009 and continuing until terminated pursuant to the WCA.

5. Respondents' defense that Claimant was terminated for cause is denied and dismissed.

6. The parties agreed to reserve the issue of average weekly wage and the issue is so reserved.

7. The parties stipulated that the authorized treating physician is Dr. Suzanne Malis and the Court so recognizes the stipulation.

8. Respondent-Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due..

9. All matters not determined herein are reserved for future determination.

DATE: November 2, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-744-496

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she injured her left shoulder during the course and scope of her employment with Employer on December 6, 2007.

2. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

FINDINGS OF FACT

1. Claimant worked as a nurse supervisor for Employer. On December 6, 2007 Assistant Chief of Nursing Operations Lavonne Walker asked Claimant to go to her office to remove a coat from a coat rack. Ms. Walker had been delayed in returning to her office from a dental appointment and did not want her expensive coat to remain in plain view through her window.

2. Claimant walked to Ms. Walker's office to move the coat. The coat rack was approximately six feet high with six hooks that curved inward. Claimant intended to move the coat to a hook on the back of a bathroom door located approximately two to three feet away from the coat rack. Ms. Walker's full-length leather coat weighed 4.6 pounds.

3. Claimant reached for the coat with her left arm because she had injured her right arm in a December 2005 motor vehicle accident. As Claimant

removed the coat from the rack, the weight of the coat caused Claimant's left arm to fall straight down. She then transferred the coat to her right arm and placed it on the hook on the back of the bathroom door.

4. Because Claimant began to experience pain on her left side she contacted private physician Deborah Saint-Phard, M.D. Dr. Saint-Phard had previously treated Claimant for her right arm symptoms. On December 11, 2007 Claimant visited Dr. Saint-Phard for an evaluation. She reported that she was experiencing neck pain and numbness in her left shoulder after lifting a coat that weighed approximately 50 pounds. Dr. Saint-Phard noted that Claimant was awaiting right shoulder surgery because of her December 2005 motor vehicle accident. She commented that Claimant did not exhibit any neurological deficits on examination and concluded that Claimant had a "known C6-7 disc bulge" with an exacerbation that was now affecting the left side.

5. On December 12, 2007 Claimant reported her left shoulder symptoms to Employer. On December 13, 2007 she visited Authorized Treating Physician (ATP) Cynthia Kuehn, M.D. at the Denver Health Medical Center. Claimant reported that she had lifted a coat weighing approximately 40-50 pounds from a coat rack. About 30 to 60 minutes later she felt a burning sensation in her left arm, shoulder and neck. Claimant also reported low back pain and episodes of incontinence.

6. Dr. Kuehn determined that Claimant's left-sided neck and upper extremity pain could be consistent with a cervical radiculitis. She expressed concerns about the cause of Claimant's left-sided symptoms. Dr. Kuehn remarked that the "issue of whether lifting overhead is sufficient to cause cervical spine pathology needs to be addressed." She commented that the Medical

Treatment Guidelines suggested "lifting overhead was not a common cause of cervical radicular pathology."

7. On December 20, 2007 Claimant underwent an MRI of her cervical spine. Claimant had previously undergone an MRI after her December 2005 motor vehicle accident. The MRI revealed "1. No change since 03/31/06 demonstrating central and right ventral lateral disc and bone at C6-7 narrowing mildly the right neural foramina. 2. No change in the bulging disc and neural foramina compromise at C5-6."

8. On December 21, 2007 Claimant returned to Denver Health Medical Center and visited Karen B. Mulloy, M.D. for an evaluation. Dr. Mulloy commented that it was important to have Claimant evaluated by a specialist to determine whether her symptoms were related to a prior motor vehicle accident or lifting the coat off the coat rack. She thus referred Claimant to Lawrence A. Lesnak, D.O. for a causality determination.

9. On January 8, 2008 Dr. Saint-Phard reviewed Claimant's MRI results. She agreed that there were no changes in Claimant's neck area between March 31, 2006 and December 20, 2007. Dr. Saint-Phard diagnosed left cervical radiculitis into the left shoulder.

10. Claimant has also received medical treatment for her shoulder conditions from John A. Reister, M.D. Claimant reported to Dr. Reister that she had suffered an injury to her left shoulder when she was trying to lift a heavy coat that weighed approximately 40 pounds. Dr. Reister noted that Claimant suffers from bilateral impingement syndrome. He stated that Claimant underwent surgery on her right shoulder but that the left shoulder requires surgical repair. Dr. Reister attributed Claimant's need for left shoulder surgery to the

December 6, 2007 incident.

11. Based on the referral from Dr. Malloy Claimant visited Dr. Lesnak for a causality determination on March 4, 2008. Dr. Lesnak remarked that Claimant's past medical history was significant for chronic depression. On physical examination, Dr. Lesnak noted decreased range of motion in Claimant's cervical spine. Left shoulder flexion was 170 degrees and abduction was 180 degrees. Claimant had full internal and external rotation of her left shoulder. The remainder of Claimant's shoulder examination was normal.

12. Dr. Lesnak issued a report and testified at the hearing in this matter. He explained that Claimant has suffered from chronic pain syndrome since December 2005. Claimant had been unable to utilize her right shoulder due to her pain and used her left shoulder for most upper extremity activities. Dr. Lesnak remarked that Claimant's cervical range of motion and left shoulder range of motion had essentially remained unchanged since September 2007. Furthermore, there had been no changes in Claimant's MRI findings. Dr. Lesnak thus concluded that, although Claimant experiences subjective pain, there have been no objective changes in Claimant's condition and no medical evidence of an injury "whatsoever" as a result of lifting a 4.6 pound coat off a rack. Lifting a 4.6-pound coat is not an activity that is likely to cause structural damage.

13. Dr. Lesnak explained that Claimant developed an overuse syndrome as a result of using her non-dominant hand for activities. The overuse syndrome probably caused Claimant's left neck symptoms. He commented that an overuse syndrome develops over time and could have been caused by any of Claimant's activities. Dr. Lesnak stated that shoulder impingement syndrome can be caused by overuse. However, objective tests and provocative maneuvers revealed that

Claimant did not suffer from impingement syndrome in her left shoulder.

14. Dr. Lesnak concluded that Claimant did not suffer an injury on December 6, 2007 but only experiences subjective pain. He explained that chronic depression plays a major role in Claimant's pain complaints. Dr. Lesnak commented that individuals who suffer from chronic pain have a propensity for developing new pain complaints without reason.

15. Claimant has failed to demonstrate that it is more probably true than not that she suffered a compensable left shoulder injury during the course and scope of her employment with Employer on December 6, 2007. Her employment activities on December 6, 2007 did not aggravate, accelerate, or combine with her pre-existing condition to produce a need for medical treatment. Claimant explained that she injured her left shoulder on December 6, 2007 while moving a 4.6-pound coat from a coat rack. Initially, a December 20, 2007 MRI of Claimant's cervical spine did not reveal any changes compared to a March 31, 2006 MRI taken after Claimant's motor vehicle accident. While providing treatment for Claimant's left shoulder pain, Dr. Kuehn expressed concerns about the cause of Claimant's left-sided symptoms and questioned whether lifting a coat overhead could cause cervical radicular pathology. Dr. Mulloy subsequently commented that it was important to have Claimant evaluated by a specialist to determine whether her symptoms were related to a prior motor vehicle accident or were caused by lifting the coat off the coat rack. She thus referred Claimant to Dr. Lesnak for a causality determination. Dr. Lesnak persuasively determined that, although Claimant experiences subjective pain, there have been no objective changes in Claimant's condition and no medical evidence of an injury "whatsoever" as a result of lifting a 4.6 pound coat off a rack. He emphasized

that lifting a 4.6-pound coat is not an activity that is likely to cause structural damage. He credibly explained that Claimant probably developed an overuse syndrome as a result of using her non-dominant hand for activities. Dr. Lesnak commented that an overuse syndrome develops over time and could have been caused by any of Claimant's activities. He remarked that chronic depression likely plays a major role in Claimant's pain complaints.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among

other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß8-41-301(1)(c) C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. Faulkner, 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. Duncan v. Industrial Claim Appeals Office, 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. In re Cotts, W.C. No. 4-606-563

(ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that she suffered a compensable left shoulder injury during the course and scope of her employment with Employer on December 6, 2007. Her employment activities on December 6, 2007 did not aggravate, accelerate, or combine with her pre-existing condition to produce a need for medical treatment. Claimant explained that she injured her left shoulder on December 6, 2007 while moving a 4.6-pound coat from a coat rack. Initially, a December 20, 2007 MRI of Claimant's cervical spine did not reveal any changes compared to a March 31, 2006 MRI taken after Claimant's motor vehicle accident. While providing treatment for Claimant's left shoulder pain, Dr. Kuehn expressed concerns about the cause of Claimant's left-sided symptoms and questioned whether lifting a coat overhead could cause cervical radicular pathology. Dr. Mulloy subsequently commented that it was important to have Claimant evaluated by a specialist to determine whether her symptoms were related to a prior motor vehicle accident or were caused by lifting the coat off the coat rack. She thus referred Claimant to Dr. Lesnak for a causality determination. Dr. Lesnak persuasively determined that, although Claimant experiences subjective pain, there have been no objective changes in Claimant's condition and no medical evidence of an injury "whatsoever" as a result of lifting a 4.6 pound coat off a rack. He emphasized that lifting a 4.6-pound coat is not an activity that is likely to cause structural damage. He credibly explained that Claimant probably developed an overuse syndrome as a result of using her non-dominant hand for activities. Dr. Lesnak commented that an overuse syndrome develops over time

and could have been caused by any of Claimant's activities. He remarked that chronic depression likely plays a major role in Claimant's pain complaints.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Workers' Compensation benefits is denied and dismissed.

DATED: November 2, 2009.

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Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-732-489

ISSUES

Whether Claimant is entitled to an award of whole-person permanent impairment for her admitted bilateral upper extremity injuries.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed as a manufacturing associate by Employer. Claimant's date of hire for full time employment was June 13, 1996. Claimant's job required her to work assembling, packaging and measuring plastic molded parts. Claimant's job physically required repetitive hand use, lifting, palletizing product and driving a forklift. Claimant was required to perform frequent gripping and grasping and fine dexterity movements with her hands for assembling and fixturing parts.

2. Claimant sustained an admitted injury as an occupational disease from inspecting and assembling parts with a date of injury of August 3, 2007.

3. Claimant was referred by Employer to Broadmoor Medical Clinic where she was evaluated by Physicians Assistant Denver Hager on August 3, 2007. Claimant complained on that date of right upper extremity arm and hand pain for approximately the last 2 years. Claimant denied any neck pain. Claimant complained of pain from her wrist radiating up the arm to the ulnar and radial aspects of the forearm. Physicians Assistant Hager diagnosed right upper extremity cumulative trauma disorder ("CTD").

4. Claimant was evaluated by Dr. John Ogrodnick, M.D. at Broadmoor Medical Clinic on August 22, 2007. Dr. Ogrodnick noted that Claimant had had pain radiating into the elbow, but that there had been no shoulder symptoms lately. Dr. Ogrodnick noted left-sided symptoms of numbness. Dr. Ogrodnick's assessment was bilateral upper extremity CTD.

5. Dr. Ogrodnick evaluated Claimant on December 12, 2007 noting that an injection into Claimant's right elbow had provided 70 ñ 80% improvement. Dr. Ogrodnick further noted that Claimant's neck pain had not returned for four days. Dr. Ogrodnick's assessment was right carpal tunnel syndrome and left cubital tunnel syndrome. Dr. Ogrodnick noted a complaint that Claimant felt as though a brick was sitting on the right side of her neck and shoulder that limited range of motion. Dr. Ogrodnick continued with the assessment of right carpal tunnel syndrome and left cubital tunnel syndrome.

6. Dr. Ogrodnick referred Claimant to Dr. Timothy Hart, M.D. Dr. Hart initially evaluated Claimant on March 12, 2008 and noted complaints of bilateral hand numbness and tingling with the right-sided symptoms being more severe than the left. Dr. Hart planned to proceed with a right carpal tunnel release. Dr. Hart performed right carpal tunnel release surgery on April 1, 2008.

7. Dr. Ogrodnick evaluated Claimant on May 12, 2008 and noted that Claimant reported the previous week that her right hand had swelled with pain from the wrist to the shoulder. Dr. Ogrodnick noted that the achiness, numbness and tingling in the right upper extremity had resolved above the forearm. On examination, Dr. Ogrodnick noted right greater than left trapezius tenderness. At a follow up visit on May 27, 2008 Dr. Ogrodnick noted that the right shoulder problems had resolved.

8. Dr. Hart performed left carpal tunnel release surgery on June 5, 2008. At a visit on June 12, 2008 Dr. Ogrodnick found on examination that Claimant did not have tenderness in the right shoulder and had full range of motion of the upper extremities.

9. Claimant returned to Dr. Hart for a post-operative visit on July 30, 2008. Dr. Hart noted that the left sided numbness and tingling had improved substantially from preoperatively. Claimant complained to Dr. Hart of a year's worth of pain in the left anterior upper arm, anterior shoulder and chest area. Dr. Hart did not have an explanation for this pain and noted it was in a nondermatomal distribution. Dr. Hart opined that this pain was not related to Claimant's carpal tunnel or carpal tunnel surgery.

10. Dr. Ogrodnick evaluated Claimant on August 27, 2008. Dr. Ogrodnick noted that Claimant had shooting pain from the palm and over the volar wrist into the distal forearms, bilaterally. Claimant also had daily lateral elbow pain. On examination, Dr. Ogordnick found tenderness over the left lateral and medial epicondyles. Dr. Ogrodnick placed Claimant at maximum medical improvement and assigned 19% impairment for each upper extremity.

11. Claimant was evaluated by neurologist Dr. Bruce Peters, M.D. on September 3, 2008 for complaints of bilateral leg pain. Dr. Peters noted complaints of pain going from the ankles to the shin that were bilateral and equal. Dr. Peters performed electro-diagnostic testing that was found to be abnormal and suggested a S-1 radiculopathy. On physical examination Dr. Peters found Claimant's neck to be supple and with normal range of motion. Dr. Peters ordered an MRI of the lumbosacral spine.

12. Dr. Peters again evaluated Claimant on October 21, 2008 following the MRI. Dr. Peters now strongly doubted his prior diagnosis of S-1 radiculopathy. Dr. Peters noted complaints of pain in Claimant's feet going up into her legs and also in her arms. Dr. Peters noted symptoms of leg cramps, stiffness of muscles or joints, severe pain in Claimant's arms and/or legs,

painful feet and neck pain. Dr. Peters further noted Claimant's complaints of shooting pain from her hand and palm up to the shoulder and neck. Dr. Peters found pain behavior and giveaway weakness consistent with fibromyalgia. Dr. Peters stated that Dr. Ogrodnick had been treating the arms and hands and did not find weakness or numbness in these areas to explain Claimant's continued symptoms. Dr. Peters felt the symptoms raised an issue of fibromyalgia.

13. Dr. Ogrodnick evaluated Claimant on October 21, 2008 and noted a complaint that Claimant felt like her upper back was "smashed with a hammer". On physical examination Dr. Ogrodnick found diffuse tenderness including the feet through the shins, calves and thighs bilaterally. Dr. Ogrodnick's assessment was fibromyalgia.

14. Dr. Timothy Hall, M.D. performed a DIME of Claimant on April 6, 2009. Dr. Hall noted complaints of bilateral upper extremity symptoms with symptoms into the shoulders and left anterior chest wall with diffuse symptoms through the upper extremities. Claimant's primary problems were in the hand and finger, particularly the dorsum of the hand. Dr. Hall stated that he had minimal notes to review but did note the prior diagnosis of overuse syndrome with diagnoses of bilateral carpal tunnel syndrome and medial and lateral epicondylitis.

15. Dr. Hall's impression was cumulative trauma disorder bilateral upper extremities, including bicipital tendonitis at the shoulders. Dr. Hall used the cumulative trauma disorder guide to provide Claimant with impairment ratings of 30% of the upper extremity bilaterally. Dr. Hall did not express an opinion on whether Claimant had sustained any functional impairment above the level of the arm at the shoulder. Dr. Hall converted Claimant's

bilateral upper extremity impairments under the AMA Guides to 33% whole person impairment. Dr. Hall agreed that Claimant reached maximum medical improvement on August 27, 2008 as found by Dr. Ogrodnick.

16. Dr. Ogrodnick testified that Claimant's symptoms that were causally related to her compensable injury were below the level of the arm at the shoulder. Dr. Ogrodnick further opined in his testimony that the diagnosis of fibromyalgia was not causally related to Claimant's work injury as it is an idiopathic disease. Dr. Ogrodnick testified that Claimant's symptoms above the level of the arm were more likely related to fibromyalgia that was not caused by Claimant's carpal tunnel or cubital tunnel syndromes.

17. Dr. Ogrodnick's testimony that Claimant's symptoms above the level of the arm are related to fibromyalgia and are not causally related to Claimant's compensable injury is found to be credible, persuasive and is found as fact. Dr. Ogrodnick's opinion in this regard is supported by the opinions of Dr. Peters and Dr. Hart that are also found to be credible and persuasive.

18. Claimant has failed to prove by a preponderance of the evidence that she has sustained a functional impairment above the level of the arm at the shoulder that is causally related to her admitted compensable injury. The situs of Claimant's functional impairments of her bilaterial upper extremities is below the level of the arm at the shoulder.

19. Insurer filed a Final Admission of Liability on June 19, 2009 admitting for the 30% upper extremity impairments of the Claimant's right and left upper extremities as assessed by Dr. Hall.

CONCLUSIONS OF LAW

20. The purpose of the Workers' Compensation Act of Colorado (Act),

ßß8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

21. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

22. Section 8-42-107(1)(a), C.R.S. limits a claimant to a scheduled disability award if the claimant suffers an "injury or injuries" described in ß 8-42-107(2), C.R.S. 2004. Strauch v. PSL Swedish Healthcare System, 917 P.2d 366 (Colo. App. 1996). The term "injury," as used in ß 8-42-107(1)(a), refers to the situs of the functional impairment, meaning the part of the body that sustained the ultimate loss, and not necessarily the situs of the injury itself. Walker v. Jim Fuoco Motor Co., 942 P.2d 1390 (Colo. App. 1997). The term “injury” refers

to the manifestation in a part or parts of the body that have been functionally impaired or disabled as a result of the industrial accident. Warthen v. Indus. Claim Appeals Office, 100 P.3d 581 (Colo. App. 2004). It is not the location of physical injury or the medical explanation for the “ultimate loss” which determines the issue. Blei v. Tuscorora, W.C. No. 4-588-628 (June 17, 2005)

23. Whether a claimant has suffered an impairment that can be fully compensated under the schedule of disabilities is a factual question for the ALJ, whose determination must be upheld if it is supported by substantial evidence. Walker v. Jim Fuoco Motor Co.,supra. That determination is distinct from, and should not be confused with, the treating physician's rating of physical impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (rev. 3d ed.) (AMA Guides). Strauch v. PSL Swedish Healthcare System, supra; see also City Market, Inc. v. Indus. Claim Appeals Office, 68 P.3d 601, 603 (Colo. App. 2003)("The determination whether a claimant sustained a scheduled or nonscheduled injury is a question of fact or the ALJ, not the rating physician."). Kolar v. ICAO, 122 P.3d 1075 (Colo. App. 2005).

24. The initial question of whether the Claimant has sustained a scheduled injury is one of fact for determination by the ALJ. Although opinions and findings of a DIME physician may be relevant to this determination a DIME physician’s opinion is not mandated by the statute nor is the ALJ required to afford it any special weight. Delaney v. Indus. Claim Appeals Office, 30 P.3d 691 (Colo. App. 2000). It is only after the ALJ determines the Claimant sustained a whole person impairment that the DIME physician’s rating becomes

entitled to presumptive effect under Section 8-42-107(8)(c), C.R.S., See, Egan v. Indus. Claim Appeals Office, 971 P.2d 664 (Colo. App. 1998).

25. As found, Claimant has failed to prove by a preponderance of the evidence that she has sustained functional impairment above the level of the arms at the shoulders as a result of her compensable injury. While it is true that Claimant did complain at various times of upper arm or neck symptoms to Dr. Ogrodnick, those symptoms were transitory in nature and later resolved. As opined by Dr. Ogrodnick, Dr. Peters and Dr. Hart, Claimant's more recent symptoms of pain into her neck, upper back and chest are more likely related to a diagnosis of fibromyalgia and are unrelated to Claimant's injury. Dr. Hall, the DIME physician, converted Claimant's impairment rating to a whole person under the AMA Guides. However, Dr. Hall did not express an opinion on whether Claimant had sustained any functional impairment above the level of the arm at the shoulder and Dr. Hall's conversion to whole person impairment under the AMA Guides is not dispositive of the issue. Neither is the fact that Claimant has bilateral upper extremity impairments. See, Kolar, supra. Thus, Dr. Hall's report and opinions fail to support Claimant's claim for whole person impairment. Dr. Ogrodnick credibly opined that Claimant's symptoms related to the compensable injury were below the level of Claimant's arms at the shoulders. Dr. Ogrodnick's opinion is credible, persuasive and supports a finding that Claimant has not sustained functional impairment above the level of the arm at the shoulder as a result of her compensable injury.

ORDER

It is therefore ordered that:

Claimant's claim for conversion to whole person impairment is denied

and dismissed. Respondents' admission for 30% scheduled impairment of the bilateral upper extremities is adopted as the Order and award of the Court.

All matters not determined herein are reserved for future determination.

DATED: November 3, 2009

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Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-334-401

ISSUES

ÿ Did the claimant prove by a preponderance of the evidence that arthroscopic wrist surgery constitutes reasonable and necessary medical treatment to relieve her symptoms or prevent deterioration of her condition?

ÿ Does the evidence establish that the need for surgery is causally related to the industrial injury?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following

findings of fact:

1. The claimant sustained a compensable injury to her right wrist on February 9, 2006. The injury resulted in scapholunate and lunotriquetral ligament tears.

2. As a result of the injury the claimant underwent several invasive procedures. These included fluoroscopic examinations of the wrist performed by Dr. Thomas Arganese, M.D., in May 1996 and October 1997. On August 27, 1998, Dr. Arganese performed a wrist arthroscopy with debridement. This procedure was terminated because the scapholunate ligament tear was greater than expected. However, Dr. Arganese noted that the triangular fibrocartilage complex (TFC) was intact. On October 26, 1998, Dr. Arganese performed a limited wrist arthrodesis or four-corner fusion.

3. On February 10, 2000, Dr. David Conyers, M.D. examined the claimant and reviewed x-rays. Dr. Conyers recommended excision of the distal pole of the scaphoid bone because it appeared to him that this bone abutted the styloid on radial deviation. Dr. Conyers opined that this would provide the claimant some relief of the ongoing symptoms at the radial side of the wrist

4. On March 31, 2000, Dr. Arganese authored a letter expressing disagreement with the surgery recommended by Dr. Conyers. Dr. Arganese stated that he had excised the distal pole of the scaphoid and there would not be any benefit to performing the procedure proposed by Dr. Conyers.

5. In 2000 Dr. Thomas Mordick, M.D., took over the claimant's care following the death of Dr. Arganese. In August 2000 Dr. Mordick noted there was a small residual fragment of the scaphoid present, but opined this was

normal and not the cause of the claimant's ongoing symptoms. In December 2000 Dr. Mordick opined the best option for the claimant was to undergo a fusion of the wrist, noting that multiple procedures had only perpetuated her symptoms. Dr. Mordick referred the claimant to Dr. Donald Ferlic, M.D., for a second opinion.

6. On January 31, 2001, Dr. Ferlic examined the claimant. The claimant exhibited radial and ulnar wrist pain. Dr. Ferlic's impression was "multifactorial wrist pain." He opined that removing the scaphoid remnant would not do any good and recommended putting the claimant in a cast to see if that would help.

7. Ultimately the claimant declined to undergo the wrist fusion proposed by Dr. Mordick and he placed her at MMI in July 2001. In a report dated August 20, 2001, Dr. Linda Mitchell, M.D., another of the claimant's treating physicians, agreed with Dr. Mordick that the claimant was at MMI.

8. Nevertheless, the claimant expressed her desire to undergo the surgical procedure still being recommended by Dr. Conyers.

9. In September 2001 Dr. Lawrence Lesnak, M.D., performed an IME. Dr. Lesnak examined the claimant and reviewed medical records. Dr. Lesnak agreed the claimant was at MMI and recommended against any further surgical intervention, stating that the "chance of her experiencing any functional or symptomatic improvement from any further intervention is minimal."

10. In September 2002, Dr. Howard J. Entin, M.D., performed a psychiatric independent medical examination (IME). Dr. Entin interviewed the claimant, reviewed the claimant's medical records, and reviewed a videotape of the claimant performing various activities. In a report dated September 20,

2002, Dr. Entin opined the majority of the claimant's problems result from "premorbid characterologic issues," and that the videotape evidences someone who has no obvious limitations. In a follow-up report dated October 1, 2002, Dr. Entin opined the claimant exhibits symptom magnification and is not a good candidate for surgery from a psychological perspective. Dr. Entin "cautioned" prospective surgeons that they should "only treat objective pathology and not [the claimant's] subjective complaints."

11. Ultimately, the matter proceeded to hearing before an ALJ concerning whether or not the procedure proposed by Dr. Conyers constituted reasonable and necessary medical treatment. At the hearing Dr. Mordick expressed the view that no further surgical treatment was likely to benefit the claimant, but if a further surgery was performed it should be a fusion. However, the ALJ ruled that the procedure proposed by Dr. Conyers was reasonable and necessary.

12. On February 4, 2003, Dr. Conyers performed a surgery described as a distal scaphoid excision, radial styloidectomy, pisiform excision, and TFC repair. The indications for the surgery were described as persistent radial and ulnar-sided wrist pain.

13. Dr. Conyers examined the claimant on February 25, 2004, more than a year after the surgery. The claimant still reported significant complaints of ulnar and radial-sided wrist pain. Dr. Conyers discharged the claimant and returned her to the regular treating physician, Dr. Mitchell, for further follow-up. Dr. Conyers stated, "There are no further surgical indications," but stated he would see the claimant again if Dr. Mitchell believed that further surgical evaluation was appropriate.

14. Dr. Mitchell placed the claimant at MMI on March 31, 2004. At that time Dr. Mitchell assessed chronic right wrist pain, a major depressive disorder, a pain disorder associated with psychological factors and medical condition, and opiate dependency. The claimant reported that she was improved, but still had pain in the radial and ulnar aspects of the wrist, and a "painful pop in the ulnar aspect of the wrist." Dr. Mitchell recommended maintenance care consisting of a home exercise program, and medications including Vicodin.

15. On May 4, 2004, the respondents filed a Final Admission of Liability admitting for ongoing medical benefits after MMI in accordance with Dr. Mitchell's report.

16. After MMI Dr. Mitchell frequently saw the claimant to provide maintenance treatment. The claimant continued to report wrist pain to Dr. Mitchell and she continued to prescribe medications including Vicodin.

17. On January 12, 2006, Dr. Mitchell recorded, "she has been working as a sales associate and cashier at Target, exceeding her restrictions, and having increased pain in the dorsum of the wrist." On March 2, 2006, Dr. Mitchell recorded, "she is working at Target three days a week and has been doing inventory lately. She has had increased discomfort in her wrist, along the ulnar aspect with extension." On April 3, 2006, Dr. Mitchell recorded, "she reports worsening numbness on the dorsum of the right thumb, and twitching of the thenar eminence musculature since our last visit." On this date, Dr. Mitchell recommended securing EMG studies. On June 22, 2006, Dr. Mitchell noted, "she states that her wrist pain is the same with increased aching depending upon how much she does at work."

18. On June 26, 2006, Dr. Kavi Sachar, M.D., examined the claimant

on referral from Dr. Mitchell. Dr. Sachar is a partner of Dr. Mordick. The claimant reported residual radial-sided pain with numbness along the dorsal aspect, and shooting pain on the ulnar side of the wrist. Dr. Sachar diagnosed right wrist pain with radial sensory nerve irritation. He recommended an EMG to study the radial nerve but doubted the need for further surgery. Dr. Sachar could not explain the ulnar-sided pain or the persistent deep radial pain.

19. An EMG was completed on September 29, 2006. It was reported as demonstrating right radial sensory neuropathy at the wrist, but no other abnormalities.

20. In March 2007 the claimant told Dr. Mitchell that she had been under "a lot of stress lately and that the wrist has been aching more."

21. On July 26, 2007, Dr. Mitchell examined the claimant. The claimant reported that she was experiencing increased wrist pain, predominantly on the ulnar side, but also quite diffusely. The claimant had exhausted her monthly supply of medication. Dr. Mitchell referred the claimant back to Dr. Conyers for an evaluation because she was concerned about the claimant's use of narcotics.

22. In August 2007 the claimant returned to Dr. Conyers on referral from Dr. Mitchell. The claimant reported that her ulnar sided wrist pain had recently increased because she was doing data entry. Dr. Conyers recommended an MR arthrogram to check for TFC pathology.

23. On March 12, 2008, Dr. Conyers reported the arthrogram was negative for TFC pathology. However, he noted the claimant showed "well localized tenderness over the ulnar snuffbox." Dr. Conyers stated that he was "still convinced, based on the examination that [the claimant] has a triangular

fibrocartilage injury." Dr. Conyers recommended arthroscopic evaluation of the ulnar aspect of the wrist.

24. On November 30, 2008, Dr. Conyers wrote a letter in which he stated that in March 2008 the claimant had such "well localized tenderness over the ulnar aspect of the wrist" that he recommended surgery to diagnose and treat the problem. Dr. Conyers wrote that MRI results are "unfortunately inaccurate in diagnosing trying her cartilage [sic] in 20% of cases."

25. Dr. Mordick again examined the claimant after Dr. Conyers authored the letter dated November 30, 2008. The results of the examination and Dr. Mordick's opinions are recorded in his report dated January 16, 2009. The claimant advised Dr. Mordick that her primary area of pain was increased numbness in the thumb and that this was more of an issue than the popping in the ulnar aspect of her wrist. Upon examination, Dr. Mordick found the maximal area of discomfort was not over the TFC, but over the pisiform incision site. He noted the claimant advised him that this has been extremely painful since the last surgery. Dr. Mordick reviewed the most recent MR arthrogram of November 29, 2007, and opined that it revealed "no objective pathology of the extensor tendons." Dr. Mordick noted that the clicking in the ulnar aspect of the wrist was documented in 2001, and had not abated despite the surgery (including TFC repair) performed by Dr. Conyers in 2003. Dr. Mordick stated he could see no reason that, "re-exploration of the triangular fibrocartilage with a normal MRI and arthrogram, or any other procedure, would have any reasonable chance for improvement of her symptoms."

26. On May 4, 2009, Dr. Mitchell saw the claimant for a "maintenance visit." Dr. Mitchell noted the claimant was tender along the site of the

pisiform excision and ulnar aspect of the wrist. However. Dr. Mitchell stated that, “her wrist is nontender to palpation when she is distracted.”

27. Dr. Mordick testified at the hearing on August 28, 2009. Dr. Mordick has performed over 600 hand surgeries per year since 1991. Consistent with his report of January 16, 2009, Dr. Mordick opined that he does not believe the claimant will benefit from the procedure suggested by Dr. Conyers. Dr. Mordick based his opinion on several factors. Dr. Mordick noted the claimant has experienced 13 years of wrist pain and five operations with no significant improvement in her symptoms. This includes the 2003 surgery performed by Dr. Conyers during which he reportedly repaired the TFC. Further, Dr. Mordick noted that the most recent MRI does not show any TFC pathology, and stated that in his experience MRI studies are 95 to 97 percent diagnostic for TFC tears. Dr. Mordick also noted that in 2002 Dr. Entin concluded there were psychological issues involved in the claimant’s pain and that he recommended against further operative procedures in the absence of clear pathology because of the claimant’s tendency to magnify her symptoms. Dr. Mordick also relied on the fact that in May 2009 Dr. Mitchell stated the claimant did not appear to experience tenderness when her wrist was palpated while distracted.

28. A preponderance of the credible and persuasive evidence establishes that the exploration of the wrist proposed by Dr. Conyers does not constitute medical treatment that is reasonably necessary to relieve the claimant’s symptoms or prevent deterioration of her medical condition. The ALJ finds that the Dr. Mordick’s report of January 16, 2009, and his testimony at the hearing are credible and persuasive. Specifically, Dr. Mordick persuasively opined that the procedure proposed by Dr. Conyers is unlikely to benefit the

claimant in light of the 2008 MR arthrogram because the arthrogram does not show any TFC tear. The ALJ concludes the arthrogram is objective evidence that there is no tear, and that Dr. Mordick credibly testified that such studies are highly reliable in diagnosing tears. Dr. Mordick also credibly opined that the performance of another procedure is unlikely to affect the claimant's symptoms considering that she has previously undergone numerous surgical procedures (including a TFC repair performed by Dr. Conyers in 2003) that have not significantly improved her symptoms. Finally, the ALJ is persuaded that the claimant's symptoms are to some degree the result of psychiatric features and are not, as predicted by Dr. Mordick and Dr. Entin, likely to be improved by surgery unless there is clear pathology. Dr. Mordick has persuasively established that there is no clear pathology as shown by the negative MR arthrogram results, the fact that the claimant's ulnar symptoms have not abated despite being present since 2001, and the fact that the claimant does not report symptoms when her wrist is palpated during distraction.

29. The ALJ is not persuaded by the opinion of Dr. Conyers that another procedure to explore the wrist and the TFC is needed to assess the claimant's condition and provide treatment. First, the ALJ is not persuaded that the MRI results are as unreliable in predicting the presence of a TFC tear as Dr. Conyers states. In any event, even Dr. Conyers admits that such tests are at least 80% reliable in identifying the presence or absence of TFC tears. Second, the ALJ is not persuaded that the claimant's clinical picture is as definitive and supportive of the need for surgery as Dr. Conyers states. Although Dr. Conyers reported the claimant's symptoms were "well localized" over the ulnar aspect of the wrist, ALJ is persuaded that in January 2009 Dr. Mordick

found the claimant's pain was mostly associated with the pisiform incision site rather than the TFC, and that many of her ulnar symptoms have been present since 2001. Third, Dr. Conyers does not credibly explain why he believes another surgery would improve the claimant's symptoms when the 2003 surgery, including the TFC repair, has not resulted in any lasting relief.

30. Evidence and inferences contrary to or inconsistent with these findings are not credible and persuasive.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the

testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

REASONABLENESS AND NECESSITY OF PROPOSED SURGERY

The claimant contends that she proved by a preponderance of the evidence that the surgery proposed by Dr. Conyers constitutes reasonable and necessary medical treatment "to maintain her condition after reaching MMI." The respondents dispute this assertion and argue that, in any event, the evidence proves any need for surgery is not causally related to the industrial injury. The ALJ concludes the evidence establishes that the proposed surgery is not reasonable and necessary to relieve the effects of the injury, or to prevent deterioration of the claimant's condition.

The respondents are liable to provide such medical treatment "as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee of the effects of the injury." Section 8-42-101(1)(a), C.R.S. Colorado courts have ruled that the need for medical treatment may extend beyond the point of MMI where the claimant presents substantial evidence that future medical treatment will be

reasonably necessary to relieve the effects of the injury or prevent further deterioration of her condition. Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988); Stollmeyer v. Industrial Claim Appeals Office, 916 P.2d 609 (Colo. App. 1995).

In cases where the respondents file a final admission of liability admitting for ongoing medical benefits after MMI they retain the right to challenge the compensability, reasonableness, and necessity of specific treatments. Hanna v. Print Expediters Inc., 77 P.3d 863 (Colo. App. 2003). When the respondents challenge the claimant's request for specific medical treatment the claimant bears the burden of proof to establish entitlement to the benefits. Ford v. Regional Transportation District, W.C. No. 4-309-217 (ICAO February 12, 2009). The question of whether the claimant proved that specific treatment is reasonable and necessary to maintain her condition after MMI or relieve ongoing symptoms is one of fact for the ALJ. See Kroupa v. Industrial Claim Appeals Office, 53 P.3d 1192 (Colo. App. 2002).

The ALJ concludes that a preponderance of the evidence establishes the surgery proposed by Dr. Conyers is not reasonable and necessary because it will not relieve the claimant's symptoms or prevent deterioration of her condition. As determined in Findings of Fact 28 and 29, the ALJ credits and is persuaded by the opinions of Dr. Mordick. Dr. Mordick has persuasively explained that the proposed surgery is not supported by the MRI findings, is unlikely to benefit the claimant in light of her history of numerous surgical procedures producing only limited relief, and the claimant's psychological propensity to magnify her symptoms. For the reasons stated in Finding of Fact 29, the ALJ is not persuaded by the contrary opinions expressed by Dr. Conyers.

Because the ALJ has determined that the proposed surgery is not reasonable and necessary to relieve the claimant's symptoms or prevent deterioration of her condition the ALJ need not consider the respondents' argument that the evidence does not establish that the need for surgery is causally related to the industrial injury.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The claimant's request for medical benefits in the form of surgery recommended by Dr. Conyers is denied and dismissed.

2. Issues not resolved by this order are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final.

DATED: November 3, 2009

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David P. Cain

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-788-336

ISSUES

∑ Whether Claimant sustained a compensable injury or occupational disease;

∑ Whether Claimant is entitled to medical treatment for the injury or occupational disease; and

∑ whether Claimant is entitled to temporary total disability (TTD) from March 13, 2009, and ongoing.

∑ The parties stipulated that Claimant's average weekly wage is $876.

FINDINGS OF FACT

1. Claimant has worked for Employer as a master carpenter since July 1979.

2. The first time Claimant injured his back on the job was on March 22, 1989. He was placed at maximum medical improvement (MMI) on March 15, 1990, without impairment. During the course of treatment for this injury, Dr. Arnold opined that Claimant would likely need periodic treatment for recurring symptoms once or twice per year indefinitely. A Final Admission of Liability was filed on October 24, 1990.

3. Prior to his work-related back injury in 1989, Claimant had sought treatment for low back pain complaints. One physician told Claimant that he would have to live with these problems for the rest of his life.

4. On November 29, 1990, an MRI taken of Claimant's low back revealed degenerative disc changes at L4-5 with bulging disc material encroaching the neural foramina as well as degenerative change with mild disc bulging at L5-S1.

5. Claimant sustained a second work-related back injury on August 30, 1991. Dr. Tashof Bernton performed a functional capacity examination on November 22, 1991, which resulted in the following restrictions: no lifting over 30 pounds on an occasional basis and no lifting over 19 pounds on a frequent basis in addition to no continuous lifting, twisting or bending regardless of weight. Dr. Bernton also restricted Claimant from repetitive ladder or stair climbing. At that time Dr. Bernton assigned a seven percent whole person impairment rating.

6. Dr. Bernton saw Claimant again for a functional capacity evaluation and impairment rating on August 4, 1992. Dr. Bernton's new restrictions were: no lifting over 30 pounds to shoulder level or above on an occasional basis; maximum lifting of 21 pounds on a frequent basis; no more than 20 minutes at a time of frequent or continuous lifting, twisting or bending, regardless of weight and no more than a total of three hours in an eight-hour

day. There was no limit for sitting, standing, or walking as long as Claimant has the opportunity for hourly position changes. Claimant may do occasional stair climbing, but no frequent or continuous stair climbing and no ladder climbing.

7. The third injury occurred on September 20, 1994. Claimant was placed at MMI by Dr. Scott Primack on June 12, 1995, and assigned a whole person impairment of 11 percent (4 percent new impairment) for that injury. Dr. Primack also opined that Claimant's permanent restrictions were 30 hours per week, no ascending/descending greater than six feet, be careful about placing self in dangerous positions, 25 pound occasional lift and 15 pound frequent lift.

8. On or about September 26, 1994, Dr. Jeffery Rumph opined that Claimant should never be expected to work full duty and that he should have periodic symptoms and problems.

9. On April 24, 1995, Claimant returned to Dr. Arnold after sudden onset of increased pain in his buttocks and thighs. On May 1, 1995, Claimant returned to Dr. Arnold for follow-up at which time Dr. Arnold opined that Claimant should expect exacerbations to keep recurring no matter what he does.

10. Claimant's fourth date of injury while employed as a master carpenter occurred on September 14, 1996. He was placed at MMI in

February 1998 and assigned an additional 3 percent whole person impairment. There was no mention of any change to Claimant's permanent work restrictions.

11. Claimant saw Dr. James Gebhard on November 15, 1996, and reported low back pain complaints aggravated by walking. Dr. Gebhard opined that Claimant had developed a chronic pain syndrome and recommended a back reconditioning program. Claimant returned to Dr. Gebhard on December 23, 1996, with reports of improvement in his symptoms. Claimant had also returned to work.

12. On September 15, 1997, Claimant sought treatment after developing spasms with pain radiating into his left hip. Claimant received a prescription for physical therapy. Claimant returned for follow-up on September 30, 1997.

13. Between September 30, 1997, and August 2007, Claimant continued to work in the position of master carpenter and was not given specific modified duty by Employer. For the most part, Claimant was able to complete the full duties of his position. If he needed help to complete a particular project he would request it. Sometimes he would receive help and other times he had to complete the project on his own.

14. Claimant saw his physician for back pain only three times between September 30, 1997, and January 2009. Specifically, Claimant went to Dr. Arnold at the 7 Mile Clinic on May 14, 2003, January 23, 2006, and May

31, 2006.

15. Claimant's job duties as a master carpenter included maintenance of the buildings at the ski resort, such as base village maintenance, restaurants, lift shacks and other buildings on the mountain. He performed all phases of carpentry, cabinet making, framing, stone work, block work, installation and repair of doors and windows and maintenance of the carpentry equipment.

16. Claimant testified that the doors on which he worked were commercial doors weighing anywhere from 50 pounds to 300 pounds. Additionally maintenance of the carpentry equipment required moving shop saws, the older models of which weighed 50 pounds and over. He frequently carried ladders weighing over 25 pounds and sometimes carried materials that weighed more than 25 pounds.

17. In August 2007, Claimant developed back pain after performing work duties outside of his physical restrictions. Claimant took Tylenol, applied ice packs, and rested it on his days off. He did not seek medical attention at that time.

18. Claimant was fine for another 14 months until November 2008 when he performed two projects that required him to work outside of his restrictions. He experienced increased tightness in his back. He also had more burning in his low back than in his legs and increased numbness in his

legs, but did not seek medical attention.

19. In January 2009, Claimant was given a work order to install new closet doors at the administration building. This job required three different dates of working on the doors to ensure proper installation. Claimant does not remember the exact dates, but the first date he worked on the doors was prior to his January 13, 2009, office visit with Hannah Foley, F.N.P.C, at Timberline Family Practice. He believes the next two dates he worked on the doors were over the subsequent weeks in January 2009.

20. In order to install the doors, Claimant had to replace two sets of closet doors, one in a six foot opening and one in an eight foot opening. The doors weighed 20-25 pounds each. Because the building was so old and out of square, he ended up lifting the doors numerous times to check the fit. In order to level the doors, Claimant had to get down on his knees and had to lie on the floor to adjust them. After this job, Claimant experienced numbness in legs unlike the numbness he had experienced in the past. Claimant's back pain and leg pain was also more severe. Moreover, the pain began to run down the sides of both of legs, and down to the balls of his feet. He found it hard to walk, dress himself, sit or stand for any length of time and he had to elevate his legs while sitting. Claimant also felt a significant increase in the burning and sharp pain in his low back and legs. At this time he sought medical attention because he felt he could not continue without seeking medical help.

21. Ms. Foley's note dated January 13, 2009, references the exacerbation to Claimant's low back pain which she attributed to Claimant's work duties although Claimant did not report a traumatic event. Ms. Foley imposed restrictions of no lifting or carrying greater than 10 pounds, no sitting greater than one hour at a time, avoid activities that increase pain, and referred Claimant to Dr. Phil Engen for pain management. When Claimant returned to work he provided the restrictions to his supervisor and reported his injury to his Employer. The supervisor in Human Resources/Risk Management indicated to Claimant that his case was open. Claimant subsequently received a Notice of Contest indicating an injury date of January 23, 2009.

22. Claimant was subsequently instructed to report to an onsite restaurant to repair a water damaged ceiling. There were approximately six areas that required repair work. Claimant first needed to scrape, tape, and repair some areas with a battery operated cordless drill. He climbed a six foot ladder carrying the tape, mud, screws, and a cordless drill (weighing about six pounds) 10-15 times within a two hour time span. When this job was finished on February 4, his lower back and upper neck were painful.

23. Although Claimant was able to complete this job over four different time periods, he was under pressure each day to get in at 10:00 a.m. after breakfast, move tables, work on the ceiling and clean up prior to 12:00 p.m. when lunch would be served. He had to move several tables that weighed about 30 pounds each, as well as carrying a six foot ladder. Claimant stated that although he had help for this job it was still necessary for him to

work outside of his restrictions in order to get the work done and meet the daily time requirements imposed by his supervisor.

24. Claimant attended weekly safety meetings. Sometimes the subject of those safety meetings centered on an employee's need to ask for help when necessary. Claimant was given help approximately 60% of the time he asked, however, there were a significant number of occasions where Employer was short handed and could not provide him with help. Claimant noted that after 1998, for the most part, he could handle the flare ups in his back from the increased workload. However, through the end of 2008 and into the beginning of 2009, the work assignments significantly caused a significant increase in pain.

25. Claimant returned to Ms. Foley on March 17, 2009, at which time she removed him from work completely for two weeks. On March 31, 2009, Ms. Foley continued to keep Claimant off work indefinitely. As of the date of hearing, Claimant had not returned to work.

26. Claimant received short term disability from March 13, 2009 through September 5, 2009.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any

litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

4. A claimant must prove by a preponderance of the evidence that his injury arose out of the course and scope of his employment with employer. Section

8-41-301(1)(b), C.R.S.; see City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985). An injury occurs "in the course of" employment where claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. See Triad Painting Co. v. Blair, 812 P.2d 638 (Colo. 1991). The "arise out of " requirement is narrower and requires claimant to show a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. See Id.

5. A preexisting condition does not disqualify a claimant from receiving workers' compensation benefits. Rather, where the industrial injury aggravates, accelerates, or combines with a preexisting disease or infirmity to produce the need for treatment, the treatment is a compensable consequence of the industrial injury. H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App.1990). Resolution of that issue is one of fact for the ALJ. F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985).

6. Claimant has established that he sustained a compensable injury, specifically an exacerbation of his pre-existing low back condition, in January 2009 while replacing closet doors for the Employer. This incident combined with Claimant’s pre-existing conditions to produce the need for treatment. While it is true that Claimant had a significant history of pre-existing low back injuries, Claimant credibly testified that following completion of the closet door installation in January 2009, the low back pain and other symptoms were

worse than ever before and necessitated treatment. Claimant's testimony is supported by the medical records which reflect that he sought medical attention for his low back pain only three times between September 1997 and January 2009.

Moreover, Hannah Foley noted that Claimant had a work-related diagnosis of low back pain with radiculopathy throughout the medical records. Ms. Foley also specifically noted that Claimant was suffering an exacerbation of his pre-existing back injuries, which she attributed to Claimant's work activities. In addition, Claimant's testimony that he experienced increased pain in his low back following installation of the doors is credible and persuasive. There was no credible or persuasive evidence that Claimant's increase in low back pain was merely a natural progression of his pre-existing condition rather than an exacerbation brought on by his work activities in January 2009.

7. Based on the finding of compensability, Claimant has also established that he is entitled to reasonable and necessary medical treatment to cure and relieve the effects of this work injury. Respondents are responsible for providing to Claimant such reasonable, necessary and related medical benefits including payment for treatment already received.

8. Claimant has established that he is entitled to TTD commencing on March 17, 2009, and ongoing subject to applicable offsets. In the medical record dated March 17, 2009, Dr. Foley noted "unable to work x 2 wks." Claimant

returned to Dr. Foley on March 31, 2009, when she decided to keep Claimant off work indefinitely. Claimant has received short term disability benefits. Thus, Respondents shall pay Claimant TTD benefits based upon the average weekly wage of $876 commencing March 17, 2009, and continuing until terminated pursuant to statute or order. Respondents are entitled to an offset for the short term disability payments made to Claimant.

ORDER

It is therefore ordered that:

1. Claimant sustained a compensable injury on January 23, 2009.

2. Claimant is entitled to reasonable and necessary medical benefits related to his injury.

3. Respondents shall pay temporary total disability from March 13, 2009, and continuing until terminated pursuant to statute or order, at the agreed upon average weekly wage of $876. Respondents are entitled to an offset for short term disability paid to Claimant

4. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

DATED: November 3, 2009

_____

Laura A. Broniak

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-779-845

ISSUES

The sole issue presented for determination was Claimant's request for a change of physicians from the ATP's at Concentra Medical Center to Dr. Patrick Higgins, D.O., Claimant's primary care physician.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed by Employer as a Security Officer with a date of hire of December 16, 2006. Claimant sustained an admitted injury to her right knee on December 16, 2008 when she slipped on some stairs and fell onto her right knee.

2. Claimant was evaluated at Concentra Medical Centers by Dr. Randall Jones, D.O. on December 18, 2008. Dr. Jones noted that Claimant had been seen at Memorial Hospital and given the medication Vicodin. Claimant stated to Dr. Jones that she still had 10 (ten) Vicodin left. Claimant later stated to Dr. Jones that she had been given Percocet at Memorial, not Vicodin.

Dr. Jones noted a history of thyroid disease and that Claimant was on the medications Synthroid and Premarin. On physical examination, Dr. Jones found mild peripatellar tenderness with some ecchymosis of the right knee, and a negative drawer sign. Dr. Jones was unable to do a McMurray's test due to pain. Dr. Jones diagnosed acute contusion of the right knee, prescribed the medications Naproxen and Percocet, placed Claimant on work restrictions and ordered a physical therapy evaluation and treatment.

3. Claimant was again evaluated by Dr. Jones at Concentra on December 22, 2008 and at that time Claimant's pain was decreasing. On physical examination, Dr. Jones noted moderate to severe peripatellar swelling with ecchymosis and marked tenderness. Claimant was unable to do full range of motion and was able to flex only to about 40 degrees with onset of patella area pain. Dr. Jones scheduled an MRI, continued the medication Naproxen and gave Claimant a new prescription for Ultram.

4. Dr. Jones again evaluated Claimant on December 29, 2008 and noted that Claimant had been taking the medications, had noted improvement and had no side effects from the medications. Dr. Jones performed a physical examination finding swelling had decreased, now mainly peripatellar swelling with minimal medial/lateral joint line tenderness.

5. Dr. Jones evaluated Claimant on January 8, 2009 and reviewed the MRI. Dr. Jones stated that physical therapy was the mainstay of Claimant's treatment at this point.

6. Claimant was evaluated at Concentra on February 6, 2009 by Dr. Jan Updike, M.D. The record does not reflect why Claimant was seen on this date by Dr. Updike instead of Dr. Jones. Dr. Updike noted complaints of

locking and catching of the knee that was a recent problem. Dr. Updike noted that Claimant was taking Celebrex and had obtained an MRI showing chondromalacia. Dr. Updike further noted that Claimant had a past medical history of injection therapy in her left knee. Dr. Updike performed a physical examination finding tenderness with palpation over the lateral joint line, intact anterior cruciate and medial collateral ligaments and negative McMurray's and Apley tests. Dr. Updike referred Claimant to an orthopedist for further review of the management of Claimant's treatment and recommendation for any additional studies. Dr. Updike recommended Claimant to continue use of Celebrex and also prescribed Vicodin.

7. Claimant was evaluated by orthopedist Dr. Wiley Jinkins, M.D. at Concentra on February 10, 2009. Dr. Jinkins reviewed results of X-rays and the MRI done of Claimant's right knee and performed a physical examination. Dr. Jinkins recommended a corticosteroid injection and did note that Claimant had previously had problems with her left knee and received injections, without reported benefit. Dr. Jinkins further recommended that Claimant continue physical therapy, use of a brace and the use of the medication Celebrex as prescribed by Dr. Jones.

8. Following the evaluation by Dr. Jinkins Claimant returned to Dr. Jones on February 26, 2009. Dr. Jones noted that Claimant had run out of medications, and had used 9 of the Vicodin that had been given by Dr. Updike. Dr. Jones performed a physical examination of the Claimant's knee noting marked tenderness at the lateral infrapatellar area. Dr. Updike issued prescriptions for Ultram, Celebrex, and continued rare use of Vicodin.

9. Claimant was evaluated by Dr. Jinkins on March 3, 2009.

Dr. Jinkins noted that the corticosteroid injection given at the February 10 visit had not helped. Dr. Jinkins noted that Claimant had previously treated with Dr. John Xenos for her left knee and received viscosupplementation from Dr. Xenos, although without relief. Dr. Jinkins recommended Claimant consider viscosupplementation for the right knee and felt that Claimant would not benefit from surgery.

10. Claimant returned to Dr. Jones for evaluation on March 23, 2009. Dr. Jones noted that Claimant complained of some depressive symptoms from being out of work and that Claimant had been treated with fluoxetine for depression for 2 ñ3 years until 1 year ago. Dr. Jones further noted that Claimant had been on the medication Zoloft before which worked well and that Claimant felt she needed an antidepressant. Dr. Jones prescribed Zoloft for Claimant. Dr. Jones' progress note documents that he provided medication education sheets to Claimant and advised her of medication usage and side effects.

11. Dr. Jinkins again evaluated Claimant on March 31, 2009 and performed a physical examination noting tenderness to deep palpation of the medial and lateral peripatellar region. Dr. Jinkins note documents that he had a lengthy discussion with Claimant regarding the potential benefit from viscosupplementation (Hylagen injection). Dr. Jinkins continued Claimant on the medication Limbrel and gave a new prescription for Ultram. Dr. Jinkins again evaluated Claimant on April 28, 2009 and obtained a history from Claimant that the Limbrel and Ultram had not afforded significant pain relief. Claimant stated to Dr. Jinkins that she would like to try a topical nonsteriodal as had been discussed with Dr. Jinkins at the March 31 visit. Dr. Jinkins prescribed

Restoril for sleep, Celebrex and Voltaren gel, a topical transdermal nonsteriodal anti-inflammatory medication.

12. Dr. Jones last evaluated Claimant on April 13, 2009. He noted that Claimant stated that Zoloft had helped and was requesting a higher dosage. Dr. Jones recommended Claimant continue Limbrel and Ultram. He noted Claimant was out of Vicodin and directed that she obtain that medication through Dr. Jinkins. Because of the persistence of Claimant's condition and Dr. Jinkin's recommendation for Hylagen injections, Dr. Jones recommended a referral of Claimant to with Dr. Hattem or Dr. Quick for a transfer of care to them. Claimant was advised by Dr. Jones of this transfer of care and understood the reasons for the transfer.

13. Dr. Hattem first evaluated Claimant on May 12, 2009 and performed a physical examination on that date. Dr. Hattem described the course of Claimant's treatment and that she was to proceed with the Hylagen injections through Dr. Jinkins. Dr. Hattem further noted Claimant's past history of treatment with Dr. Xenos. Dr. Hattem stated that Claimant would be at MMI once she completed the viscosupplementation treatment.

14. Dr. Jinkins evaluated Claimant on June 3, 2009 following the second of the Hylagen injections. Dr. Jinkins prescribed the medication Talwin for pain because Claimant had indicated to the physician that her use of Tylenol #3 had not been effective and had "done nothing". Dr. Jinkins recommended avoiding Schedule II opioids.

15. Claimant first took the medication Talwin on June 5, 2009. Within 30 to 45 minutes of taking the medication Claimant had no pain but felt "fluttery" and "happy". Claimant does not remember what occurred after this

time. The next day Claimant felt shaky, was crying and did not understand what was occurring. Claimant felt as though she was “zoning”. Claimant discontinued using the Talwin.

16. Claimant called Concentra on Monday, June 8, 2009 and was seen on that date by Dr. Daniel Peterson, M.D. Dr. Peterson noted that Claimant was confused about her medications and reported a “bizarre” set of side effects from taking Talwin. Dr. Peterson reviewed the medications that had been prescribed to Claimant, recommended she discontinue some of the medications, including Talwin, and to continue taking the remaining medications. Dr. Peterson referred Claimant to keep her scheduled appointment the next day with Dr. Hattem.

17. Dr. Hattem placed Claimant at MMI effective September 17, 2009 and assigned 18% impairment of the lower extremity. Insurer filed a Final Admission of Liability on October 9, 2009 admitting to the permanent impairment given by Dr. Hatterm and denying liability for post-MMI medical treatment.

18. Claimant was seen by Dr. Patrick Higgins, D.O. on February 26, 2008 for a chief complaint of low back and left knee pain, although, Dr. Higgins typewritten progress note on that date stated that Claimant was “here with Sinusitis”. Dr. Higgins referred Claimant to Dr. John Xenos, M.D. who initially evaluated Claimant on March 12, 2008 for complaints of bilateral knee pain.

19. Dr. Xenos’ impression was bilateral knee degenerative joint disease secondary to osteoarthritis. Dr. Xenos discussed the treatment options and noted in his report that typically the first line of treatment included use of nonsteroidal medication, physical therapy, brace wear and activity modification. Dr. Xenos stated the next phase of treatment included injections,

either cortisone injections or visco supplementation. Dr. Xenos recommended visco supplementation and this was administered initially by Dr. Xenos' physicians assistant on April 15, 2008.

20. The treatment protocol suggested by Dr. Xenos is consistent with and essentially similar to the treatment regimen that was provided to Claimant by the Concentra physicians for her complaint of right knee pain. Dr. Higgins did not provide treatment to Claimant for her pre-existing bilateral knee pain complaints, instead, referring Claimant to Dr. Xenos for care.

21. The ALJ finds that Claimant has failed to establish a good and sufficient reason or a proper showing for the requested change of physicians to Dr. Higgins. The ALJ finds the medical records from the Concentra physicians documenting their findings, recommendations and discussions with Claimant about her treatment to be credible and persuasive.

CONCLUSIONS OF LAW

22. The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall

be decided on its merits. Section 8-43-201 (2008) C.R.S.

23. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

24. Pursuant to C.R.S. ß 8-43-404(5)(a) permits the employer or insurer to select the treating physician in the first instance. Once the respondents exercised their right to select the treating physician, the claimant may not change physicians without permission from the insurer or "upon the proper showing to the division." Gianetto Oil Co. v. Industrial Claim Appeals Office, 996 P.2d 570 (Colo. App. 1996). The ALJ possesses broad discretionary authority to grant a change of physician depending on the particular circumstances of the claim. Yeck v. Industrial Claim Appeals Office, 996 P.2d 228 (Colo. App. 1999); Szocinski v. Powderhorn Coal Co., W.C. No. 3-109-400 (December 14, 1998); and Merrill v. Mulberry Inn, Inc., W.C. No. 3-949-781 (November 16, 1995). The ALJ is not required to approve a change in physician because of a claimant's personal reason, including mere dissatisfaction. Greager v. Industrial Comm. Of the State, 701 P.2d 168 (Colo. App. 1985). The ALJ's decision to grant a change of physician should consider the need to insure that the Claimant was provided with reasonable and necessary medical treatment as required by C.R.S. ß 8-42-101(1), while protecting Respondent's interest in being apprised of medical treatment for which it will be held liable. Yeck v. Industrial Claim Appeals

Office, 996 P.2d 228 (Colo. App. 1999).

25. Claimant initially argues that Respondents failed to make a showing that Employer complied with the provisions of Section 8-43-404(5)(I)(A), C.R.S. Claimant's argument essentially is that the right of selection of the ATP should therefore have passed to Claimant entitling Claimant to select Dr. Higgins. The ALJ declines to address this argument as it was not endorsed in Claimant's Application for Hearing or as an issue at the commencement of the hearing in this matter. The only issue endorsed in Claimant's Application was "Change of Physician".

26. In support of her request for a change of physician Claimant next contends that she received a continuity of care from Dr. Higgins and was not "shuffled" around to different providers. Claimant contends that such continuity was lacking in her care by the ATPs at Concentra. Claimant contended in her testimony at hearing that she was not regularly examined by the Concentra physicians. Claimant further contends that she now fears taking any medications not prescribed by Dr. Higgins because of the lack of attention to detail by the Concentra physicians. The ALJ is not persuaded.

27. As found, Dr. Higgins when presented with complaints of knee pain referred Claimant to another physician, Dr. Xenos. Dr. Xenos' recommended treatment plan is essentially the treatment plan that has been followed by the physicians at Concentra. Contrary to Claimant's assertion that Dr. Higgins did not "shuffle" her around, Dr. Higgins referred Claimant to Dr.

Xenos who then had Claimant seen by his physicians' assistant for a medical procedure, the visco supplementation injection. In comparison, Claimant was seen at regular intervals by one physician at Concentra, Dr. Jones, until such time as Dr. Jones felt a specialist referral was needed. Claimant's care was then undertaken by Dr. Jones in conjunction with Dr. Jinkins. When Dr. Jones felt Claimant's care would be better placed with a different physician, he referred Claimant to Dr. Hattem and as documented by Dr. Jones' notes, Claimant understood the reason for the transfer of care. The ALJ concludes that Claimant has been no more "shuffled" around for care by the physicians at Concentra than she was by her personal physician, Dr. Higgins, and his referrals. Claimant's further assertion that she lacked cohesive treatment by a primary provider at Concentra and was not regularly examined by the Concentra physicians is found to be unpersuasive. Similarly, the ALJ is not persuaded that the treatment by the Concentra physicians lacked attention to detail. The records of the Concentra physicians reflect an understanding of Claimant's past medical history, her current treatment, her progress with treatment and the medications that had been prescribed.

28. The ALJ further concludes that Claimant has failed to show that she was not provided with adequate medical care by the physicians at Concentra. As noted above, the treatment provided to Claimant by the Concentra physicians is essentially the same treatment protocol recommended by Dr. Xenos for Claimant's complaints of knee pain prior to her compensable injury. While Claimant had an unfortunate reaction to a medication prescribed by Dr. Jinkins, Claimant had not persuasively shown that the use of this medication was

medically contra-indicated or that the response to Claimant's side effects by the physicians at Concentra were medically inappropriate or inadequate.

29. The ALJ has addressed Claimant's request for a change of physician and therefore need not further address the jurisdictional issues raised by the parties at the commencement of the hearing and discussed in the parties post-hearing submissions. As stated at hearing, the ALJ concludes that he at least had jurisdiction to address Claimant's request for a change of physicians as to the need for post-MMI medical care. As concluded above, the ALJ is not persuaded that Claimant has made a proper showing for a change of physician, either for the purpose of obtaining further treatment prior to MMI or for treatment after MMI.

ORDER

It is therefore ordered that:

Claimant's request for a change of physicians to Dr. Patrick Higgins, D.O. is denied.

DATED: November 4, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-752-592

ISSUES

The issues determined herein are maximum medical improvement ("MMI") and liability for a left total knee replacement ("TKR") surgery.

FINDINGS OF FACT

1. Claimant was employed as a teacher for the employer. She is 67 years old and weighs 213 pounds.

2. On November 28, 1995, claimant suffered a work injury in a motor vehicle accident. She underwent left knee arthroscopic surgery. She also suffered continuing right knee symptoms since that accident.

3. On July 21, 1998, Dr. Struck performed a Division Independent Medical Examination ("DIME") for the 1995 work injury. At that time, claimant still reported continuing left knee pain and some functional limitations.

4. On May 30, 2006, claimant sought additional treatment for left knee pain.

5. Claimant suffered increased right knee pain. On May 10, 2007, Dr. Farnworth performed a right TKR.

6. On June 22, 2007, claimant returned to modified duty work for the employer. Claimant subsequently returned to full duty work as a teacher for the employer. On August 23, 2007, claimant successfully completed tactics training, including the ability to stand on each leg and kick an assailant with the other leg.

7. On February 15, 2008, claimant suffered an accidental injury to her left knee when she had to turn suddenly to confront an inmate who was in an improper position. She suffered immediate pain in the left knee and reported her work injury.

8. A February 20, 2008, magnetic resonance image (”MRI”) of the left knee showed osteoarthritis, grade IV chondromalacia, and torn medial and lateral menisci.

9. Claimant was referred to Dr. Farnworth. On March 7, 2008, Dr. Farnworth examined claimant and recommended a left TKR due to severe osteoarthritis that was exacerbated by the work injury.

10. On July 10, 2008, Dr. Fall performed an independent medical examination (”IME”) for respondents. Dr. Fall concluded that claimant did not suffer a work injury aggravation of her preexisting osteoarthritis. Dr. Fall noted that the majority of the need for the left TKR was due to preexisting conditions.

11. On July 11, 2008, Dr. Hall performed an IME for claimant. Dr. Hall concluded that the work injury included the meniscal tears and aggravation of the preexisting osteoarthritis.

12. Claimant was referred to Dr. Walden for a second opinion regarding surgery. On December 2, 2008, Dr. Walden examined claimant and recommended a left TKR.

13. On January 8, 2009, Dr. Nanes determined that claimant was at MMI for the work injury.

14. On February 16, 2009, Dr. Shemesh performed the DIME for the current claim. Dr. Shemesh determined that claimant was not at MMI. He noted that claimant had preexisting left knee osteoarthritis, but the work injury caused additional injury and accelerated the need for a TKR.

15. On May 1, 2009, claimant retired from the employer because, due to her left knee injury, she was unable to take the required personal protection and tactics course.

16. On June 16, 2009, Dr. Roth performed an independent medical record review for respondents. Dr. Roth disagreed with Dr. Shemesh that the work injury accelerated the need for a left TKR.

17. In his deposition testimony, Dr. Roth explained that claimant probably had advanced arthritis in the left knee by 1998 and that she would be expected to suffer flare-ups of symptoms from progressing arthritis. Dr. Roth noted that arthritis is essentially a genetic condition, except that obesity can accelerate it. He concluded that the work injury was only a temporary exacerbation of symptoms, but did not change the underlying disease process or accelerate the need for the TKR. He agreed that claimant needed a left TKR.

18. Respondents have failed to prove by clear and convincing evidence that the determination by the DIME, Dr. Shemesh, is incorrect. Dr. Shemesh determined that claimant is not at MMI and needs a left TKR due to preexisting left knee arthritis that was accelerated by the work injury. That determination is supported by the opinions of Dr. Farnworth, Dr. Fall, and Dr. Hall. Dr. Roth's contrary opinion does not prove that it is highly probable that the DIME determination is incorrect.

CONCLUSIONS OF LAW

1. Section 8-42-107(8)(b)(III), C.R.S., provides that the determination of the DIME with regard to MMI shall only be overcome by clear and convincing evidence. A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. Metro Moving & Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995). In this case, the DIME, Dr. Shemesh, determined that claimant was not at MMI. Consequently, respondents must prove by clear and convincing evidence that this determination is

incorrect.

2. “Maximum medical improvement” is defined in Section 8-40-201(11.5), C.R.S. as:

A point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition. The requirement for future medical maintenance which will not significantly improve the condition or the possibility of improvement or deterioration resulting from the passage of time shall not affect a finding of maximum medical improvement. The possibility of improvement or deterioration resulting from the passage of time alone shall not affect a finding of maximum medical improvement.

Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent on the opinions of medical experts. Villela v. Excel Corporation, W.C. Nos. 4-400-281, 4-410-547, 4-410-548, & 4-410-551 (Industrial Claim Appeals Office, February 1, 2001). As found, respondents have failed to prove by clear and convincing evidence that the determination by Dr. Shemesh is incorrect. Claimant is not at MMI and needs the left TKR to cure or relieve the effects of the work injury. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988).

ORDER

It is therefore ordered that:

1. The insurer shall pay for the left TKR, according to the Colorado fee schedule.

2. All matters not determined herein are reserved for future determination.

DATED: November 5, 2009 /s/ original signed

by:_____

Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-776-811

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she sustained a compensable occupational disease during the course and scope of her employment with Employer.

2. Whether Claimant has demonstrated by a preponderance of

the evidence that she is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

3. A determination of Claimant's Average Weekly Wage (AWW).

4. Whether Claimant has proven by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits from March 13, 2009 until terminated by statute.

FINDINGS OF FACT

1. Claimant has worked for Employer since 2001 as an equipment operator in the imaging department. Her job duties included lifting trays of checks into a machine that images the checks. Claimant was required to stand on rubber mats for the majority of her eight to ten hour work shifts.

2. In late October 2008 Claimant began to experience swelling and pain in her legs. Employer referred her to Healthone Occupational Medicine for an evaluation.

3. On November 11, 2009 Claimant visited Authorized Treating Physician (ATP) Craig Anderson, M.D. for an examination. Her chief complaint was "bilateral leg swelling." Claimant explained that she began to develop "discomfort in both distal legs, ankles and feet associated with swelling" approximately two weeks earlier. She also expressed concerns about varicose veins in several areas of her legs. Claimant did not report any trauma but attributed her symptoms to her inability to sit down during her work shifts. Dr. Anderson diagnosed Claimant with bilateral edema that was possibly related to chronic venous insufficiency. He noted that Claimant's condition was not work-related and referred her to her primary care physician for treatment.

4. Claimant subsequently consulted with her primary care physician and was referred to vascular surgeon Omar Mubarak, M.D. for an evaluation. On February 25, 2009 Dr. Mubarak conducted a complete vascular evaluation. He determined that Claimant had no venous system problems except for cosmetic spider veins. Dr. Mubarak suggested a consultation with a sports medicine physician or orthopedic specialist.

5. On March 12, 2009 Claimant requested leave from Employer under her short-term disability insurance coverage. She explained that she was unable to work because of her continued pain.

6. On March 24, 2009 Claimant visited orthopedic specialist Robert R. Rokicki, M.D. for an examination. He remarked that Claimant had no evidence of edema, full range of motion in her left knee and complete range of motion in her left ankle. Dr. Rokicki determined that Claimant suffered from subjective swelling in both legs that included some aching in the left leg. He attributed Claimant's left leg pain to early osteoarthritis.

7. On June 3, 2009 Claimant underwent a neurosurgical examination with Chad J. Prusmack, M.D. She reported "[a]xial back pain and pain wrapping down into the right SI distribution." Dr. Prusmack commented that Claimant had experienced an "eight-month history of progressive back pain and left lower extremity radicular symptoms in the SI distribution." He noted that x-rays revealed "some mild loss of disc height at L5-S1 and foraminal stenosis." Dr. Prusmack thus referred Claimant for an MRI.

8. After reviewing Claimant's MRI Dr. Prusmack issued a neurosurgical follow-up on June 17, 2009. He noted that Claimant had a relatively normal MRI of the lumbar spine "with possible sacroiliac (SI) joint

dysfunction and/or piriformis syndrome."

9. Beginning on June 22, 2009 Claimant returned to work for two weeks. Claimant's supervisor Kari Palmer testified that Employer attempted to accommodate Claimant's concerns by permitting her to work for four hours while standing and four hours in a sedentary capacity for two or three days. Claimant subsequently performed a sedentary job in which she was permitted to sit for almost the entire day. Ms. Palmer credibly explained that Employer never obtained specific work restrictions for Claimant. Claimant was then excused from work pending more specific restrictions. She has not subsequently returned to work for Employer.

10. Respondents provided Dr. Anderson with Claimant's medical records that had been generated since his initial evaluation in November 2008 and asked him to address the issue of whether Claimant's leg and back symptoms were causally related to her job duties for Employer. On July 27, 2009 Dr. Anderson issued a report. He noted that Claimant had been referred to a podiatrist and stated:

[i]n the absence of trauma, and with the mechanism of injury she has reported, the kinds of problems that they usually treat are generally due to underlying medical problems or preexisting musculoskeletal issues. In these cases there is a potential risk of pain and swelling with any prolonged walking and standing. The underlying problem however is the cause of the symptoms.

Dr. Anderson recounted that in November 2008 Claimant had reported pain of a diffuse nature in the lower back and legs associated with prolonged standing at work. He summarized that his findings were consistent with a pre-existing non-work-related medical condition. Dr. Anderson remarked that there are a

myriad of medical problems that can cause the type of pain and fluid retention that Claimant had experienced. He noted that he was unaware of any medical studies that "describe standing on a concrete floor as an etiology for fluid retention." Dr. Anderson commented that standing and walking constituted activities of daily living and that it was just as likely that Claimant would experience pain and swelling with prolonged standing outside of work as she would while performing her job duties. He summarized that his review of Claimant's medical records did not change his opinion that Claimant's leg pain and swelling were not related to her job duties for Employer.

11. On July 29, 2009 Claimant again visited Dr. Prusmack for an evaluation. Dr. Prusmack remarked that he could not "definitively correlate the onset of [Claimant's] symptoms with the performance of her work duties." Nevertheless, he noted that it was "reasonable to surmise that the performance of her job has certainly, to some degree, exacerbated her symptoms." Dr. Prusmack commented that he lacked the expertise to determine whether Claimant had suffered a compensable aggravation of an underlying condition. He explained that it would be reasonable for Claimant to return to work with accommodations for sitting.

12. Claimant testified at the hearing in this matter. She stated that she stands for a substantial portion her workday and that standing aggravates her back and leg pain. Claimant noted that shoe inserts, injections and physical therapy have provided some relief for her symptoms. She explained that she was involved in a minor February 17, 2005 motor vehicle accident. Claimant noted that her symptoms after the accident were different than what she began to experience in October 2008.

13. Claimant has failed to establish that it is more probably true than not that she sustained an occupational disease during the course and scope of her employment with Employer. Claimant's back and leg symptoms were not caused, intensified or to a reasonable degree aggravated by her job duties for Employer. In late October 2008 Claimant began to experience diffuse leg and back symptoms that she attributed to her work duties for Employer. She specifically remarked that standing for long periods of time at work caused her symptoms. Subsequent medical evaluations revealed that Claimant did not have any venous insufficiencies but has mild degenerative disc disease and possible SI joint dysfunction. ATP Dr. Anderson initially determined that Claimant's work duties for Employer did not cause her condition. After Claimant had undergone additional evaluations and treatment, Dr. Anderson reviewed Claimant's medical records. He persuasively explained that Claimant's back and leg symptoms were caused by an underlying condition and were not related to her job duties for Employer. Dr. Anderson remarked that there are a myriad of medical problems that can cause the type of pain and fluid retention that Claimant has experienced. He commented that standing and walking constituted activities of daily living and that it was just as likely that Claimant would experience pain and swelling with prolonged standing outside of work as she would while performing her job duties. Therefore, Claimant's back and leg symptoms cannot be fairly traced as a proximate cause to her employment with Employer.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any

litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß8-41-301(1)(c) C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP,

Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. Faulkner, 12 P.3d at 846.

5. The test for distinguishing between and accidental injury and an occupational disease is whether the injury can be traced to a particular time, place and cause. Campbell v. IBM Corp., 867 P.2d 77, 81 (Colo. App. 1993). "Occupational disease" is defined by ß8-40-201(14), C.R.S. as:

[A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

6. A claimant is required to prove by a preponderance of the evidence that the alleged occupational disease was directly or proximately caused by the employment or working conditions. Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office, 989 P.2d 251, 252 (Colo. App. 1999). Moreover, ß8-40-201(14), C.R.S. imposes proof requirements in addition to those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. Anderson v. Brinkhoff, 859 P.2d 819, 824 (Colo. 1993). A claimant is entitled to recovery only if the

hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. Id. Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. Id.

7. As found, Claimant has failed to establish by a preponderance of the evidence that she sustained an occupational disease during the course and scope of her employment with Employer. Claimant's back and leg symptoms were not caused, intensified or to a reasonable degree aggravated by her job duties for Employer. In late October 2008 Claimant began to experience diffuse leg and back symptoms that she attributed to her work duties for Employer. She specifically remarked that standing for long periods of time at work caused her symptoms. Subsequent medical evaluations revealed that Claimant did not have any venous insufficiencies but has mild degenerative disc disease and possible SI joint dysfunction. ATP Dr. Anderson initially determined that Claimant's work duties for Employer did not cause her condition. After Claimant had undergone additional evaluations and treatment, Dr. Anderson reviewed Claimant's medical records. He persuasively explained that Claimant's back and leg symptoms were caused by an underlying condition and were not related to her job duties for Employer. Dr. Anderson remarked that there are a myriad of medical problems that can cause the type of pain and fluid retention that Claimant has experienced. He commented that standing and walking constituted activities of daily living and that it was just as likely that Claimant would experience pain and swelling with prolonged standing outside of work as she would while

performing her job duties. Therefore, Claimant's back and leg symptoms cannot be fairly traced as a proximate cause to her employment with Employer.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Worker's Compensation benefits is denied and dismissed.

DATED: November 5, 2009.

_____

Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-778-079

ISSUES

The issues to be determined by this decision are:

1. Whether Claimant's left upper extremity symptoms are related to the October 14, 2008 industrial injury.

2. Whether Claimant's neck symptoms are related to the October 14, 2008 industrial injury.

3. Whether Claimant has made a proper showing for a change of physician.

The parties reached the following stipulations:

1. Claimant is entitled to 50% of the temporary total disability benefits from May 14, 2009 to August 28, 2009 and 100% of the temporary total disability benefits from August 29, 2009 ongoing due to his admitted right shoulder injury.

2. Respondents admit to any reasonable and necessary treatment of Claimant's psychological condition.

FINDINGS OF FACT

1. Claimant began working for Employer as a driver on May 17, 2008. On October 14, 2008, Claimant injured his right shoulder while pulling a pallet of water off a delivery truck with a pallet jack. The pallet jack jammed. Claimant jerked the pallet free, straining his right shoulder.

2. Claimant testified that following the admitted right shoulder injury, he injured his left elbow on October 29,

2008 while he was placing chains on truck tires. Claimant has not filed a new claim for this injury and this is not the incident that caused the admitted October 14, 2008 injury. Medical records do not note Claimant mentioning this alleged second injury prior to the September 2, 2009 hearing. Dr. Watson and Dr. Cedillo both deny Claimant telling them about this alleged incident. Dr. Watson and Dr. Cedillo both testified that if the incident had occurred as Claimant alleges, it would be a new injury and not related to the October 14, 2008 injury.

3. Claimant first sought treatment for the October 14, 2008 injury with Dr. Lawrence Cedillo on October 30, 2008. Dr. Cedillo noted complaints of right shoulder pain and occasional neck stiffness. Claimant did not mention any left upper extremity symptoms. Dr. Cedillo noted that Claimant was “nontender to palpitation in regards to the right cervical spine, thoracic spine, and lumbar spine area.” Dr. Cedillo assessed Claimant with “Right shoulder/ AC joint strain work-related to his present employer.” Dr. Cedillo did not assess Claimant with a neck, cervical, or left upper extremity injury. Dr. Cedillo testified that Claimant did not complain of any pain on October 30, 2008 besides his right shoulder. Dr. Cedillo also testified that his objective examination did not indicate a neck injury because Claimant did not exhibit any discomfort in the muscles along the spine or in the cervical region.

4. On November 13, 2008, Dr. Cedillo noted that Claimant had no other complaints besides right shoulder pain.

Claimant did not complain of neck or left elbow pain. Dr. Cedillo noted that Claimant was non-tender to palpitation to the cervical spine, thoracic spine, and right upper extremity.

5. On November 19, 2008, Dr. Cedillo noted complaints of right shoulder pain and tingling and numbness in Claimant's right side of his face. Claimant did not complain of neck or left elbow pain. Claimant specifically denied any distal neurovascular compromise elsewhere. On examination, Dr. Cedillo noted that Claimant was non-tender in the cervical and thoracic spine areas. Dr. Cedillo did not assess Claimant with a neck, cervical, or left upper extremity injury. Dr. Cedillo opined that Claimant's right face symptoms were not work-related. Claimant was referred to Dr. Ferrari for evaluation of his right shoulder.

6. Dr. James Ferrari examined Claimant on November 24, 2008. Dr. Ferrari noted only complaints of right shoulder pain. Dr. Ferrari did not note any complaints of neck or left elbow pain. Claimant underwent a cortisone injection for his right shoulder pain.

7. On December 3, 2008, Claimant complained of right shoulder pain and stiffness in his neck. Dr. Cedillo noted that Claimant had "no other complaints, other than some persistent discomfort in regards to the right shoulder."

8. On December 23, 2008, Dr. Cedillo

noted that Claimant “wakes up with a stiff neck at times.” Dr. Cedillo assessed Claimant with a right shoulder strain. Dr. Cedillo testified that Claimant’s stiff neck did not indicate an injury. Dr. Cedillo opined that a stiff neck could be the result of “something that they did throughout the day, the way they slept, something they performed incorrectly as far as activity ñ activity goes or movement.”

9. Dr. Ferrari noted on December 29, 2008 that the cortisone injection had provided approximately three days of relief. Dr. Ferrari recommended Claimant undergo decompression and distal clavicle resection.

10. On January 7, 2009, Dr. Cedillo noted that Claimant complained of no other symptoms besides persistent discomfort in his right shoulder.

11. Claimant underwent a right shoulder arthroscopic subacromial decompression and right shoulder arthroscopic distal clavicle resection on February 5, 2009. On February 9, 2009, Dr. Ferrari noted Claimant’s shoulder was healing nicely.

12. On February 9, 2009, Claimant again complained of right shoulder pain and Dr. Cedillo noted, “There are no other complaints besides.”

13. On March 2, 2009, Dr. Cedillo noted that

Claimant had “No proximal complaints of any kind from the shoulder itself. No other complaints besides.” On examination, Dr. Cedillo noted that Claimant was non-tender to palpitation in regards to the cervical spine and thoracic spine areas.

14. Claimant first complained of left elbow pain on March 5, 2009. Claimant told Dr. Cedillo that his pain had begun two months before. This is contrary to Claimant’s testimony at hearing that his left elbow was injured on October 29, 2008 while putting chains on truck tires. Dr. Cedillo testified that even though he examined Claimant multiple times during the two months proceeding March 5, 2009, Claimant did not complain of any left elbow symptoms prior to March 5, 2009.

15. In the March 5, 2009 report, Dr. Cedillo opined that Claimant’s left elbow discomfort and symptoms were “not related to the date of injury in question of October 14, 2008. I do not believe that it is secondary to his current physical rehabilitation. He is not currently working and thus this is not related to that aspect. Ö If it does not improve within the next one to two weeks’ time he is to follow up with his primary care physician through his private health insurance for continued care in regards to the tendon complaints of the left elbow.”

16. On March 16, 2009, Dr. Cedillo noted that Claimant had no complaints in addition to his right shoulder except for the left uninvolved tennis elbow. Dr. Cedillo opined that the left elbow was an

unrelated condition. Dr. Cedillo did not assess Claimant with a neck or cervical injury. On March 16, 2009, Dr. Ferrari noted that Claimant was “coming along appropriately” following his surgery.

17. On April 27, 2009, both Dr. Ferrari and Dr. Cedillo examined Claimant. Dr. Ferrari released Claimant without restrictions. Dr. Ferrari did not note any complaints of left upper extremity or neck symptoms. Dr. Cedillo noted that Claimant was non-tender to palpitation in regards to the cervical spine, thoracic spine, and lumbar spine. Dr. Cedillo did not assess Claimant with a neck or cervical injury.

18. Claimant returned to Dr. Cedillo on May 6, 2009. Dr. Cedillo noted that Claimant complained of discomfort in the right cervical area and left lateral elbow pain. Dr. Cedillo opined that these conditions were not work-related. Dr. Cedillo told Claimant to follow up with his primary care physician for the left elbow pain as it was not work-related. On examination, Dr. Cedillo noted that Claimant had full range of motion without difficulty in his cervical spine, was non-tender to palpitation in the cervical, thoracic, and lumbar areas, and had no radiculopathy or spasm in the right paraspinal cervical spine region.

19. On May 14, 2009, Dr. Cedillo noted that Claimant had full range of motion in the cervical spine. Dr. Cedillo did not assess Claimant with a neck or cervical injury. Dr. Cedillo also opined that Claimant’s left elbow and left upper extremity symptoms were not work-related

and that he needed to followup with his primary care physician.

20. Dr. Ferrari examined Claimant on June 1, 2009. Dr. Ferrari discharged Claimant from care and opined that Claimant was "essentially at maximum medical improvement." Dr. Ferrari did not note any complaints of left upper extremity or neck pain.

21. Between November 5, 2008 and June 2, 2009, Claimant underwent 28 sessions of physical therapy. Records first mention any neck pain or tenderness on December 10, 2008. By December 17, 2008, the neck symptoms had resolved and Claimant did not complain of neck pain again until April 2, 2009. Claimant did not complain of any left upper extremity symptoms to his physical therapist until May 1, 2009.

22. Dr. Edwin Healey examined Claimant on June 17, 2009. Dr. Healey opined that Claimant suffered a work-related neck injury. Dr. Healey testified that the medical records do not document complaints of neck pain initially following the industrial injury. Dr. Healey opined that Claimant's neck symptoms were the result of overcompensation. Dr. Healey testified that:

[O]ver time, if you compensate with the secondary muscle groups, this would include a sternoclynomastid ñ these are the anterior neck muscles ñ the lebator scapula, which is a muscle that attaches to the occipital or posterior part of the cranium, then attaches to the scapula, that helps lift it. People use auxiliary muscles in order to be able to flex and abduct, that is lift, the

shoulder to the shoulder level, or to high chest or shoulder level or above the head. They use auxiliary muscles, they put extra strain on these muscles, and these muscles become painful, stiff. They become foreshortened. People develop trigger points, secondary pain. They get a vicious cycle of pain spasms, attempts to use, and so, this is the mechanism or the pathogenic ñ to the pathological reason why he does have the cervical trapezius, rhomboid pain, secondary headaches, and the facial pain.

23. Dr. Healey concluded that Claimant's neck symptoms are the result of myofascial trigger points. Dr. Watson and Dr. Cedillo do not concur with this diagnosis.

24. Dr. Healey opined in his report and testified that Claimant's left elbow injury developed due to overcompensation. Dr. Healey testified that:

And, again, this is not unusual to have an individual develop epicondylitis and symptoms of pain in the other extremity, particularly when an individual undergoes surgery, and really has marked decreased use of the ñ of his dominant extremity.

25. Dr. Healey testified that Claimant did not complain of elbow pain until March 5, 2009.

26. Dr. Robert Watson examined Claimant on

August 7, 2009. Dr. Watson noted that:

Dr. Cedillo was very careful in his notes to document the fact that [Claimant] had no cervical, thoracic, or lumbar pain. This was documented on 10-30-08, 11-13-08, 11-19-08. He first mentioned to Dr. Cedillo that he had neck tightness on 12-03-08, and he had begun to develop a little bit of stiffness in his neck. Throughout the rest of the medical records, he is noted on occasion to have some neck stiffness, but there was never any documentation that [Claimant] sustained an injury to his cervical spine that would be related to this particular accident. In my opinion, there is no evidence of a cervical spine injury and impairment would not be warranted for the cervical spine.

27. At a post-hearing deposition, Dr. Watson testified that there was no documentation of Claimant suffering a neck injury and that Dr. Cedillo referred Claimant to his primary care physician after opining the injury was not work-related. Dr. Watson testified that he concurred with Dr. Cedillo that Claimant's neck symptoms are not work-related.

28. Dr. Watson noted that Claimant had left elbow pain at various times in the medical records. Claimant told Dr. Watson that he had reported left elbow pain to Dr. Cedillo in November 2008. The medical records do not substantiate this claim. Dr. Watson noted that Claimant did not complain of any elbow pain until March 2009, five months after the industrial injury. Dr. Watson testified that Dr. Cedillo did not note any elbow

complaints prior to March 5, 2009 and that on that date, Dr. Cedillo opined the injury was not work-related and referred Claimant to his primary care physician. Dr. Watson opined that he agreed with Dr. Cedillo's opinions regarding the work-relatedness of Claimant's left elbow.

29. Claimant told Dr. Watson that the injury was the result of him favoring his right arm. Dr. Watson stated that this did not seem medically plausible and that studies do not document that this type of injury resulting from a shoulder injury. Claimant contradicted his own statements to Dr. Watson by testifying that his left elbow hurt in November 2008 and that his left elbow pain was the result of an injury on October 29, 2008 when he was placing chains on tires.

30. At hearing, Claimant testified that he complained to Dr. Cedillo of left elbow pain in November 2008. However, on November 13, 2008, Dr. Cedillo noted that Claimant had no other complaints besides right shoulder pain. Also, on November 19, 2008, Claimant did not complain of left elbow pain. Dr. Cedillo noted that Claimant specifically denied any distal neurovascular compromise elsewhere besides the right shoulder injury. Dr. Cedillo testified consistent with the medical records that Claimant did not complain of any left elbow pain prior to March 5, 2009.

31. At hearing, Claimant testified that as a result of the work injury, he tasted a flavor that was "kind of like copper" in his mouth. Medical records do not mention this symptom. There are no medical

records or opinions that support this being work-related.

32. Claimant testified that he complained to Dr. Cedillo about depression in November 2008 and was frustrated because Dr. Cedillo did not refer him for treatment for the condition until June 2009. Claimant complained of depression one time in November 2008 and did not complain again of depression until June 2009. Dr. Cedillo testified that he did not refer Claimant for depression treatment in November 2008 because a referral was not warranted based on a one time complaint. Medical records support Dr. Cedillo's conclusion that Claimant's depression did not warrant a referral because it appeared that the condition had resolved after November 2008 until June 2009.

33. Claimant testified that as a result of the industrial injury to his right shoulder, he was experiencing hearing loss and vision loss. Claimant testified that he told Dr. Healey about the hearing and vision loss. Dr. Healey stated that Claimant did not tell him he was having vision loss.

34. Dr. Watson testified that he reviewed Dr. Healey's IME report and noted several errors in Dr. Healey's findings. First, Dr. Watson opined that Dr. Healey's finding that Claimant had continued "right cervical pain with stiffness and tightness, which he claims have been present since the original injury" was not consistent with the medical records. Second, Dr. Watson opined that Dr. Healey's records noting an injury to Claimant's right face and ear are also not supported by the medical records. Dr.

Watson further opined that Claimant's mechanism of injury is not consistent with an injury to Claimant's right face or right ear. Third, Dr. Watson opined that Dr. Healey's diagnosis of "cervical, upper trapezius, rhomboid, and scalene myofascial pain post-strain and associated with using the accessory muscles to help with abduction and flexion of his right shoulder" was wrong and inconsistent with the medical records because the records document that Claimant's right shoulder motion was continuously improving and the neck pain did not become a problem until six months post-injury when his shoulder had greatly improved. Dr. Watson opined that Dr. Healey's conclusion that Claimant suffered left lateral epicondylitis secondary to over-compensation was not supported by the medical records. Dr. Watson concluded that Dr. Healey's opinions regarding relatedness of the cervical and left elbow symptoms were wrong because "[t]here is no documentation of injury to the cervical spine or documentation of injury to his left lateral epicondyle. And taking the history from [Claimant], there's great inconsistency as to what happened, where it happened, and when it happened."

35. Dr. Watson testified that he has never seen paresthesia in the face occur as a result of foreshortened muscles in the trapezius and neck. Dr. Watson opined that it is highly unlikely that Dr. Cedillo failed to document neck and left elbow pain if Claimant had repeatedly complained of it as he alleged in his testimony at hearing. Dr. Watson also opined that it was unlikely Claimant's neck pain or left elbow pain had been masked by the narcotics he was taking for his shoulder pain.

36. Dr. Cedillo testified that Claimant's occasional complaints of neck stiffness did not indicate a neck injury. Dr. Cedillo testified that he did not diagnose Claimant with a neck injury and that in his opinion, Claimant did not suffer an injury to his neck as a result of the work injury.

37. Dr. Cedillo also testified that Claimant did not have a work-related left elbow injury as a result of the October 14, 2008 accident. Dr. Cedillo's opinion was based in part on Claimant not reporting any left elbow symptoms prior to March 5, 2009. Dr. Cedillo also testified that Claimant's pain medications would not have masked the fact that he was experiencing left elbow symptoms. Dr. Cedillo further opined that he disagreed with Dr. Healey that Claimant's left elbow injury was due to over-compensation because:

He has not been working since October 30th or 31st of '08 and there was no mention of any type of aggravation through normal everyday activities that he was doing at home or outside home, not work, that involved the left elbow. It was more of a gradual onset as far as I can recall and I don't believe that it was secondary to an overcompensation to the shoulder.

38. Dr. Cedillo opined that the care he had provided Claimant was reasonable and necessary. Dr. Cedillo testified that he is willing to remain Claimant's authorized treating provider and treat his right shoulder injury. Dr. Cedillo further testified that if Claimant's neck symptoms

or left elbow are found to be a compensable part of the October 14, 2008 injury, then he would be willing to treat Claimant for both of these injuries.

39. The ALJ finds the opinions of Dr. Cedillo to be persuasive. The opinions of Dr. Watson support the persuasive opinions of Dr. Cedillo. The opinions of Dr. Healey are less persuasive than the opinions of Dr. Cedillo and Dr. Watson.

40. Claimant's left upper extremity symptoms are not related to the October 14, 2008 industrial injury.

41. Claimant's neck symptoms are not related to the October 14, 2008 industrial injury.

CONCLUSIONS OF LAW

1. Insurer is liable for medical treatment that is reasonably needed to cure or relieve the claimant from the effects of the compensable injury. Section 8-42-101, C.R.S. There must be a causal relationship between the industrial accident and the injury for which medical benefits are sought. Snyder v. Indus. Claims Appeal Office, 942 P.2d 1337 (Colo. App. 1997). A claimant bears the burden of proof to establish the causual relationship. The question of whether he has done so is one of fact. Faulkner v. Indus. Claim Appeals Office, 12 P.3d 844 (Colo. App. 2000).

2. Dr. Watson and Dr. Cedillo both testified that Claimant did

not have an injury to his neck based on his lack of symptoms or complaints of neck pain immediately following the October 14, 2008 injury. The ALJ finds these opinions to be persuasive and affords them more weight than the opinions of Dr. Healey.

3. Dr. Watson and Dr. Cedillo both persuasively testified that Claimant did not suffer an accident resulting in an injury to his neck. Claimant has failed show that treatment to his cervical spine is related to the compensable injury.

4. Claimant testified that his left elbow symptoms were caused by an accident that occurred on October 29, 2008 when he was placing chains on tires of a truck and not due to over-compensation. This testimony is contradictory to the medical records that show that Claimant had not previously mentioned a second injury prior to the hearing on September 2, 2009. Claimant's testimony is not persuasive. Dr. Watson and Dr. Cedillo both credibly testified that even if Claimant's testimony was correct, this incident would be a separate date of injury and not related to the October 14, 2008 injury. Claimant's left elbow tendonitis is not caused by the October 14, 2008 industrial injury.

5. Dr. Healey opined that Claimant's left elbow injury was due to over-compensation. Dr. Watson opined that it is not medically plausible to develop tendinitis due to over-compensation when Claimant's shoulder was improving during the time period of the alleged over-compensation injury. Dr. Cedillo opined that Claimant's left elbow and left upper extremity symptoms are

not work-related and he needs to seek treatment with his primary care physician. Dr. Cedillo testified that Claimant's left elbow injury was not the result of over-compensation because it is not supported by the medical records or Claimant's own testimony. There is not a causal relationship between the industrial accident and the injury. Claimant has failed to prove that treatment of his left upper extremity is related to the compensable injury.

6. An ALJ may grant a request of a claimant to have his own physician attend him upon a "proper showing." Section 8-43-404(5)(a), C.R.S.; Carlson v. Indus. Claim Appeals Office, 950. P.2d 663 (Colo. App. 1997). A claimant's dissatisfaction with the treating physician does not compel the ALJ to grant a request for change of physician. Gracia v. King's Table, No. 92CA1570 (Colo. App. May 27, 1993). The ALJ's decision should be made with a view towards insuring the claimant is being provided reasonable and necessary medical treatment as required by Section 8-42-101(1)(a), C.R.S., while protecting the respondent's legitimate interest in being apprised of the course of treatment for which it may ultimately be held liable. Landeros v. CF and I Steel, W.C. No. 4-395-314 (I.C.A.O., Oct. 26, 2000) (citing Yeck v. Indus. Claim Appeals Office, 996 P.2d 228 (Colo. App. 1999)).

7. Claimant argues that Dr. Cedillo has not provided treatment for his neck or left elbow and Dr. Cedillo did not refer him for evaluation for depression until June 2009. Dr. Cedillo's denial of treatment for Claimant's neck and left elbow was proper based on the delayed reporting of neck and left elbow pain, the lack of objective findings to support a neck injury, and Dr.

Cedillo's determination that the injuries were not work-related, which is supported by Dr. Watson's opinion. Dr. Cedillo's failre to refer Claimant for depression evaluation until June 2009 was reasonable based on the Claimant's lack of subjective complaints and only report of symptoms of depression one time in November 2008. Claimant has failed to make the proper showing that the care by Dr. Cedillo has not been reasonable, that Dr. Cedillo is unwilling to continue treating the industrial injury, and that a change of physician is warranted. Therefore, the claimant's request for a change of physician is denied because Claimant failed to bear his burden of showing entitlement to a change of physician.

ORDER

It is therefore ordered that:

1. Claimant's request for medical care for his neck symptoms is denied.

2. Claimant's request for medical care for his left elbow is denied.

3. Claimant's request that his own physician attend him is denied.

4. All matters not determined herein are reserved for future determination.

DATED: November 5, 2009

Bruce C. Friend, ALJ

Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-779-599

ISSUES

Claimant's average weekly wage (AWW).

Claimant's entitlement to temporary total disability (TTD) benefits from May 20, 2009 and ongoing.

Whether Claimant was given a full duty release by the treating doctor on October 8, 2008 and put at MMI on that date, thus terminating TTD.

FINDINGS OF FACT

1. The Claimant injured her left ankle on November 6, 2007. Nurse Melanie Vanhook initially saw Claimant at the Rocky Ford Family Health

Center. She was treated briefly and placed at MMI by Nurse Vanhook on November 21, 2007. Her report stated the Claimant "agreed that she no longer needed care". The diagnosis was an ankle strain.

2. On June 11, 2008, the Claimant returned to the Health Center and was seen by Nurse Doug Miller. She told him she began having pain again in her ankle that started in January 2008. Claimant was taking ibuprofen with little or no relief. An MRI of the ankle at that time showed bone bruising of the calcaneus with inflammation.

3. Claimant was referred to Dr. Timothy O'Brien who saw her on August 6, 2008. Dr. O'Brien diagnosed Haglund's syndrome with an insertional Achilles tendinopathy. He recommended a cast and discussed a possible surgical treatment. On August 21, Dr. O'Brien changed this to a boot with a heel lift. Dr. O'Brien saw her again on September 3 and September 9.

4. On October 8, 2008, Dr. O'Brien saw the Claimant and she complained of some continued pain of the Achilles tendon. The Claimant however, did not want to undergo surgery and felt she could return to her regular work. Dr. O'Brien stated "she will return to unrestricted work" stating "We could close the case and rate her disability at this point in time although issuing the caveat that she is a candidate for an Achilles tendon debridement and retrocalcaneal bursectomy and Haglund's exostectomy at some point in the future." However, in a note on Dr. O'Brien's Consulting Physician Report, dated the same day, he unequivocally states that the Claimant is not at MMI. The Claimant did not return to Dr. O'Brien after October 8, 2008.

5. There is insufficient credible evidence that any ATP saw Claimant after the October 8, 2008 appointment with Dr. O'Brien.

6. There is insufficient credible evidence to indicate that any ATP, subsequent to Dr. O'Brien stating that Claimant was not at MMI on October 8, 2008, put Claimant at MMI up to the date of the hearing herein.

7. Respondents filed a general admission of liability on January 7, 2009, indicating that the Claimant was not at MMI. There is no evidence in the record to indicate that any other admissions have been filed in this matter.

8. The ALJ finds that Claimant was not put at MMI subsequent to treatment beginning on June 11, 2008, when she returned to Dr. James Satt for treatment after a worsening of her work-related condition. Claimant has not been placed at MMI as of the date of the hearing in this matter as noted above.

9. Claimant went to see her own doctor, Dr. Satt, on May 20, 2009. Dr. Satt was not an ATP. She told Dr. Satt on May 20, 2009 that she had not worked since December 2008. Dr. Satt recommended "home rehab activities" and imposed walking and standing restrictions of five hours per day. The ALJ finds that Dr. Satt's medical findings and restrictions establish that at the time of her examination Claimant ës condition had deteriorated such that she was not able to continue to earn a wage. Respondents are responsible for Claimant's wage loss.

10. Claimant has been unable to work since May 20, 2009 as a result of her admitted work-related injury of November 6, 2007.

11. Claimant is entitled to temporary total disability benefits from May 20, 2009 and ongoing until terminated by operation of law.

12. In order to arrive at a fair approximation of Claimant's wage loss at the time of her work injury, the ALJ adopts the Claimant's method of

calculation. In the twelve weeks from August 15, 2007 through October 31, 2007, Claimant earned a total of $4,607.20. Dividing $4,607 by twelve weeks produces an average weekly wage of $383.93. Calculating Claimant's average weekly wage in this manner generates an average weekly wage that is the most fair approximation of Claimant's wage loss the time of her work injury, taking into account the fluctuations both in Claimant's hours and in Claimant's hourly rate.

CONCLUSIONS OF LAW

1. The central focus of an average weekly wage calculation is to arrive at a fair approximation of the Claimant's actual wage loss and diminished earning capacity at the time of the injury. Campbell v. IBM Corp., 867 P.2d 77, 82 (Colo.App. 1993); C.R.S. ß 8-40-201(19)(a). An ALJ has broad discretion in determining how to compute AWW, and an ALJ's determination of AWW my only be overturned when unsupported by evidence or contrary to law. Pizza Hut v. CAO, 18 P.3d 867, 869 (Colo.App. 2001). In this instance, Claimant did not work a set number of hours per day or per week. Although Claimant was paid at an hourly rate, the fluctuation both in Claimant's hours and in Claimant's hourly rate renders it impossible to arrive at a fair approximation of Claimant's wage loss at the time of her work injury simply by multiplying an hourly wage by the number of hours worked per day and then by the number of days worked per week.

2. The ALJ concludes that a fair approximation of Claimant's average weekly wage is $383.93, as determined above.

3. Claimant's position statement addresses the issue of termination for cause. If the worsening of a Claimant's work injury causes a subsequent wage loss, temporary total disability payments are payable regardless of whether Claimant's termination from work was voluntary or for cause. See Anderson v. Longmont Toyota, Inc., 102 P.3d 323 (Colo. 2004).

4. Here Claimant's termination for cause was not a factor as the issue was not raised by Respondents. There was clearly insufficient evidence to create even a prima facie argument of responsibility for termination.

5. Commencing May 20, 2009, Claimant was unable to return to her usual job due to the effects of the work injury. Consequently, Claimant was "disabled" within the meaning of section 8-42-105, C.R.S. and entitled to TTD benefits. Culver v. Ace Electric, 971 P.2d 641 (Colo. 1999); Hendricks v. Keebler Company, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused Claimant to leave work, and Claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995).

6. The ALJ concludes that Claimant did suffer a wage loss as a result of the work-related injury beginning May 20, 2009, and is entitled to temporary total disability benefits from that date onward until terminated by operation of law.

ORDER

It is therefore ordered that:

1. Respondent-Insurer shall pay Claimant temporary total disability benefits beginning May 20, 2009 and continuing until terminated buy operation of law.

2. Claimant's average weekly wage is $383.93.

3. Respondent-Insurer shall pay indemnity benefits to Claimant based upon an average weekly wage of $383.93 per week.

4. The Respondent-Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

DATE: November 6, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-742-749

ISSUES

ÿ Did claimant prove by a preponderance of the evidence that an average weekly wage of $698.25 more fairly approximates her wage loss from her injury?

ÿ Did claimant prove by a preponderance of the evidence that insurer should be penalized for failing to admit to an average weekly wage of $698.25?

ÿ Did claimant prove by a preponderance of the evidence that insurer should be penalized for late payment of temporary total disability benefits?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

Claimant worked as a teacher for the School District for some 15 years before sustaining an admitted injury on September 21, 2007. The School District referred claimant to HealthOne, where David Kistler, M.D., provided her medical treatment. Dr. Kistler referred claimant to Dr. Chan, who placed claimant at maximum medical improvement (MMI) in March of 2008.

During the years claimant worked as a teacher for the School District, her salary was determined annually. Each July, the School District would set claimant's salary for the upcoming year. That salary was effective September 1 of the school year and continued to the following September. On July 30, 2007, the School District sent claimant its Annual Salary Notification Letter for school-year 2007-2008. Under the terms of the contract for hire for school-year 2007-2008, the School District and claimant agreed to a salary of $25,137.00 to be paid in monthly installments over 12 months. The School District thus agreed to pay claimant $2,094.75 per month.

Claimant's salary of $25,137.00 was based upon her working seven-hour workdays spread over 180 days during the school year. The School District paid claimant an hourly rate of $19.95. There was no persuasive evidence showing that the School District used any time cards, kept hourly records, or actually paid claimant only for hours worked. Claimant did not work for the School District during the summer months, school holidays, or breaks.

During the school year, claimant held concurrent employment working part-time for Hyland Hills Recreation District. During the summer and during school vacations, claimant worked full-time for Hyland Hills. Throughout the year of 2007, claimant earned gross wages of $8,340.23 at Hyland Hills. This included claimant's part-time wages during the school year, her full-time wages during the summer, and a bonus and raise claimant received in November 2007.

Claimant was unable to return to her regular teaching job at the School District after her injury on September 21, 2007. The School District continued to pay claimant her wages under a salary continuation plan approved by the Director of the Division of Workers' Compensation. The School District continued to pay claimant her regular monthly salary of $2,094.75 for September, October, and November of 2007. The School District thus paid claimant under the salary continuation plan from September 22nd through November 30, 2007.

Claimant testified inconsistently and contradicted herself concerning any lost time from work at Hyland Hills following her injury. The Judge found claimant's testimony lacked credibility and ruled from the bench at hearing that claimant failed to show it more probably true that she lost time or wages from her concurrent employment at Hyland Hills as a result of her injury at the School District.

On January 28, 2008, insurer filed a General Admission of Liability (GAL), admitting liability for benefits based upon an average weekly wage (AWW) of $483.42. Insurer calculated claimant's AWW by dividing her annual salary of $25,137.00 by 52 weeks, in accordance with the statutory formula for salaried workers under ß8-42-102(2)(a). Insurer's calculation of claimant's AWW was reasonable because, under the contract of hire, both parties agreed to pay claimant her salary spread over 52 weeks.

Under the GAL, insurer commenced paying claimant temporary total disability (TTD) benefits as of November 24, 2007, or one week early, since claimant was also paid her wages for that week under the salary continuation plan. As found, claimant's injury resulted in no lost time from claimant's work at Hyland Hills.

In calculating claimant's AWW for purposes of TTD benefits, insurer properly excluded any wages from claimant's concurrent employment at Hyland Hills. Claimant showed it more probably true that an AWW of $698.25 more fairly approximates her wage loss from the injury. Crediting the School District's representation in the Annual Salary Notification Letter, claimant's salary of $25,137.00 is based upon an hourly rate of $19.95 for 7 hours per day, times 180 days per year. Claimant typically worked 5 days per week at the School District during the school year, but she did not work there during summer or during breaks in the school year. During the summer, claimant worked full time for a different employer in order to supplement her salary from the School District. While the School District spread payment of what claimant earned in 180 days over a 12-month period, the method of payment is artificial and fails to reflect claimant's demonstrated earning capacity during those 180 days. Calculating claimant's AWW based upon her hourly wage multiplied over the average number of

days per week that she actually worked more fairly approximates her lost earning capacity and wage loss from the injury ($25,137.00 / 180 = $139.65 per day, multiplied by 5 days per week equals $698.25).

Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Jeffrey A. Wunder, M.D., the DIME physician. Crediting the medical opinions of Dr. Wunder and Dr. Chan, claimant's injury is limited to discogenic back pain. Dr. Wunder wrote:

In my opinion, [claimant] would not be a good surgical candidate. She has only very minor disc abnormalities on MRI. She did have some moderate facet joint disease at L5-S1 but had no findings on physical examination suggesting facetogenic pain.

(Emphasis added). Dr. Wunder agreed claimant reached MMI on March 8, 2008. Dr. Wunder rated claimant's permanent medical impairment at 14% of the whole person based upon regional impairment of the lumbar spine. Dr. Wunder opined that claimant might need 2 additional epidural steroid injections to maintain her status at MMI.

On October 6, 2009, insurer filed a Final Admission of Liability (FAL), admitting liability for permanent partial disability (PPD) benefits based upon Dr. Wunder's 14% whole person rating. The parties stipulated that claimant's weekly earnings at Hyland Hills averaged $307.73 based upon full-time work during the summer. Under the FAL, insurer calculated claimant's PPD benefits based upon an AWW that includes claimant's concurrent average weekly earnings of $307.73. In the FAL, insurer further admitted liability for maintenance care to prevent further deterioration of claimant's physical condition (Grover-type medical benefits) so long as such care is reasonable, necessary and related, and

so long as claimant obtains prior authorization for such care.

Claimant testified that she did not receive any wages from the School District or TTD benefits from insurer after November 23, 2007, until insurer issued a check to her on January 29, 2008. However, the actual paycheck from the School District issued November 26 2007, shows it paid claimant her regular salary of $2,094.75 through November 30th under the wage continuation plan. Claimant stated that she was unable to pay her rent for December or January, could not buy food, and almost lost her car. Claimant stated that she had to borrow money from her daughter to sustain herself through January 29, 2008. Claimant's testimony however lacks credibility when weighed against insurer's payment log. The Judge finds claimant here grossly misrepresented her situation in December and January as dire. Claimant attributed her dire circumstances to insurer's alleged failure to pay her TTD benefits. The Judge infers that clamant intended to mislead the court and garner antipathy for insurer.

Section 8-42-105(2)(a), supra, requires insurer to pay claimant TTD benefits at least once every 2 weeks. Insurer timely initiated payment of claimant's TTD benefits for the period of November 24 through December 7, 2007, by check issued December 5, 2007. Insurer timely paid claimant TTD benefits for the period of December 8 through December 21, 2007, by check issued December 19, 2007. Insurer timely paid claimant TTD benefits for the period of December 22, 2007, through January 4, 2008, by check issued January 2, 2008. Insurer failed to pay claimant her TTD benefits within 2 weeks of January 4, 2008. Insurer should have paid claimant her next periodic payment of TTD benefits no later than January 18, 2008. However, for the period of January 5 through January 28, 2008, insurer paid claimant her TTD benefits by check issued January 29, 2008.

By paying claimant TTD benefits from November 24th through November 30, 2007, insurer had overpaid claimant TTD benefits by one week because TTD benefits should have started as of December 1, 2007. Insurer thus had paid claimant TTD benefits through January 11th, instead of January 4th. Insurer was required to pay claimant her next installment of TTD benefits within 2 weeks of January 12th, or by January 25th. By paying claimant her installment of TTD benefits by check of January 28th, insurer paid claimant those benefits 4 days late (January 26th through 29th equals 4 days).

Claimant thus showed it more probably true that insurer failed to comply with ß8-42-105(2)(a) for 4 days from January 26th through 29, 2008. Although insurer failed to provide any evidence reasonably explaining the late payment of TTD benefits, the Judge finds insurer's failure likely was the result of negligence, and was not intentional. As found, claimant's testimony concerning any effect of insurer's late payment of TTD benefits lacked credibility and was intentionally misleading to the court. There was no persuasive evidence otherwise showing that insurer's late payment of TTD benefits harmed claimant. Claimant's TTD rate is $66.43 per day ($698.25 x .666 = 465.03, divided by 7 equals $66.43). The Judge finds that a penalty of $265.72 ($66.43 x 4 days) remedies claimant's loss of benefits for 4 days and reasonably punishes insurer for late payment of TTD benefits.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, supra. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

A. Average Weekly Wage:

Claimant argues she has proven by a preponderance of the evidence

that an AWW of $698.25 more fairly approximates her wage loss from her injury. The Judge agrees.

The judge must determine an employee's average weekly wage by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of injury. Celebrity Custom Builders v. Industrial Claim Appeals Office, 916 P.2d 539 (Colo. App. 1995). Section 8-42-102(3), supra, grants the judge discretionary authority to alter a statutory formula for calculating AWW if for any reason it will not fairly determine claimant's AWW. Coates, Reid & Waldron v. Vigil, 856 P.2d 850 (Colo. 1993). The overall objective of calculating AWW is to arrive at a fair approximation of claimant's wage loss and diminished earning capacity. Ebersbach v. United Food & Commercial Workers Local No. 7, W.C. No. 4-240-475 (ICAO May 7, 1997). Earnings from concurrent employment may be included in a claimant's AWW where the injury impairs earning capacity from such employment. Jefferson County Schools v. Dragoo, 765 P.2d 636 (Colo. App. 1988).

Here, the Judge found claimant showed it more probably true that an AWW of $698.25 more fairly approximates her wage loss from the injury. Claimant thus proved by a preponderance of the evidence her AWW should be $698.25. As found, claimant's salary of $25,137.00 is based upon her working 180 days per year at an hourly rate of $19.95 for 7 hours per day. Claimant typically worked 5 days per week at the School District during the school year, but she did not work there during summer or during breaks in the school year. During the summer, claimant worked full time for a different employer in order to supplement her salary from the School District. While the School District spread payment of what claimant earned in 180 days over a 12-month period, the

Judge found the method of payment artificial and failing to reflect claimant's demonstrated earning capacity during those 180 days. The Judge found that an AWW of $698.25, calculated based upon claimant's hourly wage multiplied over the average number of days per week that she actually worked more fairly approximates her lost earning capacity and wage loss from the injury.

The Judge concludes that insurer should recalculate claimant's TTD benefits based upon an AWW of $698.25 and should recalculate claimant's PPD benefits based upon an AWW of $1,005.98 ($698.25 + $307.73 = $1,005.98).

B. Grover-Type Medical Benefits:

Claimant contends, and the Judge agrees, that insurer's requirement that she obtain prior authorization for Grover-type maintenance care is unsupported by ß8-42-101, supra.

Section 8-42-101(1)(a), supra, provides:

Every employer Ö shall furnish Ö such medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury Ö and thereafter during the disability to cure and relieve the employee from the effects of the injury.

Respondents thus are liable for authorized medical treatment reasonably necessary to cure and relieve the employee from the effects of the injury. Section 8-42-101, supra; Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo. App. 1990).

The need for medical treatment may extend beyond the point of MMI where claimant requires periodic maintenance care to prevent further deterioration of her physical condition. Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988).

An award for Grover medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. Holly Nursing Care Center v. Industrial Claim Appeals Office, 992 P.2d 701 (Colo. App. 1999); Stollmeyer v. Industrial Claim Appeals Office, 916 P.2d 609 (Colo. App. 1995). Section 8-42-101, supra, thus authorizes the judge to enter an order for future maintenance treatment if supported by substantial evidence of the need for such treatment. Grover v. Industrial Commission, supra.

The Judge concludes that, pursuant to ß8-42-101, insurer should provide claimant reasonably necessary Grover-type care to maintain her discogenic back pain at MMI.

C. Penalty Claims:

Claimant argues she has proven by a preponderance of the evidence that insurer should be penalized for failing to admit to an AWW of $698.25 and for late payment of TTD benefits. The Judge partially agrees.

Section 8-43-304(1), supra, authorizes the imposition of penalties up to $500 per day where a party fails, refuses, or neglects to obey a lawful order or to perform any duty lawfully enjoined or mandated within the time prescribed by the director or administrative law judge. This statute thus encompasses an order issued by a judge. Holiday v. Bestop, Inc., 23 P.3d 700 (Colo. 2001); Giddings v. Indus. Claim Appeals Office, 39 P.3d 1211 (Colo. App. 2001). Likewise, the term "order" as used in this penalty provision includes a rule of the director. Spracklin v. Indus. Claim Appeals Office, 66 P.3d 176 (Colo. App. 2002).

Section 8-43-304(1) thus identifies four categories of conduct and authorizes the imposition of penalties when an employer or insurer: (1) Violates any

provision of the Act; (2) does any act prohibited by the Act; (3) fails or refuses to perform any duty lawfully mandated within the time prescribed by the director or Panel; or (4) fails, neglects, or refuses to obey any lawful order of the director or Panel. Pena v. Industrial Claim Appeals Office, 117 P.3d 84 (Colo. App. 2005).

For purposes of ß8-43-304(1), supra, an insurer neglects to obey an order if it fails to take the action a reasonable insurer would take to comply with the order. The reasonableness of the insurer's actions depends upon whether such actions were predicated upon a rational argument based in law or fact. Diversified Veterans Corporate Center v. Hewuse, 942 P.2d 1312 (Colo. App. 1997). Insurer must advance a rational argument to support the reasonableness of its actions. See Pueblo School District No. 70 v. Toth, 924 P.2d 1094 (Colo. App. 1996). Section 8-43-304(1), supra, further provides that an award of a penalty shall be apportioned, 25% payable to the Subsequent Injury Fund, and 75% payable to the aggrieved party.

As found by the Judge, insurer calculated claimant's AWW in accordance with the statutory formula for salaried workers under ß8-42-102(2)(a), supra. Insurer's calculation of claimant's AWW thus was reasonable under ß8-42-102(2)(a). Claimant failed to show any persuasive legal basis for her penalty claim where insurer reasonably calculated claimant's AWW under ß8-42-102(2)(a). Claimant failed to show that insurer violated a provision of the Act or regulatory rule warranting imposition of a penalty under ß8-43-304(1), supra.

The Judge however found that claimant showed it more probably true that insurer failed to comply with ß8-42-105(2)(a) for 4 days from January 26th through 29, 2008. Claimant thus proved by a preponderance of the evidence that insurer is

subject to a penalty under ß8-43-304(1) based upon its violation of ß8-42-105(2)(a).

As found, ß8-42-105(2)(a), supra, requires insurer to pay claimant TTD benefits at least once every 2 weeks. Although insurer failed to provide any evidence reasonably explaining the late payment of TTD benefits, the Judge found insurer's failure likely was the result of negligence, and was not intentional. Claimant's testimony concerning any effect of insurer's late payment of TTD benefits lacked credibility and was intentionally misleading to the court. There was no persuasive evidence otherwise showing that insurer's late payment of TTD benefits harmed claimant. The Judge found that a penalty of $265.72 remedies claimant's loss of benefits for 4 days and reasonably punishes insurer for late payment of TTD benefits.

The Judge concludes that claimant's request for an award of penalties against insurer for failure to admit to the higher AWW should be denied and dismissed. Insurer however should pay a penalty of $265.72 in the following amounts: Insurer should pay $66.43 (25%) to the Subsequent Injury Fund and $199.29 (75%) to claimant.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Insurer shall recalculate claimant's TTD benefits based upon an AWW of $698.25.

2. Insurer shall recalculate claimant's PPD benefits based upon an AWW of $1,005.98.

3. Insurer shall provide claimant reasonably necessary Grover-type care

to maintain her discogenic back pain at MMI.

4. Claimant's request for an award of penalties against insurer for failure to admit to the higher AWW is denied and dismissed.

5. Insurer shall pay a penalty of $265.72 in the following amounts: Insurer shall pay $66.43 (25%) to the Subsequent Injury Fund and $199.29 (75%) to claimant.

6. Insurer shall pay the Director of the Division of Workers' Compensation on behalf of the Subsequent Injury Fund as follows: Insurer shall issue any check payable to "Subsequent Injury Fund" and shall mail the check to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Brenda Carrillo, Subsequent Injury Fund.

7. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

8. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _November 9, 2009__

_____

Michael E. Harr,

Administrative Law Judge

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-778-974

ISSUES

The issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant was employed by Employer as a records clerk beginning on or about April 28, 2008. She also occasionally worked overtime to help the correctional officers when they were short-staffed.

2. Claimant had preexisting left knee problems after a July 2007 accidental injury when she jumped off the bed of a truck. On September 25, 2007, Dr. Johnson performed arthroscopic surgery on the left knee.

3. Claimant subsequently returned to work and resumed her usual activities, although she continued to have left knee symptoms.

4. In July 2008 Claimant had a flare up of left knee symptoms. On July 10, 2008, Dr. Johnson prescribed a brace for the left knee. On July 30, 2008, Dr. Johnson administered an injection to the left knee. Claimant returned to work for the employer, although she wore the brace and used a cane.

5. Soon after starting work for the employer, claimant experienced personal difficulties with her supervisor, Ms. Blake. Ms. Blake had told claimant that she was not to work any overtime in her records clerk job.

6. Claimant alleges that she suffered a right knee injury on September 10, 2008, when she “hurried” while walking down the hallway to exit the facilities in the presence of Ms. Blake.

7. No one else witnessed this event and Claimant drove herself home. Claimant’s husband testified that he observed claimant icing her right knee at night and that the right knee swelled. Claimant continued to work through October 21, 2008.

8. Claimant did not immediately provide a written incident statement to her supervisor or human resources representative. Claimant alleges that she orally reported the injury the next day to Ms. Blake, who gave no response. Claimant alleges that she “forgot” to provide a written report of the injury. Claimant also testified that she only thought about the injury being work-related after October 21, 2008. Ms. Blake denied that claimant made any such report. Ms. Blake testified that claimant reported only that she hurt her right knee in a carpool commute with another employee.

9. On September 19, 2008, Dr. Buchanan examined claimant and issued only a brief prescription note that claimant needed to use crutches, walker, or a wheelchair at work because of a knee injury two weeks ago.

10. On October 17, 2008, Dr. Johnson examined claimant, who reported a history of the right medial knee pain beginning on September 11, 2008, with

unknown etiology. Dr. Johnson found Claimant had overcompensated for her left knee, altered her gait and developed a pes tendonitis in the right knee. Dr. Johnson suspected a medial meniscus tear.

11. On October 22, 2008, claimant took a discretionary leave of absence from her job due to her knee problems.

12. Claimant began a course of physical therapy for her right knee. On October 24, 2008, she reported a history of right knee pain beginning mid-September 2008, but she was unable to recall any mechanism of injury for her knee pain.

13. On November 21, 2008, Dr. Johnson reexamined claimant, who reported improvement, but pain with walking. Dr. Johnson released claimant to return to work with no restrictions and specifically approved the job of administrative clerk.

14. On November 21, 2008, the employer notified claimant that the job of records clerk had been filled.

15. On December 3, 2008, claimant wrote to Ms. Jackson, reporting a September 2008 work injury to her right knee.

16. Claimant accepted a job as administrative clerk and began that job on December 22, 2008. She suffered increasing right knee pain and used a

cane at work.

17. On January 21, 2009, claimant received a job performance evaluation indicating that she needed improvement.

18. On January 23, 2009, claimant began another discretionary leave of absence. She provided an incident report for the alleged work injury, but provided no medical documentation of disability. On February 10, 2009, the employer wrote to claimant, indicating that she needed to provide medical documentation of her disability. Claimant never provided the documentation.

19. On February 5, 2008, Dr. Jesus Perez examined claimant, who reported a history of a September 11, 2008, right knee pop while walking with resulting excruciating pain in the medial aspect. She informed Dr. Perez that she did not immediately report to her employer that she suffered a right knee injury at work. She informed Dr. Perez that she merely reported that she had right knee problems and needed to get medical attention. She also admitted that she had not informed Dr. Buchanan that she suffered a work injury to the right knee.

20. On February 18, 2009, Dr. Perez agreed to complete disability forms for claimant, noting that he was not surprised that respondents had denied liability for the workers' compensation claim.

21. At hearing, Dr. Perez testified that it was possible that

claimant's walking was a mechanism for a meniscus injury. He also noted that it was very common for patients to alter gait due to a knee problem on one leg and then suffer overcompensation problems in the other knee.

22. Claimant again requested that Ms. Jackson complete a disability information form and Ms. Jackson did so on February 23, 2009.

23. On May 28, 2009, the employer informed claimant that her employment was terminated due to expiration of the six-month discretionary leave. Claimant did not contact her employer following expiration of her discretionary leave.

24. Claimant has failed to prove by a preponderance of the evidence that she suffered an accidental injury to her right knee arising out of and in the course of her employment on September 10, 2008. She failed to report any work injury to her employer until months later. She failed to report a work injury to Dr. Buchanan on September 19, 2008. She failed to report any work injury to Dr. Johnson on October 17, 2008. She first reported a work injury only in a December 2008 letter to Ms. Jackson, after claimant's position had been filled when she was unable to return to work following discretionary leave due to her knee problems. Claimant might sincerely believe that she suffered an injury at work on September 10, but she appears to be trying to reconstruct her memory of events. The contemporaneous medical records do not demonstrate any work injury on that date. Claimant's testimony to the contrary is not persuasive.

CONCLUSIONS OF LAW

1. Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; see, Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844 (Colo. App. 2000); City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985); Pacesetter Corp. v. Collett, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office, 989 P.2d 251 (Colo. App. 1999); Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997), cert. denied September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979).

2. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. Colorado Jury Instructions, Civil, 3:16.

3. As found, claimant has failed to prove by a preponderance of the evidence that she suffered an accidental injury to her right knee on September 10, 2008, arising out of and in the course of her employment.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits is denied and dismissed.

DATED: November 10, 2009 /s/ original signed

by:_____

Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-731-219

ISSUES

The issues determined herein are medical benefits and penalties pursuant to section 8-43-304, C.R.S.

FINDINGS OF FACT

1. Claimant suffered injuries in a work-related motor vehicle accident on August 4, 2005. Dr. Timothy Hall at Intermountain Rehabilitation was the authorized treating physician for the injuries.

2. Dr. Hall referred claimant to various other providers for treatment and diagnostic evaluation, including Radiology and Imaging, Life Touch Associates, Dr. Redfern, Rubicon Physical Therapy, Southwest Diagnostics, and Memorial Hospital. The treatment provided by the above providers was reasonable and necessary due to the work related injury.

3. On January 27, 2007, Dr. Hall determined that claimant was at maximum medical improvement ("MMI") for the work injuries.

4. The billing for these providers were as follows:

Radiology and Imaging	$37.00
Life Touch Associates	$2,340.00
Dr. Redfern	$8,257.36
Rubicon Physical Therapy	$750.00
Southwest Diagnostics	$1,758.00
Intermountain Rehabilitation	$780.00

Memorial Hospital

$3,054.72

TOTAL

$16,977.08

5. On August 6, 2007, claimant filed a workers' claim for compensation for the injury.

6. On September 12, 2007, claimant's attorney sent the workers' compensation insurance adjuster a summary of medical treatment received by claimant.

7. Claimant never wrote to the insurer to request reimbursement for claimant's out-of-pocket medical expenses for the work injury.

8. Claimant pursued a third-party lawsuit against the driver in the motor vehicle accident. Claimant settled the third-party claim for $34,000. On March 4, 2008, from the proceeds of the settlement, claimant, through her attorney, paid $780 to Dr. Hall, $2,340 to Life Touch Associates, $7,995.35 to Dr. Redfern, and $1,758 to Southwest Diagnostics. Claimant's total out-of-pocket medical expenses were $12,873.35.

9. Claimant provided copies of the treatment records by Radiology and Imaging, Life Touch Associates, Dr. Redfern, Rubicon Physical Therapy, Southwest

Diagnostics, and Memorial Hospital to Respondents attorney at an April 9, 2008 hearing on the compensability of the workers' compensation claim. At the hearing, claimant did not request reimbursement for out-of-pocket medical expenses. The May 23, 2008, order found the claim to be compensable, but denied the claim for temporary disability benefits.

10. Claimant underwent a Division Independent Medical Examination ("DIME") with Dr. Terry Struck, M.D. on October 13, 2008. Dr. Struck diagnosed chronic cervical and lumbosacral pain syndrome, temporamandibular joint ("TMJ") syndrome, headaches, and shoulder girdle pain caused by the motor vehicle collision. Dr. Struck agreed that claimant was at MMI. She determined that claimant suffered 16% whole person impairment for the work injury. Dr. Struck also recommended medical treatment after MMI in the form of over-the-counter pain medications and quarterly bite orthotic adjustments by Dr. Redfern.

11. On November 4, 2008, the insurer filed a final admission of liability for permanent partial disability benefits based upon 16% whole person impairment. The permanent partial disability award, prior to any offset, is $27,151.49. The insurer denied liability for all medical benefits to-date and after MMI. The insurer asserted a credit for the entire amount of the third party settlement proceeds.

12. On April 29, 2009, hearing was held on the amount of the offset to the insurer due to the third-party settlement, liability for medical benefits to

Performance Back and Champion Health Associates, and liability for post-MMI medical treatment. At the hearing, the Judge struck claimant's request for a penalty against the insurer because the application for hearing did not plead the penalty with requisite specificity. In his May 19, 2009, order, the Judge determined that the insurer was entitled to an offset for the full $34,000 third-party settlement, ordered post-MMI medical benefits, and denied claimant's claim for payment of the bills of Performance Back and Champion Health Associates because the bills were not submitted to the insurer within 120 days of the provision of services.

13. The May 19, 2009, order did not close the claim. The order expressly held open all issues not determined. In his preliminary rulings at the April 29, 2009, hearing, the Judge expressly noted that he was not deciding the issue of the other medical bills and was not deciding the merits of any request for penalties.

14. After deducting the $27,151.49 for permanent partial disability benefits from the $34,000 credit already established, the insurer is entitled to credit for the amount of $6,848.51 against medical liabilities.

15. Claimant paid $12,873.35 directly to Dr. Hall, Dr. Redfern, Life Touch, and Southwest Diagnostic. After deducting the $6,848.51 in remaining credit, claimant is entitled to reimbursement in the amount of $6,024.84.

16. The request for payment of the bills for Performance Back and Champion Health were previously denied in the May 19, 2009 order and was not part of the September 23, 2009 hearing.

17. Claimant has failed to prove that she directly paid any sums to Memorial Hospital or Radiology & Imaging. The disbursement of the third party

settlement indicated that additional sums were held in the plaintiff attorney's trust account to satisfy other liens. Claimant could not provide any record evidence that she had paid additional sums to other providers. She acknowledged that she had never paid Rubicon Physical Therapy and had never even received treatment from Sanders Chiropractic.

18. The record evidence does not demonstrate that Rubicon Physical Therapy complied with WCRP 16-11 by submitting the required bills and documents to the insurer.

19. Claimant is persuasive that the insurer had receipt of the bills for all providers on April 9, 2008. Nevertheless, on May 9, 2008, claimant also knew or reasonably should have known of the alleged violation of WCRP by the insurer for failure to pay any of the medical bills within 30 days from April 9, 2008. On June 8, 2009, more than one year later, claimant filed her application for the current hearing on the issue of penalties against the insurer.

CONCLUSIONS OF LAW

1. Respondents' argument that the claim is closed by the final admission of liability and the May 19, 2009, order is not persuasive. Section 8-43-203(2)(b)(II), C.R.S., provides that issues may be closed by final admission of liability if claimant does not seek a DIME and apply for a hearing on ripe issues. Claimant applied for hearing. The May 19, 2009, order determined certain issues and expressly held open all issues not determined. Consequently, the order did not close the claim because it reserved jurisdiction to determine additional issues. Brown & Root, Inc. v. Industrial Claim Appeals

Office, 833 P.2d 780 (Colo. App. 1991).

2. Respondents' argument of claim preclusion is not persuasive. Claim preclusion may apply in workers' compensation proceedings. Holnam, Inc. v. Industrial Claim Appeals, 159 P.3d 795 (Colo.App. 2006). For a claim in a second proceeding to be precluded by a previous judgment, there must exist (1) finality of the first judgment, (2) identity of subject matter, (3) identity of claims for relief, and (4) identity of or privity between parties to the actions. Cruz v. Benine, 984 P.2d 1173 (Colo. 1999). A more recent case from the Industrial Claim Appeals Office addressed the applicability of claim preclusion in workers' compensation cases. Mahana v. Grand County, W.C. No. 4-430-788 (ICAO, February 15, 2007), held that claim preclusion requires a final judgment that completes the trial court's adjudicatory process. See Estate of Scott v. Holt, 151 P.3d 642 (Colo. App. 2006) citing Smeal v. Oldenettel, 814 P.2d 904 (Colo. 1991). That requirement is not met in the current workers' compensation claim, in which Judge Friend specifically reserved for future decision all issues not determined by his order. This workers' compensation claim has not been subject to a final judgment terminating all of the adjudicatory process. Consequently, claim preclusion does not apply to claimant's current claim for medical benefits and penalties.

3. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988). WCRP 16-11(F) requires the insurer to reimburse claimant for payments that she made

directly for authorized and reasonably necessary medical treatment. As found, claimant has proven by a preponderance of the evidence that she is entitled to reimbursement for medical expenses in the amount of $12,873.35 that claimant paid directly to Dr. Hall, Dr. Redfern, Life Touch Associates, and Southwest Diagnostic. As found, all of the treatment by Dr. Hall and his referrals was reasonably necessary and authorized for the work injury. Claimant paid these providers out of the $34,000 settlement in the third party suit. After deducting the $6,848.51 in remaining credit, claimant is entitled to reimbursement by the insurer in the amount of $6,024.84. As found, claimant has failed to prove that she directly paid any sums to Memorial Hospital or Radiology & Imaging. She acknowledged that she had never paid Rubicon Physical Therapy and had never even received treatment from Sanders Chiropractic.

4. Claimant has failed to prove that the insurer is liable for payment of the Rubicon Physical Therapy bill directly to the provider. WCRP 16-11 establishes requirements for providers to submit medical bills with supporting documentation to the insurer. WCRP 16-11(A)(1) provides: "Providers shall submit their bills for services rendered within one hundred twenty (120) days of the date of service or the bill may be denied unless extenuating circumstances exist." Additionally, WCRP 16-7 requires that all medical bills be submitted using "required forms." These bills must contain proper billing codes (WCRP 16-7(C)) and supporting medical records must be attached (WCRP 16-7(E)). As found, the record evidence does not demonstrate that Rubicon Physical Therapy complied with WCRP 16 by submitting the required forms and documents to the insurer.

5. Claimant alleges that the insurer violated WCRP 16-11(F) by not reimbursing claimant within 30 days after its April 9, 2008, receipt of the bills and supporting medical records from the providers. This penalty issue was stricken from the April 29, 2009 hearing. Claimant applied for hearing on this issue on June 8, 2009. Respondents are correct that claimant's request for a penalty pursuant to section 8-43-304, C.R.S., is barred by the one-year statute of limitations in section 8-43-304(5), C.R.S. WCRP 16-11(F) provides:
An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered as covered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within thirty (30) days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the medical fee schedule (Rule 18), the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

If claimant is correct that the insurer had receipt of the bills on April 9, 2008, she knew or reasonably should have known of the violation of the rule on May 9, 2008. She had one year from that date to request penalties. She failed to do so and the penalty claim is time barred. She had one year from that date to request penalties. She failed to do so and applied for hearing on the penalty issue only on June 8, 2009. The penalty claim is time barred.

6. Because the penalties are barred by the statute of limitations, the Judge need not address the argument that only the penalty in section 8-43-401(2), C.R.S., applies. Claimant did not pursue this penalty at hearing. Similarly, the Judge need not address whether the insurer unreasonably violated WCRP 16-11(F).

ORDER

It is therefore ordered that:

1. The insurer shall reimburse claimant in the amount of $6,024.84 for claimant's out-of-pocket payments directly to Dr. Hall, Dr. Redfern, Life Touch Associates, and Southwest Diagnostic.

2. Claimant's request for reimbursement for payments to Memorial Hospital and Radiology & Imaging is denied and dismissed.

3. Claimant's request for payment of bills to Rubicon Physical Therapy is denied and dismissed.

4. Claimant's claim for penalties against the insurer pursuant to section 8-43-304, C.R.S. is denied and dismissed.

5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

DATED: November 10, 2009 /s/ original signed by:_____

Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-786-539 and WC 4-784-213

ISSUES

The following issues were raised for consideration at hearing:

1) Compensability;

2) AWW;

3) TTD benefits from April 24, 2008 and on-going; and

4) Medical benefits.

FINDINGS OF FACT

1. On January 31, 2008, Claimant was employed as a bus driver for the Respondent-Employer. As Claimant was coming out of an office, she tried to close the door behind her, stopped abruptly and jarred her right shoulder. (W.C. 4-786-539). Although Claimant's worker's claim for compensation reflects a date of injury of February 6, 2008, the accident actually occurred on January 31, 2008.

2. Claimant did not seek any medical attention nor did she lose any time from work following the accident on January 31, 2008. Claimant did not complete a worker's claim for compensation until February 26, 2009, more than one year after the accident.

3. On April 24, 2008, Claimant was involved in another accident while trying to get in the back door of her bus. (W.C. 4-784-213). Claimant testified that the side door to the bus was shut tight and she went to the back door to open it. While standing on a 5-gallon bucket, attempting to get in the bus, Claimant grabbed the back of the seats of the bus and jerked her right shoulder.

4. Claimant's right shoulder "hurt very badly," although she did not seek medical attention. Claimant did not lose any time from work in the immediate weeks following the injury. Claimant thought that her right shoulder pain was related to a prior injury in 2007.

5. Claimant suffered a prior right shoulder injury on February 9, 2007, while working as a supervisor for Schwann's in Alamosa, following which she received treatment from Russell DeGroote, M.D., in Pueblo. Claimant underwent right shoulder surgery on June 27, 2007, for a rotator cuff tear and SLAP lesion. Claimant was seen in follow-up by Dr. DeGroote through October 9, 2007, at which time she was considered to be at maximum medical improvement and released to return to work without limitations.

6. Claimant was subsequently given a 7% permanent impairment rating in March 2008. Claimant does not recall the name of the doctor who provided the impairment rating.

7. On January 16, 2008, Sally L. Fabec, M.D. of Spanish Peaks Family Clinic, examined Claimant. Claimant complained of multiple joint symptoms including her back, shoulder, neck, arm and right shoulder which, "in spite of the surgical intervention is still painful."

8. On February 2, 2008, Claimant presented to the emergency room of San Rafael Hospital complaining of pain in her right shoulder, stating that her pain started at 5 a.m. Claimant denied any recent injury but stated she has been using her right upper extremity a lot for the last week. Claimant stated that she had similar symptoms previously following a right rotator cuff repair in June 2007. Claimant gave no medical history of an injury at work for the Respondent-Employer.

9. Claimant returned to Dr. Fabec on February 18, 2008, again complaining of shoulder discomfort. Dr. Fabec noted that Claimant was scheduled for a functional assessment. Dr. Fabec stated that it appears Claimant is always going to have problems and that Claimant hasn't been able to lift and even driving for long distances is now bothering her. The functional assessment referred to by Dr. Fabec was in connection with Claimant's prior injury occurring in 2007.

10. On May 6, 2008, Dr. Christopher Wilson examined Claimant at Spanish Peaks Family Clinic. Claimant presented with complaints of nasal congestion and wheezing, although she provided no history of any recent injury at work for the Respondent-Employer. Claimant returned to Spanish Peaks Family Clinic on August 29, 2008, and was examined by Dr. Valerie Borsa, who noted a chief complaint of right shoulder pain "from the thoracic outlet syndrome" as well as her chronic low back pain. Again, there is no medical history of an injury at work for the Respondent-Employer. Claimant was provided with Vicodin for pain relief and Claimant was advised to undergo an MRI scan for further evaluation.

11. On September 9, 2008, Claimant underwent an MRI scan of the lumbar spine as well as an MRI scan of the right shoulder. The MRI of the right shoulder revealed evidence of a full thickness tear of the supraspinatus tendon, a questionable tear of the long head of the biceps and degenerative changes of the AC joint. Claimant thereafter underwent an MRI scan of the thoracic spine on September 16, 2008, which was interpreted as normal. Claimant further underwent an MRI scan of the cervical spine on September 16, 2008, which revealed multiple levels of degenerative changes and mild to moderate stenosis.

12. Claimant was referred by her family physician to Dr. Bruce Taylor for an orthopedic evaluation on October 1, 2008. Claimant recited a medical history of having undergone surgery on her right shoulder in June 2007,

by Dr. DeGroote, following which she “never quit hurting” after the surgery and has never been able to put her arm behind her back. Claimant further reported having pain particularly over the past 8 months. It has been getting progressively worse. Claimant reported to Dr. Taylor that she drives a school bus with a manual door and therefore has to use her right arm to reach and pull the handle to open and close the door. Claimant stated this is very painful for her; however, Claimant recited no medical history of having injured her right shoulder at work for the Respondent-Employer on either January 31, 2008 or April 24, 2008. Dr. Taylor recommended surgery for a rotator cuff tear involving the supraspinatus, which, according to Dr. Taylor, was not noted on the MRI scan from 2007.

13. Claimant contacted the Respondent-Insurer in October 2008 and requested medical treatment. Claimant reported at this time because she suffered a new tear in her right shoulder. Claimant was referred to Nicholas Kurz of the Southern Colorado Clinic on December 5, 2008. Dr. Kurz diagnosed right biceps tendonitis, right rotator cuff injury and right shoulder strain which he believed to be related to the work injury on April 24, 2008 (Although his record indicates a date of injury of April 29, 2009, the ALJ concludes this is an error.) According to Dr. Kurz, Claimant’s symptoms began 4-6 months ago and the injury occurred at work due to slipping and falling off the back of a bus while trying to use a stool to climb in the back door. Dr. Kurz opined that the Claimant’s condition is work-related.

14. There is insufficient evidence to indicate that Claimant was

veer put on restrictions. Dr. Kurz specifically indicates no restrictions in his reports of February 18, 2009 and June 5, 2009. The ALJ finds that Claimant has failed to establish she has a work-related disability that has resulted in a wage loss.

15. On April 28, 2009, Claimant underwent an independent medical examination (IME) with Dr. James Lindberg at the request of the Respondents. Claimant recited a history of injury on April 24, 2008, when she fell off the back of a bus and landed on her right shoulder. Claimant did not report any injury at work on or about January 31, 2008. Dr. Lindberg noted that Claimant underwent prior shoulder surgery by Dr. DeGroote on June 27, 2007, where she had arthroscopic repair of the subscapularis and a biceps tenotomy. Dr. Lindberg agreed with Dr. Kurz that the Claimant's more recent MRI scan revealed a supraspinatus/rotator cuff tear in the right shoulder, a different tendon than that involved in the prior surgery and a new injury. According to Dr. Lindberg, however, there was a significant lag in time in which Claimant sought medical care with respect to the current condition. Dr. Lindberg opined that to a reasonable degree of medical probability, if Claimant injured her shoulder falling out of a bus, she would have sought medical attention sooner than 5 months after the injury. Based upon a totality of the evidence presented the ALJ finds that this opinion is not credible.

16. Claimant underwent an independent medical examination (IME) with Dr. Timothy Hall at the request of her attorney on July 9, 2009. Dr. Hall opined that Claimant's right rotator cuff tear was related to the April 24, 2008

work injury. Dr. Hall agreed that this was a different tear than her previous work injury and a different part of the rotator cuff. According to Dr. Hall, it is not unusual for people to do fairly well with a torn rotator cuff until more strenuous activities is undertaken. Based upon a totality of the evidence presented the ALJ finds that Dr. Hall's opinion is credible.

17. Claimant's right shoulder condition has not improved and has gradually become worse. Claimant is not currently working. Claimant wants to undergo treatment including surgery for her right shoulder.

18. Dr. Lindberg testified by deposition on September 30, 2009. Dr. Lindberg testified that he is a board-certified orthopedic surgeon and that he is Level II certified with the Colorado Division of Workers' Compensation. In the context of his practice as an orthopedic surgeon in the Denver area, Dr. Lindberg estimated that he has performed surgery for rotator cuff tears "a thousand" times. Dr. Lindberg testified that based upon a reasonable degree of medical probability, the right shoulder complaints pre-dated the injury of April 2008. According to Dr. Lindberg, less than 5% of the rotator cuff tears for which surgery is performed involve an "acute" tear, and the vast majority, 95% of the time, surgery is performed for "attritional" tears. Dr. Lindberg opined that attritional tears, meaning tears that occur from overuse, wear and tear, and the natural process of aging, may be asymptomatic for months until more strenuous activity is undertaken. In the case of an acute rotator cuff tear, however, this leaves people significantly disabled and with significant pain. Dr. Lindberg testified that he has never seen anybody with that kind of injury

wait 5 months for medical care.

19. Dr. Lindberg further testified that there is a significant difference in the symptoms involved in the pain that occurs following a new injury from ongoing pain that results from an old injury. According to Dr. Lindberg, this would not be a continuation of the same pain especially because there are two different injuries and two different tendons that are involved. Further, Dr. Lindberg testified that he would expect a patient to have different symptoms for different injuries to the rotator cuff whether or not it was an acute tear or an attritional tear.

20. The ALJ finds that Dr. Lindberg's opinion is less credible than other medical evidence in that his analysis inadequately connects his generalized assessment of shoulder conditions to the specific facts of Claimant's injury.

21. The Respondents submitted into evidence the Claimant's payroll records reflecting Claimant's earnings from April 26, 2007 through February 26, 2009. Claimant's average weekly wage listed on the employer's first report of injury of $239.30 accurately reflects Claimant's earnings at and prior to the time of the accident on April 24, 2008. Claimant presented no evidence to the contrary. The ALJ finds that Claimant's AWW is $239.30.

22. The ALJ finds that the Claimant has failed to establish that it is more likely than not that the incident occurring on January 31, 2008

resulted in a compensable injury.

23. The ALJ finds that Claimant has established by a preponderance of the evidence that she did sustain an injury to her right shoulder, including but not limited to, right biceps tendonitis, right rotator cuff injury, right shoulder strain, and a full thickness tear to the supraspinatus, arising out of and in the course of her employment with the Respondent-Employer on or about April 24, 2008. In this regard the ALJ finds Claimant to be credible.

24. The ALJ finds that Claimant has established by a preponderance of the evidence the need for medical treatment necessary to cure or relieve her from the effects her work-related injury.

25. The ALJ finds that Claimant has failed to establish a current right to temporary total or partial disability benefits.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), ß 8-40-101, C.R.S. (2007), et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. ß 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. ß 8-43-201, C.R.S.. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark,

197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. ß 8-43-201, C.R.S.

2. A workers' compensation case is decided on its merits. ß 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P. 3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of a witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he or she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß 8-41-301(1) (c), C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for the

determination of the Judge. Faulkner, 12 P.3d. at 846.

5. The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undersigned occurrence. ß 8-40-201(1), supra. By contrast, an "injury" refers to the physical trauma caused by the accident. Thus, an "accident" is the cause and an "injury" the result. City of Boulder v. Payne, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one, which results in an injury requiring medical treatment or causing disability. H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990).

6. The ALJ finds that Claimant has failed to prove that she sustained a compensable injury on January 31, 2008. (W.C. 4-786-535). The ALJ finds that Claimant did suffer an injury on that date but not of a severity that rises to the level of a compensable injury, as the injury did not require medical treatment and did not result in a disability. The claimant did not seek medical attention for this injury, did not lose any time from work and did not file a workers' claim for over one year. When examined at the San Rafael Hospital on February 2, 2008, claimant did not recite any history of injury occurring on January 31, 2008. Further, when examined by Dr. Fabec on February 18, 2008, claimant still did not present any history of a work injury but rather, attributed her right shoulder problems to her prior 2007 injury. The ALJ further finds that claimant's right shoulder condition, for which surgery has been recommended, is not causally related to the injury at work on January 31, 2008.

7. The ALJ finds that claimant did establish by a preponderance

of the evidence that she did suffer a compensable injury on April 24, 2008. (W.C. 4-784-213). Claimant reported this accident immediately, although she did not seek any medical treatment at that time. Claimant continued working. During two office visits to Spanish Peaks Family Clinic on May 6, 2008 and August 28, 2008, Claimant failed to recite a history of work injury. Further, she did not attribute her right shoulder problems to any injury at work for the employer-respondent. Nonetheless, the credible medical and lay evidence establishes that there is a causal link between Claimant's current shoulder condition and the injury of April 24, 2008.

8. The medical evidence establishes that claimant suffered a new "injury", involving a tear of the supraspinatus tendon in the right shoulder, and claimant has established by a preponderance of the evidence that this new tear was caused by an accidental injury occurring at work on April 24, 2008. The ALJ finds the opinions of Dr. Kurz and Dr. Hall to be credible and persuasive.

9. Claimant is entitled to medical treatment to cure or relieve her from the effects of her injury.

10. Claimant has failed to establish that she is currently entitled to temporary total or partial disability benefits.

11. The ALJ concludes that the Claimant's average weekly wage is $239.30.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits under the Workers' Compensation Act of Colorado in claim WC 4-786-539 for an injury on or about January 31, 2008 is denied and dismissed.

2. Claimant's claim for benefits under the Workers' Compensation Act of Colorado in claim WC 4-784-213 for an injury on or about April 24, 2008 is compensable and Respondent-Insurer shall pay for Claimant's reasonable, necessary, and related medical care to cure or relieve her from the effects of her injury.

3. Claimant's claim for temporary total and/or temporary partial disability benefits is denied and dismissed.

4. Respondent-Insurer shall pay any benefits that may accrue in the future upon a n average weekly wage of $239.390.

5. The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

6. All matters not determined herein are reserved for future determination.

DATE: November 10, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-786-539 and WC 4-784-213

ISSUES

The following issues were raised for consideration at hearing:

Compensability;

AWW;

TTD benefits from April 24, 2008 and on-going; and

Medical benefits.

FINDINGS OF FACT

1. On January 31, 2008, Claimant was employed as a bus driver for the Respondent-Employer. As Claimant was coming out of an office, she tried to close the door behind her, stopped abruptly and jarred her right shoulder. (W.C. 4-786-539). Although Claimant's worker's claim for compensation reflects a date of injury of February 6, 2008, the accident actually occurred on January 31, 2008.

2. Claimant did not seek any medical attention nor did she lose any time from work following the accident on January 31, 2008. Claimant did not complete a worker's claim for compensation until February 26, 2009, more than one year after the accident.

3. On April 24, 2008, Claimant was involved in another accident while trying to get in the back door of her bus. (W.C. 4-784-213). Claimant testified that the side door to the bus was shut tight and she went to the back door to open it. While standing on a 5-gallon bucket, attempting to get in the bus, Claimant grabbed the back of the seats of the bus and jerked her right shoulder.

4. Claimant's right shoulder "hurt very badly," although she did not seek medical attention. Claimant did not lose any time from work in the immediate weeks following the injury. Claimant thought that her right shoulder pain was related to a prior injury in 2007.

5. Claimant suffered a prior right shoulder injury on February 9, 2007, while working as a supervisor for Schwann's in Alamosa, following which she received treatment from Russell DeGroote, M.D., in Pueblo. Claimant underwent right shoulder surgery on June 27, 2007, for a rotator cuff tear and SLAP lesion. Claimant was seen in follow-up by Dr. DeGroote through October 9, 2007, at which time she was considered to be at maximum medical improvement and released to return to work without limitations.

6. Claimant was subsequently given a 7% permanent impairment rating in March 2008. Claimant does not recall the name of the doctor who provided the impairment rating.

7. On January 16, 2008, Sally L. Fabec, M.D. of Spanish Peaks Family Clinic, examined Claimant. Claimant complained of multiple joint symptoms including her back, shoulder, neck, arm and right shoulder which, "in spite of the surgical intervention is still painful."

8. On February 2, 2008, Claimant presented to the emergency room of San Rafael Hospital complaining of pain in her right shoulder, stating that her pain started at 5 a.m. Claimant denied any recent injury but stated she has been using her right upper extremity a lot for the last week. Claimant stated that she had similar symptoms previously following a right rotator cuff repair in June 2007. Claimant gave no medical history of an injury at work for the Respondent-Employer.

9. Claimant returned to Dr. Fabec on February 18, 2008, again complaining of shoulder discomfort. Dr. Fabec noted that Claimant was scheduled for a functional assessment. Dr. Fabec stated that it appears Claimant is always going to have problems and that Claimant hasn't been able to lift and even driving for long distances is now bothering her. The functional assessment referred to by Dr. Fabec was in connection with Claimant's prior injury occurring in 2007.

10. On May 6, 2008, Dr. Christopher Wilson examined Claimant at Spanish Peaks Family Clinic. Claimant presented with complaints of nasal congestion and wheezing, although she provided no history of any recent injury at work for the Respondent-Employer. Claimant returned to Spanish Peaks Family Clinic on August 29, 2008, and was examined by Dr. Valerie Borsa, who noted a chief complaint of right shoulder pain "from the thoracic outlet syndrome" as well as her chronic low back pain. Again, there is no medical history of an injury at work for the Respondent-Employer. Claimant was provided with Vicodin for pain relief and Claimant was advised to undergo an MRI scan for further evaluation.

11. On September 9, 2008, Claimant underwent an MRI scan of the lumbar spine as well as an MRI scan of the right shoulder. The MRI of the right shoulder revealed evidence of a full thickness tear of the supraspinatus tendon, a questionable tear of the long head of the biceps and degenerative changes of the AC joint. Claimant thereafter underwent an MRI scan of the thoracic spine on September 16, 2008, which was interpreted as normal. Claimant further underwent an MRI scan of the cervical spine on September 16, 2008, which revealed multiple levels of degenerative changes and mild to moderate stenosis.

12. Claimant was referred by her family physician to Dr. Bruce Taylor for an orthopedic evaluation on October 1, 2008. Claimant recited a medical history of having undergone surgery on her right shoulder in June 2007, by Dr. DeGroote, following which she "never quit hurting" after the surgery and

has never been able to put her arm behind her back. Claimant further reported having pain particularly over the past 8 months. It has been getting progressively worse. Claimant reported to Dr. Taylor that she drives a school bus with a manual door and therefore has to use her right arm to reach and pull the handle to open and close the door. Claimant stated this is very painful for her; however, Claimant recited no medical history of having injured her right shoulder at work for the Respondent-Employer on either January 31, 2008 or April 24, 2008. Dr. Taylor recommended surgery for a rotator cuff tear involving the supraspinatus, which, according to Dr. Taylor, was not noted on the MRI scan from 2007.

13. Claimant contacted the Respondent-Insurer in October 2008 and requested medical treatment. Claimant reported at this time because she suffered a new tear in her right shoulder. Claimant was referred to Nicholas Kurz of the Southern Colorado Clinic on December 5, 2008. Dr. Kurz diagnosed right biceps tendonitis, right rotator cuff injury and right shoulder strain which he believed to be related to the work injury on April 24, 2008 (Although his record indicates a date of injury of April 29, 2009, the ALJ concludes this is an error.) According to Dr. Kurz, Claimant's symptoms began 4-6 months ago and the injury occurred at work due to slipping and falling off the back of a bus while trying to use a stool to climb in the back door. Dr. Kurz opined that the Claimant's condition is work-related.

14. There is insufficient evidence to indicate that Claimant was veer put on restrictions. Dr. Kurz specifically indicates no restrictions in

his reports of February 18, 2009 and June 5, 2009. The ALJ finds that Claimant has failed to establish she has a work-related disability that has resulted in a wage loss.

15. On April 28, 2009, Claimant underwent an independent medical examination (IME) with Dr. James Lindberg at the request of the Respondents. Claimant recited a history of injury on April 24, 2008, when she fell off the back of a bus and landed on her right shoulder. Claimant did not report any injury at work on or about January 31, 2008. Dr. Lindberg noted that Claimant underwent prior shoulder surgery by Dr. DeGroote on June 27, 2007, where she had arthroscopic repair of the subscapularis and a biceps tenotomy. Dr. Lindberg agreed with Dr. Kurz that the Claimant's more recent MRI scan revealed a supraspinatus/rotator cuff tear in the right shoulder, a different tendon than that involved in the prior surgery and a new injury. According to Dr. Lindberg, however, there was a significant lag in time in which Claimant sought medical care with respect to the current condition. Dr. Lindberg opined that to a reasonable degree of medical probability, if Claimant injured her shoulder falling out of a bus, she would have sought medical attention sooner than 5 months after the injury. Based upon a totality of the evidence presented the ALJ finds that this opinion is not credible.

16. Claimant underwent an independent medical examination (IME) with Dr. Timothy Hall at the request of her attorney on July 9, 2009. Dr. Hall opined that Claimant's right rotator cuff tear was related to the April 24, 2008 work injury. Dr. Hall agreed that this was a different tear than her previous

work injury and a different part of the rotator cuff. According to Dr. Hall, it is not unusual for people to do fairly well with a torn rotator cuff until more strenuous activities is undertaken. Based upon a totality of the evidence presented the ALJ finds that Dr. Hall's opinion is credible.

17. Claimant's right shoulder condition has not improved and has gradually become worse. Claimant is not currently working. Claimant wants to undergo treatment including surgery for her right shoulder.

18. Dr. Lindberg testified by deposition on September 30, 2009. Dr. Lindberg testified that he is a board-certified orthopedic surgeon and that he is Level II certified with the Colorado Division of Workers' Compensation. In the context of his practice as an orthopedic surgeon in the Denver area, Dr. Lindberg estimated that he has performed surgery for rotator cuff tears "a thousand" times. Dr. Lindberg testified that based upon a reasonable degree of medical probability, the right shoulder complaints pre-dated the injury of April 2008. According to Dr. Lindberg, less than 5% of the rotator cuff tears for which surgery is performed involve an "acute" tear, and the vast majority, 95% of the time, surgery is performed for "attritional" tears. Dr. Lindberg opined that attritional tears, meaning tears that occur from overuse, wear and tear, and the natural process of aging, may be asymptomatic for months until more strenuous activity is undertaken. In the case of an acute rotator cuff tear, however, this leaves people significantly disabled and with significant pain. Dr. Lindberg testified that he has never seen anybody with that kind of injury wait 5 months for medical care.

19. Dr. Lindberg further testified that there is a significant difference in the symptoms involved in the pain that occurs following a new injury from ongoing pain that results from an old injury. According to Dr. Lindberg, this would not be a continuation of the same pain especially because there are two different injuries and two different tendons that are involved. Further, Dr. Lindberg testified that he would expect a patient to have different symptoms for different injuries to the rotator cuff whether or not it was an acute tear or an attritional tear.

20. The ALJ finds that Dr. Lindberg's opinion is less credible than other medical evidence in that his analysis inadequately connects his generalized assessment of shoulder conditions to the specific facts of Claimant's injury.

21. The Respondents submitted into evidence the Claimant's payroll records reflecting Claimant's earnings from April 26, 2007 through February 26, 2009. Claimant's average weekly wage listed on the employer's first report of injury of $239.30 accurately reflects Claimant's earnings at and prior to the time of the accident on April 24, 2008. Claimant presented no evidence to the contrary. The ALJ finds that Claimant's AWW is $239.30.

22. The ALJ finds that the Claimant has failed to establish that it is more likely than not that the incident occurring on January 31, 2008 resulted in a compensable injury.

23. The ALJ finds that Claimant has established by a preponderance of the evidence that she did sustain an injury to her right shoulder, including but not limited to, right biceps tendonitis, right rotator cuff injury, right shoulder strain, and a full thickness tear to the supraspinatus, arising out of and in the course of her employment with the Respondent-Employer on or about April 24, 2008. In this regard the ALJ finds Claimant to be credible.

24. The ALJ finds that Claimant has established by a preponderance of the evidence the need for medical treatment necessary to cure or relieve her from the effects her work-related injury.

25. The ALJ finds that Claimant has failed to establish a current right to temporary total or partial disability benefits.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), ß 8-40-101, C.R.S. (2007), et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. ß 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. ß 8-43-201, C.R.S.. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case

must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. ß 8-43-201, C.R.S.

2. A workers' compensation case is decided on its merits. ß 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P. 3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of a witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he or she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß 8-41-301(1) (c), C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for the determination of the Judge. Faulkner, 12 P.3d. at 846.

5. The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undersigned occurrence. ß 8-40-201(1), supra. By contrast, an "injury" refers to the physical trauma caused by the accident. Thus, an "accident" is the cause and an "injury" the result. City of Boulder v. Payne, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one, which results in an injury requiring medical treatment or causing disability. H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990).

6. The ALJ finds that Claimant has failed to prove that she sustained a compensable injury on January 31, 2008. (W.C. 4-786-535). The ALJ finds that Claimant did suffer an injury on that date but not of a severity that rises to the level of a compensable injury, as the injury did not require medical treatment and did not result in a disability. The claimant did not seek medical attention for this injury, did not lose any time from work and did not file a workers' claim for over one year. When examined at the San Rafael Hospital on February 2, 2008, claimant did not recite any history of injury occurring on January 31, 2008. Further, when examined by Dr. Fabec on February 18, 2008, claimant still did not present any history of a work injury but rather, attributed her right shoulder problems to her prior 2007 injury. The ALJ further finds that claimant's right shoulder condition, for which surgery has been recommended, is not causally related to the injury at work on January 31, 2008.

7. The ALJ finds that claimant did establish by a preponderance of the evidence that she did suffer a compensable injury on April 24, 2008.

(W.C. 4-784-213). Claimant reported this accident immediately, although she did not seek any medical treatment at that time. Claimant continued working. During two office visits to Spanish Peaks Family Clinic on May 6, 2008 and August 28, 2008, Claimant failed to recite a history of work injury. Further, she did not attribute her right shoulder problems to any injury at work for the employer-respondent. Nonetheless, the credible medical and lay evidence establishes that there is a causal link between Claimant's current shoulder condition and the injury of April 24, 2008.

8. The medical evidence establishes that claimant suffered a new "injury", involving a tear of the supraspinatus tendon in the right shoulder, and claimant has established by a preponderance of the evidence that this new tear was caused by an accidental injury occurring at work on April 24, 2008. The ALJ finds the opinions of Dr. Kurz and Dr. Hall to be credible and persuasive.

9. Claimant is entitled to medical treatment to cure or relieve her from the effects of her injury.

10. Claimant has failed to establish that she is currently entitled to temporary total or partial disability benefits.

11. The ALJ concludes that the Claimant's average weekly wage is $239.30.

ORDER

It is therefore ordered that:

7. Claimant's claim for benefits under the Workers' Compensation Act of Colorado in claim WC 4-786-539 for an injury on or about January 31, 2008 is denied and dismissed.

8. Claimant's claim for benefits under the Workers' Compensation Act of Colorado in claim WC 4-784-213 for an injury on or about April 24, 2008 is compensable and Respondent-Insurer shall pay for Claimant's reasonable, necessary, and related medical care to cure or relieve her from the effects of her injury.

9. Claimant's claim for temporary total and/or temporary partial disability benefits is denied and dismissed.

10. Respondent-Insurer shall pay any benefits that may accrue in the future upon a n average weekly wage of $239.390.

11. The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

12. All matters not determined herein are reserved for future determination.

DATE: November 10, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-786-539 and WC 4-784-213

ISSUES

The following issues were raised for consideration at hearing:

Compensability;

AWW;

TTD benefits from April 24, 2008 and on-going; and

Medical benefits.

FINDINGS OF FACT

1. On January 31, 2008, Claimant was employed as a bus driver for the Respondent-Employer. As Claimant was coming out of an office, she tried to close the door behind her, stopped abruptly and jarred her right shoulder. (W.C. 4-786-539). Although Claimant's worker's claim for compensation reflects a date of injury of February 6, 2008, the accident actually occurred on January 31, 2008.

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complete a worker's claim for compensation until February 26, 2009, more than one year after the accident.

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14. There is insufficient evidence to indicate that Claimant was veer put on restrictions. Dr. Kurz specifically indicates no restrictions in his reports of February 18, 2009 and June 5, 2009. The ALJ finds that Claimant has failed to establish she has a work-related disability that has resulted in a

wage loss.

15. On April 28, 2009, Claimant underwent an independent medical examination (IME) with Dr. James Lindberg at the request of the Respondents. Claimant recited a history of injury on April 24, 2008, when she fell off the back of a bus and landed on her right shoulder. Claimant did not report any injury at work on or about January 31, 2008. Dr. Lindberg noted that Claimant underwent prior shoulder surgery by Dr. DeGroote on June 27, 2007, where she had arthroscopic repair of the subscapularis and a biceps tenotomy. Dr. Lindberg agreed with Dr. Kurz that the Claimant's more recent MRI scan revealed a supraspinatus/rotator cuff tear in the right shoulder, a different tendon than that involved in the prior surgery and a new injury. According to Dr. Lindberg, however, there was a significant lag in time in which Claimant sought medical care with respect to the current condition. Dr. Lindberg opined that to a reasonable degree of medical probability, if Claimant injured her shoulder falling out of a bus, she would have sought medical attention sooner than 5 months after the injury. Based upon a totality of the evidence presented the ALJ finds that this opinion is not credible.

16. Claimant underwent an independent medical examination (IME) with Dr. Timothy Hall at the request of her attorney on July 9, 2009. Dr. Hall opined that Claimant's right rotator cuff tear was related to the April 24, 2008 work injury. Dr. Hall agreed that this was a different tear than her previous work injury and a different part of the rotator cuff. According to Dr. Hall, it is not unusual for people to do fairly well with a torn rotator cuff until more

strenuous activities is undertaken. Based upon a totality of the evidence presented the ALJ finds that Dr. Hall's opinion is credible.

17. Claimant's right shoulder condition has not improved and has gradually become worse. Claimant is not currently working. Claimant wants to undergo treatment including surgery for her right shoulder.

18. Dr. Lindberg testified by deposition on September 30, 2009. Dr. Lindberg testified that he is a board-certified orthopedic surgeon and that he is Level II certified with the Colorado Division of Workers' Compensation. In the context of his practice as an orthopedic surgeon in the Denver area, Dr. Lindberg estimated that he has performed surgery for rotator cuff tears "a thousand" times. Dr. Lindberg testified that based upon a reasonable degree of medical probability, the right shoulder complaints pre-dated the injury of April 2008. According to Dr. Lindberg, less than 5% of the rotator cuff tears for which surgery is performed involve an "acute" tear, and the vast majority, 95% of the time, surgery is performed for "attritional" tears. Dr. Lindberg opined that attritional tears, meaning tears that occur from overuse, wear and tear, and the natural process of aging, may be asymptomatic for months until more strenuous activity is undertaken. In the case of an acute rotator cuff tear, however, this leaves people significantly disabled and with significant pain. Dr. Lindberg testified that he has never seen anybody with that kind of injury wait 5 months for medical care.

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difference in the symptoms involved in the pain that occurs following a new injury from ongoing pain that results from an old injury. According to Dr. Lindberg, this would not be a continuation of the same pain especially because there are two different injuries and two different tendons that are involved. Further, Dr. Lindberg testified that he would expect a patient to have different symptoms for different injuries to the rotator cuff whether or not it was an acute tear or an attritional tear.

20. The ALJ finds that Dr. Lindberg's opinion is less credible than other medical evidence in that his analysis inadequately connects his generalized assessment of shoulder conditions to the specific facts of Claimant's injury.

21. The Respondents submitted into evidence the Claimant's payroll records reflecting Claimant's earnings from April 26, 2007 through February 26, 2009. Claimant's average weekly wage listed on the employer's first report of injury of $239.30 accurately reflects Claimant's earnings at and prior to the time of the accident on April 24, 2008. Claimant presented no evidence to the contrary. The ALJ finds that Claimant's AWW is $239.30.

22. The ALJ finds that the Claimant has failed to establish that it is more likely than not that the incident occurring on January 31, 2008 resulted in a compensable injury.

23. The ALJ finds that Claimant has established by a preponderance

of the evidence that she did sustain an injury to her right shoulder, including but not limited to, right biceps tendonitis, right rotator cuff injury, right shoulder strain, and a full thickness tear to the supraspinatus, arising out of and in the course of her employment with the Respondent-Employer on or about April 24, 2008. In this regard the ALJ finds Claimant to be credible.

24. The ALJ finds that Claimant has established by a preponderance of the evidence the need for medical treatment necessary to cure or relieve her from the effects her work-related injury.

25. The ALJ finds that Claimant has failed to establish a current right to temporary total or partial disability benefits.

CONCLUSIONS OF LAW

The purpose of the Workers' Compensation Act of Colorado (Act), ß 8-40-101, C.R.S. (2007), et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. ß 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. ß 8-43-201, C.R.S.. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. ß 8-43-201, C.R.S.

A workers' compensation case is decided on its merits. ß 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P. 3d 385 (Colo. App. 2000).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of a witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

For a claim to be compensable under the Act, a claimant has the burden of proving that he or she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß 8-41-301(1) (c), C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for the determination of the Judge. Faulkner, 12 P.3d. at 846.

The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undersigned occurrence. ß 8-40-201(1), supra. By contrast, an "injury" refers to the physical trauma

caused by the accident. Thus, an "accident" is the cause and an "injury" the result. City of Boulder v. Payne, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one, which results in an injury requiring medical treatment or causing disability. H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990).

The ALJ finds that Claimant has failed to prove that she sustained a compensable injury on January 31, 2008. (W.C. 4-786-535). The ALJ finds that Claimant did suffer an injury on that date but not of a severity that rises to the level of a compensable injury, as the injury did not require medical treatment and did not result in a disability. The claimant did not seek medical attention for this injury, did not lose any time from work and did not file a workers' claim for over one year. When examined at the San Rafael Hospital on February 2, 2008, claimant did not recite any history of injury occurring on January 31, 2008. Further, when examined by Dr. Fabec on February 18, 2008, claimant still did not present any history of a work injury but rather, attributed her right shoulder problems to her prior 2007 injury. The ALJ further finds that claimant's right shoulder condition, for which surgery has been recommended, is not causally related to the injury at work on January 31, 2008.

The ALJ finds that claimant did establish by a preponderance of the evidence that she did suffer a compensable injury on April 24, 2008. (W.C. 4-784-213). Claimant reported this accident immediately, although she did not seek any medical treatment at that time. Claimant continued working. During two office visits to Spanish Peaks Family Clinic on May 6, 2008 and August 28, 2008, Claimant failed to recite a history of work injury. Further, she did not

attribute her right shoulder problems to any injury at work for the employer-respondent. Nonetheless, the credible medical and lay evidence establishes that there is a causal link between Claimant's current shoulder condition and the injury of April 24, 2008.

The medical evidence establishes that claimant suffered a new "injury", involving a tear of the supraspinatus tendon in the right shoulder, and claimant has established by a preponderance of the evidence that this new tear was caused by an accidental injury occurring at work on April 24, 2008. The ALJ finds the opinions of Dr. Kurz and Dr. Hall to be credible and persuasive.

Claimant is entitled to medical treatment to cure or relieve her from the effects of her injury.

Claimant has failed to establish that she is currently entitled to temporary total or partial disability benefits.

The ALJ concludes that the Claimant's average weekly wage is $239.30.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado in claim WC 4-786-539 for an injury on or about January 31, 2008 is denied and dismissed.

Claimant's claim for benefits under the Workers' Compensation Act of Colorado in claim WC 4-784-213 for an injury on or about April 24, 2008 is compensable and Respondent-Insurer shall pay for Claimant's reasonable, necessary, and related

medical care to cure or relieve her from the effects of her injury.

Claimant's claim for temporary total and/or temporary partial disability benefits is denied and dismissed.

Respondent-Insurer shall pay any benefits that may accrue in the future upon a n average weekly wage of $239.390.

The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATE: November 10, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

W.C. No. 4-793-095

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern compensability and, if compensable, Respondents' liability for medical benefits and temporary total

(TTD) and temporary partial (TPD) disability benefits.

At the commencement of the hearing, the parties stipulated that Claimant's average weekly wage (AWW) is $560.00, and the ALJ so finds.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. Claimant has been a full-time employee with the Employer since April 29, 2009. The Employer is primarily in the business of directional drilling and underground utility location.

2. Claimant had surgery on his right wrist in late 2000 or early 2001 for scapholunate repair and acromioplasty. Craig A. Davis, M.D., was the treating physician at the time. Claimant received an arthrogram, which requires injection of a blue dye at the injury site, in his right wrist.

3. On May 6, 2009, during the course and scope of his employment for the Employer herein, the Claimant was using a 3-inch diameter hose to vacuum mud from a drill pit at 6th Avenue and Dexter Street in Denver, Colorado. At approximately 1:00 PM, the hose became blocked with mud. Holding the hose with his left hand, the Claimant reached for a pressure-washing gun with his right hand. The hose twisted or kicked back, snapping back the Claimant's left arm. He immediately felt sharp pain in his left wrist.

4. Claimant promptly notified his foreman, Chris King, and his project manager, Tim Baxter. While filling out an injury report at the work site, Claimant spoke to three coworkers, Chris King, Manuel Ortiz, and Jose Gonzalez,

and compared the pain in his left wrist to the unrelated pain he previously experienced in his right wrist. At hearing, Juan Gonzalez, a coworker on the same crew as Claimant, testified through Interpreter Lambruschini that Claimant told him (Gonzales) that Claimant injured both of his wrists at some time before May 6, 2009. Gonzales' testimony may be characterized as vague, uncertain and hesitant. This cannot be attributed to the fact that he testified in Spanish, which was translated into English. The ALJ finds, at best, Gonzales was confused when he said that Claimant had injured both wrists. This is inconsistent with contemporaneous medical records that indicate an old right wrist injury. For this reason, the ALJ finds that Gonzales' testimony lacks credibility. On the other hand, the medical record corroborates Claimant's testimony that he had an old injury in 2000 or 2001, and was comparing his present left wrist injury to the old right wrist injury. The ALJ finds the Claimant credible in this regard, thus, resolving the conflict in the testimony against Gonzales and in favor of the Claimant's testimony.

5. On May 6, 2009, the Employer filed an Employer's First Report of Injury with the Division of Workers' Compensation (DOWC).

6. Upon referral from his Employer, the Claimant initially sought treatment at Rocky Mountain Urgent Care on May 7, 2009. He received x-rays of his left hand and thumb, left wrist, and left elbow. The x-rays revealed no fractures or dislocations in the left thumb, no fractures in the left wrist, and no fractures or dislocations in the left elbow. Medical records indicate a diagnosis of a strain of the left wrist, a sprain of the left thumb, and epicondylitis of the left elbow. Dale J. Kliner, M.D., told the Claimant to wear a splint and a follow-up appointment was scheduled for May 14, 2009.

7. The Claimant attended a follow-up appointment with Bethany Wallace, D.O., on May 14, 2009. Dr. Wallace recommended that Claimant wear a splint on his left wrist and only perform right-handed work. Dr. Wallace referred the Claimant to Craig A. Davis, M.D., and Eric Tentori, D.O., for continued treatment. These referrals were within the authorized chain of referrals.

8. On May 20, 2009, the Claimant attended an initial appointment with Dr. Tentori of Healthone Occupational Medical Centers in Aurora. Dr. Tentori recommended that Claimant wear a splint on his left wrist and avoid repetitive grasping or gripping work. He noted that Claimant was anticipated to reach maximum medical improvement (MMI) in four to six weeks and referred the Claimant to Dr. Davis.

9. On May 29, 2009, the Claimant attended a follow-up appointment with Dr. Tentori. Dr. Tentori noted that Claimant had persistent pain and functional limitation from his injury. Dr. Tentori recommended that Claimant wear a brace and limit use of his left arm. He estimated MMI in one to two months.

10. On June 1, 2009, the Claimant attended an appointment with Dr. Davis. Dr. Davis diagnosed Claimant with a possible scapholunate ligament tear in the left wrist, joint strain in the left thumb, and a contusion in the left elbow. Dr. Davis performed a comparison x-ray of Claimant's right wrist, which showed evidence of previous injury. Dr. Davis ordered an MR arthrogram of Claimant's left wrist and suggested therapy for his left elbow, but the medical record does not provide any persuasive evidence of follow-up appointments with Dr. Davis.

11. According to the medical records, the Claimant was able to return to

modified duty subject to wearing a brace on his left wrist and limited use of his left arm, including a weight restriction of two pounds. The Employer, however, made no modified-duty available to the Claimant, and terminated Claimant's employment in August or September 2009. The Claimant found temporary marketing work for approximately three weeks but has not otherwise worked.

12. The Claimant last worked for the Employer on May 6, 2009 and, with the exception of working in marketing for three weeks, has neither worked an earned wages nor has he been released to return to work without restrictions or declared to be at MMI. Thus, he has been TTD from May 7, 2009 through October 22, 2009, both dates inclusive, a total of 148 days, both dates inclusive, excluding the 21 days he worked in marketing. Based on the stipulated and found AWW of $560, a TTD rate of $373.33 per week, or $53.33 per day (for mathematical convenience) is yielded. No persuasive evidence was presented concerning Claimant's earnings in marketing for the 21 days. Therefore, Claimant failed to prove entitlement to TPD benefits during this period.

13. The Claimant has not been released from treatment at maximum medical improvement, nor has he been released to return to work without medical restrictions. He has not received medical treatment since June 2009 because his claim was denied, and he has not paid for any medical treatment himself. He still experiences pain in his left wrist and left elbow, but not in his left thumb.

14. On June 18, 2009, Claimant was surreptitiously filmed mowing his lawn. He used both hands to maneuver the lawnmower and turned it both to the left and to the right. The Claimant acknowledges mowing the lawn but maintains that he primarily pushed the lawnmower with his right hand and guided it with his left,

and that he wore a skin-colored mesh brace while mowing. Based on a viewing of the video showing the Claimant mowing his lawn, the ALJ finds the Claimant's explanation of what he was doing plausible and credible.

15. The Claimant has proven, by a preponderance of the evidence that he sustained a compensable injury to his left wrist on May 6, 2009, arising out of the course and scope of his employment for the Employer herein. The Claimant has further proven by preponderant evidence that all of his medical care and treatment for his left wrist injury was authorized, reasonably necessary to cure and relieve the effects of his compensable injury of May 6, 2009, and causally related thereto. Additionally he has proven entitlement to TTD benefits from May 7, 2009 through October 22, 2009, both dates inclusive, a total of 148 days, excluding the 21 days he worked in marketing.

16. The Claimant has failed to prove entitlement to TPD benefits during the 21 days he worked in marketing.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

ALJs may "[d]etermine the competency of witnesses who testify in a workers' compensation hearing or proceeding . . . ." ß 8-43-207(1)(m), C.R.S. (2009).

In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." See Kroupa v. Industrial Claim Appeals Office, 53 P.3d 1192, 1197 (Colo. App. 2002); Penasquitos Village, Inc. v. NLRB, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. See Prudential ins. Co. v. Cline, 98 Colo. 275, 57 P. 2d 1205 (1936), overruled in part on other grounds; Chapman v. Redwine, 370 P.2d 147, at 149-50 (Colo. 1962) [quoting 20 Am. Jur. 1033, Evidence, ßß 1183, 1184]; CJI, Civil, 3:16 (2005). As found, the Claimant's testimony was credible because it was consistent with the medical record and plausible. Jose Gonzales' testimony was not credible. Thus, Claimant's credible testimony supports the occurrence of a compensable injury to his left wrist on May 6, 2009.

The medical evidence concerning authorization, reasonable necessity and causal relatedness is essentially un-contradicted. See, Annotation, Comment: Credibility of Witness Giving Un-contradicted Testimony as Matter for Court or Jury, 62 ALR 2d 1179, maintaining that the fact finder is not free to disregard un-contradicted testimony. It is credible.

An injury is compensable when it "aris[es] out of and in the course of"

employment. ß 8-41-301 (1) (b), C.R.S. (2009). An injury occurs in the course of employment when it occurs "within the time and place limits of the employment relation . . . ." Popovich v. Irlando, 811 P.2d 379, 383 (Colo. 1991). An injury arises out of employment "when it has its origin in an employee's work-related functions and is sufficiently related thereto as to be considered part of the employee's service to the employer in connection with the contract of employment." Id. If an injury arises out of employment, it satisfies the statutory requirement of proximate causation. Miller v. Denver Post, 322 P.2d 661, 662 (Colo. 1958); ß 8-41-301(c). As found, Claimant's injury arose out of and in the course of his employment. Claimant's description of the cause of the injury and the pain he experienced as a result are supported by medical records and are not contradicted by any persuasive evidence. Accordingly, Claimant's injury is compensable.

Because this matter is compensable, Respondents are liable for medical treatment which is reasonably necessary to cure or relieve the effects of an industrial injury. ß 8-42-101(1)(a), C.R.S. (2009); Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997). Pursuant to ß 8-43-405(a), Respondents, "in the first instance", have the authority to select the treating provider for Claimant. As found, the Employer referred the Claimant to Rocky Mountain Urgent Care, which is an authorized medical provider. Also, to be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. See Mason Jar Restaurant v. Industrial Claim Appeals Office, 862 P. 2d 1026 (Colo. App. 1993); One Hour Cleaners v. Industrial Claim Appeals Office, 914 P. 2d 501 (Colo. App. 1995);

City of Durango v. Dunagan, 939 P.2d 496 (Colo. App. 1997). As found, all of the medical referrals for treatment of the Claimant's compensable left wrist injury emanated from Rocky Mountain Urgent Care and are, therefore, authorized.

Claimant's medical treatment has been that which "may reasonably be needed . . . to relieve the employee from the effects of the injury." ß 8-42-101(1)(a), C.R.S. (2009). Courts have found reasonably necessary benefits to be those prescribed by doctors or incidental to receiving authorized treatment. See Atencio v. Quality Care, 791 P.2d 7, 8 (Colo. App. 1990). Claimant's treatment has included emergency care, follow-up appointments and referrals, x-rays, prescribed pain medication, a splint, and a brace. These appointments and treatment measures were reasonably necessary to diagnose and remedy Claimant's injury.

TTD benefits are "sixty-six and two-thirds percent of said employee's average weekly wages so long as such disability is total . . . ." ß 8-42-105(1), C.R.S. (2009). TTD payments extend from the time of the injury until the employee reaches MMI, begins modified employment, is authorized to return to regular employment without medical restrictions, or is authorized to return to "modified employment," which the employee is offered and fails to pursue. ß 8-42-105(3), C.R.S. (2009); see also, Workers' Compensation Rules of Procedure (WCRP), Rule 6-1(A) (2009), 7 CCR, 1101-3. As found, the Claimant has neither reached MMI nor been offered modified employment. Medical records from Dr. Tentori in late May 2009 indicated that Claimant would not reach MMI for one to two months. Additionally, although Claimant pursued modified work in marketing as authorized

by Drs. Kliner, Wallace, and Tentori, the Employer did not provide such work and instead terminated Claimant's employment. Accordingly, Claimant is entitled to TTD benefits from May 7, 2009 through October 22, 2009, both dates inclusive, a total of 148 days, both dates inclusive, excluding the 21 days he worked in marketing. Based on the stipulated and found AWW of $560, a TTD rate of $373.33 per week, or $53.33 per day (for mathematical convenience) is yielded. To establish entitlement to TTD benefits, the Claimant must prove that the industrial injury has caused a "disability," and that he has suffered a wage loss that, "to some degree," is the result of the industrial disability. ß 8-42-103(1), C.R.S. (2009); PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). When a temporarily disabled employee loses his employment for other reasons which are not his responsibility, the causal relationship between the industrial injury and the wage loss necessarily continues. Disability from employment is established when the injured employee is unable to perform the usual job effectively or properly. Jefferson Co. Schools v. Headrick, 734 P.2d 659 (Colo. App.1986). This is true because the employee's restrictions presumably impair his opportunity to obtain employment at pre-injury wage levels. Kiernan v. Roadway Package System, W.C. No. 4-443-973 [Industrial Claim Appeals Office (ICAO), December 18, 2000]. Claimant's termination in this case was not his fault but as a result of the Employer's decision to terminate him and nothing more. Once the prerequisites for TPD and/or TTD are met (e.g., no release to return to full duty, MMI has not been reached, a temporary wage loss is occurring, modified employment is not made available, and there is no actual return to work), TPD and TTD benefits are designed to compensate for temporary wage loss. TTD benefits are designed to compensate for a 100% temporary wage

loss. TPD benefits are designed to compensate for the difference between the AWW and the lesser wages actually earned. See Eastman Kodak Co. v. Industrial Commission, 725 P. 2d 107 (Colo. App. 1986); City of Aurora v. Dortch, 799 P. 2d 461 (Colo. App. 1990). As found, the Claimant has been TTD since May 7, 2009, with the exception of the three weeks he worked in marketing whereby he may be entitled to TPD benefits.

ORDER

IT IS, THEREFORE, ORDERED THAT:

Respondents shall pay the costs of authorized medical care and treatment for the Claimant's injury to the left wrist, thumb, and elbow, in accordance with the Division of Workers' Compensation Medical Fee Schedule.

Respondents shall pay the Claimant temporary total disability benefits of $373.33 per week, or $53.33 per day, from May 7, 2009 through October 22, 2009, both dates inclusive, a total of 148 days excluding the 21 days the Claimant worked in marketing, in the aggregate amount of $7,892. 84, which is payable retroactively and forthwith. From October 23, 2009 and continuing until discontinuance of benefits is warranted by law, Respondents shall continue to pay the Claimant temporary total disability benefits of $373.33 per week.

Any and all claims for temporary partial disability benefits during the 21 days that Claimant worked in marketing are hereby denied and dismissed.

Respondents shall pay the Claimant statutory interest at the rate of eight percent (8%) per annum on all amounts of indemnity benefits due and not paid when due.

Any and all issues not determined herein are reserved for future decision.

DATED this_____day of November 2009.

_____

EDWIN L. FELTER, JR.

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-767-903

ISSUES

1. Whether Claimant has established by a preponderance of the

evidence that a series of three surgeries to his right middle finger as recommended by Dr. Viola constitute reasonable and necessary medical procedures designed to cure and relieve the effects of his industrial injury.

2. A determination of Claimant's Average Weekly Wage (AWW).

FINDINGS OF FACT

1. Claimant worked for Employer as a concrete laborer. On July 28, 2008, while he was unloading a dump truck, the tailgate of the truck unexpectedly closed on his right middle finger. As a result of the incident, Claimant suffered a crush injury to the distal portion of his finger.

2. Claimant obtained emergency medical treatment for his injury at St. Anthony's Hospital. X-rays of his right middle finger revealed a fracture and a flexion deformity consistent with a tendon injury.

4. Hand surgeon Peter C. Janes, M.D. subsequently performed an open reduction of the fracture and a fixation of the distal joint. He inserted a screw to ensure that the joint would not move.

5. Because Claimant was unhappy with the results of the surgery he returned to Dr. Janes for an evaluation on October 30, 2008. Claimant reported that his right middle finger had become stiffer and more sensitive to cold. Dr. Janes offered additional surgery in the form of a fusion of the distal joint. He also encouraged Claimant to seek a second or third opinion regarding additional treatment options.

6. On November 26, 2008 Claimant returned to Dr. Janes for an evaluation. Dr. Janes offered three procedures in order to provide Claimant with a straighter, less painful and more functional finger. However, Dr. Janes cautioned that the procedures would not provide Claimant with normal flexion or

sensation.

7. On December 8, 2008 Dr. Janes performed a second surgery on Claimant's right middle finger. He removed the screw that had been placed in the distal joint and replaced it with an Acutrak fusion screw. Dr. Janes also straightened the finger with a volar plate advancement and performed a radial dorsal hood repair. During the procedures Claimant became unresponsive, suffered an "intraoperative respiratory arrest" and had to be assisted with breathing.

8. On February 23, 2009 Claimant visited Dr. Janes for an examination. Dr. Janes noted that Claimant had an "obvious" fusion of the DIP joint. He expressed concerns about Claimant's motivation to improve and remarked that "most people are doing much better in this situation than he is." Dr. Janes commented that Claimant was scheduled to visit William Milliken, M.D. for "other issues" and sought his opinion regarding Claimant's finger.

9. On March 6, 2009 Claimant visited Dr. Milliken for an evaluation. Claimant reported pain from his right middle finger that extended towards his elbow. Dr. Milliken stated that Claimant was in "delayed recovery" because he reported that he was "terribly disabled by the injury." He remarked that additional surgery should be deferred pending evaluation after Claimant controlled his depression and improved his coping/insight abilities.

10. On March 31, 2009 Claimant underwent a psychological evaluation regarding factors affecting his recovery. Claimant was diagnosed with Major Depressive Disorder.

11. Authorized Treating Physician (ATP) Corey McCarty, M.D. subsequently referred Claimant to hand specialist Randall W. Viola, M.D. for a

surgical consultation. In his initial report of April 7, 2009 Dr. Viola ordered an MRI of Claimant's right middle finger to ascertain whether the distal joint was fused and there was any pathology in the finger requiring additional surgery.

12. On April 10, 2009 Claimant underwent an MRI of his right middle finger. The MRI revealed that Claimant's radial collateral ligament was "chronically torn" at the "interphalangeal joint" and there was "[n]o solid bony fusion."

13. Based on the results of the MRI Dr. Viola recommended a series of three procedures on Claimant's right middle finger. The first procedure was a revision fusion of the DIP joint with a bone graft. During the same surgery, Dr. Viola recommended nerve allograft reconstructions of the radial and ulnar digital nerves. After six weeks of recovery, he suggested a tenolysis or stripping of the FDS and FDP tendons in Claimant's right middle finger.

14. On April 22, 2009, at Insurer's request, hand surgeon Jonathan Sollender, M.D. reviewed the surgical recommendations of Dr. Viola. After considering Claimant's medical history Dr. Sollender determined that none of the procedures were reasonable and necessary. Respondents thus denied Dr. Viola's request for the procedures.

15. Regarding a revision fusion of the DIP joint, Dr. Sollender noted that a "solid bony fusion" of the joint would not be unexpected because the joint was locked in place by an Acutrak screw. Furthermore, Dr. Sollender noted that even Dr. Viola "did not indicate any instability of the DIP joint nor abnormal positioning, angulation or rotational deformity." Because the joint was stable Dr. Sollender did not recommend additional surgery.

16. Regarding nerve allograft reconstructions, Dr. Sollender commented that there was no documented digital nerve injury in Claimant's right middle finger. Although Claimant had complaints of chronic pain, Dr. Sollender remarked that "specific nerve exam has not demonstrated a specific nerve injury of either the radial or ulnar digital nerves." Dr. Sollender thus recommended denial of the procedure unless there was adequate information identifying a specific nerve injury and location.

17. Regarding a tenolysis of the FDS and FDP tendons, Dr. Sollender explained that the tendons control flexion and extension of the joints in the middle finger. Because Claimant's DIP joint was fused, it was unnecessary to strip the tendons. Furthermore, there was no suggestion that there were any intrinsic problems with the tendon mechanisms. Dr. Sollender noted that any problems with the tendons would be reflected in range of motion measurements but Dr. Viola did not record the measurements.

18. On April 28, 2009 Dr. McCarty urged Respondents to reconsider the denial of Dr. Viola's surgical recommendations. He noted that Claimant's "depression, anxiety, anti-inflammatory induced gastritis and chronic pain (with risk for chronic narcotic use) could all abate if this surgical revision is successful." Dr. McCarty also remarked that Claimant was a "good candidate for this surgery."

19. On June 17, 2009 hand surgeon Kulvinder Sachar, M.D. performed an independent medical examination of Claimant. The parties also conducted the evidentiary deposition of Dr. Sachar. He concluded that the three procedures recommended by Dr. Viola did not constitute reasonable and necessary medical treatment of Claimant's right middle finger injury. Dr. Sachar determined that

Claimant had reached a treatment plateau and should be placed at Maximum Medical Improvement (MMI).

20. Dr. Sachar first noted that an MRI was not the ideal test to ascertain whether Claimant had a bony fusion because MRI's tend to work better in assessing soft tissues. He thus took x-rays during his examination to review the status of Claimant's fusion. Although acknowledging that the small joint and screw made a determination difficult, Dr. Sachar saw "bridging bone" and the fusion appeared to be healed. Moreover, he did not find any instability in the joint and the metallic screw had not loosened. Dr. Sachar thus determined that a revision fusion of the DIP joint was not reasonable and necessary.

21. In terms of the proposed nerve allograft reconstructions, Dr. Sachar noted that he did not find any wounds on the part of Claimant's right middle finger where the nerves travel and thus there was no "indication that the nerves had been cut in any way." He explained that a damaged area must be identified prior to replacing a finger nerve. However, Dr. Viola had not identified any specific nerve damage. Dr. Sachar also remarked that Claimant could feel light touch in his finger and could lose sensation after a nerve graft.

22. Regarding the proposed tenolysis or stripping of the tendons, Dr. Sachar explained that Claimant did not require surgery because he had near normal range of motion in his right middle finger. He remarked that Claimant had 90 degrees of PIP motion and that a tenolysis is less successful when attempting to "make very small gains in motion." Dr. Sachar did not believe that he could reliably improve Claimant's motion through the procedure because he was already capable of motion that was close to normal.

23. Dr. Viola testified through an evidentiary deposition in this matter. He explained that the revision fusion, nerve allograft reconstruction and tenolysis on Claimant's right middle finger constituted reasonable and necessary medical procedures designed to cure or relieve the effects of Claimant's industrial injury. Dr. Viola commented that Claimant required a revision fusion surgery because he experienced pain in the DIP joint and that pain in the joint reflected a nonunion. He explained that Claimant required a nerve allograft because the crush injury prevented his digital nerve from functioning. Dr. Viola noted that a new product had become available in the past year that increased the likely success of a nerve graft. Finally, he recommended a tenolysis because Claimant suffered both range of motion deficits and weakness in his right middle finger. Nevertheless, Dr. Viola acknowledged that Claimant's joint may have fused in the period since the examination, his right middle finger nerves may be functioning normally and the tendons may have near normal range of motion. He also failed to consider Claimant's delayed recovery and other psychological issues documented in the medical records.

24. Claimant has failed to demonstrate that it is more probably true than not that the three surgeries to his right middle finger recommended by Dr. Viola are reasonable and necessary medical procedures designed to cure or relieve the effects of his industrial injury. Initially, the medical records reveal that Claimant has exhibited a number of psychological issues that present concerns for proceeding with additional surgical procedures. More importantly the persuasive opinions of doctors Sollender and Sachar suggest that the three procedures recommended by Dr. Viola are not reasonable and necessary. Regarding a revision fusion of the DIP joint, Dr. Sachar noticed "bridging bone" and the

fusion appeared to be healed. Moreover, there was no instability in the joint and the metallic screw had not loosened. In terms of the proposed nerve allograft reconstructions, Dr. Sachar noted that he did not find any wounds on the part of Claimant's right middle finger where the nerves travel and thus there was no "indication that the nerves had been cut in any way." Moreover, Dr. Sollender did not document any injury to either the radial or ulnar digital nerves. Finally, regarding the tenolysis or stripping of the tendons, Dr. Sachar explained that Claimant did not require surgery because he had near normal range of motion in his right middle finger. He remarked that Claimant had 90 degrees of PIP motion and that a tenolysis is less successful when attempting to remedy small deficits in motion. Dr. Sollender also noted that there were no intrinsic problems with the tendon mechanisms. Although Dr. Viola explained that the three procedures were reasonable and necessary, he acknowledged that Claimant's joint may have fused in the period since his examination, his right finger nerves may be functioning normally and the tendons may have near normal range of motion. Dr. Viola also failed to consider Claimant's delayed recovery and other psychological issues documented in the medical records.

25. On July 7, 2008 Claimant received a raise from $10.00 to $12.00 per hour from Employer. In the ensuing three weeks up to the date of Claimant's industrial injury on July 28, 2008 he worked an average of 54.67 hours per week. However, relying on the three-week period distorts the number of hours that Claimant typically worked for Employer each week. Instead, examining the 12 weeks prior to Claimant industrial injury reveals that Claimant worked an average of 48.25 hours each week. Multiplying 40 hours each week times $12.00

each hour yields earnings of $480.00 per week. Adding eight and one-quarter hours of overtime each week at an overtime rate of $18.00 per hour yields another $148.50. Adding $480.00 plus $148.50 thus yields an AWW of $628.50. An AWW of $628.50 constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and

actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Proposed Hand Surgeries

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. ß8-42-101(1)(a), C.R.S.; Colorado Comp. Ins. Auth. v. Nofio, 886 P.2d 714, 716 (Colo. 1994). The determination of whether a particular treatment modality is reasonable and necessary to treat an industrial injury is a factual determination for the ALJ. In re of Parker, W.C. No. 4-517-537 (ICAP, May 31, 2006); In re Frazier, W.C. No. 3-920-202 (ICAP, Nov. 13, 2000). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office, 989 P.2d 251, 252 (Colo. App. 1999).

5. As found, Claimant has failed to demonstrate by a preponderance of the evidence that the three surgeries to his right middle finger recommended by Dr. Viola are reasonable and necessary medical procedures designed to cure or relieve the effects of his industrial injury. Initially, the medical records reveal that Claimant has exhibited a number of psychological issues that present concerns for proceeding with additional surgical procedures. More importantly the persuasive opinions of doctors Sollender and Sachar

suggest that the three procedures recommended by Dr. Viola are not reasonable and necessary. Regarding a revision fusion of the DIP joint, Dr. Sachar noticed "bridging bone" and the fusion appeared to be healed. Moreover, there was no instability in the joint and the metallic screw had not loosened. In terms of the proposed nerve allograft reconstructions, Dr. Sachar noted that he did not find any wounds on the part of Claimant's right middle finger where the nerves travel and thus there was no "indication that the nerves had been cut in any way." Moreover, Dr. Sollender did not document any injury to either the radial or ulnar digital nerves. Finally, regarding the tenolysis or stripping of the tendons, Dr. Sachar explained that Claimant did not require surgery because he had near normal range of motion in his right middle finger. He remarked that Claimant had 90 degrees of PIP motion and that a tenolysis is less successful when attempting to remedy small deficits in motion. Dr. Sollender also noted that there were no intrinsic problems with the tendon mechanisms. Although Dr. Viola explained that the three procedures were reasonable and necessary, he acknowledged that Claimant's joint may have fused in the period since his examination, his right finger nerves may be functioning normally and the tendons may have near normal range of motion. Dr. Viola also failed to consider Claimant's delayed recovery and other psychological issues documented in the medical records.

Average Weekly Wage

6. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The

Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. Pizza Hut v. ICAO, 18 P.3d 867, 869 (Colo. App. 2001). However, ß8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. Campbell v. IBM Corp., 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. Ebersbach v. United Food & Commercial Workers Local No. 7, W.C. No. 4-240-475 (ICAO May 7, 1997). As found, an AWW of $628.50 constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's request for three additional surgical procedures on his right middle finger is denied and dismissed.

2. Claimant earned an AWW of $628.50.

3. Any issues that have not been resolved by this Order are reserved for future determination.

DATED: November 10, 2009.

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Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-778-802

ISSUES

The issue for determination is the compensability of Claimant's claim.

FINDINGS OF FACT

1. The Respondent-Employer has employed Claimant as a security guard for in excess of three years.

2. Claimant's duties include ensuring that both the inside and outside portions of the premises are secure. This includes ensuring that doors are locked as necessary and other security measures.

3. Claimant is also responsible for providing aide to employees who work on the premises. Claimant is an employee of the Respondent-Employer and not of the business that has contracted with Respondent-Employer to provide security services. The Respondent-Employer assigns Claimant to the work location.

4. Claimant's duties require Claimant to make walking rounds of the premises during his shift. Although the amount of time

Claimant is on his feet walking during any given day varies, minimally Claimant is walking for two hours but usually not more than three hours. The walking occurs at different intervals and is not constant throughout the shift. The remaining time on shift Claimant sits at a desk.

5. Claimant was required to wear either walking shoes or dress shoes while on the job. Claimant chose to wear walking shoes. Claimant does not recall whether the shoes were new or worn during the time period in question herein

6. On the evening of August 18, 2008, Claimant was at work, doing his usual walking rounds. Claimant walked approximately two hours that night.

7. For several days prior to starting his shift on August 18, 2009 Claimant had notice that he was experiencing pain in his toe. The pain kept getting worse over time.

8. Prior to August 19, 2008, Claimant did not notice that an ulcer was developing on his great toe. Upon examining his foot on August 19, 2008, Claimant noticed his toe was turning black. Claimant was not aware of any accident or injury to the great toe that had occurred in this time frame.

9. Claimant called the Respondent-Employer and informed them of his situation and told them he would not be into work that day. Claimant was told to go the emergency room.

10. On August 19, 2008 Claimant went to the emergency room at Memorial Hospital and was there for over six hours being treated because Claimant had an ulcer on his toe that was infected. Claimant was treated at the

hospital with an intravenous antibiotic solution. Claimant was advised to follow up with the Wound Clinic at Memorial Hospital.

11. Claimant was restricted from walking by RN Shaheen on August 19, 2008, with the proviso that the restriction remains in effect until cleared by podiatry. Six days later, on August 25, 2008, the podiatrist, Dr. Conner, released Claimant to work without restriction.

12. Claimant missed approximately three to five shifts the following week and then returned to work without restrictions following his appointment with the podiatrist.

13. Claimant still works for Respondent-Employer and continues to do the same job.

14. Subsequent to the discovery of Claimant's ulcer in August 2008, his toe did not completely heal. Claimant did continue to do his three hours of walking per day on his shifts. Because Claimant's toe condition did not completely heal in this time Claimant underwent surgery in July 2009.

15. Claimant believed that the foot condition was work related because it only hurt when he was walking at work.

16. Claimant did report his toe condition as work related approximately one week after the emergency room visit. Claimant reported this to his supervisor, Mr. Day. Mr. Day was unsure if it was a workers' compensation matter but reported to be safe. Claimant's claim was initially denied. The Respondent-Employer then attempted a second time to have it covered as a workers' compensation injury but it was denied again.

17. Dr. J Tashof Bernton examined Claimant on August 31, 2009, during an independent medical evaluation (IME) requested by the

Respondent-Insurer. Dr. Bernton is board certified in both internal medicine and occupational medicine. Dr. Bernton did not have records from Claimant's podiatrist at the time of his examination but did subsequently review those records. Dr. Bernton's opinion was unchanged by the review of the additional records.

18. Dr. Bernton IME revealed that Claimant is a single male who smokes one to two packs of cigarettes a week and occasionally drinks alcohol on the weekends. Claimant was having problems with his foot, off and on, for most of the year 2008.

19. Claimant has a history of EKG's with evidence of lateral ischemic changes, diabetes intermittently under poor control, hypertension, neck pain, and depression.

20. Claimant's medical history revealed that on January 22, 2008 Claimant received a referral to a podiatrist for a "callous, plantar, medial, left great toe. Had similar lesion in the past leading to open wound ñ diabetic ñ eval and treat."

21. On August 19, 2008 Claimant advised the ER that he had a sore on his left great toe times two weeks. Claimant's toe at that time revealed an open foul-smelling ulcer with exposure tendon.

22. Dr. Bernton ultimately opined that Claimant's condition is as the direct result of his diabetes. Dr. Bernton noted that Claimant is at a very high risk for infection due to his diabetic condition with a previous history of infection of that area pre-operatively.

23. Dr. Bernton further opined that Claimant's toe ulcer is not work related, as it is a diabetic ulcer. He opined that Claimant's

clinical course would be little different if he were not employed or were employed in a different type of occupation.

24. The ALJ finds Dr. Bernton to be credible in his assessment and analysis of Claimant's condition and gives it great weight.

25. The ALJ notes that there is clearly insufficient medical evidence in the record supporting the work-relatedness of Claimant's condition. While the ALJ is free to adopt Claimant's opinion over that of medical opinion as to work-relatedness, under the facts herein the ALJ declines to do so. Claimant has failed to establish that it is more likely than not that his ulcerous toe condition arose out of or in the course of his employment with the Respondent-Employer, as either a distinct injury or as an occupational disease.

26. The ALJ finds that Claimant's need for medical treatment hereunder was due to Claimant's underlying disease process of diabetes and its natural progression. Claimant has not brought forth credible evidence that the wearing of the designated shoes and walking on the job, in some way served as a catalyst that aggravated, accelerated or combined with Claimant's diabetes to set in motion events that ultimately lead to Claimant's forming a diabetic ulceration in his great toe.

27. According to the Employee Accident Report, Claimant was hired on August 30, 2006. There is sufficient evidence to establish that Claimant worked between August 30, 2006 and January 2008 without exhibiting symptoms related to the ulceration of his great toe. Claimant indicates that he is not sure if the shoes he was wearing at the time of discovery of the ulceration were new or worn. The evidence does not establish that the doctors

treating Claimant for the ulceration focused or brought suspicion upon the Claimant's shoes as being a causative factor. The evidence is insufficient to establish that Claimant has changed the actual shoes he was wearing at the time of the discovery of the ulceration or that he has changed the style or comfort level of his shoes since that time. The ALJ infers that the wearing of shoes in the workplace and the walking of rounds, even in the shoes as dictated by the Respondent-Employer herein, is a ubiquitous condition. The mere act of wearing shoes and walking is found generally outside of the Claimant's employment.

28. The factual record is inadequate to establish that the wearing of the shoes and walking as dictated by the Respondent-Employer created a hazard of employment.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A Claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits.

ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a Claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß8-41-301(1)(c) C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. Faulkner, 12 P.3d at 846.

5. Claimant brought his pre-existing diabetic condition and his susceptibility to injury with him to the workplace. It is well established that

this in and of itself is not a bar to recovery under the Workers' Compensation Act of Colorado. However, Claimant must show that the employment aggravated, accelerated, or combined with the pre-existing condition or susceptibility to produce a need for medical treatment.

6. The ALJ concludes that Claimant's need for medical treatment hereunder was due to Claimant's underlying disease process of diabetes and its natural progression. Claimant has not brought forth credible evidence that the wearing of the designated shoes, in conjunction with the intermittent walking, in some way served as a catalyst that aggravated, accelerated or combined with Claimant's diabetes to set in motion events that ultimately lead to Claimant's forming a diabetic ulceration in his great toe.

7. Claimant was restricted from walking by RN Shaheen on August 19, 2008, with the proviso that the restriction remains in effect until cleared by podiatry. Six days later, on August 25, 2008, the podiatrist, Dr. Conner, released Claimant to work without restriction. The ALJ infers that Dr. Conner was not concerned that wearing shoes and walking would aggravate, accelerate or combine with Claimant's diabetic condition to bring on a further deterioration of Claimant's condition.

8. The ALJ concludes that Claimant has failed to establish that it is more likely than not that his diabetic condition was aggravated, accelerated, or combined with Claimant's walking and wearing of designated shoes to produce the need for medical treatment.

9. The ALJ concludes that the wearing of shoes in the workplace, even the shoes as dictated by the Respondent-Employer herein, is a ubiquitous condition. The mere act of wearing shoes and walking is found

generally outside of the Claimant's employment.

10. Claimant must therefore establish that his diabetic condition combined with a hazard of the job to bring about his need for medical treatment. The factual record is inadequate to establish that the wearing of the shoes and walking, as dictated by the Respondent-Employer, created a hazard of employment.

11. As found above, Claimant has failed to establish by a preponderance of the evidence that his employment aggravated, accelerated, or combined with the pre-existing condition or susceptibility to produce a need for medical treatment. Claimant's great toe condition did not arise out of or in the course of his employment with the Respondent-Employer.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: November 12, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-740-056

ISSUES

Whether Respondents Petition to Modify, Terminate, or Suspend Compensation, which seeks to suspend Claimant's temporary total disability benefits should be granted an order approving said petition.

Whether Respondents have proven by a preponderance of the evidence that Claimant's TTD benefits should be terminated beginning May 28, 2009, until Claimant receives an SI joint injection and curative medical benefits resume, because of an intervening, superseding cause; Claimant's May 28, 2009, unrelated stroke.

FINDINGS OF FACT

1. Claimant sustained an admitted injury in this claim on October 25, 2007. Respondents admitted liability, and provided Claimant with medical and temporary total disability benefits. Claimant, on May 28, 2009, suffered a stroke, specifically a vertebral artery dissection. Claimant was treated for that condition at Memorial Hospital on May 28, 2009. Claimant received care outside of the hospital for his stroke with M. Annette Seagraves, M.D. Dr. Seagraves placed Claimant on Coumadin for treatment of his stroke.

2. On May 28, 2009, Claimant was scheduled for an SI joint injection with Kenneth Finn, M.D. On June 24, 2009, Claimant saw Dr. Finn. At that visit Claimant was not taking any pain medication for his pain associated

with this claim. Dr. Finn, in his report of June 24, 2009, stated Claimant's stroke was a complicating medical issue that prevented Claimant from having further treatment in this claim until cleared for treatment by Dr. Seagraves. Dr. Schwender, Claimant's ATP, saw Claimant on July 15, 2009, and agreed Claimant could not proceed with further treatment in this claim because of his anticoagulant treatment for his stroke.

3. On August 6, 2009, Dr. Schwender sent a letter to respondents' attorney. In that letter, Dr. Schwender stated Claimant would need to be on his anticoagulant therapy for three to six months after that therapy began on May 28, 2009. Dr. Schwender stated he anticipated Claimant would remain on anticoagulants, and unable to receive treatment in this claim, until the end of November, or early December 2009. He wrote, "At this point, we are not providing any curative or diagnostic evaluations for the patient's work-related injury of 10/25/2007." Dr. Schwender noted that Claimant was to have an SI joint injection on May 28, 2009, in this claim, but it was cancelled due to the stroke. Dr. Schwender thought Claimant's curative medical treatment could resume in December 2009.

4. Dr. Schwender testified at an evidentiary deposition taken by respondents on September 15, 2009. Dr. Schwender testified Claimant's stroke of May 28, 2009, was not causally related to the injury that occurred on October 25, 2007. He reiterated Claimant's treatment, the SI joint injection with Dr. Finn, was cancelled on May 28, 2009, because of his stroke. He explained that Claimant was also to maintain appointments for evaluations and treatment with

Dr. Schwender. Dr. Schwender testified that Claimant had received no curative medical benefits since May 28, 2009, and that curative medical benefits were stopped due to Claimant's treatment and drug therapy for his stroke that made Claimant unable to receive any curative medical treatment in this claim. Claimant could only resume treatment, Dr. Schwender said, after he stropped his anticoagulant therapy. Dr. Schwender testified that Claimant may be able to resume treatment in this claim in December 2009. Dr. Schwender also testified that the medication Claimant currently received, Vicodin, is a maintenance treatment, and not a curative medical treatment or benefit. Dr. Schwender said that if Claimant had not sustained a stroke on May 28, 2009, he anticipated Claimant's treatment would have been completed by September 15, 2009, and that he would have reached maximum medical improvement in this claim. This was did not occur because of Claimant's stroke.

5. The ALJ finds the estimates provided by Dr. Schwender are more speculative than certain and find that Respondents have failed to establish by a preponderance of the evidence the requisite grounds to suspend temporary total disability benefits.

6. Claimant has not prevented ongoing treatment but cannot participate because of an intervening event. At the time of the intervening event Claimant was temporarily totally disabled and pursuing active treatment. Thus, the ALJ finds that Claimant's industrial injury contributed in some degree to his temporary total disability existing after the intervening event.

7. Notwithstanding who has the burden of proof, Claimant has established by a preponderance of the evidence that Claimant's industrial injury contributed to some degree to Claimant's temporary total disability.

CONCLUSIONS OF LAW

1. At the conclusion of the Respondents' case in chief the Claimant moved for a directed verdict. That motion is hereby denied.

2. The purpose of the Workers' Compensation Act of Colorado ("Act") is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß 8-40-102 (1), C.R.S. Claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Worker' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß 8-43-201, C.R.S.

3. Temporary total disability benefits are due where the Claimant proves the industrial injury causes a disability and the Claimant leaves work as a result of the disability. Section 8-42-105(1), C.R.S. 2001. An insurer is only liable for disabilities which are a natural consequence of the industrial injury. Standard Metals Corp. v. Ball, 172 Colo. 510, 474 P.2d 622 (1970). An intervening event may sever the causal connection between the injury and the temporary wage loss. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). PDM is not limited to cases in which the intervening event is

termination from employment. Horton v. Industrial Claim Appeals Office, 942 P.2d 1209 (Colo. App. 1996).

4. The industrial disability need not be the sole cause of the wage loss to recover temporary disability benefits. PDM Molding, Inc. v. Stanberg, supra. Rather, it is sufficient if the Claimant proves that the wage loss is to, "some degree," attributable to the industrial injury. Bestway Concrete v. Industrial Claim Appeals Office, 984 P.2d. 680 (Colo. App. 1999); Black Roofing, Inc. v. West, 967 P.2d 195 (Colo. App. 1998). Temporary total disability benefits are precluded where the industrial injury plays no part in the temporary wage loss. Horton v. Industrial Claim Appeals Office, supra. An intervening event does not automatically trigger the termination of temporary disability benefits, but can if respondents adequately prove Claimant's wage loss is due to an intervening unrelated cause, and not the industrial injury. Roe v. Industrial Commission, 734 P.2d 138 (Colo. App. 1986), held that an ALJ may suspend temporary disability benefits when intervening events indicate that the Claimant's wage loss results from factors other than the industrial injury.

5. The termination of TTD analysis was applied in Parks v. Ft. Collins Ready Mix, Inc., W. C. No. 4-251-955 (March 31, 1999). In that case, benefits were not suspended, for respondents did not show Claimant's TTD would have resolved had he been able to receive medical treatment in the claim. The Court wrote, "Under PDM [supra], it was incumbent upon the respondents to show that at some particular point, the injury no longer contributed in any degree to the Claimant's wage loss. The respondents do not cite any evidence that the Claimant's temporary disability would have resolved by a date certain if he undergone the surgery." Cf. Zanandrie v. Castle Garden Nursing Home (Colo.

App. No. 92CA1406, October 7, 1993) (not selected for publication)" Parks v. Ft. Collins Ready Mix, Inc., W. C. No. 4-251-955 (March 31, 1999)

6. If a Claimant establishes that his work-related injury contributed, at least to some degree, to Claimant's wage loss, Claimant is eligible for temporary disability benefits. Horton v. Indus. Claims Appeals Office of the State of Colorado, 942 P.2d 1209, 1210 (Colo.App. 1996). Benefits are only barred when the work injury plays no part in a Claimant's subsequent wage loss. Id. Thus, if Claimant's work related injury contributes in part to the subsequent wage loss, TTD benefits can only be denied, suspended, or terminated due to of the four statutory factors defined in CRS ß 8-42-105(3). Id. at 1211. The four statutory factors in C.R.S. ß 8-42-105(3) are: 1) The employee reaching MMI; 2) The employee returning to regular or modified employment; 3) The attending physician giving the employee a written release to return to regular employment; 4) The attending physician giving the employee a written release to return to modified employment, such employment being offered to the employee in writing, and the employee failing to begin such employment.

7. Here, the Respondents have failed to establish that the intervening event severed the causal relationship between the Claimant's industrial injury and current disability.

8. Claimant's have established by a preponderance of the evidence that Claimant's work-related injury contributed, at least to some degree, to Claimant's wage loss, therefore, Claimant is eligible for temporary disability benefits

ORDER

It is therefore ordered that:

1. Respondents' petition to suspend Claimant's temporary total disability benefits is denied and dismissed.

2. The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

3. All matters not determined herein are reserved for future determination.

DATE: November 12, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-730-506

ISSUE

The sole issue presented at the time of the hearing was medical benefits, specifically, whether the injury, which Claimant received to his left shoulder and left upper extremity is causally related to the original admitted injury to his right shoulder.

FINDINGS OF FACT

Based upon the evidence presented at the hearing and contained in the record, the following Findings of Fact are entered:

1. Claimant received an injury to his right shoulder in the course and scope of his employment on July 22, 2007. This right shoulder injury was admitted by Respondents, and Claimant has been receiving temporary disability benefits and medical benefits for his right shoulder injury.

2. Michael Hewitt, M.D. performed a surgical repair of Claimant's right shoulder in September 2007.

3. Claimant continued to experience problems with his right shoulder injury subsequent to his surgery. Those problems included, pain, weakness, loss of range of motion, numbness, diminished strength, and a diminished ability to control his right shoulder and arm. Claimant did not have a good surgical outcome from his right shoulder surgery.

4. Subsequent to his surgery, Claimant came under the care of Phillip Stull, M.D. Inasmuch as Claimant was continuing to experience significant problems with his right shoulder, Dr. Stull scheduled another surgery. The second right shoulder surgery is scheduled to take place on October 26, 2009.

5. On or about January 7, 2009, Claimant went up on the roof of his garage to inspect for possible damage from a windstorm the day before. Claimant was concerned about possible damage to the roof, because stored in the garage were

tools and books, which he needed for his livelihood. He did not want them to be damaged by water in the event of a rainstorm.

6. Prior to going up on the roof, Claimant attempted to get someone else to go up on the roof and check it for him, but to no avail. He also attempted to go into the neighbor's yard so that he could survey any possible roof damage from the ground, but that proved also to be unsuccessful. Claimant chose not to pay someone to inspect his roof.

7. While in the process of climbing down from the roof on the ladder, Claimant reached with his right arm to gain support. However, as he did so, he felt a pain in his right shoulder, and the right shoulder gave way. This caused Claimant to fall to the ground. While he was falling, Claimant tried to turn his body so as to protect his injured right shoulder, and he fell on his left side. As a result of this incident, Claimant received injuries to his left shoulder.

8. Claimant was not exceeding his work restrictions on January 7, 2009, at the time his right shoulder collapsed and caused him to fall off the ladder. Claimant used his right upper extremity to balance himself not for the purpose of supporting his weight.

9. Claimant's admitted work injury to his right shoulder caused this body part to be in a weakened condition. The weakened condition of Claimant's right shoulder was a causative factor in the injury to his left shoulder, which

occurred on January 7, 2009. Claimant's right shoulder "collapsed" and "gave way" on January 7, 2009, because of its weakened condition as a result of the July 22, 2007, admitted right shoulder injury.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the following Conclusions of Law are reached.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S., et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

2. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals

Office, 5 P. 3d 385 (Colo. App. 2000).

3. In the Colorado Court of Appeals case, Jarosinski v. ICAO, 62 P.3rd 1082 (Colo. App. 2002), and the Colorado Supreme Court case, Standard Metals v. Ball, 172 Colo. 510, 474 P.2d 622 (1970), the courts held that if the work injury leaves a claimant's body in a weakened condition, and the weakened condition plays a causative role in a subsequent injury, then the additional injury is compensable. The evidence established that this is what happened in this case.

4. The record reflects that Claimant received an admitted injury to his right shoulder on July 22, 2007. Although he underwent surgery for his shoulder, he did not have a good surgical outcome, and the injury, which Claimant received to his right shoulder resulted in that body part being left in a weakened condition. He continued to experience pain and weakness in his right shoulder and right upper extremity, so much so that another surgery on his right shoulder has been scheduled.

5. The evidence established that Claimant climbed on to the roof on January 7, 2009, because he was concerned that there had been wind damage to the roof, which might damage tools and books Claimant stored in his garage and needed for his livelihood. When he went up on the roof, Claimant did not violate his work restrictions since he credibly testified that he used his right upper extremity to balance himself and not to hold his weight.

6. Accordingly, it is determined that the work related injury of July 22, 2007, left Claimant's body in a weakened condition, and the weakened condition played a causative role in the January 7, 2009, injury, therefore, the January 7, 2009, injury is compensable. More specifically stated, it is concluded that Claimant's right shoulder played a causative role in his fall from the ladder causing injury to his left shoulder. Therefore, it is concluded that the injuries Claimant received on January 7, 2009, are compensable and that he is entitled to receive medical benefits to cure and relieve him from the effects of that injury. Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988).

ORDER

It is hereby ORDERED, ADJUDGED AND DECREED that:

1. Respondents shall provide and pay for all authorized, reasonably necessary and related medical benefits which are needed by Claimant to cure and relieve him from the effects of the January 7, 2009, injury to his left shoulder.

2. All matters not determined herein are reserved for further decision.

DATED: November 12, 2009

_____

Margot W. Jones

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-766-273

ISSUES

ÿ Did the claimant prove by a preponderance of the evidence that Dr. Darin Busse, D.C., is an authorized chiropractic medical provider?

ÿ Did the claimant prove by a preponderance of the evidence that she is entitled to an increase in the average weekly wage over the wage previously admitted by the respondents?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. The claimant sustained an admitted back injury on June 25, 2008, while employed as a "bagger" at the employer's meat packing facility.

2. The claimant was originally hired as a probationary bagger on September 7, 2007, and was paid $11.85 per hour. On September 28, 2007, the claimant was promoted to regular bagger and received a raise to $12.05 per hour. The claimant also earned overtime pay at the rate of time and a half. On November 30, 2007, the claimant received another raise to $12.30 per hour.

At the time of the injury on June 25, 2008, the claimant was still earning $12.30 per hour and continued to earn overtime pay at the rate of time and a half. On June 25, 2008 the claimant was typically working 40 regular hours per week and an average of 13.71 overtime hours per week (based on the average overtime hours worked per week from November 30, 2007 through June 20, 2008, or 411.22 hours OT divided by 30 weeks = 13.71). Thus, if the claimant's AWW is calculated as of June 25, 2008, the ALJ finds it would be $744.94 (40 regular hours per week x $12.30 per hour = $492, and 13.71overtime hours per week x $18.45 = $252.94; $492 + $252.94 = $744.94).

3. Despite the imposition of medical restrictions limiting her to modified duty, the claimant continued working after the injury on June 25, 2008. The claimant has not claimed that the imposition of the restrictions resulted in any wage loss that might entitle her to temporary disability benefits.

4. By January 12, 2009, the claimant had been awarded another pay raise to $12.55 per hour. The ALJ finds that if the claimant's AWW were calculated on that date it would be $760.02 (40 regular hours per week x $12.55 per hour = $502, and 13.71 overtime hours per week x $18.82 = $258.02; $502 + $258.02 = $760.02).

5. The claimant credibly testified that she reported the injury to her supervisor, and that the supervisor referred her to the employer's on-site health care facility (employer's clinic) for treatment. The ALJ finds, based on the First Report of Injury [Exhibit A] the claimant reported the injury to the supervisor on the date it occurred, June 25, 2008. Medical records reflect the claimant was seen at the employer's clinic with various complaints,

including left shoulder, neck and upper back pain, on June 27, 2008, July 3, 2008, July 7, 2008 and July 10, 2008. Treatments included heat and massage. On July 10, 2007, it was noted that the claimant had not shown improvement and would be referred "to see doc" on the next visit. On July 10, 2008, there is a notation that the claimant "refused to sign Dr. form ñ argued ñ walked out."

6. On July 2, 2008, the claimant sought treatment from Dr. Darin Busse, D.C., at Cornerstone Chiropractic (Cornerstone). The claimant admitted that she sought this treatment "on her own" without referral from the employer's clinic. Dr. Busse's records indicate that on July 2 the claimant gave a history that her "symptoms appeared or accident happened" at work on June 25, 2008. The claimant credibly testified that when she visited Dr. Busse she told him she had been hurt on the job.

7. On July 18, 2008, the employer provided the claimant a Workers' Compensation Designated Medial Provider List (provider list). The provider list named three physicians (including Dr. Hector Brignoni at the on-site clinic) that were authorized by the respondents to treat the claimant for her injury. The claimant signed and dated the list. The respondents did not provide the claimant any written "list" of authorized providers on or before July 7, 2008, the seventh business day after the employer received notice of the injury (June 25, 2008).

8. On August 1, 2008, claimant's counsel sent a letter to the respondents' claims adjuster. Citing ß 8-43-404(5)(a)(I)(A), C.R.S., the letter states as follows:

"the employer or insurer are [sic] required to provide a list of at least two medical providers from which the employee may select a provider. In this case,

a designated provider list was not provided to the claimant. In accordance with Rule 8-2 of the Workers' Compensation Rules of Procedure, the Respondents' failure to provide a providers list gives the claimant the right to select an authorized treating physician of her own choosing. At this time, the claimant has chosen, Dr. David Yamamoto, M.D. Ö as an authorized treating physician."

9. There is no credible or persuasive evidence that the respondents advanced any objection to the claimant's assertion that, under the circumstances, she had a statutory right to select Dr. Yamamoto as an authorized treating physician (ATP).

10. Dr. Yamamoto began treating the claimant on August 27, 2008. Dr. Yamamoto's note reflects that the claimant advised him that she had received treatment from the employer and from Dr. Busse. Dr. Yamamoto assessed a cervical sprain, strain of the thoracic region and a shoulder/arm sprain. Dr. Yamamoto prescribed medications, limited the claimant to modified duty with restrictions on lifting, carrying and pushing and pulling. Dr. Yamamoto also recommended chiropractic treatment and stated he would contact Dr. Busse to see if he treated workers' compensation cases.

11. On September 30, 2008, Dr. Yamamoto referred the claimant to Dr. Michael Larimore, D.C., for additional chiropractic treatment. Dr. Larimore first saw the claimant on September 30, 2008.

12. The claimant credibly testified that after Dr. Yamamoto referred her to Dr. Larimore she stopped treatment with Dr. Busse. Although the copies of Dr. Busse's records submitted into evidence are blurred and unclear, the ALJ infers from them that the claimant last received treatment from Dr. Busse sometime in September 2008.

13. On December 1, 2008, Dr. Yamamoto released the claimant to return to work at full duty. Dr. Yamamoto noted that chiropractic treatment was helping, and he continued to prescribe medications.

14. On January 12, 2009, Dr. Yamamoto issued a report placing the claimant at maximum medical improvement (MMI) with a 4 percent whole person impairment rating. Dr. Yamamoto stated that it was his opinion the claimant sustained "a mild permanent injury to the upper back, which will likely continue to be a problem off and on for her, although it has not limited her in the workplace." No permanent work restrictions were imposed.

15. On March 17, 2009, the respondents filed a Final Admission of Liability (FAL) admitting for permanent partial disability benefits based on Dr. Yamamoto's impairment rating. The respondents also admitted to an average weekly wage (AWW) of $652.86.

16. The claimant proved it is more probably true than not that she selected Dr. Busse as the authorized treating chiropractor following the respondents' failure timely to provide her with a written "list" of authorized medical providers as required by ß 8-43-404(5)(a)(I)(A). The right of selection passed to the claimant after the respondents failed to provide the list on or before July 7, 2008, seven business days after they were notified of the injury. On July 7, 2008, the claimant visited Dr. Busse for treatment. The claimant had already advised Dr. Busse, on July 2, 2008, that she associated her symptoms with an incident at work on June 25, 2008, and Dr. Busse was fully aware that he was treating what might be a work-related condition. Further, the claimant continued seeking and receiving chiropractic treatment from Dr. Busse until after she began treatment with Dr. Yamamoto and was referred to Dr. Larimore.

This treatment by Dr. Busse continued for more than one month after the respondents failed to provide the required list of providers. The ALJ finds that by her actions in seeking treatment with Dr. Busse, advising him that she had suffered a work related injury and needed treatment, and continuing treatment with Dr. Busse for more than one month she "selected" Dr. Busse as the authorized treating chiropractor.

17. The ALJ has considered the respondents' assertions that the evidence demonstrates the claimant selected Dr. Yamamoto rather than Dr. Busse as the ATP, but does not find this evidence and the accompanying inferences to be persuasive. First, the claimant did not see and was not examined by Dr. Yamamoto until August 27, 2008, long after the respondents failed to give the claimant the provider list and long after she began receiving regular treatments from Dr. Busse. Although the letter sent by claimant's counsel to the adjuster on August 1, 2008 states the claimant has "chosen" Dr. Yamamoto as the ATP, counsel qualified that statement by adding the words "at this time." Thus, the letter implicitly recognizes that, considering the amount of treatment already rendered by Dr. Busse, there were substantial legal and factual questions concerning whether or not the claimant was even entitled to "select" Dr. Yamamoto as the ATP without pursuing one of the statutory remedies for a change of physician. Moreover, the ALJ finds the fact that Dr. Yamamoto acted as the treating physician beginning in August 2008 is as much attributable to the respondents' acquiescence in the claimant's desire to change physicians as the claimant's decision to select Dr. Yamamoto. Indeed, the respondents ultimately relied on Dr. Yamamoto's MMI determination and impairment rating when they filed the FAL. In any event, the ALJ does not consider Dr. Yamamoto's

understanding of his status as the ATP to be particularly persuasive evidence concerning whether he was in fact the ATP.

18. The ALJ exercises his discretion to determine that the claimant's AWW is most fairly calculated in accordance with the calculation contained in Finding of Fact 4. The ALJ notes that the claimant did not actually suffer any compensable wage loss prior to reaching MMI on January 12, 2009. Between the date of the initial accident and injury on June 25, 2008 and January 12, 2009, the claimant was awarded a wage increase. The ALJ infers this wage increase, as well as the claimant's history of wage increases over a substantial period of time prior to the injury, demonstrates the claimant's is a good and desirable worker with a positive outlook for future employment opportunities. This evidence, taken with Dr. Yamamoto's permanent impairment rating and credible opinion that the claimant's upper back symptoms will likely continue to bother her, causes the ALJ to infer the injury has caused the claimant a permanent loss of future earning capacity that she would not otherwise have suffered. The ALJ finds that in these circumstances it would be manifestly unfair to base the claimant's AWW, and hence her award for permanent partial disability benefits, on the earnings she was receiving on the date of the accident rather than increased wage she was earning on the date of MMI. Accordingly, the ALJ finds the claimant's AWW is $760.02.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et

seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

AVERAGE WEEKLY WAGE

The claimant argues the ALJ should exercise his discretion to base

her AWW on the wages she was earning on January 12, 2009, the date of MMI. The claimant asserts that this calculation would fairly compensate her for medical impairment. The respondents argue that the circumstances do not justify the exercise of such discretion and the AWW should be determined as of June 25, 2008, the date the claimant sustained the accidental injury. The ALJ agrees with the claimant.

Section 8-42-102(2), C.R.S., requires the ALJ to base the claimant's AWW on his earnings at the time of injury. However, under certain circumstances, the ALJ may determine the claimant's AWW from earnings received on a date other than the date of injury. Avalanche Industries, Inc. v. Clark, 198 P.3d 589 (Colo. 2008); Campbell v. IBM Corp., 867 P.2d 77 (Colo. App. 1993). Specifically, ß 8-42-102(3), C.R.S., grants the ALJ discretionary authority to alter the statutory formula if for any reason it will not fairly determine the claimant's AWW. Coates, Reid & Waldron v. Vigil, 856 P.2d 850 (Colo. 1993). The overall objective in calculating the AWW is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity. Campbell v. IBM Corp., supra. Where the claimant's earnings increase periodically after the date of injury the ALJ may elect to apply ß 8-42-102(3) and determine that fairness requires the AWW to be calculated based upon the claimant's earnings during a given period of disability, not the earnings on the date of the injury. Avalanche Industries, Inc. v. Clark, supra; Campbell v. IBM Corp., supra.

The ALJ notes that where, as here, permanent partial disability (PPD) benefits are payable based on a whole person impairment rating, the claimant's AWW factors into the calculation of the total PPD award. Section 8-42-107(8)(d), C.R.S. (PPD rate includes temporary total rate, which is dependent on AWW

pursuant to ß8-42-105). PPD benefits are payable from the date of MMI when temporary disability ends and the claimant's permanent impairment becomes determinable. MGM Supply Co. v. Industrial Claim Appeals Office, 62 P.3d 1001 (Colo. App. 2002); Nunnally v. Wal-Mart Stores, Inc., 943 P.2d 26 (Colo. App. 1996). Moreover, PPD benefits are payable for permanent loss of earning capacity and are not directly comparable to temporary disability benefits that compensate for an actual wage loss of wages during the hearing period prior to MMI. See Pizza Hut v. Industrial Claim Appeals Office, 18 P.3d 867 (Colo. App. 2001); Broadmoor Hotel v. Industrial Claim Appeals Office, 939 P.2d 460 (Colo. App. 1996). When considering the appropriate AWW the ALJ may consider what impact the claimant's permanent impairment may have on her future earning capacity. Pizza Hut v. Industrial Claim Appeals Office, supra.

As determined in Finding of Fact 5, the ALJ concludes, in the exercise of his discretion under ß 8-42-102(3), that it would be manifestly unfair to base the claimant's award of PPD benefits on the AWW that she was receiving on the date of the accident (June 25, 2008) rather than the AWW she was receiving on the date she became permanently and partially disabled (January 12, 2009). The increase in wages that the claimant received between the date of the accident and the date of MMI, and the previous wage increases, demonstrate the claimant's future earning capacity is greater than suggested by the earnings she was earning on the date of the accident. Moreover, Dr. Yamamoto's statements finding that the claimant has sustained permanent impairment, and that he expects this impairment to affect the claimant in the future supports the conclusion that the claimant's future earning capacity has been adversely affected by the industrial injury. Therefore, the ALJ concludes the claimant's

AWW is $760.02.

AUTHROIZATION OF DOCTOR BUSSE

The claimant contends that Dr. Busse is an authorized medical provider because the respondents failed timely to provide a list of authorized medical providers in accordance with ß 8-43-404(5)(a)(I)(A), and she properly selected Dr. Busse to treat her. The claimant further contends that the August 1, 2008, letter constituted a proper request for a "one-time change of physician" to Dr. Yamamoto, and that the respondents did not timely respond to this request. For their part, the respondents concede they did not timely provide a list of providers to the claimant as required by ß 8-43-404(5)(a)(I)(A). However, they argue the evidence establishes that the claimant selected Dr. Yamamoto, not Dr. Busse, as the ATP. The ALJ agrees with the claimant that she properly selected Dr. Busse as the authorized treating chiropractor.

Authorization to provide medical treatment refers to a medical provider's legal authority to provide medical treatment to the claimant with the expectation that the insurer will compensate the provider for the services rendered. Bunch v. Industrial Claim Appeals Office, 148 P.3d 381 (Colo. App. 2006); One Hour Cleaners v. Industrial Claim Appeals Office, 914 P.2d 501 (Colo. App. 1995).

Section 8-43-404(5)(a)(I)(A), applicable to this 2008 injury and claim for benefits, provides that:

"In all cases of injury, the employer or insurer shall provide a list of at least two physicians or two corporate medical providers or at least one physician and one corporate medical provider, where available, in the first

instance, from which list an injured employee may select the physician who attends said injured employee."

The statute further provides that if "the services of a physician are not tendered at the time of injury, the employee shall have the right to select a physician or chiropractor."

This statute affords the employer the right to designate at least two physicians and/or corporate providers that are deemed authorized to provide medical treatment. Consistent with the version of ß 8-43-404(5)(a) that was amended in 1997, the current version provides that the employer's right to designate the authorized providers may be lost and the right of selection passed to the claimant if medical services are not tendered "at the time of injury." See Rogers v. Industrial Claim Appeals Office, 746 P.2d 565 (Colo. App. 1987).

Moreover, the ALJ concludes that cases holding that once the ATP is "selected" the claimant may not change physicians or employ additional providers without obtaining permission from the insurer or exercising a right granted by statute remain good law. This is true because the current version of ß 8-43-404(5)(a)(I)(A) still gives the employer the initial right to designate the authorized provider, and the respondents still remain interested in the selection of the ATP since they are liable to pay for the medical treatment. See Yeck v. Industrial Claim Appeals Office, 996 P.2d 228 (Colo. App. 1999).

Section 8-43-404(5)(a)(II)(B), C.R.S., provides that if an employer "has its own on-site health care facility, the employer may designate such on-site health care facility as the authorized treating physician." However, the statue further provides that the employer must comply with subparagraph (III) of this paragraph (a) of the statute. Section 8-43-404(5)(a)(III)

establishes a method by which an employee may "obtain a one-time change in the designate authorized treating physician" if the employee follows certain statutorily prescribed procedures.

The Director (Director) of the Division of Workers' Compensation (DOWC) has adopted regulations governing the application of these statutory provisions. Recognizing that the statute does not define precisely when and how the mandated "list" of providers must to be given to the injured worker, the Director has adopted WCRP 8-2(A)(1). This rule states that the "list can initially be provided to the injured worker verbally or through an effective pre-injury designation." However, the rule also requires that a "written designated provider list shall be mailed, hand-delivered or furnished in some other verifiable manner to the injured worker within seven (7) business days following the date the employer had notice of the injury." WCRP 8-2(D) provides that if "the employer fails to comply with this Rule 8-2, the injured worker may select an authorized treating physician of the worker's choosing."

WCRP 8-4 governs situations in which the employer maintains a "qualified on-site health care facility." Consistent with the statute, the rule provides that the employer may designate the on-site facility as the ATP provided the facility meets certain criteria. Significantly, WCRP 8-4(C) recognizes, consistent with ß 8-43-404(5)(a)(I)(A), that an employer that maintains a qualified on-site facility is not exempted from complying with the statutory requirement to provide a "list" of alternative providers. Rather, "within seven (7) business days following notice of an on the job injury" the employer must "provide the injured worker with a designated provider list consistent with the provisions of Rule 8-2(A)(2)." WCRP 8-4(C) further provides

that while the on-site provider shall be the initial ATP, the claimant may change to a provider on the list by complying with the requirements of ß 8-43-404(5)(a)(III).

Here it is not disputed that the employer maintained a qualified on-site health care facility, and that the claimant's supervisor referred the claimant to the facility for treatment after notice of the injury on June 25, 2007. Moreover, the respondents do not actually dispute that they failed to comply with 8-43-404(5)(a)(I)(A) and WCRP 8-4(C) by providing the claimant with a written list of providers within seven business days of June 25, 2008. Consequently, the ALJ concludes that on July 8, 2008, "right of selection" passed to the claimant in accordance with ß 8-43-404(5)(a)(I)(A) and WCRP 8-2(D).

In Squitieri v. Tayco Screen Printing, Inc., W.C. No. 4-421-960 (ICAO September 18, 2000), the ICAO held that held that the term "select," as it appears in the predecessor to ß 8-43-404(5)(a)(I)(A) is unambiguous and should be construed to mean "the act of making a choice or picking out a preference from among several alternatives. Thus, the ICAO held that a claimant "selects" a physician when she "demonstrates by words or conduct that [she] has chosen a physician to treat the industrial injury." The ICAO also indicated that the question of whether the claimant selected a particular physician as the ATP is one of fact for determination by the ALJ, and the ALJ's resolution of this issue must be upheld if supported by the record.

As determined in Findings of Fact 16 and 17, the ALJ concludes the claimant proved it is more probably true than not that by her actions she selected Dr. Busse as the authorized treating chiropractor after the respondents failed

timely to give her a provider list on or before July 7, 2008. As found, the claimant began treatment with Dr. Busse on July 2, 2008, advised him that she had been injured at work. She continued treatment with Dr. Busse until approximately September 2008, after Dr. Yamamoto referred her to another chiropractor, Dr. Larimore. These acts demonstrate the claimant chose to be treated by Dr. Busse, and he became the authorized provider after the right of selection passed to the claimant on July 8, 2008. For the reasons stated in Finding of Fact 17 the ALJ is not persuaded that the claimant selected Dr. Yamamoto as the ATP.

Because the ALJ has determined that the claimant selected Dr. Busse as the authorized treating chiropractor, the ALJ need not consider the claimant's assertion that the August 1, 2008, letter constituted a request for a "one-time change of provider" and that the respondents waived any objection to this request by failing to respond to it.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

2. The claimant's average weekly wage is $760.02. The respondents shall pay the admitted permanent partial disability benefits in accordance with the statutory formula, including this modified average weekly wage.

3. Dr. Busse is an authorized chiropractic provider for purposes of the industrial injury that the claimant sustained on June 25, 2008.

4. Issues not resolved by this order are reserved for future

determination.

DATED: November 12, 2009

_____

David P. Cain

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-785-525

ISSUES

The issues for determination are compensability, employment, average weekly wage, temporary total disability benefits, medical benefits, and penalty for failure to insure. Claimant, in his position statement, argued for a penalty for failure to timely report the injury to the Division of Workers' Compensation. This issue was not mentioned at the beginning of the hearing and was not argued by Respondent. This penalty issue, and other issues not determined by this hearing, will be reserved for future determination.

FINDINGS OF FACT

1. Claimant entered into a Taxicab Operation Agreement with Respondent on January 28, 2009. By entering into the agreement, Claimant and Respondent acknowledged that Claimant was an independent contractor, free from authority and control of Respondent. Further, in the agreement Claimant

acknowledged that he is not entitled to workers' compensation benefits and that he is obligated to pay federal and state income tax on any monies earned pursuant to the agreement. Pursuant to the agreement, Claimant is required to pay a "stand" fee of $672.00 per week. The stand fee entitles Claimant to lease the cab and to take advantage of Respondent's dispatch system.

2. Claimant was involved in an accident that resulted in serious injury on February 8, 2009. The accident occurred when a driver of a stolen vehicle broadsided Claimant while he was driving the taxi pursuant to the Taxicab Operation Agreement with Respondent. This occurred on the second day that Claimant had driven the taxi since signing the Taxicab Operation Agreement.

3. Denver Health has treated Claimant since his injury. The treatment he has received from Denver Health has been reasonably necessary to cure and relieve him from the effects of the injury.

4. Claimant had worked for Respondent on and off for some years. In August 2007, Claimant and his wife went overseas and spent the entire year of 2008 overseas. Claimant did not work for Respondent and earned no wages from August 2007 through 2008.

5. Claimant and his wife testified as to his gross receipts during the full day and part day Claimant worked for Respondent in February 2008. The two days were a Friday and Saturday, which are busier than other days of the week. The gross receipts from those two days do not accurately reflect his average weekly wage.

6. In 2007, Claimant filed a US Income Tax Return showing that his wife earned $8,902 and that he earned nothing. Claimant indicated his

occupation as “unemployed.” In 2006, Claimant filed a US Income Tax Return showing that his wife earned $7,856 in wages and that he earned $926 in business income. Claimant claimed that he paid $9,800 for his lease and $5,874 for car and truck expenses. Claimant also claimed that he drove 13,200 business miles and that he had evidence to support this deduction. In 2005, Claimant filed a US Income tax Return showing that his wife earned $25,622. Claimant claimed a business loss of $2,538 for 2005, claiming that he paid $11,780 for his lease and $7,148 in car and truck expenses. He also claimed that he drove 17,560 business miles and that he had documentation for his deductions. The income tax returns for the prior years are not credible evidence of his earnings during those years.

7. Claimant testified as to his earnings as a taxi driver in prior years. However, his tax returns show either a lack of understanding of income and expenses, or a deliberate underreporting of his income to the IRS. In either event, Claimant’s testimony as to his income is not credible or persuasive.

8. Claimant and his wife testified that he earned adequate income to fund their living expenses and to pay for extraordinary medical expenses during the time he worked for Respondent and during his year off. Claimant’s wife had earnings during these years and the evidence does not show what earnings Claimant had from his work for Respondent.

9. Taxi drivers testified as to their earnings before the PUC in 2008. The drivers were seeking higher fares. Drivers reported earning $15.00 to $25.00 per hour before expenses. However, the PUC report notes that “drivers’ costs and profitability were not a focus of this report.”[1] This PUC report is

not persuasive evidence of taxi drivers' earnings in 2009.

10. Elsayed, a former taxi driver for Respondent, testified that he made about $100.00 per day after expenses and worked five days per week. This testimony is credible and persuasive.

11. Claimant testified that in the prior years he had worked six days per week for Respondent, and that he was planning on working six days per week when he resumed working for Respondent. It is likely that Claimant would not have worked six days per week every week due to an occasional illness or illness of a family member, and an occasional vacation. It is found that it is more likely than not that Claimant would work five days per week and earn $100.00 per day after expenses. Claimant's average weekly wage is fairly computed to be $500.00 per week.

12. At the time of the accident, Respondent had a policy with AIG that covered Claimant. The policy covers medical expenses with a deductible of $500.00 and a maximum amount of $100,000.00. The policy also provides for indemnity benefits with a maximum amount of $200.00 per week for up to 52 weeks. The policy has an aggregate limit of $250,000.00. No benefits are paid for permanent impairment or disability. The AIG Insurance coverage does not provide similar coverage to a worker's compensation policy.

13. Claimant has not returned to work since the accident due to the injuries he sustained in the accident. As of the date of the hearing, Claimant has been disabled for 37.2857 weeks.

CONCLUSIONS OF LAW

Claimant has established by a preponderance of the evidence that, at

the time of the accident, he working as a driver with Respondent, a common carrier. Respondent provided coverage under an insurance policy issued by AIG. That policy capped temporary disability benefits and medical benefits. That policy did not provide coverage for any permanent impairment or disability. The policy is not similar to a workers' compensation policy. Section 8-40-301(6), C.R.S.; Gebrekidan v. MKBS, LLC, W.C. 4-687-723 (ICAO, May 10, 2007).

The physicians and other providers at Denver Health who treated Claimant for his injuries from the accident are authorized. Section 8-43-404(5), C.R.S. The treatment Claimant has received from Denver Health was reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Respondent is liable for the medical care Claimant receives from Denver Health. Section 8-42-101(1), C.R.S. Liability is limited to the amounts established by the Division of Workers' Compensation fee schedule. Section 8-43-404(5), C.R.S. Respondent may credit any amounts paid by AIG. Respondent shall reimburse Claimant for any amounts not paid by AIG and paid by Claimant.

On the evidence presented, Claimant's average weekly wage has been fairly determined to be $500.00 per week. Section 8-42-102(3), C.R.S. Temporary total disability is payable at the rate of two-thirds of that amount, which is $333.33 per week. Section 8-42-105(1), C.R.S. As of the date of the hearing, Claimant has been temporary and totally disabled for 37.2857 weeks. Claimant is entitled to temporary disability indemnity benefits totaling $12,428.57. AIG has paid disability indemnity benefits of $200.00 per week, except for the first two weeks, for a total of 35.2857 weeks as of the date of the hearing. AIG has therefore paid $7,057.14. Respondent is liable to Claimant for temporary total disability benefits in the amount of $5,371.43. Respondent is also liable for

interest at the rate of eight percent per annum on all benefits not paid when due. Section 8-43-410, C.R.S.

Respondent did not carry workers' compensation insurance on Claimant at the time of the injury. Compensation is increased by 50% for the failure to insure. As of the date of the hearing, Claimant was entitled to $12,428.57 in compensation in the form of temporary disability benefits. Respondent is liable for 50% of that amount, or $6,214.29, as a penalty for failure to insure.

Respondent must pay a deposit or post a bond for the amount of the present value of all unpaid compensation or benefits. Section 8-43-408(2), C.R.S. As of the date of the hearing, there is $5,371.43 in unpaid temporary disability benefits, and $6,214.29 in unpaid penalty for failure to insure. The amount of the interest, the future temporary and permanent disability benefits, and the unpaid and future medical bills is not known. The amount of the bond or deposit is set at $12,000.00.

Respondent is liable for temporary disability benefits increased by fifty percent after the date of the hearing until temporary disability benefits are terminated pursuant to Section 8-42-105(3), C.R.S., or other provision of the Worker's Compensation Act.

ORDER

It is therefore ordered that:

1. Respondent is liable for the medical care Claimant receives from Denver Health. Liability is limited to the amounts established by the Division of Worker's Compensation fee schedule. Respondent may credit any amounts paid by AIG. Respondent shall reimburse Claimant for any amounts not paid by AIG and paid by Claimant.

2. Respondent shall pay Claimant temporary total disability benefits due as of the date of the hearing in the amount of $5,371.43. Respondent shall pay interest at the rate of eight percent per annum.

3. Respondent shall pay Claimant $6,214.29 as a penalty for failure to insure.

4. Respondent shall pay Claimant temporary disability benefits and penalty for failure to insure from the date of the hearing until terminated pursuant to law. Respondent may credit any disability indemnity benefits paid by AIG.

5. In lieu of payment of the above compensation and benefits to the Claimant, Respondent shall:

a. Deposit the sum of $12,000.00 with the Division of Workers' Compensation, as trustee, to secure the payment of the unpaid compensation and benefits awarded. The check shall be payable to and sent to the Division of Workers' Compensation, 633 17th Street, Suite 900, Denver, Colorado, 80202, Attention Sue Sobolik; or

b. File a bond in the sum of $12,000.00 with the Division of Workers' Compensation within ten (10) days of the date of this Order (i) signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or (ii) issued by a surety company authorized to do business in Colorado. The bond shall guarantee payment of the compensation and benefits awarded.

It is further ordered that Respondent shall notify the Division of Workers' Compensation of payments made pursuant to this Order.

It is further ordered that the filing of any appeal, including a petition to

review, shall not relieve Respondent of the obligation to pay the designated sum to the trustee or to file the bond. Section 8-43-408(2), C.R.S.

6. Matters not determined herein are reserved for future determination.

DATED: November 12, 2009

Bruce C. Friend, ALJ

Office of Administrative Courts

W.C. No. 4-792-207

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUE

The sole issue to be determined by this decision concerns the compensability of an aggravation of an alleged occupational disease of the Claimant's back.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. Claimant is a 56-year old male who sustained a compensable

occupational disease to his lumbar spine, with no specific date of event or traumatic injury noted. He began work with the Employer on August 8, 1983 and worked continuously at heavy duties until his last day of work on April 30, 2009. Claimant had sustained a prior low back stain with the Employer in 1988 for which he filed a workers' claim for compensation, and for which he received medical treatment. His 1988 lumbar strain resolved by 1990 and is unrelated to his present symptomatology or present workers' claim for compensation.

2. The Claimant was employed as a sanitation worker/janitor, which entailed heavy lifting, the cleaning of machines, snow removal, trash disposal into containers at chest level or above, i.e., overhead, cleaning offices, sweeping, mopping, buffing floors, cleaning bathrooms, the lunchroom, hallways and stairwells. According to the Claimant, most of his job duties entailed heavy work. This is undisputed by any persuasive evidence, and the ALJ so finds.

3. Claimant advised Henry J. Roth, M.D., the Independent Medical Examiner (IME) hired by Respondents, that he back pain following his 1988 strain and it resolved in 1990. He began experiencing back pain symptoms in 2007. He went to see his personal physician, Harry Walter, D.O., who ultimately obtained an MRI (magnetic resonance imaging) scan which revealed degenerative disc disease at every level of Claimant's thoracic and lumbar spine, with spinal stenosis present at levels L1-L2, L2-L3, L3-L4, and L4-L5. As a result of Dr. Walter's findings and the MRI findings, the Claimant underwent a spinal fusion in September 2007, and a second emergency fusion due to continuing symptoms on September 24, 2008. According to Dr. Walter, repeat fusion surgeries are not uncommon. Following Claimant's second spinal fusion surgery, he returned to

work, and began experiencing increasing back pain after performing his heavy job duties. Claimant voluntarily terminated his employment with the Employer in April 2009. Thereafter, on May 1, 2009, he filed a workers' claim for compensation based upon an alleged occupational disease to his lumbar spine. He affixes the onset date of his occupational disease at February 5, 2008.

4. Dr. Walter is of the opinion that Claimant's present disability is proximately caused by Claimant's employment that required that Claimant perform "heavy lifting, mopping, reaching, twisting under considerable stress, etc." At hearing, Dr. Walter stated that the constant spinal loading, or lifting, in connection with Claimant's employment, as well as the continual twisting movement of the joints in Claimant's spine aggravated or caused his spine to degenerate by wearing out the soft tissue which then resulted in the diagnosis of spinal stenosis and the need for surgery. Dr. Walter based his opinion on his personal knowledge and practice for 35 years as a practitioner of family medicine, and the numerous patients he had treated in the past with work related injuries, plus his long-term familiarity with Claimant's medical condition. Dr. Walter is not Level II accredited, but has continuously been licensed to practice medicine in Colorado for 35 years. He has treated 10-15 patients in his practice with degenerative disc disease. Based on Dr. Walter's opinion, which the ALJ finds more credible and persuasive than Dr. Roth's opinion, the ALJ finds that Claimant's work for the Employer herein caused a substantial and permanent aggravation of the Claimant's underlying degenerative back condition.

5. Respondents' IME, Dr. Roth, examined the Claimant once at his office on September 8, 2008. This examination lasted for approximately one hour. Dr. Roth never spoke with any other medical providers in this case. Dr. Roth is of

the opinion that Claimant's diagnoses include degenerative disease throughout his spine with resultant spinal stenosis at numerous levels, and that the spinal stenosis is caused by the degeneration in his lumbar spine. Further, he expressed the opinion that Claimant's degenerative disc disease was not caused or aggravated by his work environment. Like Dr. Walter, Dr. Roth relied on his personal medical practice of lesser duration than that of Dr. Walter, and upon so-called recent trends and medical studies. He cited 10 medical studies related to the cause of degenerative disc disease and its relationship to the work place and genetic factors, and produced along with his report the results of several related studies pertaining to spinal loading (lifting) as a risk factor for back pain, intervertebral disc aging and degeneration, and lumbar disk degeneration epidemiology in support of his opinion. He stated the alleged avant- garde opinion that there is now a shift in current medical "science" that degeneration of a person's lumbar spine or intevetrabal disc, without evidence of a traumatic injury, is due largely to genetic make-up and has essentially no relationship to a person's work environment. Dr. Roth's opinion runs contrary to conventional medical wisdom as revealed by Dr. Walter's testimony, and it also defies reason and common sense to maintain that years of heavy lifting has absolutely no relationship to an aggravation and acceleration of a degenerative back condition. The ALJ resolves the conflict in medical opinion in favor of Dr. Walter's opinion and against Dr. Roth's opinion in this regard.

6. Claimant has no family history of any type of degenerative arthritis or disc disease, which makes Dr. Roth's opinion that these degenerative conditions have genetic origins unlikely and the ALJ so finds.

7. The Claimant has proven that it is more reasonably probable than not that Claimant's 25 years of heavy work for the Employer herein aggravated and accelerated his degenerative condition of the back, substantially and permanently aggravating his back condition, to the point that Claimant could no longer work as of April 30, 2009. Therefore, the Claimant has proven by preponderant evidence that he sustained a compensable occupational disease to his back, proximately resulting directly from his 25-year employment for the Employer and the conditions under which his work was performed, which followed as a natural incident of his work and the exposure occasioned thereby and did not come from a hazard to which the Claimant would have been equally exposed outside of his employment ñ in this case his family tree and walking the earth as a homo sapiens sapiens.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." See Kroupa v. Industrial Claim

Appeals Office, 53 P.3d 1192, 1197 (Colo. App. 2002); Penasquitos Village, Inc. v. NLRB, 565 F.2d 1074 (9th Cir. 1977). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. See Burnham v. Grant, 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. See Prudential ins. Co. v. Cline, 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). See Young v. Burke, 139 Colo. 305, 338 P. 2d 284 (1959). As found, he opinion of Dr. alter concerning the proximate causal relationship of Claimant's work duties to the acceleration and aggravation of his occupational back disease is more credible and persuasive than Dr. Roth's opinion to the contrary.

An "occupational disease" is a disease resulting directly from the employment as a proximate cause and one that does come from a hazard to which the employee would have been equally exposed outside of the employment. ß 8-40-201 (14), C.R.S. (2009). See City of Colorado Springs v. Industrial Claim Appeals Office, 89 P. 3d 504 (Colo. App. 2004). As found, Claimant has proven an occupational disease with an onset date of February 2008, and a last injurious exposure of April 30, 2009.

The purpose of ß 8-41-304(1), C.R.S. (2009), is to assign liability for an occupational disease where a claimant has been exposed to the hazards of the disease during successive employments. Robbins Flower Shop v. Cinea, 894 P.2d 63 (Colo. App. 1995); Seyhouwer v. Kristin F. Robbins, D.D.S. W. C. Nos. 4-462-729, 4-471-878 (ICAO, May 20, 2003). If a claimant proves an injurious exposure with the employer, then he must prove by a preponderance of the evidence that her preexisting condition was substantially and permanently aggravated. See Monfort Inc. v. Rangel, 867 P.2d 122 (Colo. App. 1993); Fisher v. United Parcel Service, W.C. Nos. 4-114-768 & 4-221-453 (ICAO, May 8, 1996); aff'd, (Colo. App. No. 96CA0943, February 20, 1997) [not selected for publication]. As found, Claimant has proven exposure while working for the same Employer herein; and, he has proven that his continuous exposures substantially and permanently aggravated his preexisting degenerative back condition.

Under ß 8-41-304(1), C.R.S. (2009), a injured worker is not required to exactly pinpoint which period of employment most injuriously exposed him to the hazards of the occupational disease; instead, the worker is allowed to recover from the last employer in whose employ the last injurious exposure occurred and resulted in an aggravation that is both permanent and substantial. Monfort, Inc. v. Rangel, supra. The length of employment with a particular employer continues to be immaterial to a finding of liability; the focus is on both the harmful nature of the concentration of the exposure and the magnitude of the effect of the exposure. As found, Claimant's exposure to the aggravating factors of his degenerative back condition with the Employer herein was long-term and intensive and it had a substantial impact on the aggravation and acceleration of his

degenerative back condition.

ß 8-41-304 (1), C.R.S. (2009), also provides that the employer in whose employment the employee was last injuriously exposed and suffered a substantial permanent aggravation of an occupational disease shall alone be liable for the substantial permanent aggravation, without right of contribution. See Monfort, Inc. v. Rangel, supra; Robbins Flower Shop v. Cinea, supra. Also, where an occupational disease is the proximate cause of the disability, there exists an occupational disease with no apportionment. Anderson v. Brinkoff, 859 P.2d 819 (Colo. 1993). This is also true for a substantial, permanent aggravation of a preexisting occupational disease. The Anderson v. Brinkoff rule, however, only applies to occupational diseases not to accidents. Lindner Chevrolet v. industrial Claim Appeals Office, 914 P.2d 496 (Colo. App. 1995). Indeed, there is no right of contribution even though there are other injurious exposures with previous employers. Claimants in the Matter of the Death of Garner v. Vanadium Corp. of America, 194 Colo. 358, 572 P.2d 1205 (1977). As found, Claimant sustained a substantial, permanent aggravation of his previous degenerative back condition, with an onset in February 2008, and a last injurious exposure on April 30, 2009.

The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. ßß 8-43-201 and 8-43-210, C.R.S. (2009). See City of Boulder v. Streeb, 706 P. 2d 786 (Colo. 1985); Faulkner v. Industrial Claim Appeals Office, 12 P. 3d 844 (Colo. App. 2000); Lutz v. Industrial Claim Appeals Office, 24 P.

3d 29 (Colo. App. 2000). A “preponderance of the evidence” is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. Page v. Clark, 197 Colo. 306, 592 P. 2d 792 (1979); People v. M.A., 104 P. 3d 273 (Colo. App. 2004); Hoster v. Weld County Bi-Products, Inc., W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. Also see Ortiz v. Principi, 274 F.3d 1361 (D.C. Cir. 2001). As found,

Claimant has sustained his burden with respect to compensability of the aggravation and acceleration of the occupational disease of his back.

ORDER

IT IS, THEREFORE, ORDERED THAT:

The Claimant sustained a compensable occupational disease to his back, arising out of the course and scope of his employment for the Employer, with a last injurious exposure date of April 30, 2009.

Any and all issues not determined herein are reserved for future decision.

DATED this_____day of November 2009.

_____

EDWIN L. FELTER, JR.

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-756-823

ISSUES

ÿ What is Claimant's appropriate average weekly wage ("AWW")?

FINDINGS OF FACT

1. Claimant testified that he suffered an admitted injury arising out of and in the course of his employment with employer on December 2, 2007. Claimant continued to work for employer until April 7, 2008 when he was taken off of work.

2. Claimant testified that he received temporary total disability ("TTD") for the periods of April 7, 2008 through April 23, 2008. Claimant also received TTD benefits from Respondents for the period of June 4, 2009 through August 4, 2009. Claimant returned to modified duty and received temporary partial disability benefits from August 5, 2009 through September 15, 2009. The ALJ finds the testimony of Claimant credible. Claimant's testimony was not challenged by Respondents.

3. According to the wage records entered into evidence, in the eight weeks between February 4, 2008 through March 30, 2008 (the last full pay period before Claimant began receiving temporary total disability benefits), Claimant earned $10,546.13. This equates to a weekly average of $1,318.26. Claimant's wages include his regular hourly wage, plus additional compensation for ski school work. Employer also paid a portion of Claimant's health benefits.

4. Claimant testified that through his attorney he requested wage information from Respondent Insurer on June 8, 2009 but did not receive a response to his inquiry.

5. Claimant testified that he was laid off by his employer as of September 15, 2009.

6. The ALJ finds the testimony of Claimant credible. The ALJ finds that the appropriate calculation for Claimant's average weekly wage includes the eight weeks of earnings in the full pay periods prior to Claimant being taken off of work as of April 7, 2008.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792

(1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2007. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

The ALJ must determine an employee's average weekly wage ("AWW") by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of the injury, which must include any advantage or fringe benefit provided to the Claimant in lieu of wages. Section 8-42-102(2), C.R.S.; Celebrity Custom Builders v. Industrial Claim Appeals Office, 916 P.2d 539 (Colo. App. 1995). Section 8-42-102(3), C.R.S., provides the ALJ with discretion for computing Claimant's AWW where "by reason of the nature of the employment or the fact that the injured employee has not worked a sufficient length of time to enable earnings to be fairly computed thereunder or has been ill or has been self-employed or for any other reason, will not fairly compute

the average weekly wageÖ”

Claimant argues that due to the fact that he did not begin to miss time from work as a result of his injury until April, 2008, the appropriate calculation for his AWW is the amount of money he earned prior to his becoming “disabled.” The ALJ agrees.

As noted by the Colorado Supreme Court in Avalanche Industries, Inc. v. Clark, 198 P.3d 589 (Colo. 2009), in 1963, the default provision under Section 8-42-102(2), C.R.S. provides for the calculation of the injured workers’ AWW at the time of the “injury”. Based on the lay definition of “accident” and “injury”, the Colorado Supreme Court determined that is the AWW is tied to the “time of the injury,” and the “injury” includes the “disability resulting from the accident,” then the “time of the injury” necessarily includes the time of disablement, not only the time of the precipitating accident.

Alternatively, based on the lack of any other evidence presented at hearing, the ALJ finds Claimant has shown by a preponderance of the evidence that the discretionary method for calculating the Claimant’s AWW should be applied in this case. The ALJ notes that Respondents failed to present any evidence that Claimant’s AWW should be calculated in any other way than the proposed calculation using the weeks leading up to Claimant’s temporary disability beginning. While the ALJ notes that the burden of proof is on Claimant in this matter, the ALJ finds that Claimant has met that burden of proof and finds that the appropriate calculation of Claimant’s AWW to be $1,318.26. This figure represents Claimant’s earnings in the eight weeks prior to his beginning to lose time as a result of the industrial injury.

Additionally, Claimant argued at hearing that the cost of Claimant’s continuing

health insurance should be included in this matter. However, because Claimant had been laid off on September 15, 2009, the court concludes that this issue was not ripe for adjudication. Certainly, if Claimant is entitled to indemnity benefits after September 15, 2009, Claimant's AWW should be increased by the cost of continuing COBRA benefits. However, evidence as to what the cost of continuing benefits would be after September 15, 2009 was not available at the hearing, and the court refuses to rule on this issue at this time.

ORDER

It is therefore ordered that:

1. Claimant's average weekly wage for the periods of temporary disability benefits paid to Claimant in this case shall be increased to $1,318.26.

The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: October 27, 2009

_____

Keith E. Mottram

Administrative Law Judge

STATE OF COLORADO

WORKERS' COMPENSATION NO.

ISSUES

ÿ Whether Claimant suffered a compensable injury arising out of and in the course of his employment with employer?

FINDINGS OF FACT

Claimant testified that he began working for employer in October 2007 as a laborer. Employer performed work for Sillich Construction in Aspen. While Claimant had also worked for Sillich Construction in the past, at the time of his alleged injury, he was employed with employer. On or about December 17, 2008, Claimant was performing work duties at a job site where Mr. Angeles was the supervisor for Sillich Construction. Claimant testified that Mr. Angeles instructed him to go outside to clean a large water drain that was covered with rocks, snow and debris. Claimant testified that while lifting a large rock, he felt a strong pain in his back. Claimant testified the rock weighed between 80-100 pounds. Claimant testified that he was not sure of the date of the injury.

Claimant testified that after the rock incident, his supervisor, Mr. Angeles called him over and asked him to help clean inside. When Mr. Angeles asked him to help pick up a bag of cement, Claimant attempted to lift the bag, but could not complete the lift. Mr. Angeles testified that when Claimant attempted to lift the bag, Claimant looked to be in pain. When Mr. Angeles asked him what happened, Claimant indicated he hurt himself lifting outside. Mr. Angeles asked Claimant if he wanted to make a report of the incident, but Claimant denied

wanting to report the injury. Mr. Angeles gave Claimant lighter work to perform, including helping organize wood. Mr. Angeles testified that he spoke to Claimant on the phone later and Claimant told him he was working in a restaurant and was still experiencing back pain. Mr. Angeles told Claimant to consult an attorney. Mr. Angeles also testified that if an employee does not report an injury within 48 hours, the employer does not listen to the employee's report of injury. Mr. Angeles further testified that he and the Claimant are friends.

Claimant continued to work for employer until December 24, 2008 when the crew he was working on was laid off. During this period of time, Claimant continued to work eight hours per day. Claimant testified that after Christmas, his pain got worse.

Mr. Angeles testified that when he continued to work for the employer as a sub-contractor performing maintenance around a sub-division. Mr. Angeles testified he was contacted by employer and filled out an Accident Report dated April 7, 2009. According to the accident report, Mr. Angeles recalled the incident in question and recalled moving bags of cement and wood. Mr. Angeles indicated in the report that Claimant reported to him that he had injured his back, but did not think it was a big deal. The ALJ finds the testimony of Mr. Angeles credible and persuasive.

Claimant sought medical treatment with Dr. Abernathy on April 15, 2009. Claimant testified that he sought medical treatment after first going to an attorney. Claimant reported a history of having hurt his lower back between 12/12/08 and 12/20/08. Claimant was diagnosed with a muscle spasm and sciatica and prescribed medications. Claimant was evaluated by Dr. Goyette on April 17,

2009. Claimant reported pain in the lower left side of his back that radiates down his left leg. Claimant reported the pain medication he was previously prescribed was too strong and made him sleep. Claimant was referred for physical therapy, provided with work restrictions of no lifting over 15 pounds and prescribed Vicodin.

Claimant was evaluated by Dr. St. John on May 1, 2009 and reported a back injury when lifting a heavy rock. Dr. St. John noted Claimant reportedly felt an immediate pop in the left side of his low back, which radiated into the left lower extremity. Dr. St. John diagnosed Claimant with left sided low back pain radiating into the left lower extremity that he opined was the result of a work related injury. Dr. St. John also recommended Claimant undergo a magnetic resonance image (”MRI”) of the lumbar spine. The MRI was performed on May 5, 209 and revealed a mild diffuse annular bulge at both the L3-4 and L4-5 levels. At the L5-S1 level, there was a left inferior disc extrusion narrowing the subarticular gutter. It was noted that the S1 was transitional in nature.

Claimant returned to Dr. St. John on July 16, 2009, after undergoing an L5-S1 epidural steroid injection approximately one week earlier. Claimant was diagnosed with multilevel degenerative disk disease, herniated nucleus pulposus on the left at the L5-S1 level, and low back pain predominant symptoms. Dr. St. John recommended Claimant undergo physical therapy and return in 4-6 weeks for reevaluation. Claimant returned to Dr. Hahn and Dr. Goyette for epidural steroid injections and physical therapy. Claimant reported to Dr. Goyotte on August 13, 2009 that his symptoms were overall slightly better. Claimant was instructed to follow up with Dr. St. John.

The ALJ credits the testimony of the Claimant and Mr. Angeles and finds that

Claimant has proven that it is more likely true than not that he suffered an industrial injury arising out of and in the course of his employment with employer. The testimony of the Claimant and Mr. Angeles was consistent and supported by the medical records. While Claimant and Mr. Angeles are personal friends, the ALJ finds that Mr. Angeles' testimony is consistent with his report filled out in April for employer. The ALJ further finds that Claimant's testimony is consistent with that of Mr. Angeles and consistent with the medical records entered into evidence in this case.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of

the disability or need for treatment. See H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990); see also Subsequent Injury Fund v. Thompson, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. See H & H Warehouse v. Vicory, supra.

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

As found, Claimant has proven by a preponderance of the evidence that the lifting incident that took place on or about December 17, 2008 resulted in an injury to Claimant resulting in the need for medical treatment.

ORDER

It is therefore ordered that:

Claimant suffered a compensable injury arising out of and in the course of his employment with employer on or about December 17, 2008.

All matters not determined herein are reserved for future determination.

DATED: October 23, 2009

_____

Keith E. Mottram

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-689-785

ISSUES

ÿ Whether Claimant proved by a preponderance of the evidence that he is entitled to medical treatment that is reasonable, necessary and related to his June 30, 2005 industrial injury?

ÿ Whether Claimant proved by a preponderance of the evidence that he is entitled to temporary total disability ("TTD") benefits for the period of April 13, 2009 until May 4, 2009?

ÿ Whether Claimant proved by a preponderance of the evidence that he is entitled to temporary partial disability ("TPD") benefits beginning May 5, 2009 and continuing until terminated by law?

FINDINGS OF FACT

1. Claimant suffered an occupational disease to his low back arising out of and in the course of his employment with employer as found by

Administrative Law Judge Martinez in an Order dated August 10, 2007. By virtue of the August 10, 2007 Order, Respondents were required to pay for ongoing medical treatment that is authorized and reasonably necessary to cure and relieve Claimant from the effects of the occupational disease.

2. As a result of the occupational disease, Claimant received treatment from Dr. Slater, the authorized treating physician. Further complicating this matter, Claimant had suffered prior work related injuries to his cervical spine that are the result of different workers' compensation claims. However, ALJ Martinez found that Claimant's low back complaints were related to an occupational disease and separate from Claimant's admitted cervical spine injuries.

3. Despite the fact that the claim was found compensable by ALJ Martinez, Respondents have not filed an admission of liability, as the Order did not require one to be filed, and did not order temporary disability benefits to be paid to Claimant.

4. Claimant sought treatment with Dr. Slater on March 18, 2008 for neck pain related to his prior workers' compensation claim. While Dr. Slater issued a work release for Claimant taking Claimant off of work beginning March 18, 2008 due to "back" pain, it appears Claimant's complaints with regard to this visit were largely related to Claimant's neck injury, and not to the occupational disease to Claimant's back. Claimant subsequently underwent surgery for his neck under the auspices of Dr. Lopez on April 2, 2008, that appear to be related to his prior claim.

5. Claimant was evaluated by Dr. Nelson on May 8, 2008 and reported that after his cervical surgery, his primary complaint was his low back

with pain anywhere from 5-8 out of 10 with occasional pain radiating down his legs, left greater than right. Dr. Nelson noted that Claimant's magnetic resonance image ("MRI") of his lumbar spine, obtained on October 26, 2007 revealed mild degenerative disk and facet joint changes without significant spinal stenosis or nueuroforminal narrowing with a broad based disk bulge at L4-L5. Dr. Nelson recommended epidural steroid injections and possible facet joint injections.

6. Claimant followed up with Dr. Lopez on June 26, 2008 with complaints of very significant low back pain. Claimant reported his cervical symptoms were greatly resolved, with less neck pain and much less radiating left arm pain. Dr. Lopez noted that claimant may benefit from a lumbar fusion, but was skeptical overall. For this reason, Dr. Lopez recommended a discogram at L4-5 and L5-S1 with control level at L3-4. Dr. Lopez indicated Claimant must undergo a discogram before he would make a final recommendation about an operation.

7. Claimant followed up with Dr. Slater after his surgery for both his cervical pain and back pain. Claimant was continued on work restrictions of no lifting greater than 25 pounds. Claimant returned to Dr. Lopez on September 9, 2008 with complaints of increased neck pain. Dr. Lopez again indicated Claimant had significant complaints of low back pain and noted that they would attempt to make arrangements for the discogram. The discogram was apparently denied by Respondents on or about September 26, 2008 and has not yet been performed.

8. Claimant was evaluated by Dr. Slater on December 16, 2008 for his cervical spine issues. Dr. Slater noted that Claimant also had injuries

to his low back that was covered under a different workers' compensation claim and different carrier. These multiple claims resulted in issues developing when trying to obtain care, and Claimant admitted to getting frustrated with his frequent denials, including the recent denial of the proposed discogram and injection. Claimant returned to Dr. Slater on December 30, 2008 and reported his lumbar pain had worsened, especially over the past three weeks. Claimant had been off of work for the previous two weeks due to the increased pain. Examination revealed no inconsistencies with Waddell testing. Dr. Slater continued claimant on his prescription medications and suggested a trial of lumbar support brace. Dr. Slater again recommended Claimant obtain a discogram and noted that prolonged sitting in a jury bench in response to jury duty Claimant had been called for was likely not appropriate for Claimant.

9. Claimant presented the testimony of Ms. Kenyon, the office manager for employer. According to Ms. Kenyon, Claimant called in to work sick on or about April 13 and April 14, 2009. Ms. Kenyon spoke to Claimant on the phone on April 15, 2009 and Claimant had just left the hospital. Ms. Kenyon requested Claimant receive a written release to return to work prior to coming back. Claimant returned to work for employer on May 4, 2009.

10. Claimant presented to the emergency room at St. Mary's Hospital on April 15, 2009, April 17, 2009 and April 19, 2009 and reporting he "injured [his] low back on Tuesday while shoveling dog poop." After going to the emergency room on April 15, 2009, Claimant contacted Dr. Lopez via telephone pursuant to instructions from the emergency room and reported that he bent over to pick something up and his back completely went out on him resulting in instant low back pain and right leg pain. Claimant reported that no tests were

performed at the emergency room and he was instructed to see Dr. Lopez as soon as possible. At the emergency room on April 19, 2009, Claimant reported a chief complaint of acute exacerbation of low back pain. The emergency room had obtained x-rays or Claimant's lumbar spine on April 17, 2009 that revealed degenerative changes and endplate changes of L4-L5 with no abnormal motion with flexion and extension views. Nothing on the x-rays revealed any new findings as a result of the April 14, 2009 incident. Claimant was diagnosed with acute exacerbation of chronic low back pain with no evidence of cauda equine or cord syndrome. Claimant returned to work on May 4, 2009 with a lifting restriction of 25 pounds as set forth by Dr. Slater.

11. Claimant returned to Dr. Lopez on May 18, 2009 and reported that after his exacerbation of low back pain in April, he feels that he continues to slowly get worse. Dr. Lopez noted Claimant continued to have significant low back problems and chronic pain and recommended Claimant undergo a repeat MRI of the lumbar spine, in addition to the discogram previously recommended. Claimant continued to follow up with Dr. Slater, being evaluated on May 27, 2009 with complaints of pain at 8 out of 10 with regard to his low back. Claimant returned to Dr. Slater on July 29, 2009 for treatment of his chronic low back pain. Dr. Slater continued Claimant on medications including Cymbalta. In response to an inquiry from Claimant's attorney, Dr. Slater opined that Claimant's complaints on April 15, 2009 were the result of an acute exacerbation of Claimant's chronic disease and noted that Claimant had not reached maximum medical improvement ("MMI") for his occupational disease to his low back. Dr. Slater opined Claimant's prescription medications, including Cymbalta, Clonezepan, Percocet and Fentenyl were related for the treatment of Claimant's

low back pain. The ALJ finds the medical records from Dr. Slater and Dr. Lopez credible and persuasive.

12. Respondents obtained a records review IME of the Claimant with Dr. Brodie on August 25, 2009. Dr. Brodie noted claimant had chronic low back pain prior to the incident on April 14, 2009 and suffered an increase in his back pain after scooping dog feces. Dr. Brodie noted that after the April 14, 2009 incident, Claimant sought additional medical care and was prescribed additional medications, and further noted that the x-rays did not demonstrate substantial change in the underlying pathology of Claimant's lumbar spine. Dr. Brodie found that Claimant may have sustained a temporary increase in his pre-existing level of physical disability after the April 14, 2009 incident, but has since returned to his baseline levels of function.

13. Claimant applied for hearing requesting medical benefits for treatment of his low back, including the proposed discogram and possible injections. Claimant also sought TTD benefits for the period of April 13, 2009 through May 4, 2009 and TPD benefits from May 5, 2009 through ongoing. Claimant testified at hearing that the medical benefits he is seeking include the discogram, injections and prescription medications. Despite the fact that this claim has been found compensable by virtue of ALJ Martinez' August 10, 2007 Order, Claimant testified that he has to pay for prescription medications out of his own pocket.

14. Respondents presented the testimony of Mr. MacEhlenay, the owner of employer. Mr. MacEhlenay testified that they have been able to accommodate Claimant's work restrictions, but the availability of work has declined. Mr. MacEhlenay attributed the lack of work to the current economic conditions. On

cross examination, Mr. MacEhlenay testified that Claimant's hours began to decline in 2007 due to Claimant's increased work restrictions.

15. The ALJ finds Claimant has shown that it is more probably true than not that Claimant's time off of work beginning on April 15, 2009 was causally related to the occupational disease to Claimant's low back. While Claimant suffered an exacerbation of his occupational disease while picking up dog feces at home on April 14, 2009, the ALJ finds that this exacerbation was insufficient to sever the causal connection to Claimant's occupational disease. Notably, the ALJ finds that Claimant's medical providers had documented Claimant's low back condition as worsening leading up to the April 14, 2009 incident. Nonetheless, Respondents refused to provide the medical care, including the proposed discogram, necessary for Claimant to receive appropriate ongoing treatment for his occupational disease.

16. While Claimant suffered a temporary exacerbation of his occupational disease on April 14, 2009, this exacerbation is to be expected when the attempts of the medical providers to offer treatment to Claimant is frustrated by denials from Respondents. While the ALJ recognizes that such denials are within the rights of Respondents in adjusting the claim, the ALJ does not find that the inevitable exacerbation of Claimant's occupational disease to be one that severs the causal relationship of Claimant's condition from his work related claim. As such, the ALJ finds that Claimant's exacerbation, including the emergency room treatment, is related to Claimant's occupational disease that was determined to be compensable by virtue of ALJ Martinez' August 10, 2007 Order.

17. The ALJ credits the testimony of the Claimant that he misses

work as a result of his back pain and has turned down jobs involving checking springs as the job puts a lot of pressure on Claimant's lower back. The ALJ finds that Claimant has shown that it is more probably true than not that his temporary partial disability beginning May 5, 2009 when he returned to employer is causally related to his occupational disease. While Claimant returned with the same 25 pound work restriction, Claimant had not yet been placed at MMI for his occupational disease. As such, Claimant's entitlement to temporary partial disability benefits begins as of May 5, 2009 and continues until terminated by law.

18. The ALJ credits the reports from Dr. Slater and Dr. Lopez and finds that Claimant has shown that it is more probably true than not that the medical treatment for Claimant's low back is reasonable, necessary and related to Claimant's occupational disease. Specifically, the ALJ credits the reports from Dr. Slater and Dr. Lopez and finds that the discogram, repeat MRI and prescription medications, including Cymbalta, Clonezepan, Percocet and Fentenyl are reasonable and necessary to cure and relieve the Claimant from the effects of the occupational disease and are related to Claimant's occupational disease. The ALJ finds that Respondents presented no credible evidence to substantiate the argument that Claimant's ongoing medical treatment was not related to Claimant's occupational disease.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation

claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), supra, requires claimant to establish a causal connection between a work-related

injury and a subsequent wage loss in order to obtain TTD benefits. PDM Molding, Inc. v. Stanberg, supra. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. Culver v. Ace Electric, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. Lymburn v. Symbios Logic, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. Ortiz v. Charles J. Murphy & Co., 964 P.2d 595 (Colo.App. 1998).

4. As found, Claimant has proven by a preponderance of the evidence that he is entitled to TTD benefits from April 15, 2009 through May 4, 2009 when he was released to return to work with a 25 pound lifting restriction.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; see Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo. App. 1990). Pursuant to Section 8-42-404(5), C.R.S., Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once Respondents have exercised their right to select the treating physician, Claimant may not change physicians without first obtaining permission from the insurer or an ALJ. See Gianetto Oil Co. v. Industrial Claim Appeals Office, 931 P.2d 570 (Colo. App. 1996).

6. As found, Claimant has proven by a preponderance of the evidence that the emergency room treatment at St. Mary's Hospital on April 15, 2009, April 17, 2009 and April 19, 2009 is reasonable, necessary and related to Claimant's occupational disease. The ALJ further finds that the treatment recommended by Dr. Slater and Dr. Lopez, including the repeat MRI of the lumbar spine, the discogram and the prescription medications are reasonable, necessary and related to Claimant's occupational disease.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant temporary total disability benefits for the period of April 15, 2009 through May 4, 2009.

2. Respondents shall pay Claimant temporary partial disability benefits from May 5, 209 until terminated by law.

3. Respondents shall pay for all reasonable, necessary and related medical treatment for Claimant's occupation disease, including but not limited to the medical bills from St. Mary's Hospital for April 15, 2009, April 17, 2009 and April 19, 2009 and the recommended discogram, the repeat MRI exam and the prescription medications.

The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: October 23, 2009

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Keith E. Mottram

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-629-269

ISSUES

ÿ The sole issue for determination is whether Claimant's medication prescription for MS Contin is a reasonable, necessary and related maintenance medical benefit.

ÿ The parties stipulated that if the contested medical benefit is reasonable necessary and related, a medical bill from August 7, 2007 should be ordered to be paid by Respondents pursuant to the Colorado Medical Fee Schedule.

FINDINGS OF FACT

1. Claimant suffered an admitted injury to his lower back on September 27, 2004 while employed with employer when he was struck by a motor vehicle in the employer's parking lot. Claimant sought treatment after his injury with Dr. Giffith and eventually underwent surgery on December 17, 2004 that included a right L5-S1 laminectomy, medial facetoctomy, forminotomy and diskectomy.

2. Claimant was subsequently referred to Dr. Price. Dr. Price eventually placed Claimant at maximum medical improvement ("MMI") and provided

Claimant with a permanent partial disability (”PPD”) rating of 18% whole person on August 19, 2005. Respondents filed a final admission of liability (”FAL”) on April 11, 2006 admitting for the impairment rating provided by Dr. Price and for general maintenance medical benefits. At the time Claimant was placed at MMI, Dr. Price was prescribing Ultram and had switched Claimant’s Skelaxin prescription for Robaxin. Dr. Price opined that she did not believe Claimant should use stronger prescriptions.

3. Claimant subsequently moved to California and Respondents agreed to transfer his post-MMI care to Dr. Badgley. When Claimant was initially evaluated by Dr. Badgley, his medications included Robaxin, Pamelor, Ultram and occasional Vicodin. Dr. Badgley diagnosed Claimant with failed back operative procedure with permanent radiculopathy and pain in the low back and inadequate pain control. Dr. Badgley discussed with Claimant possible long-acting medications and Claimant agreed to try the medications as he was in constant debilitating pain. Dr. Badgley started Claimant on MS contin every twelve hours with Ultram for breakthrough pain as well as Celebrex for nonsteroidal use and Skelaxin three times a day for muscle relaxant use.

4. Claimant returned to Dr. Badgley on August 23, 2006 and reported his pain control was much improved. Dr. Badgley continued Claimant on his pain medications and Claimant continued to follow up periodically with Dr. Badgley.

5. Respondents referred Claimant to Dr. Renbaum, a physician in California, for an independent medical examination (”IME”) on November 28, 2008. Dr. Renbaum noted that Claimant was taking 30mg of MS Contin 6 times per day and morphine sulfate 15 mg 4 times per day. Claimant also reported taking

Cymbalta for depression. Dr. Renbaum noted Claimant's Waddell testing was 0/5. With regard to Claimant's narcotic use, Dr. Renbaum stated in pertinent part:

With regard to his medication, different doctors have different approaches to the use of medication. I and many other doctors try very hard to have patients avoid strong narcotic medications. On the other hand, there are doctors, primarily pain management doctors, who quickly put patients on medications like MS Contin despite the fact that they are addicting and often over time do not provide any significant increased relief. Ideally, in my opinion, it would be best to have the patient on a less addicting medication. I am sure, however, at this point that he has a dependence at minimum on the medications and serious effort would have to go into detoxing him and converting him to other medication that is less addicting. I have no objection to using Ultram or Norco, but the MS Contin is an extremely addicting medication and I would prefer to have my patients off that medication if at all possible.

6. Based upon the report from Dr. Renbaum, Respondents have denied Claimant's prescriptions for MS Contin. On June 17, 2009, Dr. Bagley provided a response to the decision to deny Claimant's prescription medication and the report from Dr. Renbaum. Dr. Bagley noted in his report that when he originally examined Claimant in 2007, Claimant was in constant and debilitating pain. Dr. Bagley noted claimant was gradually introduced to a long-acting analgesic regimen and received marked benefits from that therapy.

7. Claimant testified at hearing that he is able to function with MS Contin, but can not function while using only Ultram. Claimant testified that she has been on morphine for a couple of years and was now taking two 30 mg tablets three times per day. Claimant testified that his prescription

medications have not changed in the past year. The ALJ finds the testimony of the Claimant credible.

8. The ALJ credits the testimony of the Claimant and the medical reports of Dr. Bagley and finds that Claimant has shown that it is more probably true than not that the use of MS Contin and morphine sulfate are reasonably necessary and related to his industrial injury. The ALJ finds Claimant has shown that it is more probably true than not that the MS Contin and morphine sulfate are necessary to prevent further deterioration of his physical condition. The ALJ credits the August 23, 2006 report of Dr. Badgley in which Claimant reported improvement with his pain control through the use of morphine. The ALJ credits the reports of Dr. Badgley over the reports from Dr. Renbaum as being more persuasive due to the fact that Dr. Badgley has treated Claimant since 2006 and has been able to follow Claimant's progress. Moreover, Dr. Badgley had the opportunity to evaluate Claimant prior to his being prescribed MS Contin and morphine.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not

interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant requires periodic maintenance care to prevent further deterioration of his physical condition. Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988). Section 8-42-101, C.R.S., thus authorizes the ALJ to enter an order for future maintenance treatment if supported by substantial evidence of the need for such treatment. Grover v. Industrial Commission, supra.

4. As found, Claimant has proved by a preponderance of the evidence that the prescription medications recommended by Dr. Badgley represent reasonable and necessary maintenance medical treatment resulting from Claimant's September 27, 2004 industrial injury.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the prescription medications from Dr. Badgley including the MS Contin and morphine sulphate.

2. Pursuant to the stipulation of the parties, Respondents shall pay for the medical bill incurred by Claimant dated August 7, 2007 pursuant to the Colorado Medical Fee Schedule.

All matters not determined herein are reserved for future determination.

DATED: October 20, 2009

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Keith E. Mottram

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-725-863

ISSUES

ÿ Whether Claimant established by a preponderance of the evidence that her claim should be reopened pursuant to Section 8-43-303, C.R.S., based upon a worsening of her condition.

FINDINGS OF FACT

1. Claimant is a thirty eight (38) year old woman who suffered an admitted injury to her left shoulder on June 4, 2007 while in the course and scope of her employment with employer. Claimant was injured when she was carrying a saw that weighed over one hundred (100) pounds with another employee when the other employee dropped the load causing the full load to pull Claimant's left arm downward. Following her injury, Claimant was referred to Dr. McLaughlin for medical treatment. Claimant was initially evaluated by Dr. McLaughlin on the date of her injury. Dr. McLaughlin noted Claimant had subjecting complaints of pain in her shoulder and complaints of pain with range of motion. Dr. McLaughlin diagnosed Claimant with a possible left acromioclavicular separation and provided Claimant with a sling and prescription medications.

2. Claimant returned to Dr. McLaughlin on June 6, 2007 with continued complaints of pain in her shoulder. Dr. McLaughlin provided Claimant with a prescription for Darvocet and recommended continued observation as opposed to proceeding with a magnetic resonance image ("MRI") of the shoulder. Claimant returned to Dr. McLaughlin on June 13, 2007 and reported very little improvement in her left upper extremity. Claimant also reported frustration with being unable to work. Dr. McLaughlin noted that due to Claimant's lack of improvement and her reported pain level, he recommended an MRI of the left shoulder. The MRI/arthrogram was performed on June 20, 2007 and revealed no abnormalities.

3. Claimant returned to Dr. McLaughlin on July 9, 2007 and reported significant improvement. Dr. McLaughlin continued Claimant on work restrictions and instructed Claimant to finish her physical therapy. When

Claimant returned to Dr. McLaughlin on July 24, 2007, claimant continued to report improvement and inquired about being released to full duty. Due to the fact that Claimant still had one more physical therapy appointment, and Claimant had not worked on strengthening of her shoulder yet, Dr. McLaughlin continued her work restriction. Claimant returned to Dr. McLaughlin on August 7, 2007 and again reported significant improvements. Dr. McLaughlin continued Claimant with a diagnosis of a shoulder strain and increased her work restrictions to no lifting greater than 20 pounds. Claimant returned to Dr. McLaughlin on August 21, 2007 and reported she had a new job delivering that did not require her to lift. Dr. McLaughlin noted Claimant had full range of motion of her left upper extremity and reported that she was doing very well subjectively. Dr. McLaughlin placed Claimant at maximum medical improvement ("MMI") and released her with no permanent impairment.

4. Respondents filed a final admission of liability ("FAL") based on Dr. McLaughlin's report. Claimant did not object to the FAL and the case was closed as a matter of law.

5. Claimant began working for MHC Kenworth ("Kenworth") shortly before she was released from care. Claimant's work with Kenworth was as a parts expediter. Claimant denied any new injuries while working with Kenworth. Claimant began working for a child-care facility in November, 2008. Claimant denied any additional injuries while employed with the child-care facility. Claimant also is a foster parent for special needs children. At the time of the hearing, Claimant provided care for 2 children that she had adopted and had one foster child. Claimant denied any activities as a foster parent that caused a new injury to her shoulder. Claimant also owns several animals, including

horses. Claimant denied any new injuries to her shoulder while caring for her animals. The ALJ finds Claimant's testimony credible.

6. Claimant returned to Dr. McLaughlin on August 6, 2008 with complaints of increased left shoulder pain beginning a little bit after Christmas that had progressively gotten worse. Dr. McLaughlin noted that Claimant's prior shoulder MRI was normal, although he did note that Claimant cervical spine x-rays revealed degenerative joint disease at the C5-6 level. Dr. McLaughlin noted some bruising on her right upper arm that Claimant noted was from camping and stumbling out the back of her pickup truck. Dr. McLaughlin referred Claimant to Dr. Luker and noted that while it was possible that Claimant's current complaints related back to her June 4, 2007 shoulder injury, it was not medically probable due to the fact that Claimant had full active range of motion of the left shoulder when she was released at MMI without complaints of pain.

7. Claimant was initially evaluated by Dr. Luker on August 19, 2008. Dr. Luker examined Claimant and reviewed the MRI/arthrogram that had been performed on June 20, 2007. Dr. Luker diagnosed Claimant with left shoulder pain, quite possibly representing left shoulder subdeltoid bursitis and recommended a subacromial steroid injection. Claimant returned to Dr. McLaughlin on August 26, 2008. Dr. McLaughlin noted tat Claimant's current job involved very sedentary duties. Dr. McLaughlin recommended that Claimant undergo the steroid injection suggested by Dr. Luker and noted that the steroid injection would be helpful to clarify the causality of the issued and if it relates back to her old work injury or if it is something new. Dr. McLaughlin released the Claimant to continue to work at full activity. Claimant returned

to Dr. Luker for a steroid injection on September 9, 2008. Claimant returned to Dr. Luker for follow up on September 29, 2008 and reported approximately 50% pain relief for one week following her initial injection before her pain returned. Dr. Luker recommended a second steroid injection, but it was unclear as to whether the injection was authorized. Therefore, Dr. Luker did not proceed with the second steroid injection.

8. Claimant returned to Dr. McLaughlin on November 21, 2008. Claimant reported that her current job involved full duty at sedentary type activities. After reviewing Dr. Luker's report, Dr. McLaughlin noted that it was still unclear what her diagnosis is, whether it is bursitis and/or rotator cuff syndrome or is it an underlying personal disorder of systemic type. Dr. McLaughlin opined that it is probable that the current complaints relate to the previous traumatic event based upon Claimant's history of sedentary work and no intervening trauma. Dr. McLaughlin recommended a second opinion and referred Claimant to Dr. Vance, an orthopedic surgeon. Dr. McLaughlin released Claimant to return to work without restrictions and asked Claimant to return after her evaluation with Dr. Vance.

9. Claimant returned to Dr. McLaughlin on December 17, 2008 and reported that she had seen Dr. Vance who recommended physical therapy. Dr. McLaughlin diagnosed Claimant with bursitis and impingement and noted from a causality standpoint, Claimant had some discomfort when released at MMI and then over some period of time she had increased irritation and swelling. Dr. McLaughlin opined that after being released at MMI, her shoulder weakness progressed allowing her shoulder to become more impinged, which then continued to irritate the bursa and increase symptoms.

10. Claimant continued to follow up with Dr. McLaughlin and proceeded with physical therapy and use of a TENS unit along with prescription medication. Claimant reported some improvement with the physical therapy and TENS unit as of February 23, 2009, but Dr. McLaughlin cautioned that there was still a ways to go. As of March 20, 2009, Claimant had finished her physical therapy and Dr. McLaughlin recommended Claimant continue with her TENS unit and begin a home program. Dr. McLaughlin noted that if Claimant continued to improve she would be considered at MMI when she returned for follow up in a month.

11. Claimant returned to Dr. McLaughlin on April 24, 2009 and reported continued soreness. Dr. McLaughlin discussed possibly having Claimant return to Dr. Vance for a repeat evaluation, but Claimant indicated she did not want surgery. Dr. McLaughlin diagnosed claimant with impingement of the left shoulder and noted that Claimant had continued with physical therapy that brought improvement with waxing and waning pain and motion. Dr. McLaughlin noted that without considering surgical intervention, Claimant was at MMI as nothing medically will improve her underlying condition. Dr. McLaughlin preformed range of motion measurements and provided Claimant with a permanent partial disability (”PPD”) rating of 9% of the upper extremity. Dr. McLaughlin requested Claimant follow up with her again in three months and noted that if there was still no change he would recommend a repeat examination with Dr. Vance under post MMI maintenance care.

12. Dr. McLaughlin re-evaluated Claimant under maintenance medical care on July 17, 2009. Dr. McLaughlin noted that Claimant reported the TENS unit was not very helpful and was trying to limit her use of Darvocet.

Examination revealed the left shoulder was tender to palpation in the anterior joint line. Claimant's range of motion appeared to be similar to her range of motion when she was placed at MMI on April 24, 2009 and Dr. McLaughlin noted tightness along the left trapezius area. Dr. McLaughlin recommended a soft cervical collar to try to lead to decreased muscle tension in the shoulder region and possible psychological counseling. Claimant returned to Dr. McLaughlin on August 21, 2009 with reports of a lot of pain. Claimant attempted to use the cervical collar recommended by Dr. McLaughlin, but the cervical collar only caused more tightness to her neck. Based on Claimant's increased complaints of pain, Dr. McLaughlin recommended Claimant either seek chiropractic care with Dr. Dorenkampf, or seek another opinion regarding possible shoulder surgery. Claimant noted she was concerned about authorization issues after having to pay for the cervical collar herself, and decided to seek care with Dr. Dorenkampf.

13. The ALJ finds the records of Dr. McLaughlin credible and persuasive. The ALJ finds that Dr. McLaughlin implicitly revoked MMI as of November 21, 2008 when he opined that based upon Claimant's complaints of pain and her response to the subacromial injection, that her current condition was related to her original June 4, 2007 injury. While Dr. McLaughlin did not provide Claimant with any work restrictions, the ALJ finds that the lack of work restrictions was based upon Claimant advising Dr. McLaughlin that her current work was sedentary and, thus, no work restrictions were necessary.

14. While Claimant continued with other activities of daily living, including camping, raising children, tending to animals and continued with work for other employers, the ALJ finds no credible evidence in the record that any

of these activities represented a new injury, or intervening event, that would sever the causal connection of Claimant's need for ongoing medical treatment from the June 4, 2007 industrial injury.

15. The ALJ finds that Claimant has shown that it is more probably true than not that she suffered a worsening of her condition resulting in the need for additional medical care from Dr. McLaughlin and his subsequent referrals, including Dr. Vance, Dr. Luker and Dr. Dorenkampf. The ALJ finds that Dr. McLaughlin revoked MMI as of November 21, 2008 before placing Claimant back at MMI on April 24, 2009.

16. While Claimant has been placed at MMI and given a PPD rating by Dr. McLaughlin, the ALJ is without authority to order Respondents to pay benefits pursuant to the PPD rating of Dr. McLaughlin as the DIME process has not yet been completed.

CONCLUSIONS OF LAW

1, The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., (2007) A

Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

3. Section 8-43-303(1), C.R.S., provides:

At any time within six years after the date of injury, the director or an administrative law judge may Ö review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition Ö.

4. Section 8-43-303(1), supra, provides that an award may be reopened on the ground of, inter alia, change in condition. Claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201, supra; see Osborne v. Industrial Commission, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to change in claimant's physical or mental condition which can be causally connected to the original injury. Chavez v. Industrial Commission, 714 p.2d 1328 (Colo. App. 1985). Reopening is appropriate where the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. Richards v. Industrial Claim Appeals Office, 996 P.2d 756 (Colo. App. 2000).

5. The ALJ finds that Claimant has shown that it is more likely true than not that her current need for additional medical treatment, including

the treatment provided by Dr. McLaughlin and his referrals to Dr. Luker, Dr. Vance, and Dr. Dorenkampf are reasonable, necessary and related to Claimant's industrial injury. Based upon the testimony of the Claimant and the medical reports from Dr. McLaughlin and Dr. Luker, the ALJ finds that Claimant has shown that it is more likely true than not that her condition has worsened after being placed at MMI in August 2007 and that her worsened condition is causally related to her industrial injury of June 4, 2007.

6. The ALJ is without authority to address the issue of PPD benefits as the case was closed as a matter of law at the time that Dr. McLaughlin provided the Claimant with a PPD rating. A Division-sponsored Independent Medical Examination is a prerequisite to any hearing determining the sufficiency of a PPD rating provided by an authorized treating physician. See Town of Ignacio v. Industrial Claim Appeals Office, 70 P.3d 513 (Colo. App. 2002). The ALJ is unaware of any case requiring Respondents to request a DIME upon receiving an impairment rating on a case that is closed as a matter of law. As such, the ALJ does not have jurisdiction to consider the issue of PPD benefits.

ORDER

It is therefore ordered that:

1. Claimant's claim is reopened.

2. Respondents shall pay for all reasonable, necessary and related medical treatment provided by Dr. McLaughlin and his referrals, subject to the Colorado Medical Fee Schedule.

All matters not determined herein are reserved for future determination.

DATED: October 16, 2009

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Keith E. Mottram

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-690-346

ISSUES

ÿ Whether Claimant established by a preponderance of the evidence that his claim should be reopened pursuant to Section 8-43-303 based upon a worsening of his condition?

FINDINGS OF FACT

1. Claimant suffered an admitted injury to his left knee while employed with employer on May 13, 2006 when he twisted the knee while getting on a motorcycle. Respondents filed an admission of liability and admitted for benefits under the Colorado Workers' Compensation Act. Claimant was referred to Dr. Chansky for treatment and subsequently underwent an MRI scan of the knee that showed a complex tear of the posterior horn of the lateral meniscus and some degenerative joint disease. Claimant was referred to an orthopedic specialist who attempted injections of the left knee before performing an

arthroscopy on August 3, 2006.

2. Claimant was eventually placed at maximum medical improvement (”MMI”) by Dr. Chansky on April 16, 2007 with a permanent partial disability (”PPD”) rating of 22% of the left lower extremity. When Claimant was placed at MMI, Dr. Chansky noted claimant had no liagmentus instability, no laxity with stress on the medial collateral ligament (”MCL”) or lateral collateral ligament (”LCL”).

3. Respondents filed a Final Admission of Liability on June 12, 2007 admitting for the PPD rating provided by Dr. Chansky and Claimant’s claim was subsequently closed as a matter of law.

4. Claimant returned to Dr. Chansky on October 23, 2007 with reports of additional swelling aching and pain in the left knee over the past three (3) months. Claimant denied any new trauma or unusual activity and was referred for a repeat magnetic resonance image (”MRI”) of the left knee at the Steadman Hawkins Clinic. Claimant underwent the MRI of his left knee on November 6, 2007. The MRI revealed attenuation of medial lateral menisci that may be from his previous partial menisectomy with fraying and degenerative tearing of the remaining medial meniscus.

5. Claimant was re-evaluated by Dr. Chansky on November 19, 2007. Dr. Chansky reviewed the MRI results and opined that the meniscal tear revealed on the MRI “should be considered a complication from his previous meniscal injury. Accordingly his case should be reopened and he does warrant arthroscopic surgery on the injured left meniscus.” Claimant continued to treat with Dr. Chansky while issues involving the reopening of Claimant’s case continued. Claimant’s treatment with Dr. Chansky included injections, but

continued to complain of symptoms to his left knee. While awaiting information as to whether his case would be reopened, Claimant underwent surgery to his back, suffered an injury to his foot and was involved in a motorcycle accident. None of the above mentioned incidents represented an intervening injury sufficient to sever the causal connection to Claimant's compensable left knee injury.

6. Claimant was evaluated by Dr. Kopich on May 12, 2008 for his aforementioned unrelated foot injury. Claimant returned to Dr. Kopich on May 27, 2008 and noted that the use of the walker boot for his foot injury was aggravating his knee. Dr. Kopich provided Claimant with a conticosteroid injection. Claimant sought treatment for his injuries from his motorcycle accident with Dr. Kopich on July 3, 2008. Dr. Kopich noted Claimant had abrasions on his left knee and treated claimant's soft tissue injuries with dressings and opined that claimant may have aggravated his osteoarthritis that was pre-existing in his right knee, that was not involved in the prior workers' compensation claim.

7. Claimant returned to Dr. Chansky on October 6, 2008 and reported to Dr. Chansky that he would like to pursue repeat surgery to his left knee in the next few months. Dr. Chansky referred the Claimant back to Dr. Kopich for repeat evaluation and possible arthroscopy. Dr. Kopich re-evaluated Claimant on November 4, 2008. Claimant reported significant improvement in his symptoms following the cortisocsteroid injection in May. Dr. Kopich recommended Claimant undergo another MRI of his left knee and return after the MRI was completed. Claimant underwent yet another MRI of the left knee on November 7, 2008 that revealed small joint effusion, moderate osteoarthritic changes and a

complex tear involving the posterior horn of the medial meniscus.

8. Claimant returned to Dr. Chansky on November 11, 2008 and noted he had persistent pain despite his prior surgery. Claimant reported Dr. Kopich recommended pursuing conservative treatment and Claimant was to pursue cortisone or synvisc injections prior to repeat surgery. Claimant returned to Dr. Chansky on December 9, 2008 and reported that after his first synvisc injection his symptoms worsened for two days prior to returning to baseline. Claimant returned to Dr. Chansky on January 6, 2009 and reported being in a lot of pain following his synvisc injections. Dr. Chansky recommended Claimant attempt a steroid injection. The steroid injection purportedly took place on or about April 9, 2009. Claimant returned to Dr. Chansky on April 14, 2009 and reported no improvement with the steroid injection.

9. Claimant was again evaluated by Dr. Chansky on May 13, 2009. Dr. Chansky noted that there was some confusion regarding the cause of Claimant's symptoms. Dr. Chansky opined that Claimant had clear documentation of an abnormal MRI on his left knee as of November 2007 along with multiple follow up examinations involving his reported knee pain prior to the motor vehicle accidents. Dr. Chansky again expressed the opinion that Claimant's proposed arthroscopy be covered under the workers' compensation claim for the May 13, 2006 injury. The ALJ finds the medical records of Dr. Chansky credible and persuasive.

10. Claimant testified at hearing that he had prior injuries to his left knee including prior arthroscopic surgeries. Claimant testified that after being placed at MMI, he enrolled in nursing school. Claimant's duties at nursing school included studying and performing clinical work beginning in the

summer of 2007. Claimant also testified that he worked part time as a paramedic during this period of time for the town of Silt. Claimant denied any additional injuries to his knee while working as a paramedic or while performing his clinical work for nursing school. Claimant testified at hearing that he wishes to undergo the arthroscopic knee surgery recommended by Dr. Chansky. The ALJ finds the testimony of Claimant credible and persuasive and supported by the medical records.

11. The ALJ credits the medical records from Drs. Kopich and Chansky and credits Claimant's testimony and finds that Claimant has shown that it is more probably true than not that his condition has worsened requiring additional medical benefits in the form of an arthroscopic knee surgery and such medical benefits are causally related to his industrial injury of May 13, 2006.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., (2007) A Workers' Compensation case is decided on its merits. Section 8-43-201, supra.

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

Section 8-43-303(1), C.R.S., provides:

At any time within six years after the date of injury, the director or an administrative law judge may Ö review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition Ö.

Section 8-43-303(1), supra, provides that an award may be reopened on the ground of, inter alia, change in condition. Claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201, supra; see Osborne v. Industrial Commission, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to change in claimant's physical or mental condition which can be causally connected to the original injury. Chavez v. Industrial Commission, 714 p.2d 1328 (Colo. App. 1985). Reopening is appropriate where the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. Richards v. Industrial Claim Appeals Office, 996 P.2d 756 (Colo. App. 2000).

The ALJ finds that Claimant has shown that it is more likely true than not that his current need for additional medical treatment, including the cost of the arthroscopy recommended by Dr. Chansky. The ALJ further finds that Claimant has shown that it is more likely true than not that the arthrscopy is reasonable and

necessary to cure and relieve the Claimant from the effects of the industrial injury.

ORDER

It is therefore ordered that:

Claimant's Petition to Reopen is granted.

All matters not determined herein are reserved for future determination.

DATED: October 15, 2009

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Keith E. Mottram

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-780-205

ISSUES

Whether Claimant is entitled to TTD benefits for the period from March 25 to and including August 19, 2009.

Whether Claimant's complaints of low back pain are causally related to the admitted injury in this claim.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed by Employer as a seasonal worker on a highway crew. Claimant's date of hire was September 8, 2008. Claimant's job duties included driving trucks of all sizes, cleaning concrete road surfaces using sand blasting or high pressure air or water hoses; cutting concrete road surfaces and sealing the cuts.

2. Claimant sustained an admitted injury on September 30, 2008. On that date, Claimant was getting some gas for a machine out of the back of a truck and twisted his right ankle while getting down off the lift-gate at the back of the truck. The injury occurred around 7:00 PM and Claimant continued to work the remainder of his shift until 5:00 AM.

3. Claimant was referred by Employer to Concentra Medical Centers for treatment where on October 1, 2008 he was examined by Dr. Joel Boulder, M.D. Upon physical examination Dr. Boulder noted Claimant's right ankle to be swollen anteriorly and medially and further noted that Claimant walked with an antalgic gait favoring his right foot. Dr. Boulder diagnosed sprain of the right ankle with possible avulsion fracture of the distal tibia. Claimant was given a cam walker boot and placed on restrictions of no driving company vehicles, no prolonged standing or walking and should be sitting 98% of the time keeping the right leg elevated while sitting.

4. Dr. Boulder referred Claimant for physical therapy. At the initial physical therapy visit on October 24, 2008 Claimant complained of anterior and lateral right ankle pain and some soreness into the mid calf. The physical therapist noted on examination that Claimant had a very slightly antalgic gait with weightbearing on the right.

5. Dr. Steve Danahey, M.D. at Concentra evaluated Claimant on November 25, 2008. Dr. Danahey noted that Claimant was still complaining of a lot of pain on the anterior aspect of the right ankle. On physical examination, Dr. Danahey noted that Claimant's gait was non-antalgic. At that time Dr. Danahey offered Claimant an appointment with a specialist that Claimant preferred to defer.

6. Claimant was later referred by Dr. Danahey to Dr. David B. Hahn, M.D. who initially evaluated Claimant on December 29, 2008. Dr. Hahn is a foot and ankle specialist. On physical examination Dr. Hahn noted that Claimant had significant pain with dorsiflexion and eversion of his ankle.

7. Dr. Danahey again evaluated Claimant on February 18, 2009. Dr. Danahey noted that Claimant still had significant right anterior ankle pain. Dr. Danahey also noted that Claimant complained of right gluteal area pain over the last week, but not before this. On physical examination Dr. Danahey noted a normal gait and full range of motion in the lumbar spine. Dr. Danahey referred Claimant back to Dr. Hahn and also referred Claimant to Dr. John Burris at Concentra for further treatment and evaluation.

8. Dr. Burris evaluated Claimant on March 3, 2009 based upon the Claimant's referral to him physician for delayed recovery issues. Claimant presented to Dr. Burris complaining of continued right ankle pain. Dr. Burris noted that Claimant had failed conservative treatment and that surgery was scheduled with Dr. Hahn on March 12, 2009. Dr. Burris also obtained a history from Claimant that he had awakened that morning and developed neck and low back pain. On physical examination, Dr. Burris noted Claimant to walk with a normal gait, to have full range of motion of the ankle with tenderness over the

anterior ankle. Dr. Burris' treatment plan included Claimant proceeding with scheduled surgery by Dr. Hahn so that Claimant could return for rehabilitation. Dr. Burris gave Claimant work restrictions of no lifting over 20 pounds. Dr. Burris opined that Claimant's neck and low back pain was not causally related to the September 30 right ankle injury.

9. Dr. Hahn evaluated Claimant on March 12, 2009 noting that Claimant was still having significant pain in the front part of the ankle. Dr. Hahn examined Claimant's ankle and was concerned that anterior and anterolateral impingement was present. Dr. Hahn discussed arthroscopic surgery to address this impingement but delayed proceeding with the surgery until Claimant's low back complaints could be further evaluated. At the time he examined Claimant on March 12, 2009 Dr. Hahn placed Claimant on restrictions of sedentary work limiting lifting to 10 pounds with no ladder or stair climbing and standing and walking as tolerated. The restrictions are reflected in Dr. Hahn's report of April 1, 2009 following his March 12, 2009 examination of Claimant.

10. Dr. Burris evaluated Claimant on March 24, 2009. Dr. Burris' physical examination on this date is essentially similar to the results of the physical examination on March 12, 2009 and Dr. Burris continued to note tenderness over the anterior ankle. However, Dr. Burris now stated that Claimant had a benign examination and based upon this released Claimant to return to work without restrictions. Dr. Burris also stated that Claimant was at MMI although he noted that surgery had been placed on hold pending further evaluation of Claimant's low back complaints.

11. Claimant was terminated from his employment with Employer on March 25, 2009. Prior to that time, Claimant had returned to work performing

light duty until December 9, 2008, the last day Claimant worked for Employer. Claimant had not returned to his usual job after September 30, 2008.

12. Both Dr. Burris and Dr. Hahn were attending physicians in March 2009. Dr. Burris, as reflected in his March 3, 2009 report, was deferring further treatment of Claimant until after the surgery proposed by Dr. Hahn was completed. It was Dr. Hahn who postponed the surgery and recommended Claimant proceed first with evaluation of the low back complaints. The ALJ finds that Dr. Hahn was "the" attending physician for Claimant as it was Dr. Hahn who was exercising the primary control over Claimant's treatment.

13. Dr. Burris' determinations that Claimant remained on restrictions as of March 3, 2009 but was released to return to work without restrictions as of March 24, 2009 are found to be conflicting and inconsistent. The ALJ resolves this conflict in favor of the March 3, 2009 report and opinion of Dr. Burris that Claimant remained on work restrictions as being the most credible and persuasive.

14. Claimant was evaluated by Dr. John Aschberger for his low back complaints on May 27, 2009. Dr. Aschberger did not feel that Claimant's low back was responsible for symptoms in the right ankle. Dr. Aschberger further opined that based upon the history obtained by Dr. Burris on March 3, 2009 Claimant's neck and low back complaints were not related to the original injury to the right ankle on September 30, 2008.

15. Claimant was evaluated by Dr. David Yamamoto, M.D. on May 20, 2009. Dr. Yamamoto obtained a history from Claimant that the low back complaints had begun 2 ñ 3 weeks after the injury. Dr. Yamamoto opined that the low back complaints were probably not work related and questioned if there was

supporting evidence of work-relatedness.

16. Claimant testified that he first complained of low back pain to Dr. Danahey approximately 15 days after the injury to his right ankle. Claimant testified that he told the therapists at Concentra about his low back pain but could not remember when he had done so. The ALJ finds that Claimant's testimony regarding the onset of his low back pain is not credible and persuasive and resolves the conflicts in the evidence in favor of the report of Dr. Danahey dated February 18, 2009 noting that Claimant began complaining of gluteal area pain that had only begun one week prior.

17. Claimant was not released to return to regular employment by the attending physician as of March 25, 2009.

18. Claimant has failed to prove by a preponderance of the evidence that his neck and low back complaints are causally related to the injury of September 30, 2008 to his right ankle. The ALJ credits and finds persuasive the opinions of Dr. Burris, Dr. Aschberger and Dr. Yamamoto stating that these complaints are not related.

19. Insurer filed a General Admission of Liability dated May 15, 2009 denying liability for TTD benefits after March 23, 2009 based upon Claimant having been released to return to work full duty. This General Admission admitted for an average weekly wage of $1,255.73 for a TTD weekly rate of $786.17.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any

litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995).

The courts have held that the term "attending physician," as used in ß 8-42-105(3)(c), means a physician within the chain of authorization who assumes care of the claimant. Not all “attending physicians” are “the attending physician”. “The attending physician” connotes one with primary control over the claimant’s treatment. Popke v. Industrial Claim Appeals Office, 944 P.2d 677 (Colo. App. 1997), Witherspoon v. Metropolitan Club of Denver, W.C. No. 4-509-612 (December 16, 2004).

Whether a claimant has been released to return to work is a question of fact for the ALJ. Imperial Headware, Inc. v. Indus. Claim Appeals Office, 15 P.3d 295 (Colo. App. 2000). Where there are no conflicting opinions from physicians regarding a claimant’s release to work, the ALJ is not at liberty to disregard the attending physician’s opinion that claimant is release to return to employment. However, if there is conflict in the record regarding a claimant’s release to return to regular employment, the ALJ must resolve the conflict. Imperial Headware, supra at 296. If the record contains conflicting opinions from multiple attending physicians concerning the claimant’s ability to perform regular employment, the ALJ may resolve the conflict as a matter of fact. Bestway Concrete v. Indus. Claim Appeals Office, 984 P.2d 680 (Colo. App. 1999); Burns v. Robinson Dairy, 911 Pl2d 661 (Colo. App. 1995). If the attending physician issues ambiguous or inconsistent opinions regarding a claimant’s release to return to work, the ALJ may resolve these conflicts in the physician’s opinion as a matter of fact. Purser v. Rent-a-Center, W.C. No. 4-643-942 (April 4, 2007).

Respondents argue that Claimant is not entitled to TTD benefits after March 24, 2009 under Section 8-42-105(3)(c), C.R.S. because Claimant was released to return to regular duty by Dr. Burris. In support of his claim for TTD benefits Claimant argues that the restrictions and opinion of Dr. Hahn is more persuasive regarding Claimant's ability to return to regular employment. The ALJ agrees with Claimant. As found, Dr. Hahn was the attending physician in March 2009 and did not release Claimant to return to his regular employment. Dr. Hahn maintained the Claimant on restrictions of essentially sedentary work pending evaluation of Claimant's low back complaints and the planned surgery on Claimant's right ankle. As found, the opinions of Dr. Burris regarding Claimant's release to return to regular employment are inconsistent. On March 3, Dr. Burris continued Claimant on work restrictions. At the next appointment on March 24, Dr. Burris released Claimant to return to work stating that Claimant had a benign examination. However, review of the reports of the physical examinations done by Dr. Burris on March 3 and March 24 reflect no significant differences in the examination results to support Dr. Burris' March 24 opinion that Claimant could perform his regular duty without restrictions. Further, Dr. Burris released Claimant to return to regular duty while at the same time recognizing that Dr. Hahn planned to perform surgery on the right ankle once the low back complaints were evaluated and ruled out as a cause of any right ankle symptoms. As found, Dr. Burris' opinion of March 3, 2009 that Claimant remained on restrictions is the more credible and persuasive. As found, Claimant was not released to return to his regular work by the attending physician of March 25, 2009. Because Claimant was not released to return to

regular work by the attending physician as of March 24, 2009 Section 8-42-105(3)(c), C.R.S. does not operate to terminate Claimant's entitlement to TTD benefits.

As found, Claimant has failed to prove by a preponderance of the evidence that his low back complaints are causally related to the September 30, 2008 injury to his right ankle. Claimant's testimony that he began complaining of low back pain to Dr. Danahey about 15 days after the injury to his right ankle is not credible. Claimant did not begin complaining of pain in the area of the low back or buttocks until February 2009 as documented in Dr. Danahey's February 18, 2009 report. The finding and conclusion that Claimant's low back complaints are not causally related to the injury is supported by the persuasive opinions of Dr. Burris, Dr. Aschberger and Dr. Yamamoto. Claimant does not seek any specific benefits on account of his low back complaints other than to argue that they support Claimant's position that he remains unable to return to regular employment and is entitled to TTD benefits for the period claimed. Therefore, the ALJ makes no specific award or denial of benefits based upon Claimant's low back complaints.

ORDER

It is therefore ordered that:

Insurer shall pay TTD benefits to Claimant at the rate of $786.17 per week for the period from March 25 to and including August 19, 2009, a period of 21 weeks, in the aggregate amount of $16,509.57.

The insurer shall pay interest to claimant at the rate of 8% per annum on all

amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: November 16, 2009

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Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-774-061

ISSUES

The issues for determination are compensability and medical benefits.

FINDINGS OF FACT

Claimant has worked for Employer since June 1981. In October 1996, Claimant sustained an injury to his left knee while playing basketball. An MRI of Claimant's left knee showed a small tear of the medial meniscus. The tear would not have healed without treatment. On December 3, 2007, an incident occurred at work where some boxes of product fell and struck Claimant's left knee. The

symptoms from this incident resolved within a few months and Claimant's left knee was asymptomatic prior to October 8, 2008.

While performing his regular job duties at work on October 8, 2008, Claimant knelt on a concrete floor. As he stood up, he felt sudden pain and tightness in his left knee. There was nothing unusual about the condition of the floor where he was working.

On October 9, 2008, Claimant was evaluated by a physician assistant, Thanh Chau, PA-C. On October 14, 2008, Claimant received additional treatment by Mahin Jalifar, PA-C. Claimant reported 70% improvement at this visit. On October 15, 2008, Claimant received physical therapy treatment from Jan McNees, PT.

On October 20, 2008, Claimant was evaluated at Kaiser. Claimant reported intermittent pain and swelling since October 8, 2008, and reported that all of his symptoms were better. Claimant was released to full-duty work.

Darin Allred, M.D., in his report of February 2, 2009, diagnosed Claimant as suffering from medial compartment arthritis. He stated that Claimant did not have any symptoms consistent with a meniscus tear. He recommended that Claimant contact him if he develops additional symptoms and an MRI will be performed.

Elizabeth Bisgard, M.D., testified by deposition that the physical examinations of Claimant performed by various medical providers on October 9, 2008, October 14, 2008, October 15, 2008, October 20, 2008, December 5, 2008, and February 2, 2009, were not consistent with a meniscal tear.

In May 2009, Claimant existed his personal vehicle and his knee tightened and swelled. Claimant contacted Kaiser due to this increase in symptoms,

An MRI of the left knee was performed on June 2, 2009. The MRI showed a medial meniscal tear, a fragment of which was displaced underneath his meniscus.

Surgery to repair the medial meniscal tear was recommended.

In a report dated June 4, 2009, Dr. Allred stated that this is a workers' compensation injury as it is consistent with his on-the-job injury. Dr. Allred does not offer any further explanation for his opinion. His report is unclear on whether he is referring to the October 8, 2008, injury or a previous injury in 2007. Dr. Allred's opinion is not persuasive.

Elizabeth Bisgard, M.D., in her reports of September 29 and October 15, 2009, and her deposition, stated that Claimant's symptoms are not due to a work-related incident in October 2008. She explained her opinion in some detail in her reports and in her deposition. The opinions of Dr. Bisgard are credible and persuasive.

Dr. Bisgard testified that, based on Claimant's description of the location of his pain and his description of how the incident occurred, it is not medically probable that kneeling on the ground and standing as described by Claimant on October 8, 2008, caused the tear in his meniscus and that Claimant's current condition is not a result of his work. Dr. Bisgard's opinion is credible and persuasive.

Claimant's pain after standing up on October 8, 2008, is more likely than not a result of arthritis that was not caused or aggravated by his employment.

Claimant's medial meniscal tear diagnosed in June 2009 is more likely than not a natural progression of a tear that was diagnosed in 1996.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any

litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo.App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo.App. 2000).

When determining credibility, the ALJ should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

Claimant's pain after standing up on October 8, 2008, is more likely than not a result of arthritis that was not caused or aggravated by his employment. Claimant's medial meniscal tear diagnosed in June 2009 is more likely than not a natural progression of a tear that was diagnosed in 1996. Claimant has failed to

establish by a preponderance of the evidence that he sustained an industrial injury or occupational disease.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: November 16, 2009

Bruce C. Friend, ALJ

Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-745-328

ISSUES

ÿ What is the Division-sponsored independent medical examination physician's opinion concerning whether or not the claimant reached maximum medical improvement?

ÿ If it is determined that the Division-sponsored independent medical examination physician's opinion is that the claimant did not reach maximum medical improvement, did the respondents overcome that finding by clear and convincing evidence?

ÿ If it is determined the claimant is at maximum medical improvement, did the claimant overcome the Division-sponsored independent medical examination physician's medical impairment rating by clear and convincing evidence?

ÿ Is the claimant entitled to temporary total disability benefits from March 12, 2008, until August 23, 2008, or was his right to such benefits terminated because the attending physician released him to regular employment?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

The claimant allegedly sustained injuries in work-related incident on December 7, 2007. The incident occurred when the claimant was securing a pallet with wrapping material.

The claimant initially sought treatment at Exempla Healthcare Emergency Department where he reported low back pain and right knee pain. The claimant was then referred to Concentra Medial Center (Concentra) for further treatment.

On December 10, 2007, Concentra physician Dr. Sara Harvey, M.D., performed an examination. The claimant advised Dr. Harvey that he had fallen and lost consciousness for 2 to 3 minutes, and that he worked 3 more hours until he began doing “light duty.” Dr. Harvey noted a history of a prior right knee surgery in 1992, but without any problems since then. Dr. Harvey examined the right knee noting it was larger than the left, but with no palpable fluid, and no heat or redness. Further there was a full range of motion in the knee. Dr. Harvey diagnosed a right knee contusion, left foot contusion and a lumbar strain. Dr. Harvey imposed restrictions of no repetitive lifting over five pounds, no prolonged standing or walking, no bending more than 2 times per hour, no pushing or pulling over 10 pounds and no squatting or kneeling.

Later on December 10, 2007, Dr. Harvey appended a note to her prior dictation. The note states, “the employer called back and tapes have been reviewed.” Dr. Harvey then remarked the claimant had not lost consciousness (as he reported), and that he “struck knee, got up and worked the rest of the shift.” The ALJ infers from this notation that Dr. Harvey reviewed videotape of the actual injury and that in her opinion the events depicted on the videotape varied significantly from the history given by the claimant, particularly with respect to the alleged loss of consciousness.

On December 27, 2007, N.P. Ronald Waits of Concentra performed an examination. The claimant was still complaining of back pain and right knee pain, although he was working within his restrictions. N.P. Waits noted the right knee was stable, showed no deformity, demonstrated no effusion, and exhibited a full range of motion. However, he did note a “lateral tibial prominence.” The diagnoses remained lumbar strain and knee contusion. Medications were dispensed, the claimant was given a Neoprene knee sleeve, and modified duty restrictions were continued.

On January 18, 2008, Concentra physician Dr. Steven Bratman, M.D., examined the claimant. The claimant expressed anger at the employer “for trying to get him fired.” The claimant also advised that he was experiencing continued back pain and right knee pain. Concerning examination of the right knee Dr. Bratman stated the claimant reported pain when nearing full extension, but did not report pain when performing the same maneuver on straight leg raising to test the back. Dr. Bratman described the claimant’s knee and back examinations as “inconsistent” and recommended referral to a “delayed recovery specialist.”

On February 12, 2008, Concentra physician John Burris, M.D. examined the

claimant. On this occasion the claimant told Dr. Burris that he continued working for one hour after the injury until he "was sent home because he was unable to continue working" due to back and right knee pain. The claimant reported no improvement in his back pain despite 19 physical therapy sessions, and he insisted on having an MRI. The claimant denied that he was experiencing any locking, popping or feelings of instability in the right knee. Dr. Burris reported that his examination of the claimant's back was "relatively benign," but opined the only way to "move this case along is to get the MRI." Dr. Burris also reported examination of the right knee was "relatively benign with the exception of some tenderness along the lateral collateral ligament." Dr. Burris described the right knee injury as "isolated" because there did not appear to be any internal derangement, joint effusion or joint line tenderness. Dr. Burris suggested some physical therapy for the knee because all prior sessions had focused on the claimant's back complaints. Dr. Burris also noted "multiple inconsistencies" in the claimant's history and presentation and stated he tried to contact the employer to "straighten out some of these inconsistencies." Dr. Burris imposed restrictions of "no lifting more than 20 pounds."

On February 13, 2008, Dr. Burris made another entry in the medical records concerning his review of videotapes of the claimant's alleged injuries. Dr. Burris stated that, based on his review of the videotape showing the claimant tripping on a pallet jack, falling to his knees and returning to work "without any significant signs" of problems, "he did not believe the claimant sustained any low back injury." Dr. Burris stated that since "that is the only reason we are seeing him" the claimant should be placed at maximum medical improvement (MMI) and returned to work with no restrictions and no impairment.

On March 11, 2008, Dr. Burris performed another examination. This examination appears to have focused on the claimant's continuing low back complaints. Dr. Burris described the examination as "non-physiologic with 5/5 Waddell signs." Dr. Burris again stated he could not explain the pain complaints based on his review of the videotape, and again stated the claimant should be placed at MMI with no impairment and no restrictions.

On March 11, 2008, Dr. Burris also executed or caused to be executed two other documents. The first is a "Physician Activity Status Report" (PASR) listing Dr. Burris as the treating provider. The diagnoses are listed as "724.2 Lumbar Pain," "924.11 Contusion Of Knee," and "924.3 Contusion of Toe." The report states the claimant is released to return to regular duty on March 11, 2008. The document includes the claimant's address, and the employer's address. The ALJ infers this document was provided to the claimant and the employer by mail.

The second document is a "Physician's Report of Worker's Compensation Injury," or form WC164. On this form Dr. Burris listed the same diagnostic code numbers as were listed on the PASR. The WC164 indicates Dr. Burris marked boxes stating the claimant is released to return to full duty on March 11, 2008 with no restrictions. The WC164 also states, "A Copy of This Report Must Be Sent To The Injured Worker And The Insurer." The ALJ infers that the WC164 was sent to the claimant.

At hearing the claimant did not deny receipt of the PASR and the WC164 releasing him to regular duty.

At hearing the claimant testified that he stopped working on February 14, 2008. The claimant stated that he did not obtain employment until August 23, 2008, when he began work for a landscaping company. The claimant did not describe the

nature of the landscaping job. The claimant stated that his knee hurts if he stands or gets on his knee, but he has "to work to survive."

Apparently the respondents contested the compensability of claim for the injuries the claimant allegedly sustained on December 7, 2007. The matter proceeded to hearing before ALJ Friend on February 11, 2009. On February 13, 2009, ALJ Friend issued a Summary Order determining that on December 7, 2007, the claimant sustained compensable injuries consisting of a "right knee and left foot contusion." ALJ Friend noted that if the claim were found compensable the insurer stipulated it would be liable for temporary total disability (TTD) benefits. There is no credible or persuasive evidence that either party sought review of this order by requesting specific findings of fact and conclusions of law.

The claimant requested a Division-sponsored independent medical examination (DIME) to review the findings of Dr. Burris that he reached MMI without any medical impairment. Dr. L. Barton Goldman, M.D., was selected as the DIME physician.

Dr. Goldman issued his DIME report on May 11, 2009. Dr. Goldman noted the claimant gave a history of falling and "twisting his knee and bumping the lateral side of his knee." The claimant advised Dr. Goldman that he continued working for one hour but was unable to complete his shift. On this occasion that claimant stated that he did not believe he lost consciousness after the fall. The claimant also advised Dr. Goldman that he was working for a construction company applying water to dirt and sand. The claimant reported that he was suffering from occasional pain, swelling and locking of the right knee.

In the DIME report Dr. Goldman noted that examination of the claimant's right knee revealed "some right lateral compartment effusion, however mild, with particular tenderness in the pes anserinus bursa and to a lesser degree in the iliotibial band and lateral collateral ligament region." However, Dr. Goldman also noted that the claimant "has a fair amount of unconscious somatization and could be a guarded candidate for surgical intervention." In these circumstances Dr. Goldman stated that he "required" an additional test of the right knee, specifically an MRI. Dr. Goldman explained that since the pain and "objective signs" were in the lateral compartment he would "suggest that if specific and probable post traumatic findings are seen on the MRI in the lateral compartment such as femoral condyle injury or lateral collateral ligament injury or even lateral meniscus injury that that are clearly asymmetric compared to the medial compartment, that that would recommend MMI be postponed and an orthopedic consultation obtained." Dr. Goldman also stated that "mild to moderate arthritic changes in the knee would be difficult to relate" to the December 2007 industrial injury. Finally, Dr. Goldman stated that if the MRI proved to be "non-diagnostic, then the patient indeed" would have achieved MMI on February 13, 2008, as determined by Dr. Burris. From a "maintenance perspective" Dr. Goldman suggested up to 3 steroid injections into the pes anserinus bursa region and some additional physical therapy.

Concerning medical restrictions, Dr. Goldman noted the claimant was working in the "medium work category" and was "working full duty in this respect." Dr. Goldman considered this "reasonable based on his condition" but cautioned the claimant should not engage in twisting or lunging movements of the right leg.

The claimant returned to Dr. Burris on June 9, 2009. Dr. Burris noted a "mild

fusiform deformity" of the right knee. However, the claimant's range of motion was "grossly full" with mild crepitus over the patella, no ligamentous laxity, no joint effusion, but with mild tenderness diffusely over the medial and lateral aspects of the knee. Dr. Burris reviewed Dr. Goldman's DIME report. Dr. Burris stated that he agreed with Dr. Goldman that an MRI would be a "reasonable test." Dr. Burris did not revoke his prior release to regular duty, nor did he impose any new restrictions on the claimant.

An MRI of the right knee was performed on June 18, 2009. Dr. Eric White, M.D., reviewed the MRI results an noted a very small joint effusion. Dr. White also enumerated three conclusions. First he noted evidence of a partial lateral meniscectomy, "with evidence of a retear in the remaining posterior horn meniscal tissue." Second he noted "two compartment" degenerative joint disease (DJD), which was mild in the lateral compartment and moderate in the medial compartment. Third he noted a tear, "posterior horn and adjacent body segment of the medial meniscus."

Dr. Burris dictated an additional report after reviewing the MRI results. He noted the MRI showed "significant degenerative changes," evidence of a prior meniscectomy and two small tears, one in the lateral meniscus and one in the medial meniscus. Dr. Burris opined the tears could be degenerative in origin, but recommended a "one-time" orthopedic evaluation to "help sort out what maybe [sic] new with these findings and what is likely preexisting."

On referral from Dr. Burris, Dr. Mark Failinger, M.D., examined the claimant on July 9, 2009. Dr. Failinger noted "focal lateral joint line pain" and "mild medial joint pain." The claimant advised Dr. Failinger that his job was carrying a pack and spraying weeds and that he was on his feet all day long.

The claimant stated he and his knee would swell at times, and he was experiencing popping and clicking. Dr. Failinger also reviewed the MRI results. Dr. Failinger's impressions were "status post lateral meniscectomy" with recurrence of pain with probable chondromalacia and possible lateral meniscus tear extension, and probable medial mensicus tear and chrondromalacia. Dr. Failinger recommended an injection of cortisone, followed by arthroscopy or viscosupplementation injections if the injection failed to relieve the claimant's symptoms. The injection was performed. The report does not contain any statement that Dr. Failinger imposed any restrictions on the claimant despite Dr. Failinger's awareness the claimant was working at a job that required him to be on his feet all day.

On July 17, 2009, Dr. Failinger wrote a letter to respondents' counsel. Dr. Failinger opined that a knee contusion would "more than likely" cause patellofemoral pain and that such an injury could "flare up previous chondromalacia" depending on where the knee hit. He further stated that a twisting injury could result in a tear of the meniscus. Dr. Failinger also noted that most of the claimant's pain was in the lateral compartment where he underwent the prior surgery, and opined that the lateral compartment arthritis was "preexisting." Dr. Failinger also remarked that there is a "reasonable chance that the medial meniscus tear was probably present, but, may have been extended."

The claimant returned to Dr. Failinger on July 30, 2009. The note states that the claimant wants to try viscosupplementation injections and lateral a compartment loading brace "to try to get him more comfortable to get back to full duty."

Dr. Goldman testified by deposition on June 11, 2009. At this time he had not seen the MRI results because the MRI had not yet occurred

Dr. Goldman credibly explained that at the time he performed the DIME he was "focused on the swelling" in the claimant's knee and believed he should still have an MRI because the physical findings could not be ignored. Dr. Goldman testified that if he were to review the MRI in an attempt to determine whether the claimant's symptoms were related to the industrial injury, he would be looking for "signs that are very lateralized, towards the outside of the joint" in contrast to nonspecific changes. Dr. Goldman cited evidence of a tear to the lateral collateral ligament as the type of finding that he would associate with the claimant's mechanism of injury.

Dr Burris testified at the hearing held on September 23, 2009. Dr. Burris testified that it is his opinion that the MRI results, including the tears in the meniscus, demonstrate degenerative changes that predated the industrial injury of December 7, 2007. Dr. Burris explained that if the meniscal tears had occurred on the date of the injury he would have expected evidence of effusion (swelling) by the next day, but none was present according to the emergency room report. Further, Dr. Burris stated that if the claimant struck the front of the knee then he would expect pain in the front of the knee, but the claimant's complaints were of lateral knee pain. Dr. Burris opined the injury to the knee resulted in a contusion that may have aggravated the claimant's preexisting degenerative condition but resolved by March 11, 2008.

The ALJ finds that there is some ambiguity in Dr. Goldman's DIME report with regard to whether he believed the claimant was at MMI or needed a diagnostic MRI to reach MMI. Based on a review of Dr. Goldman's DIME report and deposition

testimony, the ALJ finds as a matter of fact that it is Dr. Goldman's opinion and finding that the claimant was not at MMI on May 11, 2009, the date of the DIME, because he needed an MRI to ascertain the precise pathology contained in the right knee. Dr. Goldman's recommendation for an MRI was based on his physical examination that revealed swelling in the claimant's right knee. Further, Dr. Goldman believed there was a reasonable possibility that the claimant's symptoms were related to the industrial injury, and that the results of the MRI could suggest further treatment, including a possible orthopedic examination. The ALJ infers that Dr. Goldman recommended the MRI for the purpose of clarifying the claimant's medical condition and recommending further treatment, and not merely for the purposes of assisting Dr. Goldman in determining causation and performing his evidentiary function as the DIME physician.

The respondents failed to prove it is highly probable and free from serious doubt that Dr. Goldman was incorrect in finding the claimant was not at MMI. Dr. Goldman explained that he recommended the MRI because it was necessary to rule out certain types of pathology that might be associated with the claimant's ongoing symptoms, and because of the presence of swelling in the knee. Even Dr. Burris acknowledged that he agreed with Dr. Goldman that the MRI constituted a "reasonable test."

Further, the respondents failed to prove it is highly probable and free from serious doubt that the cause of the need for the MRI is entirely related to the claimant's preexisting knee disease. At the time of the hearing the MRI results had not been shown to Dr. Goldman. Therefore, it is not known whether or not he would agree with Dr. Burris that the results of the MRI are best interpreted as

showing conditions that predate the December 2007 industrial injury. The MRI was interpreted as demonstrating tears of the meniscus in the lateral and medial compartments of the knee with joint fluid. Dr. Goldman's DIME report lists lateral meniscus damage as an injury-related condition that could be shown by MRI. Moreover, Dr. Mark Failinger, M.D., who treated the claimant on referral from Dr. Burris, states in his report of July 17, 2009, that "it is likely that the chondromalacia and possible lateral compartment arthritis is preexisting with a reasonable chance that the medial meniscus tear was probably present, but may have been extended." Dr. Failinger observed that he could not give a "high probability answer" to the question of the cause or causes of the claimant's pathology. In these circumstances the ALJ cannot find that it is highly probable and free from serious doubt that the respondents overcame Dr. Goldman's finding that the claimant was not at MMI because he needed an MRI to determine whether he had sustained injury-related damage that warranted additional treatment. The evidence, including the testimony and opinions of Dr. Burris, is not of sufficient weight to establish that it is highly probable and free from serious doubt that the claimant had reached MMI for all conditions related to the industrial injury.

The respondents proved it is more probably true than not that on March 11, 2008, Dr. Burris, the authorized treating physician, released the claimant to return to regular employment. Although the March 11, 2008, report of Dr. Burris focuses on the claimant's back condition, the PASR and the WC164 specifically address diagnostic codes related to the claimant's alleged knee condition, and those documents unambiguously release the claimant to return to regular duty work without restrictions. This release occurred after the medical examination

of February 12, 2008, in which Dr. Burris described the knee examination as relatively benign and inconsistent. Moreover, there is no credible or persuasive evidence that since March 11, 2008, Dr. Burris has ever changed his opinion that the claimant is able to perform regular duty. This is true despite the fact that Dr. Burris examined the claimant in after the DIME 2009.

The ALJ finds the weight of the evidence establishes that Dr. Burris and Dr. Failinger do not have any genuine conflict of opinion concerning the claimant's ability to perform regular employment as of March 11, 2008. Although Dr. Failinger's report of July 30, 2009, recommends injections and a brace to render the claimant more comfortable to "get him back to full duty," the report does not state whether the claimant's discomfort and inability to perform regular duty is a product of the claimant's own subjective judgment, or instead represents Dr. Failinger's independent medical judgment that the claimant is incapable of performing regular duty. Further, Dr. Failinger's report does not impose any express restrictions on the claimant, and does not specifically dispute Dr. Burris's March 11, 2008, release to regular employment. This is true despite Dr. Failinger's awareness that the claimant was working at a job that required him to be on his feet all day long. In these circumstances the ALJ finds the evidence does not establish that Dr. Failinger disputes the release to regular duty issued that Dr. Burris issued on March 11, 2009. To the extent the evidence might permit an inference that Dr. Failinger disagrees with Dr. Burris, the ALJ declines to draw such inference.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

OVERCOMING DIME PHYSICIAN'S OPINION CONCERNING MMI

The respondents contend the evidence establishes that it is the opinion of Dr. Goldman, the DIME physician, that the claimant reached MMI on February 13, 2008. The respondents further contend that if the ALJ finds that

it is Dr. Goldman's opinion that the claimant did not reach MMI on February 13, 2008, they overcame that opinion by clear and convincing evidence. The respondents argue the evidence establishes that to the extent the claimant had ongoing knee symptoms after February 13, 2008, it is highly probable and free from serious doubt that those symptoms are causally related to the claimant's preexisting degenerative knee condition and not to any condition causally related to the industrial injury. The ALJ disagrees with the respondents' arguments.

MMI exists at the point in time when "any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." Section 8-40-201(11.5), C.R.S. A DIME physician's finding that a party has or has not reached MMI is binding on the parties unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S.; Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

It is possible that a DIME physician may issue conflicting or ambiguous opinions concerning MMI. In such circumstances the ALJ may resolve the inconsistency or ambiguity as a matter of fact so as to determine the DIME physician's true opinion. MGM Supply Co. v. Industrial Claim Appeals Office, 62 P.3d 1001 (Colo. App. 2002); Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000). In addition to the DIME report the ALJ may consider the DIME physician's deposition testimony for purposes of determining the DIME physician's true opinion. Lambert & Sons, Inc. v. Industrial Claim Appeals Office, 984 P.2d 656, 659 (Colo. App. 1998).

Under the statute MMI is primarily a medical determination involving

diagnosis of the claimant's condition. Berg v. Industrial Claim Appeals Office, 128 P.3d 270 (Colo. App. 2005); Monfort Transportation v. Industrial Claim Appeals Office, 942 P.2d 1358 (Colo. App. 1997). A determination of MMI requires the DIME physician to assess, as a matter of diagnosis, whether various components of the claimant's medical condition are causally related to the industrial injury. Martinez v. Industrial Claim Appeals Office, 176 P.3d 826 (Colo. App. 2007). A finding that the claimant needs additional medical treatment to improve his injury-related medical condition by reducing pain or improving function is inconsistent with a finding of MMI. MGM Supply Co. v. Industrial Claim Appeals Office, 62 P.3d 1001 (Colo. App. 2002); Reynolds v. Industrial Claim Appeals Office, 794 P.2d 1090 (Colo. App. 1990); Sotelo v. National By-Products, Inc., W.C. No. 4-320-606 (ICAO March 2, 2000). Similarly, a finding that additional diagnostic procedures offer a reasonable prospect for defining the claimant's condition or suggesting further treatment is inconsistent with a finding of MMI. Abeyta v. WW Construction Management, W.C. No. 4-356-512 (ICAO May 20, 2004); Hatch v. John H. Garland Co., W.C. No. 4-638-712 (ICAO August 11, 2000). Thus, a DIME physician's findings concerning the diagnosis of a medical condition, the cause of that condition, and the need for specific treatments or diagnostic procedures to evaluate the condition are inherent elements of determining MMI.

However, where a DIME physician requests additional testing for the purpose of resolving a question of causation rather than for the purposes of treatment or diagnosis, an ALJ may find as a matter of fact that the proposed testing is not inconsistent with a determination that the DIME physician has placed the claimant at MMI. See Brickell v. Overhead Door Co., W.C. No.

4-586-287 (ICAO February 4, 2005).

The party seeking to overcome the DIME physician's finding regarding MMI bears the burden of proof by clear and convincing evidence. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, supra. Clear and convincing evidence is that quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician's finding concerning MMI is incorrect. Metro Moving and Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995). The question of whether the party challenging the DIME physician's finding regarding MMI has overcome the finding by clear and convincing evidence is one of fact for the ALJ.

As determined in Finding of Fact 27, the ALJ concludes that it was Dr. Goldman's opinion that the claimant was not at MMI on May 11, 2009, and did not reach MMI on February 13, 2008. Rather, the ALJ finds that it was Dr. Goldman's opinion that the claimant needed an MRI because of observable swelling in the knee and to rule out the need for additional treatment. Dr. Goldman did not recommend the MRI merely for the purpose of clarifying the issue of causation.

As determined in Findings of Fact 28, the respondents failed to prove it is highly probable and free from serious doubt that the claimant reached MMI on February 13, 2008. As found, Dr. Burris agreed with Dr. Goldman that the MRI constituted a reasonable diagnostic test. Thus, Dr. Burris agreed the claimant needed additional diagnostic testing to reach MMI.
Further, the ALJ understands the respondents to argue that, based on the results

of the MRI, Dr. Goldman was incorrect in finding that the MRI was necessary as a result of the industrial injury rather than the preexisting condition. While Dr. Burris apparently reached this conclusion, the MRI results have never been shown to or interpreted by Dr. Goldman. Therefore, it is not possible to know whether he would agree that all of the pathology shown on the MRI represents preexisting disease. However, the DIME report does show that a lateral meniscus injury is one of the diagnoses that Dr. Goldman listed as possibly related to the industrial injury. Subsequently, the MRI demonstrated the presence of a torn lateral meniscus. Dr. Failinger stated that it is very difficult to determine causation. Thus, as determined in Finding of Fact 29, the ALJ concludes as a factual matter that the respondents have failed to prove that it is highly probable and free from serious doubt that the cause of the need for the MRI is entirely related to the claimant's preexisting condition.

Moreover, the ALJ concludes the respondents' argument concerning the MRI results is legally flawed. As noted above, the legal status of MMI does not exist until all reasonably necessary diagnostic and curative treatments offering a reasonable prospect for improvement in the claimant's condition have been completed. It follows that once a DIME physician has determined that diagnostic procedures or tests are reasonably necessary prior to a determination of MMI, and the DIME physician's finding has not been overcome by clear and convincing evidence, the ALJ is not free to engage in retroactive review of the test results and find the DIME physician was incorrect in recommending the tests. See Villela v. Excel Corp., W.C. No. 4-400-281 (ICAO February 1, 2001). Rather, the correct procedure would be for the authorized treating physician to reach a second MMI determination, and then return the claimant to the DIME physician for

a follow-up MMI determination. Williams v. Kunau, 147 P.3d 33 (Colo. 2006).

Because the respondents have not overcome Dr. Goldman's finding that the claimant has not reached MMI, the ALJ need not consider the issue of permanent medical impairment.

TERMINATION OF TTD BASED ON RELEASE TO REGULAR EMPLOYMENT

The respondents contend that the claimant is not entitled to TTD benefits commencing March 12, 2008, and continuing until August 23, 2008, because Dr. Burris, an authorized treating physician released the claimant to regular employment on March 11, 2008. The claimant argues that Dr. Failinger expressed a conflicting view when, on July 30, 2008, he stated that the claimant needed an injection and a knee brace to return to "full duty." The claimant argues the ALJ must resolve this conflict. The ALJ agrees with the respondents. Section 8-42-105(3)(c), C.R.S., provides that the right to TTD benefits ends when the attending physician gives the claimant a written release to return to regular employment. Where, as here, the respondents conceded liability for TTD benefits in the first instance, they bear the burden of proof to establish that the claimant has been given a release to return to regular employment. Joe v. Harrison Western Construction Corp., W.C. No. 4-747-660 (ICAO February 25, 2009).

The ALJ may not disregard an attending physician's release to regular employment unless the release is ambiguous or multiple attending physicians express conflicting views concerning the claimant's ability to return to regular employment. The claimant's own opinion concerning his ability to perform regular employment is not relevant. See Imperial Headware, Inc. v. Industrial Claim Appeals Office, 15 P.3d 295 (Colo. App. 2000); Burns v. Robinson Dairy,

Inc., 911 P.2d 661 (Colo. App. 1995). If there are ambiguous or conflicting opinions, the ALJ may resolve the issue as a matter of fact. Imperial Headware, Inc. v. Industrial Claim Appeals Office, supra.

As determined in Finding of Fact 30, the respondents proved it is more probable that not that an ATP, Dr. Burris, released the claimant to return to regular duty effective March 11, 2008. As determined in Finding of Fact 31, the ALJ concludes that Dr. Burris and Dr. Failinger have not expressed conflicting opinions concerning the claimant's ability to perform regular employment. For the reasons stated in Finding of Fact 31 the ALJ determines that Dr. Failinger's July 30, 2009, report does not constitute an expression of disagreement with Dr. Burris's release to regular employment. Further, to the extent Dr. Failinger's report might permit the inference that there is a disagreement concerning the claimant's ability to perform regular employment, the ALJ has declined to draw such inference.

In light of these findings and conclusions the claimant is not entitled to TTD benefits commencing March 12, 2008, and continuing until August 23, 2008, when he commenced work at the landscape company.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

2. The respondents failed to prove by clear and convincing evidence that the DIME physician, Dr. Goldman, erred in finding the claimant did not reach maximum medical improvement.

3. The claim for temporary total disability benefits commencing March 12, 2008, and continuing until August 23, 2008, is denied and dismissed.

4. Issues not addressed by this order are reserved for future determination.

DATED: November 16, 2009

_____

David P. Cain

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-689-664

Issue

The issue for determination is whether Travelers or Wausau is the insurance carrier liable for this claim. Travelers requests that it be permitted to withdraw its admissions and that Wausau reimburse it for compensation and benefits paid to Claimant.

Findings of Fact

Claimant was exposed to Hepatitis C. She was diagnosed with that condition after blood tests in April 2006. Claimant has received treatment for her Hepatitis C. Claimant's medical care has been paid by Travelers.

Claimant has been employed by the clinic as a nurse for 29 years. During her employment she has been exposed to patients' blood. Wausau insured the clinic for relevant years ending December 31, 2003. Travelers insured the clinic for relevant years commencing January 1, 2004.

Salomon G. Garcia, M.D., reviewed Claimant's medical records. In his report of April 22, 2008, Dr. Garcia stated that it is highly probable that some of Claimant's patients were Hepatitis C positive. He stated that it was likely that Claimant was autoinoculated by Hepatitis C by an inadvertent needle stick. Dr. Garcia did not change his opinion during his deposition.

Dr. Garcia evaluated Claimant's extensive blood work, including liver enzymes associated with Hepatitis C. Dr. Garcia is of the opinion that Claimant's exposure to Hepatitis C occurred in 2001 or 2002. Dr. Garcia's opinions are based on Claimant's deposition testimony and the diagnostic testing, including blood work. The opinion of Dr. Garcia is credible and persuasive.

Claimant's Hepatitis C is the result of a single exposure to infected blood of a patient. The exposure more likely than not occurred in 2001 or 2002.

CONCLUSIONS OF LAW

Claimant suffers from an exposure to Hepatitis C. This exposure is work-related. There has been no specific patient or incident that can be identified as the specific exposure producing Claimant's Hepatitis C.

Claimant's infection with the Hepatitis C virus constitutes an injury rather than an occupational disease. An occupational disease develops as a result of conditions of employment over an extended time. Most often they develop due to repetitive activities or multiple exposures to harmful agents at work. An occupational disease does not arise from an identifiable specific trauma that can be traced to a particular time and place. Campbell v. IBM Corp., 867 P.2d 77 (Colo. App. 1993). This does not preclude an injury from being characterized as an occupational disease even though the physical results from the injury actually stem from a series of traumatic events that can be identified and traced to a particular time and place. City & County of Denver v. Moore, 31 Colo. App. 310, 504 P.2d 367 (1972). As a general rule, if the time and place of the specific activity that produced the injury is reasonably determined, that particular event constitutes an injury rather than an occupational disease. Further, even though the condition most frequently shows itself as an occupational disease, if it can be traced to a specific time and place, that condition is considered an injury rather than an occupational disease. See Delta Drywall v. Industrial Claims Appeal Office, 868 P.2d 1155 (Colo. App. 1993). Whether Claimant's condition is the result of an injury or an occupational

disease is important in determining the type of benefit the injured individual is entitled to and who is to supply that particular benefit.

Hepatitis C results from just one exposure to infected blood. The development of Hepatitis C does not result from repeated exposures to contaminated blood producing an accumulation of symptoms. Claimant did not develop Hepatitis C slowly over extended limited timeframes of exposure with patients. There was one specific accident when Claimant was infected with contaminated blood.

Dr. Garcia considered the liver enzyme testing performed on Claimant and other evidence and was able to assign a period of time for likely exposure to contaminated blood that produced the Hepatitis C. In Dr. Garcia's opinion, the exposure took place in 2001 or 2002. The opinion of Dr. Garcia is credible and persuasive. It has been established by a preponderance of the evidence that Claimant contracted Hepatitis C as a result of a single incident in 2001 or 2002.

Wausau insured the clinic in 2001 and 2002. Wausau is liable for benefits in this claim.

Travelers accepted Claimant's claim. Travelers filed admissions and paid benefits. The medical review of Claimant's potential exposure to Hepatitis C prompted the filing of the Application for Hearing seeking to withdraw the General Admission of Liability filed in this case and seeking reimbursement from Wausau. Wausau filed no response to the Application for Hearing, but were served

with the Application for Hearing and were provided ample notice of the hearing. The issues were preserved as they existed effective April 16, 2009 through a separate Stipulation and Motion for Approval that was approved by the ALJ in the Prehearing Conference Order of April 15, 2009. Wausau agreed to reimburse Travelers for payment on this claim if there is an order finding that Wausau was liable for the loss. Reimbursement of this amount includes reimbursement for payment on the 15% impairment rating provided by Dr. Quick that generated the Final Admission of Liability filed in this claim on April 30, 2009.

Claimant suffered an injury in 2001 or 2002 during one of Claimant's multiple needle-sticks. Claimant has been treated for Hepatitis C as a work-related condition with all bills and benefits paid by Travelers. Wausau is liable on this claim. Therefore, Wausau shall reimburse Travelers for amounts paid to or on behalf of Claimant in this claim. Travelers' General Admission of Liability filed in this case shall be withdrawn, and they shall receive reimbursement pursuant to the Stipulation and Motion for Approval.

Order

It is therefore ordered that

1. The admissions of liability filed by Travelers are withdrawn.

2. Wausau shall reimburse Travelers for amounts paid to or on behalf of Claimant in this claim. All matters not determined herein are reserved for

future determination.

DATED: November 16, 2009

Bruce C. Friend, ALJ

Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-714-364

ISSUES

The only issue at hearing was whether the Final Admission of Liability was valid and served to close the claim.

FINDINGS OF FACT

The Claimant sustained a work related injury and was placed at maximum medical improvement on May 15, 2007, without permanent impairment.

Claims adjuster Lucy Arguello received the maximum medical improvement report on June 8, 2007.

Ms. Arguello filed the Final Admission of Liability (FAL) on June 8, 2007. Ms. Arguello drafted the FAL herself and made a typographical error on the date of

the FAL. Instead of being dated June 8, 2007, the FAL was dated May 8, 2007. Ms. Arguello did not correct the FAL that was filed with the Division of Workers' Compensation because the forms are printed in the printing room at SRS and are automatically placed in bulk mail for the Division of Workers' Compensation. The other copies are given to the claims adjuster to mail to the Claimant and all other parties.

Claims adjuster Arguello received the copies that were not placed in bulk mail for the Division of Workers' Compensation and noticed that the date was incorrect. She scratched out the month of May and hand wrote in the month of June. Ms. Arguello addressed the envelope to the Claimant herself. It was addressed to 1514 North Linden Avenue, Trinidad, CO 81082. Ms. Arguello applied postage to the letter and mailed the date corrected FAL to the Claimant. Ms. Arguello did not receive the envelope returned from the Post Office.

The Claimant testified that he did not receive a copy of the FAL and therefore had no opportunity to object to the FAL. The Claimant did receive temporary total disability benefits from January through May 2007 at the same address to which Ms. Arguello sent the FAL. The Division screens and FAL in this matter indicate temporary total disability benefits were paid from January 20, 2007 to May 14, 2007. The Claimant stopped receiving temporary total disability checks and had his wife call to find out why the checks stopped coming. The Claimant's wife made this call about 5 days after Claimant's birthday on May 9th or May 10th, 2007.

During the same period of time the Claimant missed physical therapy appointments and declined injections. The claims adjuster sent a demand letter to the Claimant by certified mail with a demand that he attend an appointment on May 15, 2007. The Claimant did attend the appointment on May 15, 2007. The medical report of Dr. Vishai Midha for that visit is dated May 15, 2007.

The Claimant received paperwork from the adjuster at his address at 1514 North Linden Avenue, Trinidad, CO 81082 and this was the address where he received mailings. The Claimant did receive temporary total disability checks at that address. Ms. Arguello mailed the FAL to the Claimant at 1514 North Linden Avenue, Trinidad, CO 81082 with postage applied and she never received the envelope returned from the Post Office. Additionally, Ms. Arguello mailed general admissions of liability, benefit checks, the demand letter and other mail to the Claimant at 1514 North Linden Avenue, Trinidad, CO 81082 and none of the mailings were received back from the Post Office.

The report of maximum medical improvement of Dr. Midha indicates that on May 15, 2007 the Claimant was recommended to have an epidural injection but never had the injection done and that his pain had resolved. This medical record indicates that the Claimant's back pain had resolved and that he reported no leg pain, no numbness and no weakness. With respect to the Claimant's back examination, this report indicates that the Claimant had intact range of motion without significant guarding, no specific point tenderness, intact bilateral muscle strength, intact bilateral reflexes and intact bilateral sensory neurologic examination of the lower extremities. There was no evidence of

sciatic tension. The doctor assessed that the Claimant's low back pain had resolved with normal activity tolerance and she advised the Claimant to resume normal activities.

The Division of Workers' Compensation received a FAL filed by Ms. Arguello on June 13, 2007, dated May 8, 2007.

The Division of Workers' Compensation requested a Final Payment Notice be filed in this case on October 3, 2007. Ms. Arguello filed a Final Payment Notice on October 3, 2007. The Division received the Final Payment Notice on October 5, 2007.

The Division of Workers' Compensation requires that a final payment notice be filed in every compensable claim that was filed with the Division in which benefits were paid. The final payment notice shall reflect cumulative totals for all benefits paid and be submitted in the format required by the Division. A final payment notice is required to be filed after all compensation issues have been resolved by final admission, final order or stipulation. The final payment notice shall be filed within sixty (60) days after the claim is closed.

No objection to the FAL filed in June 2007 was filed within 30 days of the FAL with the corrected date.

The ALJ infers that the Claimant received the FAL in June 2007.

CONCLUSIONS OF LAW

Notice by mail suffices for purposes of due process if it is reasonably calculated to provide notice in light of the relevant circumstances. Ault v. Department of Revenue, 697 P. 2d 24 (Colo. 1985). The law creates a rebuttable presumption that a properly addressed letter deposited in the mail with sufficient postage reached the addressee. Olson v. Davidson, 142 Colo. 205; 350 P. 2d 338 (1960); First Bank of Denver v. Henning, 112 Colo. 523.

As a result, pursuant to C.R.S. ß8-43-203(2)(b)(II) the Final Admission of Liability has become final as the Claimant has failed to file an objection or notice and proposal to select a Division IME physician within thirty days of the date of the Final Admission of Liability. As a result, the claim is closed as to issues admitted in the final admission of liability. Peregoy v. Industrial Claims Appeals Office, 87 P.3d 261 (Colo. App. 2009); Dyrkopp v. Industrial Claims Appeals Office, 30 P.3d 821 (Colo. App. 2001).

Claimant has failed to establish by a preponderance of the evidence that he did not receive the FAL in a timely manner, thus his failure to object or file for a DIME closes the claim.

ORDER

It is therefore ordered that:

Claimant's request to have the final admission of liability determined to be defective and a determination that the claim remains open is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATE: November 17, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-779-612

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant suffered a compensable injury in the course and scope of his employment for the Employer;

2. Whether Claimant is entitled to an award of medical benefits;

3. What is Claimant's average weekly wage; and

4. Whether Claimant is entitled to indemnity benefits.

FINDINGS OF FACT

Having reviewed the evidence presented at hearing and having considered the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant began his employment for the Employer in June 2008 as a grounds man. Claimant testified that he is a laborer. The Employer is a company that lays high voltage power lines.

2. Claimant's work crew started the day on September 15, 2008, in Pueblo, Colorado and rode together in a van to Canon City, Colorado where they worked on "mountain #204" at a high altitude. Claimant operated an ATV to reach the job site. He was the only rider on his vehicle. Claimant operated a very large vehicle, which was referred to as a "quad". Claimant's "quad" weighed 500 to 600 lbs.

3. Claimant was assigned to work with a crew of four or five workers on a mountainside. All the workers operated ATVs. The mountainous terrain was steep and rocky in some parts and smooth in other areas.

4. At the end of the work day on September 15, 2008, Claimant and the other crewmembers that Claimant was working with descended mountain #204 on their ATVs. Claimant started his descent of the mountain first and his co-worker, Jerry Griego, followed him. Because Claimant goes very slowly on his ATV, Griego passed him on the way down. Griego reached a checkpoint about five minutes before Claimant and waited at the checkpoint for Claimant and the other workers in their crew.

5. At this checkpoint, Greigo credibly testified that Claimant did not mention to anyone that he was injured. Claimant testified that during his initial descent down the mountain he had an accident on the ATV when it flipped over. He testified that he was thrown off the vehicle. He testified that the vehicle flew over his head and landed on its side. Claimant further testified that he righted the vehicle and despite an injury he suffered in his fall to his ribcage and left chest area he continued down the mountain. Claimant testified that it took about four minutes to lift up the 500-600 lb. vehicle and continue down the mountain. Claimant testified that there was no witness to the

accident. Claimant's testimony about the mechanism of his injury was not found to be credible because it is contradicted by the testimony of his co-worker and supervisor.

6. Jerry Griego credibly testified that he passed Claimant as he descended the mountain and did not observe that Claimant was injured. Greigo further credibly testified that when the group congregated at the mid-point on the mountain, Claimant was only five minutes behind him and he never mentioned an accident or injury. Griego was also credible when he testified that Claimant's vehicle weighed 500 to 600 lbs and, if it tipped over on the side of the mountain, one person with only five minutes delay could not have lifted it up. Griego credibly testified that one person would require assistance to lift Claimant's ATV. Furthermore, Griego credibly testified that when the crew arrived at the bottom of the mountain, and on the ride home to Pueblo from Canon City, a 40 minute ride, Claimant never mentioned injuring himself and no damage to the ATV was noted.

7. On September 16, 2008, Claimant mentioned to Charlie T., Griego, and Douglas J. Ortiz, superintendent, that he injured himself the previous day. Claimant initially declined medical treatment and, later in the day on September 16, 2008, Claimant testified that, following the operation of a jackhammer, he recognized his need for medical treatment. The Employer referred Claimant for medical treatment. Claimant was placed on light duty from September 17, 2008, to October 6, 2008.

8. Claimant failed to establish by a preponderance of the evidence that he suffered a work injury in the course and scope of his employment on September 15, 2008. Claimant's testimony was less credible and

persuasive than the testimony of Respondents' witnesses. Claimant's account of the mechanism of the injury is not deemed credible in light of the proximity of Claimant's co-workers, none of whom observed an accident or injury to Claimant.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S., et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

2. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals

Office, 5 P. 3d 385 (Colo. App. 2000).

3. Claimant failed to sustain his burden of proof to establish that he suffered a work related injury on September 15, 2008. Claimant's testimony was found to be less credible and persuasive than the testimony of Respondents' witnesses with regard to the mechanism of Claimant's alleged injury.

4. Since Claimant failed to sustain his burden of proof, his claim for workers' compensation benefits is denied and dismissed.

ORDER

It is therefore ordered that:

Claimant's claim is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: November 17, 2009

Margot W. Jones

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-727-802

ISSUES

ÿ Did claimant prove by a preponderance of the evidence that treatment he received at Concentra after maximum medical improvement (Grover-type medical treatment) was reasonable and necessary to maintain his condition?

ÿ Did respondents prove by a preponderance of the evidence that 93% of claimant's Grover-type medical treatment should be apportioned to his preexisting natural degenerative aging process?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

Claimant began working for employer in July of 2006 as a machinist. Claimant's age at the time of hearing was 47 years. Claimant sustained an occupational-disease-type injury to his lower back while working for employer on March 15, 2007, which he attributed to repetitive bending, squatting, and lifting activities at employer. Insurer has admitted liability for claimant's injury.

Claimant sustained a prior industrial injury to his lower back in 1994. Claimant received a rating of 14% of the whole person for permanent medical impairment he sustained in 1994. Crediting his testimony, claimant neither sought nor received medical treatment for his lower back condition for some 12 or 13 years between the time he completed treatment in 1994 and the time he injured himself at employer on March 15, 2007. Claimant had no permanent physical activity restrictions as a result of his 1994 injury. Claimant's lower

back felt great when he began working for employer in 2006. The Judge credited claimant's testimony as consistent with the absence of medical records showing he required treatment of his lower back condition between 1994 and March of 2007. The Judge further credits claimant's testimony because his treating physicians documented the absence of pain behavior and the absence of evidence of symptom magnification. The Judge infers from such findings that claimant's treating physicians found no medical basis to doubt claimant's reporting of his symptoms.

Employer referred claimant to John J. Aschberger, M.D., for medical treatment. Dr. Aschberger diagnosed lumbosacral dysfunction. Dr. Aschberger ordered a magnetic resonance imaging (MRI) scan of the lumbar region of claimant's lower back, which claimant underwent on October 10, 2007. The MRI showed multilevel degenerative changes to the disks and facet joints of claimant's lumbar spine, as well as a small disk extrusion at the L4-5 level. Dr. Aschberger referred claimant for physical therapy treatment. Dr. Aschberger also referred claimant for epidural steroid injections, which failed to relieve claimant's symptoms. Dr. Aschberger however noted that physical therapy had helped claimant. Dr. Aschberger placed claimant at maximum medical improvement (MMI) as of January 16, 2008. Dr. Aschberger rated claimant's permanent medical impairment at 13% of the whole person, which he wholly apportioned to claimant's previous lower back injury in 1994. Dr. Aschberger recommended that claimant have additional treatment to maintain his condition at MMI (Grover-type medical treatment); Dr. Aschberger wrote:

I do recommend maintenance therapy up to 8 sessions over the next 6 months for issues of alignment and adjustment if necessary. He does not require

maintenance medical followup (sic), barring significant deterioration.

Dr. Aschberger imposed permanent physical activity restrictions, placing claimant in the light to medium category of work.

Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation (DOWC); the division appointed Albert Hattem, M.D., the DIME physician. Dr. Hattem evaluated claimant on May 14, 2008. Dr. Hattem agreed with Dr. Aschberger's determination of MMI. Dr. Hattem diagnosed discogenic lower back pain. Dr. Hattem rated claimant's permanent medical impairment at 15% of the whole person, based upon regional impairment of the lumbar spine. Dr. Hattem apportioned 14% as preexisting and assigned a 1% rating for claimant's permanent medical impairment that is attributable to his injury at employer.

Claimant told Dr. Hattem that he would like additional physical therapy treatment because he benefited greatly from it. Dr. Hattem recommended the following treatment to maintain claimant at MMI:

The [DOWC] treatment guidelines for low back pain recommends (sic) therapeutic exercises for a maximum duration of 8 weeks, three to five times per week. This would be the equivalent to Ö 24 sessions of physical therapy.

Dr. Hattem thus recommended that insurer provide claimant maintenance care of an additional 8 to 10 sessions of physical therapy.

On November 14, 2008, insurer filed a Final Admission of Liability (FAL), admitting liability for permanent partial disability benefits based upon the parties's agreement to accept Dr. Hattem's apportioned rating of 1% of the whole person.

After insurer filed the FAL, claimant requested that insurer allow him to see a

physician near his home in Fort Collins. Insurer referred claimant for a one-time evaluation by a physician at Concentra Medical Centers (CMC), where Rosalinda Pineiro, M.D., evaluated him on December 15, 2008. Claimant asked Dr. Pineiro whether he would benefit from acupuncture. Dr. Pineiro prescribed claimant the following medications: Tramadol, oxaprozin, and cyclobenzaprine. Dr. Pineiro planned to obtain copies of Dr. Aschberger's medical records and reevaluate claimant in a week.

Dr. Pineiro referred claimant to Physiatrist Jeffrey Wunder, M.D., at CMC on January 28, 2009, for a pain management assessment. Dr. Wunder diagnosed chronic lumbar strain and underlying lumbar degenerative disk disease. Dr. Wunder wrote:

It would appear that he has predominantly discogenic low back pain Ö.

Dr. Wunder recommended claimant finish out his physical therapy treatment and continue taking medications prescribed by Dr. Pineiro. Dr. Wunder scheduled claimant to return to him in 3 weeks.

Dr. Wunder reevaluated claimant on February 18, 2009, and recommended discontinuing all passive treatment modalities for treatment of claimant's chronic pain. According to respondents's counsel, claimant had undergone 20 physical therapy treatments and 8 acupuncture treatments as of February 18th. To the extent the Judge understands CMC's billing, claimant underwent 15 physical therapy treatments. The Judge is unable to determine how CMC billed for acupuncture treatments.

Dr. Wunder reported the following on February 18th:

In my opinion, [claimant] has completed the reasonable maintenance treatment at this point in time. Although, he reported some symptomatic improvement, there

has been no overall functional improvement.

(Emphasis added). When asked whether claimant required ongoing maintenance treatment as of February 18, 2009, Dr. Wunder testified:

Beyond the medications discussed, no. As I recall, Dr. Aschberger recommended eight physical therapy treatments for maintenance. And Dr. Hattem recommended 12 Ö.

Beyond that number, I did not think it was necessary.

Dr. Pineiro reevaluated claimant on February 25, 2009, agreed with Dr. Wunder's recommendation, and released claimant from medical care.

In his letter of March 30, 2009, Dr. Wunder opined that claimant's work activities at employer caused a mild aggravation of his preexisting problems with his lumbar spine. Dr. Wunder wrote:

I have been asked to give my opinion on apportionment for continued maintenance treatment and medications. I think the best way to do this would be to apportion along the lines of his impairment rating.

Dr. Wunder clarified his opinion in his letter of April 22, 2009, stating claimant's injury at employer caused 1/15th (7%) of claimant's need for medical treatment to address lumbar spine problems. When asked the medical basis for such apportionment, Dr. Wunder testified:

I just think that anybody can make up an arbitrary number. In this case, [claimant] had a preexisting impairment and had very little, if any, change in his condition as far as measured by his impairment.

(Emphasis added).

In his April 22nd letter, Dr. Wunder explained that claimant's preexisting condition really is the "natural progression of degenerative aging process".

When testifying, Dr. Wunder explained that claimant has a natural aging process in his lumbar spine playing a role in his pain presentation. Dr. Wunder explained that MRI evidence of degenerative disk disease in claimant's spine in 1994 represented a naturally progressive condition. Dr. Wunder opined it reasonable that current MRI evidence of that condition naturally would appear worse than in 1994 and will appear worse yet in another 14 years. Dr. Wunder thus stated that claimant's lower back pain is explained by the natural aging process; he testified:

On my examination, I found no other condition in his low back to explain his symptoms, other than discogenic pain.

****

And so I think he has chronic discogenic pain, related to his underlying [degenerative aging process].

Dr. Wunder stated he had not reviewed any medical records showing claimant had lower back symptoms between 1994 and March of 2007. Dr. Wunder recalled claimant telling him he was not having any pain prior to his injury in March of 2007.

Claimant showed it more probably true than not that the physical therapy, acupuncture, and medication treatment prescribed by Dr. Pineiro and by Dr. Wunder was reasonable and necessary to maintain claimant's condition at MMI. Crediting Dr. Hattem's opinion, DOWC's treatment guides allow up to 24 physical therapy treatments to treat lower back pain. Dr. Hattem noted Dr. Aschberger's report that insurer had denied claimant additional physical therapy treatment prior to the time of MMI. Dr. Hattem thus recommended additional physical therapy to complete claimant's treatment, even though he believed claimant had

reached MMI. Dr. Pineiro initially referred claimant to physical therapy and acupuncture. When Dr. Wunder first evaluated claimant, he recommended claimant complete the treatment recommended by Dr. Pineiro. Dr. Wunder also prescribed the same medications Dr. Pineiro had earlier prescribed. Dr. Wunder later changed his opinion after reviewing medical records showing claimant had a prior industrial injury causing permanent medical impairment of 14%. Dr. Wunder then opined that claimant's treatment should be apportioned. Dr. Wunder however acknowledged that both Dr. Hattem and Dr. Aschberger recommended additional physical therapy treatments. Dr. Wunder acknowledged that claimant's symptoms improved from physical therapy. And Dr. Wunder implicitly agreed with Dr. Pineiro's treatment recommendations until February 18, 2009. The Judge thus credits Dr. Pineiro's opinion in finding that such treatment was reasonable and necessary to cure and relieve claimant of the effects of his injury at employer. Dr. Pineiro's treatment recommendations were substantially supported by the recommendations of Dr. Aschberger and Dr. Hattem.

Respondents failed to show it more probably true than not that claimant's Grover-type medical treatment should be apportioned 93% to his preexisting degenerative aging process. Respondents rely upon the medical opinion of Dr. Wunder, who diagnosed claimant's injury at employer as involving a mild aggravation of his underlying lumbar spine condition, a condition that Dr. Wunder described as progression of the natural aging process. To call the natural, degenerative aging process a disease would be misleading. In addition, there was no persuasive medical evidence explaining how claimant's 1994 injury affected the progression of the natural aging process in claimant's lumbar spine, other than to show it revealed permanent functional changes or functional

impairment of that region of his spine. It was on the basis of a change in functional impairment that Dr. Wunder arbitrarily determined that claimant's medical treatment should be apportioned. The Judge credited claimant's testimony in finding claimant's lumbar spine asymptomatic for some 13 years from 1994 until March of 2007. Dr. Wunder's opinion that claimant's injury at employer caused little change in his underlying condition as measured by function ignores claimant's testimony that it caused a marked change in his pain symptoms. While function is measurable, pain is not. The Judge credited claimant's testimony in finding that physical therapy, acupuncture, and medications prescribed by Dr. Pineiro and Dr. Wunder helped relieve his symptoms of pain.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

A. Grover-Type Medical Treatment:

Claimant argues he has proven by a preponderance of the evidence that the Grover-type medical treatment he received at CMC was reasonable and necessary to maintain his condition at MMI. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant

shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, supra. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

Section 8-42-101(1)(a), supra, provides:

Every employer Ö shall furnish Ö such medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury Ö and thereafter during the disability to cure and relieve the employee from the effects of the injury.

Respondents thus are liable for authorized medical treatment reasonably necessary to cure and relieve the employee from the effects of the injury. Section 8-42-101, supra; Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo. App. 1990). The need for medical treatment may extend beyond the point of maximum medical improvement where claimant requires periodic maintenance care to prevent further deterioration of his physical condition. Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988). An award for Grover-type medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. Holly Nursing Care Center v. Industrial Claim Appeals Office, 992 P.2d 701 (Colo. App. 1999); Stollmeyer v. Industrial Claim Appeals Office, 916 P.2d 609 (Colo. App. 1995).

Here, the Judge found claimant showed it more probably true than not that the physical therapy, acupuncture, and medication treatment prescribed by Dr. Pineiro and by Dr. Wunder was reasonable and necessary to maintain claimant's condition at MMI. Claimant thus proved by a preponderance of the evidence that the Grover-type medical treatment he received at CMC was reasonable and necessary to cure and relieve the effects of his injury.

The Judge credited Dr. Hattem's opinion in finding that DOWC's treatment guides allow up to 24 physical therapy treatments to treat lower back pain. Dr. Hattem thus recommended additional physical therapy to complete claimant's treatment, even though he believed claimant had reached MMI.

While Dr. Pineiro initially referred claimant to physical therapy and acupuncture treatment, Dr. Wunder agreed claimant should complete the treatment recommended by Dr. Pineiro. Dr. Wunder also prescribed the same medications Dr.

Pineiro had earlier prescribed. The Judge found that Dr. Wunder later changed his opinion after reviewing medical records showing claimant had a prior industrial injury causing permanent medical impairment of 14%. Dr. Wunder then opined that claimant's treatment should be apportioned.

Dr. Wunder however acknowledged that both Dr. Hattem and Dr. Aschberger recommended additional physical therapy treatments. Dr. Wunder acknowledged that claimant's symptoms improved from physical therapy. And Dr. Wunder implicitly agreed with Dr. Pineiro's treatment recommendations until February 18, 2009. The Judge thus credited Dr. Pineiro's opinion in finding that such treatment was reasonable and necessary to cure and relieve claimant of the effects of his injury at employer.

The Judge concludes that insurer should be liable to pay for claimant's treatment and medications prescribed by Dr. Pineiro at CMC.

B. Apportionment of Medical Benefits:

Respondents argue they have proven by a preponderance of the evidence that 93% of claimant's Grover-type medical treatment should be apportioned to his preexisting natural degenerative aging process. The Judge disagrees. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, supra; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988). The court, in Duncan v. Industrial Claim Appeals Office, 107 P.3d 999 (Colo. App. 2004), permitted apportionment when claimant's condition is caused by successive industrial injuries and both injuries contribute to the disability and need for additional medical treatment. Respondents bear the burden of proof regarding the amount of any apportionment. Cowin & Co. v. Medina, 860 P.2d 535 (Colo.

App. 1992).

As found, respondents failed to show it more probably true than not that claimant's Grover-type medical treatment should be apportioned 93% to his preexisting degenerative aging process. Respondents thus failed to prove by a preponderance of the evidence that the Judge should apportion 93% of claimant's Grover-type medical treatment.

The Judge credited the medical opinion of Dr. Wunder in finding that claimant's injury at employer involved a mild aggravation of the progression of the natural aging process in his lumbar spine. As found, there was no persuasive medical evidence explaining how claimant's 1994 injury affected or changed the progression of the natural aging process in claimant's lumbar spine, except to show it resulted in permanent functional changes or functional impairment of that region of his spine.

The Judge found that claimant's lumbar spine was asymptomatic for some 13 years from 1994 until March of 2007. While Dr. Wunder opined that claimant's injury at employer caused little change in his underlying condition as measured by function, Dr. Wunder's opinion was inconsistent with claimant's credible testimony that it caused a marked change in his pain symptoms. However, it was on the basis of a change in functional impairment that Dr. Wunder arbitrarily determined that claimant's medical treatment should be apportioned. The Judge credited claimant's testimony in finding that physical therapy, acupuncture, and medications prescribed by Dr. Pineiro and Dr. Wunder helped relieve his symptoms of pain.

While claimant sustained successive industrial injuries in 1994 and in March of 2007, claimant's injury at employer more probably caused a mild aggravation of

the progression of the natural aging process in his lumbar spine, and not an aggravation of a condition caused by his injury in 1994. The Judge is unaware of any legal precedent requiring apportionment where a subsequent industrial injury aggravates, accelerates or worsens the natural progression of the aging process.

The Judge concludes that respondents's request for apportionment of claimant's medical benefits should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Insurer shall pay CMC for the treatment and medications prescribed by Dr. Pineiro as required by fee schedule.

2. Respondents's request for apportionment of claimant's medical benefits is denied and dismissed.

3. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _November 17, 2009_

Michael E. Harr,

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-778-290

ISSUE

Whether Claimant has made a proper showing that Jeffrey A. Wunder, M.D. should be designated as his primary Authorized Treating Physician (ATP) and John Burris, M.D. should be de-authorized as an ATP.

FINDINGS OF FACT

1. Claimant worked as a security officer for Employer. On November 23, 2008 he was injured during the course and scope of his employment while restraining a combative patient. Claimant testified that he suffered injuries to his left ankle and back as a result of the incident.

2. Employer referred Claimant to Concentra Medical Centers for treatment. On December 1, 2008 George Kohake, M.D. evaluated Claimant. Claimant reported a left ankle injury but did not mention any back symptoms. Dr. Kohake diagnosed a left ankle sprain, recommended medications and referred Claimant to physical therapy.

3. During January and February 2009 Claimant obtained follow-up treatment for his left ankle injury from William T. Chythlook, M.D. Claimant reported that he had not been working for Employer because of the absence of light duty employment. He also remarked that he had been taking his medications but ceased physical therapy because of increased pain. Claimant did not mention that he suffered from any back pain. Dr. Chythlook explained that Claimant had undergone an MRI but it did not reveal any "reason for [Claimant's] extreme discomfort." He determined that Claimant should sit 75% of the time,

continue to wear an ankle boot and use a cane.

4. Claimant was subsequently referred to John Burris, M.D. for an evaluation. On February 23, 2009 Claimant visited Dr. Burris. Claimant reported "persistent well-localized left ankle pain." Dr. Burris diagnosed Claimant with a left ankle sprain. However, he remarked that it was unclear why Claimant continued to experience pain despite negative diagnostic studies. Dr. Burris also commented that two ankle specialists had previously evaluated Claimant.

5. Dr. Burris referred Claimant to Jeffrey A. Wunder, M.D. for an evaluation. On March 19, 2009 Claimant visited Dr. Wunder. Claimant reported left ankle pain that radiated up to the mid-calf area. Dr. Wunder diagnosed Claimant with a left ankle sprain and a lumbar disc injury. He noted that Claimant's radicular symptoms in the S1 distribution produced pain and numbness in the left foot. Dr. Wunder remarked that the pain may have been hidden by the left ankle injury. He also commented that Claimant might have CRPS in the left foot and ankle. Dr. Wunder thus recommended electrodiagnostic studies of the left lower extremity and lumbar paraspinals.

6. An MRI of the lumbar spine revealed a left-sided disc protrusion at L5-S1 with moderate compression of the S1 nerve root. Electrodiagnostic studies were consistent with a left S1 radiculopathy. Claimant also underwent thermograms that were suggestive of CRPS type II.

7. On April 27, 2009 Claimant returned to Dr. Burris for an examination. After recounting the findings in the diagnostic studies, Dr. Burris agreed with Dr. Wunder that more information was required to ascertain Claimant's diagnosis. Dr. Burris specifically remarked that the information

could be obtained through diagnostic injections. He also noted that Claimant should continue with physical therapy as recommended by Dr. Wunder.

8. On April 30, 2009 Claimant again visited Dr. Wunder for an examination. Dr. Wunder remarked that many patients with lumbar radiculopathy do not experience back pain. He also noted that Claimant's lumbar radiculopathy was "misinterpreted as being CRPS." Dr. Wunder concluded that Claimant's lumbar radiculopathy was related to his work for Employer. He explained that additional treatment had been denied and expressed concern that any delay in treatment would "run the risk" of causing "significant permanent nerve injury."

9. On June 1, 2009 Dr. Burris concluded that Claimant had reached Maximum Medical Improvement (MMI) for his left ankle injury. He specifically stated:

Causality continues to be the main question regarding this patient. In particular, the original injury appeared to involve the left ankle and further workup has determined that there are numerous other issues which may be the cause of his left lower extremity complaints. If we are to go with the original diagnosis of the left ankle sprain, the patient is at maximum medical improvement.

10. Claimant continued to receive treatment from Dr. Wunder. He diagnosed left S1 radiculopathy and an L5-S1 pulposus. Dr. Wunder also noted that Claimant's left ankle sprain had resolved. He continued to recommend epidural steroid injections to ascertain whether a surgical consultation was warranted.

11. On July 23, 2009 the parties conducted the evidentiary deposition of Dr. Wunder. Dr. Wunder reiterated that Claimant's L5-S1 disc protrusion was

caused by his November 23, 2008 industrial injury. He explained that epidural injections would determine whether Claimant's herniated disc was his pain generator. Dr. Wunder also noted that Dr. Burris placed Claimant at MMI because Insurer denied additional medical treatment. He explained that, if Claimant had a work-related lumbar condition, then additional medical treatment should be recommended. Dr. Wunder also commented that Dr. Burris agreed that additional treatment should be pursued if Claimant's lumbar condition was caused by his work for Employer. He stated "that's the reason why [Dr. Burris] did not ultimately place [Claimant] at maximum medical improvement."

12. On July 27, 2009 the parties conducted the evidentiary deposition of Dr. Burris. Dr. Burris commented that all of Claimant's physicians prior to Dr. Wunder were focused solely on Claimant's left ankle injury because he did not disclose back symptoms. He noted that the prior examinations did not reveal any neurological deficits and that Claimant's radiculopathy could have been "masquerading all along." Dr. Burris stated that he had not examined Claimant since June 1, 2009 and reiterated that Claimant had reached MMI for his left ankle condition. Dr. Burris agreed with Dr. Wunder that Claimant suffered from a L5-S1 disc protrusion. However, he was uncertain whether the protrusion was related to Claimant's November 23, 2008 industrial injury. Dr. Burris explained that he would prefer to review the results of the injections proposed by Dr. Wunder in order to determine whether the L5-S1 nerve root constituted Claimant's pain generator. Notably, Insurer has authorized the injections recommended by Dr. Wunder.

13. Claimant testified at the hearing in this matter. He explained that he had lost confidence in Dr. Burris. Claimant remarked that Dr. Burris had

failed to perform a physical examination that would have resulted in an earlier diagnosis of his back condition. He commented that he was uncomfortable receiving treatment from Dr. Burris because of his failures in diagnosis and that he preferred Dr. Wunder as a treating physician.

14. Claimant has failed to make a proper showing that Dr. Burris should be de-authorized as his ATP and that Dr. Wunder should be his primary ATP. The record reveals that Claimant's back condition was not discovered until his March 19, 2009 examination with Dr. Wunder and subsequent diagnostic studies. Although Dr. Burris failed to diagnose Claimant's L5-S1 disc protrusion, Claimant had not disclosed back symptoms to prior treating physicians. Dr. Burris also noted that prior examinations did not reveal any neurological deficits and that Claimant's radiculopathy could have been "masquerading all along." Furthermore, on June 1, 2009 Dr. Burris only placed Claimant at MMI for his left ankle injury. Dr. Burris agreed with Dr. Wunder that Claimant should undergo epidural injections to ascertain his pain generator and Insurer has authorized the injections. Finally, Dr. Burris has not examined Claimant since June 1, 2009 and Dr. Wunder has continued to evaluate and provide medical treatment to Claimant. Claimant has thus been receiving adequate medical treatment, any de-authorization of Dr. Burris is unnecessary and the circumstances do not warrant a change of physician.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim

has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Section 8-43-404(5)(a), C.R.S. permits the employer or insurer to select the treating physician in the first instance. Once the respondents have exercised their right to select the treating physician, the claimant may not change the physician without the insurer's permission or "upon the proper showing to the division." ß8-43-404(5)(a), C.R.S.; In Re Tovar, W.C. No.

4-597-412 (ICAP, July 24, 2008). Because ß8-43-404(5)(a), C.R.S. does not define "proper showing" the ALJ has discretionary authority to determine whether the circumstances warrant a change of physician. Jones v. T.T.C. Illinois, Inc., W.C. No. 4-503-150 (ICAP, May 5, 2006).

5. The ALJ's decision regarding a change of physician should consider the claimant's need for reasonable and necessary medical treatment while protecting the respondent's interest in being apprised of the course of treatment for which it may ultimately be liable. Id. The ALJ may consider whether the claimant and physician were unable to communicate such that the physician's treatment failed to prove effective in relieving the claimant from the effects of the industrial injury. See Merrill v. Mulberry Inn, Inc., W.C. No. 3-949-781 (ICAP, Nov. 16, 1995). However, a change of physician is not required merely because a claimant expresses dissatisfaction with the designated treating physician or would simply prefer to receive treatment from a doctor of his choosing. In Re Hoefner, W.C. No. 4-541-518 (ICAP, June 2, 2003). Finally, where an employee has been receiving adequate medical treatment, courts need not permit a change of physician. See Greenwalt-Beltmain v. Dep't of Regulatory Agencies, W.C. No. 3-896-932 (ICAP, Dec. 5, 1995); Zimmerman v. United Parcel Service, W.C. No. 4-018-264 (ICAP, Aug. 23, 1995).

6. As found, Claimant has failed to make a proper showing that Dr. Burris should be de-authorized as his ATP and that Dr. Wunder should be his primary ATP. The record reveals that Claimant's back condition was not discovered until his March 19, 2009 examination with Dr. Wunder and subsequent diagnostic studies. Although Dr. Burris failed to diagnose Claimant's L5-S1 disc protrusion, Claimant had not disclosed back symptoms to prior treating

physicians. Dr. Burris also noted that prior examinations did not reveal any neurological deficits and that Claimant's radiculopathy could have been "masquerading all along." Furthermore, on June 1, 2009 Dr. Burris only placed Claimant at MMI for his left ankle injury. Dr. Burris agreed with Dr. Wunder that Claimant should undergo epidural injections to ascertain his pain generator and Insurer has authorized the injections. Finally, Dr. Burris has not examined Claimant since June 1, 2009 and Dr. Wunder has continued to evaluate and provide medical treatment to Claimant. Claimant has thus been receiving adequate medical treatment, any de-authorization of Dr. Burris is unnecessary and the circumstances do not warrant a change of physician.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's request to designate Dr. Wunder as his primary ATP and de-authorize Dr. Burris as his ATP is denied.

2. Any issues not resolved by this Order are reserved for future determination.

DATED: November 17, 2009.

_____

Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

W.C. No. 4-505-189

CORRECTED FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

No further hearings have been held in the above-captioned matter. On November 13, 2009, Respondents filed an "Unopposed Motion for Corrected Order," alleging that they had sent an objection to the proposed order, tendered by Claimant's counsel, to the Office of Administrative Courts (OAC) one-day after the proposed order was tendered. The ALJ did not receive the objection within the three days allowed, however, that does not mean that it did not arrive at the OAC in a timely manner. Considering the substance of the objection of which the ALJ first became aware on November 18, 2009, the ALJ determines that it has merit. Therefore, the ALJ hereby amends the previous decision and issues the following Corrected Full Findings of Fact, Conclusions of Law and Order.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on October 13, 2009, in Denver, Colorado. The hearing was digitally recorded (reference: 10/13/09, Courtroom 1, beginning at 3:48 PM, and ending at 4:45 PM).

ISSUE

The sole issue to be determined by this decision concerns medical benefits, specifically, mileage reimbursement for travel expenses incurred for travel to treating physicians and to pick up prescription medications.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. This claim involves an admitted industrial injury of February 7, 2001, and is under a General Admission of Liability (GAL) filed on April 26, 2007.

2. Between November 12, 2008, and February 25, 2009, Claimant actually traveled three-thousand, two-hundred and thirty-five (3, 235) miles to obtain medical treatment and to pick up prescriptions from pharmacies located in the Loveland, Colorado, area.

3. Between February 26, 2009, and July 29, 2009, Claimant actually traveled two thousand, two-hundred and thirty-three miles (2, 233) to obtain medical treatment and prescriptions from pharmacies located in the Loveland, Colorado, area.

4. At hearing, Respondents argued that Claimant was not entitled to actual mileage incurred for traveling to and from the providers and pharmacies, but should be paid mileage as calculated by “MapQuest” (hereinafter the so-called “MapQuest Rate”).

5. On February 25, 2009, Claimant submitted mileage reimbursement for the miles traveled between November 12, 2008, and February 25, 2009, requesting reimbursement in the amount of $1,294.00.

6. On March 20, 2009, Claimant was paid only $1,017.20, a difference of $276.80.

7. With Claimant’s check, Respondents outlined their concerns with regard to Claimant’s February 25, 2009, mileage request setting forth:

ii. I’ve ran (sic) your client’s mileage against the reported by MapQuest (enclosed). In many cases, your client seems to be overstating the amount of miles it takes to get from his home to the various physicians and pharmacies. I also found a few trips to the pharmacy that we do not have a corresponding bill. I have deleted these from the overall trip mileage.

2. On April 23, 2009, Claimant responded to Respondents’ rejection of his mileage request setting forth:

First, you rely upon Mapquest to deny [Claimant's] mileage stating that he is overstating the amount of miles it takes to get from his home to various physicians' offices and pharmacies. We note that the Mapquest you are using is reflecting that the [Claimant and his family] live on the frontage road when, in fact, their home is not on the road but is back some distance from the road. Although the address is on the frontage road the driveway to get to the home has to go around a trucking company's property and, therefore, that is one part of your Mapquest, which is incorrect.

Additionally, my client has actually clocked the mileage on his odometer and Mapquest is incorrect with regard to mileage. He will testify to these issues at hearing.

* * *

Next, you make the allegation that my client has made trips to the pharmacy for which you do not have corresponding medical bills. Often he goes to the pharmacy to pick up medication only to be told that your company has not authorized the prescribed medication.

3. At hearing, Claimant testified that prior to every trip to his authorized treating doctors, and to the pharmacy to pick up prescriptions, he pushes his trip odometer to zero. After making the round trip, he writes the mileage immediately down in a log he keeps in his car. That log is transferred to the mileage submissions he makes. Claimant further testified that he does not always follow the MapQuest route if there are delays in traffic and that the

MapQuest route is not, in fact, accurate. The ALJ finds that the Claimant presented and testified credibly because his testimony is consistent with reason and common sense, and it was not impeached in any way.

4. The stipulated testimony of the adjuster, Tammy DeWalt, who is based in Phoenix, Arizona, was that MapQuest was not run from Claimant's home, but was rounded up to allow for the address of Claimant's lot versus the address of the RV park. The Claimant's address is Space 96. DeWalt does not know what route the Claimant actually took to his doctors and pharmacies, as she was not in his car when he made his visits. While credible, DeWalt lacks a sufficient basis or foundation to dispute the Claimant's testimony concerning his actual mileage, when local traffic variables are taken into account.

5. The parties further stipulated, and the ALJ finds that Respondents hired an investigator, who, if called to testify, would state that he drove the route indicated on DeWalt's MapQuest printout, using a GPS system, and DeWalt's MapQuest calculations were basically accurate. The ALJ finds that the investigator essentially corroborates DeWalt's Mapquest calculations but does not rebut Claimant's testimony concerning his actual mileage.

6. On August 6, 2009, Claimant submitted a second mileage request for mileage traveled between February 26, 2009, and July 29, 2009. Claimant requests reimbursement of $1,228.15. That mileage has not yet been paid.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." See Kroupa v. Industrial Claim Appeals Office, 53 P.3d 1192, 1197 (Colo. App. 2002); Penasquitos Village, Inc. v. NLRB, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. See Prudential ins. Co. v. Cline, 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, the Claimant's testimony was consistent with reason and common sense, it was credible and it supports the actual mileage he claims. On the other hand, the adjuster's mechanistic use of MapQuest, corroborated by the investigator, without regard to Claimant's actual mileage was not reasonable, under the circumstances, because there is nothing in the statutes or rules that mentions MapQuest. On the contrary, the statutes and rules imply reimbursement for "actual" mileage as long as the mileage is not unreasonable.

Respondents argue that Claimant is not entitled to mileage reimbursements for

his actual miles traveling to doctor visits and to obtain prescription medications pursuant to Workers' Compensation Rules of Procedure (WCRP), Rule 18-6 (E), 7 CCR 1101-3, but rather that Claimant is only entitled to the MapQuest miles. The ALJ is not persuaded by this argument.

WCRP, Rule 18-6 (E), 7 CCR 1101-3, provides for reimbursement for reasonable and necessary medical expenses for travel to and from medical appointments and to obtain prescribed medications.

The holding in Mitchell v. Valley Welding, Inc., W.C. No. 4-312-227 [Industrial Claim Appeals Office (ICAO), October 21, 1997] is instructive. In Mitchell, the ALJ denied Claimant's request to have Respondents pay for modification of a van. The ALJ found that Respondents have provided reliable transportation services for Claimant and further found that Respondents were "willing to make adequate arrangements to deliver the claimant's medications. . . ." In that case, the ICAO held:

[T]he respondents are liable for medical services and medical apparatus which are either medical in nature or "incidental" to obtaining medical treatment. ß 8-42-101(1)(a), C.R.S. 1997; County Squire Kennels v. Industrial Claim Appeals Office, 899 P.2d 362 (Colo. App. 1995). An expense is "medical in nature" if it relieves the symptoms or effects of the injury and is directly related to the claimant's physical needs. Bellone v. Industrial Claim Appeals Office, 940 P.2d 1116, (Colo. App. 1997); Hillen v. Tool King, 851 P.2d 289 (Colo. App. 1993).

An expense is "incidental" to medical treatment if the expense "enables" the

claimant to obtain treatment or is a “minor concomitant” of medical treatment. Country Squire Kennels v. Industrial Claim Appeals Office, supra.

In Daughtry v. King Soopers, Inc., W.C. No. 3-837-001 (ICAO, January 17, 1996), an ALJ denied reimbursement for mileage expenses that the Claimant incurred to obtain medically prescribed drugs. In setting aside the ALJ’s Order, ICAO expressly held that drugs prescribed by a physician are a form of medical “supply” which ß 8-42-101(1)(a) requires Respondents to provide if reasonable and necessary to cure or relieve the effects of the industrial injury. Further, ICAO stated that they could “find no statutory basis for the ALJ’s apparent distinction between travel for the purpose of obtaining treatment by a physician and travel for the purpose of obtaining drugs (or other therapy) prescribed by a physician.” Moreover, citing Industrial Commission v. Pacific Employers Insurance Co., 120 Colo. 373, 209 P.2d 908 (1949), Sigman Meat Co. v. Industrial Claim Appeals Office, 761 P.2d 265 (Colo. App. 1988), and Country Squire Kennels v. Tarshis, 899 P.2d 362 (Colo. App. 1995), the ICAO has previously held that mileage expenses incurred to obtain prescription drugs are compensable if “incident” to obtaining the prescribed drugs.

The Daughtry holding was reaffirmed in the matter of Anderson v. United Airlines and Gallagher Bassett Services, W.C. No. 4-445-052 (ICAO, January 9, 2004).

Additionally, insofar as the Respondents argue the mileage expenses are not reasonable and necessary because the Claimant could have procured the drugs during the shopping trips to his regular grocery store, the ALJ finds this

argument unpersuasive. As noted above, the question of whether particular mileage expenses are reasonable and necessary is a question of fact for the ALJ. Kroupa v. Industrial Claim Appeals Office, 53 P.3d 1192 (Colo. App. 2002).

The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. ßß 8-43-201 and 8-43-210, C.R.S. (2009). See City of Boulder v. Streeb, 706 P. 2d 786 (Colo. 1985); Faulkner v. Industrial Claim Appeals Office, 12 P. 3d 844 (Colo. App. 2000); Lutz v. Industrial Claim Appeals Office, 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. Page v. Clark, 197 Colo. 306, 592 P. 2d 792 (1979); People v. M.A., 104 P. 3d 273 (Colo. App. 2004); Hoster v. Weld County Bi-Products, Inc., W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. Also see Ortiz v. Principi, 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has sustained his burden of proof by proving that the mileage he submitted on February 25, 2009, in the amount of 3, 235 miles was accurate and actually incurred. Claimant is entitled to a full payment of $1,294.00, less the previously paid amount of $1,017.20, resulting in an additional payment of $276.80. Also, as found, Claimant has proven that the mileage he submitted on August 6, 2009, in the amount of 2, 233 miles payable at the rate of $1,228.15 was actually incurred and should be paid.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay the Claimant $1,294.00 for mileage, less the previously paid amount of $1,017.20, resulting in an additional payment of $276.80, which is retroactively due and payable forthwith.

B. Respondents shall pay in full Claimant's mileage submission of August 6, 2009, in the amount of 2, 233 miles, in the amount of $1,228.15, which is retroactively due and payable forthwith.

C. Respondents shall pay the Claimant statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

D. Any and all issues not determined herein are reserved for future decision.

DATED this_____day of November 2009.

_____

EDWIN L. FELTER, JR.

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-749-995

ISSUES

The threshold issue to be determined by this decision is compensability.

FINDINGS OF FACT

1. Claimant first noted symptoms of back pain in 2005. Claimant could not identify a specific injurious event and did not know when this injury occurred in 2005. Claimant's attorney stated at hearing that this claim was for an injury as defined by the Colorado Workers' Compensation Act.

2. Claimant did not tell any of his providers that he had sustained any specific injurious event. Claimant is unsure as to when his symptoms began. Although Claimant indicated his symptoms were present before he left his job with t6he Respondent-Employer in 2005, Claimant did not tell the Respondent-Employer of his pain complaints.

3. Claimant moved to Texas, and found work in Texas, after quitting his job with Respondent-Employer in 2005. Claimant's symptoms remained the same when he was in Texas. When Claimant returned to Colorado in 2006, he

went back to work with Respondent-Employer on October 9, 2006. Claimant performed no work for employer at any time in 2006 until October 9, 2006.

4. Claimant voluntarily resigned from his job with the Respondent-Employer on December 29, 2007. Claimant then found work March 1, 2008, mucking and cleaning stalls at a farm for another employer. Claimant worked at this job full time for two months. Claimant then found work for another employer, Mr. Seufer, and continues working for Mr. Seufer as a farm hand. Claimant works as many hours as his employer will give him, up to 12 hours a day, 70 hours a week, and plans to continue working for this employer at this pace. Claimant wants to work as much as his current employer will allow. Claimant's job with Mr. Seufer is seasonal, and will end after the harvest work is completed in October 2009. Claimant would continue to work for Mr. Seufer if he could, and will seek work for another employer if his job with Mr. Seufer ends. Based upon this subsequent substantial and sustained work the ALJ infers Claimant had no injury or condition related to and arising out of his work for the Respondent-Employer.

5. Claimant filed both his First Report of Injury with Respondent-Employer and his Workers' Claim for compensation on February 1, 2008, more than one month after he resigned from his job with Respondent-Employer

6. Claimant's testimony at hearing substantially conflicted with the medical records received as evidence. Claimant did not specifically know when or how his symptoms arose. He described varying symptoms, in

different areas of his body, present for different lengths of time, to many medical providers. Claimant's testimony is not reliable or credible, and the ALJ find it unpersuasive.

7. David M. Dutton, D.C. evaluated claimant on August 28, 2007, for chronic pain and soreness of the neck, upper back, and low back with radiation into the upper and lower extremities and headaches. Dr. Dutton wrote these symptoms were, "[A] result of insidious onset and of two years duration." He explained Claimant had received many diagnostic studies, but no positive results or findings. Claimant told Jerome Greene, D.C. on December 5, 2007, that no accidents explained his symptoms. Claimant told Dr. Oquist on May 9, 2008, that he needed treatment for numbness in his left side, and pain in his head. Dr. Oquist found Claimant had full range of motion in his cervical spine, and no positive tests that would reveal any structural injuries. No medical expert, evaluator, or provider stated Claimant's conditions were work-related.

8. Claimant's most complete medical evaluation was coordinated and reviewed by Dr. Ruby Saulog, who first saw Claimant on April 30, 2007. Claimant told Dr. Saulog that his symptoms began a year before this visit, and began with intermittent neck pain. In the clinical history completed at this visit, Claimant said he had numbness on the left side of his body and face, tingling on his left side, and pain in his heart. These statements conflict with, and cannot be reconciled with, Claimant's testimony at hearing and his statements documented by other medical providers. The ALJ finds this is further evidence that Claimant's hearing testimony is not credible and is therefore

unpersuasive.

9. Dr. Saulog assessed Claimant with a normal gate, and found normal results to all examinations. The diagnostic studies did not reveal abnormalities to explain Claimant's symptoms or complaints. The MRI of the cervical spine showed mild degenerative changes with no spinal cord abnormality. His brain MRI showed a very mild chronic small vessel ischemia or demyelization. Claimant's lab tests were normal. A CAT scan of Claimant's brain was normal, and his upper and lower extremity EMG/NCS study was normal. Claimant's neurologic and physical examinations were normal. When Claimant returned to Dr. Saulog on May 10, 2007, Dr. Saulog again found a normal objective examination. Dr. Saulog never mentioned any diagnosis, conclusion, finding, or opinion that Claimant's condition was work-related.

10. Dennis P. Clifford, M.D, evaluated claimant. Claimant told Dr. Clifford his symptoms involved left face numbness, numbness of the left side of his head, numbness in his left arm, and numbness in his left leg. Claimant said his symptoms began in 2003. Dr. Clifford's exam did not yield any diagnoses, and he found Claimant's pulmonary allegations were more likely related to early chronic obstructive pulmonary disease from his long-term tobacco use. He did not say any diagnosis or condition was work-related. Claimant presented no opinion rebutting Dr. Clifford's conclusions. Dr. Clifford's opinions are credible and persuasive.

11. James S. Ogsbury, III, M.D. evaluated Claimant, and testified at

hearing. Dr. Ogsbury credibly and persuasively explained Claimant did not allege, and the evidence does not show, Claimant sustained any injury while working for the Respondent-Employer, or any injury that would explain his symptoms or complaints.

12. Dr. Ogsbury testified Claimant's extremity complaints are not related to any pathology or identifiable condition. He said there was no evidence Claimant sustained any injury at work for the Respondent-Employer. He said Claimant's examination was entirely normal. There were no anatomic bases for Claimant's symptoms despite the exhaustive exams, studies, and reviews of the records by Claimant's medical providers, most notably Dr. Saulog.

13. Dr. Ogsbury testified no medical record revealed any findings that would support any diagnosis or finding of any disease process, pathology, anatomic change, or condition. There was no way to know why Claimant had the problems he was alleging and those problems could be related to many different processes or conditions.

14. Claimant's symptoms may be real, and accepting that they are, Dr. Ogsbury could find no condition causally related to his work for the Respondent-Employer. Claimant presented no testimony or evidence to rebut Dr. Ogsbury's conclusions, opinions, and testimony. Dr. Ogsbury credibly testified Claimant has no condition, diagnosis, or disease that is causally related to Claimant's work for the Respondent-Employer, and the ALJ finds his testimony persuasive.

15. Claimant has failed to establish that it is more likely than not that he suffered an injury arising out of and in the course of his employment with the Respondent-Employer.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

1. The purpose of the Workers' Compensation Act of Colorado, C.R.S. Sections 8-40-101, et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. C.R.S. Section 8-40-102 (1). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of the respondents. C.R.S. Section 8-43-201.

2. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P. 3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness' testimony and actions; the reasonableness or unreasonableness of the testimony; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936). In deciding whether Claimant has met his burden of proof, the ALJ is empowered, "To resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to testimony,

and draw plausible inferences from the evidence." Kroupa v. Industrial Claim Appeals Office, 53 P.3d 1192, 1197 (Colo. App. 2002).

4. Claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence. Qual-Med, Inc. v. Industrial Claim Appeals Office, 961 P.2d 590, 592 (Colo. App. 1998) ("Claimant has the burden of proving an entitlement to benefits by a preponderance of the evidence."); Lerner v. Wal-Mart Stores, Inc., 865 P.2d 915, 918 (Colo. App. 1993) ("The burden is on the Claimant to prove his entitlement to benefits by a preponderance of the evidence."). Proof by a preponderance of the evidence requires Claimant to establish that the existence of a contested fact is more probable than its nonexistence. See Hoster v. Weld County Bi-Products, Inc., W.C. No. 4-483-341 (ICAO March 20, 2002).

5. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. C.R.S. ß8-41-301(1) (c); Faulkner, supra. Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. Wal-Mart Stores v. Industrial Claim Appeals Office, 989 P.2d 521 (Colo. App. 1999); Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997).

6. The mere fact that symptoms appear during an employment event does not require a conclusion that the employment was the cause of the symptoms, or that the employment aggravated or accelerated a preexisting

condition. Instead, the appearance of symptoms may be the logical and recurrent consequence of a preexisting condition Jiron v. Express Personnel Services, W.C. No. 4-456-131 (ICAO February 25, 2003); F.R. Orr Construction v. Rinta, 717 P.2d 965, 968 (Colo. App. 1985).

7. The ALJ concludes Claimant has not proven a compensable claim. Had Claimant sustained an injury arising out of and in the course and scope of his employment with respondent-employer, he most likely would been able to identify an injurious event to his medical providers and during his hearing testimony. Claimant was inconsistent in his complaints to medical providers. His testimony was conflicting, vague, and inherently contradictory. Claimant's testimony is not credible.

8. Additionally, no provider stated Claimant's symptoms or conditions are work-related. Dr. Clifford and Dr. Ogsbury, the credible examiners who evaluated Claimant's condition and consider causation, concluded Claimant's conditions were not related to any injury or disease process arising out of his employment for employer. The credible medical evidence is inconclusive as to Claimant's medical condition.

9. The ALJ concludes, based upon a totality of the credible medical and lay evidence, that Claimant has failed to sustain his burden to show that it is more likely than not that he sustained a work related injury or an occupational disease while in the course of his employment or arising out of his employment with respondent-employer.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: November 19, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-763-546

ISSUES

The issues presented for consideration are, the following:

1. Whether Respondents' motion for summary judgment shoulder be granted because there are no disputed issues of fact between the parties and judgment should be entered for Respondents as a matter of law; and

2. Whether the Administrative Law Judge has subject matter jurisdiction over Claimant's claim under Section 8-41-204, C.R.S.

UNDISPUTED FACTS

The following facts are undisputed between the parties .

1. On June 23, 2008, Claimant sustained an occupational disease injury

to his right shoulder while engaging in work activities. Respondents admitted liability for the injury by general admission of liability, dated July 16, 2008.

2. In deposition testimony, Claimant testified that his right shoulder began bothering him in December 2007. After December 2007, Claimant's right shoulder condition steadily worsened.

3. In June 2007, six months prior to first beginning to experience right shoulder pain, Claimant was transferred out of state to Alamogordo, New Mexico, performing work duties for the Employer.

4. Claimant worked in Alamogordo, New Mexico, from June 2007 to March 2008. In March 2008, Claimant was transferred by the Employer to St. George, Utah.

5. In June 2008, while still employed out of state, Claimant returned to Denver, CO to begin a six-week vacation. On June 19, 2008, during Claimant's vacation, Claimant was examined by Thomas R. Sachtelben, M.D. Dr. Sachtelben began the treatment of Claimant and imposed work restrictions on him.

CONCLUSIONS OF LAW

Having made the preceding findings regarding the undisputed facts, the following Conclusions of Law are entered.

The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S., et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the

evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P. 3d 385 (Colo. App. 2000).

In this case, Respondents moved for summary judgment on the grounds that Claimant's February 20, 2009, deposition testimony, Respondents' General Admission of Liability filed with the Colorado Department of Labor and Employment on July 16, 2008, and a Workers' Compensation Employer's First Report of Injury filed with the State of Utah, Labor Commission, Division of Industrial Accidents on June 23, 2008, establish that as a matter of law judgment should be entered for Respondents. Claimant contends that there are disputed facts between the parties and that several crucial facts concerning Claimant's dates of work in Colorado and date of injury must be resolved following a hearing.

Under C.R.C.P. 56, an ALJ may enter summary judgment where there are no disputed issues of material fact and the moving party is entitled to judgment as a matter of law. See e.g. Nova v. Industrial Claim Appeals Office, 754 P.2d 800 (Colo.

App. 1988) (C.R.C.P. apply in WCA proceedings insofar as it is not inconsistent with the Act's procedural or statutory provisions); Cf. In re Rivera, W.C. No. 4-574-706 (ICAO, 1/22/04).

The C.R.C.P. are applicable to Workers' Compensation proceedings to the extent that they are not inconsistent with applicable Workers' Compensation statutes. Renaissance Salon v. Industrial Claim Appeals Office, 994 P.2d 447 (Colo. App. 1999); Nova, supra.

Pursuant to C.R.C.P. Rule 56(c), summary judgment is proper where the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. McCormick v. Union Pacific Res. Co., 14 P.3d 346, 349 (Colo. 2000)(citing, Bebo Contsr. Co. v. Mattox & O'Brien, P.C., 990 P.2d 78, 83 (Colo. 1999)). C.R.C.P. Rule 56(e) provides an adverse party may not rest upon the mere allegations or denials of the opposing party's pleadings, but the opposing party's response by affidavits or otherwise provided in this Rule, must set forth specific facts showing that there is a genuine issue for trial.

The purpose of a Motion for Summary Judgment is to pierce through the formal allegations of the pleadings and save the time and expense connected with a trial, when, as a matter of law, based on undisputed facts, one party could not prevail. Ginter v. Palmer and Co., 196 Colo. 203, 205, 585 P.2d 583, 584 (1978)(citing, Abrahamsen v. Mountain States Telephone & Telegraph Corp.,

177 Colo. 422, 494 P.2d 1287 (1972)).

The burden of establishing that there is no triable issue of material fact is on the moving party. McCormick, supra (citing Greenwood Trust v. Conley, 938 P.2d 1141, 1149 (Colo. 1997). The moving party meets its burden by identifying those parts of the record to demonstrate the absence of genuine issue of material fact. Id. Once the moving party establishes that no material fact is in dispute, the burden of proving the existence of an issue of material fact for trial shifts to the opposing party. Id. If the opposing party fails to satisfy its burden of proof, the moving party is entitled to summary judgment. Id.

Summary judgment is a drastic remedy and is not warranted unless the moving party demonstrates it is entitled to judgment as a matter of law. Van Alstyne v. Housing Authority of Pueblo, 985 P.2d 97 (Colo. App. 1999). All doubts as to the existence of disputed facts must be resolved against the moving party, and the party against whom judgment is to be entered is entitled to all favorable inferences that may be drawn from the facts. Furthermore, failure to file an affidavit or other documentary evidence in opposition to a motion for summary judgment does not relieve the moving party of its burden to establish entitlement to summary judgment. People v. Hernandez and Associates, 736 P.2d 1238 (Colo. App. 1986); Cf. Division of Workers' Comp. v. Sundance, W.C. No. 2002-110238 (ICAO, 1/13/04).

A "material fact" is simply a fact that will affect the outcome of

the case. In re Water Rights of the United States, 854 P.2d 791 (Colo. 1993). Where there are disputed issues of material fact, due process requires the parties be afforded a reasonable opportunity to present evidence and confront adverse evidence. Hendricks v. Industrial Claim Appeals Office, 809 P.2d 1076 (Colo. App. 1990).

Section 8-41-204, C.R.S. provides that,

If an employee who has been hired or is regularly employed in this state receives personal injuries in an accident or an occupational disease arising out of and in the course of such employment outside of this state, the employee, or such employee's dependents in case of death, shall be entitled to compensation according to the law of this state. This provision shall apply only to those injuries received by the employee within six months after leaving this state Ö

Section 8-41-204 establishes the exclusive grounds under which Colorado may take jurisdiction of a case in which an injury occurs outside of the state. Rodenbaugh v. DEA Construction, W.C. No. 4-523-336 (I.C.A.O. 12/20/02). Without subject matter jurisdiction, the ALJ does not have authority to act. See Reed v. Industrial Claims Appeal Office, 13 P.3d 810 (Colo. App. 2000).

Claimant asserts mere allegations or denials regarding Respondents' Motion for Summary Judgment. Mere allegations and denials are contrary to the requirements of C.R.C.P. Rule 56(e), which requires Claimant to respond by affidavits and to set forth specific facts showing that there is a genuine issue

for trial. Claimant baldly asserts that he worked in Colorado in November 2007 for a one-week period. This assertion is contrary to his deposition testimony offered in support of the Motion. Claimant maintains that the Motion for Summary Judgment should be denied and that he should be permitted to present evidence at a hearing to establish that he worked in Colorado less than six months before the initial onset of his injury in December 2007.

Claimant's sworn testimony in the February 20, 2009, deposition establishes that Claimant worked out of state from June 2007 in Alamogordo, New Mexico until March 2008 when he was transferred to St. George, New Mexico. Claimant testified that he remained in St. George, Utah until June 2008 when he returned to Denver for a vacation.

Because Claimant was employed out of state for more than six month when he sustained a work injury, as established by his deposition testimony, there is no disputed issue of fact with regard to the question of the ALJ's jurisdiction to consider the claim. It is therefore found and concluded that Respondents are entitled to judgment as a matter law. It is concluded that Colorado, and thus the ALJ, lacks subject matter jurisdiction to consider Claimant's claim.

ORDER

It is therefore ordered that:

Claimant's claim for workers' compensation benefits is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: ___November 20, 2009_

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Margot W. Jones

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-021-541

ISSUE

Whether Respondents have demonstrated by a preponderance of the evidence that Claimant should be required to undergo and fully cooperate in a second Methacholine Challenge Test (MCT).

FINDINGS OF FACT

1. In the early 1990's Claimant sustained a compensable occupational asthma condition during the course and scope of her employment with Employer. Respondents were ordered to pay for Claimant's continuing medical maintenance treatment as a result of her asthma condition. Claimant has received ongoing treatment for her occupational asthma from Cecile Rose, M.D. and other physicians at National Jewish Hospital.

2. On May 8, 2008 Respondents retained Lawrence Repsher,

M.D. to perform an independent medical examination on Claimant. Dr. Repsher testified at the hearing in this matter. He explained that the purpose of his independent medical examination was to determine whether Claimant's continuing medications were related to her occupational asthma condition. Dr. Repsher commented that, because Claimant had not worked for Employer for several years, her asthma condition may have resolved. He thus recommended that Claimant undergo an MCT to ascertain whether she still suffered from asthma.

3. On May 22, 2008 Claimant underwent a MCT. The technician who administered the test stated "[p]atient was unable to achieve any consistency with efforts during testing, which put accuracy of results in question." The technician noted that Claimant "chose to stop at the 0.25mg dose of Methacholine" because she complained of chest tightness and shortness of breath. The technician also remarked that Claimant "used her Maxair inhaler and Flovent for post Bronchodialator Spirometry and stated she put forth her best efforts during testing."

4. Claimant testified at the hearing in this matter. She explained that she cooperated with the MCT instructions provided by the technician. The technician advised her that she could terminate the testing when necessary. Claimant described that she began to experience chest pain and shortness of breathe shortly after the MCT started. She used her inhaler after the MCT and noted that she gave her best effort during the testing.

5. Dr. Repsher testified that, because Claimant is no longer exposed to her occupational asthma trigger, she should undergo a second MCT to determine whether she continues to suffer from the disease. He remarked that, although a positive MCT result does not necessarily result in a diagnosis of

asthma, a negative MCT result is clear evidence that an individual does not have asthma. Dr. Repsher explained that an MCT is an invasive procedure designed to determine the presence of asthma in a patient by introducing a chemical known to induce an asthmatic response in individuals that have asthma. To administer the test the patient is required to inhale increasing doses of Methacholine. Dr. Repsher commented that after each dose the patient is required to perform a pulmonary function test to measure certain airflow velocities. Asthmatic responses are short-lived because, once an asthmatic response is induced, the patient is given Albuterol to resolve the problem.

6. Dr. Repsher also testified that it is imperative for a patient to give her best effort during an MCT in order to obtain valid results. He questioned whether Claimant provided her best effort during the May 22, 2008 MCT. Dr. Repsher explained that the laboratory that he uses at Lutheran Medical Center contains sophisticated equipment that permits a determination of whether a patient is giving her best effort during a MCT.

7. Dr. Rose testified at the hearing in this matter. She has treated and managed Claimant's occupational asthma condition for a number of years. Dr. Rose stated that, based on clinical findings in the early 1990's, Claimant suffered from occupational asthma. Claimant underwent a histamine challenge test, imaging studies and CT scans that were consistent with occupational asthma. She persuasively explained that, although a MCT can be helpful, it is not necessary in Claimant's case because she has continued to exhibit other clinical findings that are consistent with occupational asthma.

8. Dr. Rose commented that, although the occupational asthma symptoms of many patients improve when they are removed from the triggering exposure,

Claimant continues to exhibit symptoms that are consistent with occupational asthma. She remarked that Claimant continues to experience wheezing, chest tightness and coughing at the time of irritant exposures. Dr. Rose explained that Claimant's symptoms have been well managed and improve when treated with inhaler medications. She noted that imaging studies, including chest CT scans, show subtle findings of airway disease and bronchial wall thickening. Claimant has also had a positive response to bronchial dilators. Dr. Rose commented that Claimant has historically had difficulty performing pulmonary function tests but has nevertheless shown an elevation in residual volume. Dr. Rose summarized that there was no medical reason to require Claimant to undergo an MCT when she continues to suffer from occupational asthma and it is difficult for her to complete the test.

9. Respondents have failed to demonstrate that it is more probably true than not that Claimant should be required to undergo and fully cooperate in a second MCT. Dr. Rose persuasively explained that Claimant was initially diagnosed with occupational asthma in the early 1990's and continues to exhibit symptoms that are consistent with occupational asthma. She remarked that Claimant continues to experience wheezing, chest tightness and coughing at the time of irritant exposures. Dr. Rose explained that Claimant's symptoms have been well managed and improve when treated with inhaler medications. She noted that imaging studies, including chest CT scans, show subtle findings of airway disease and bronchial wall thickening. Claimant has also had a positive response to bronchial dilators. Dr. Rose summarized that, because Claimant continues to suffer from occupational asthma and has had difficulties in completing pulmonary function tests, there is simply no medical reason to

require Claimant to undergo a MCT. Dr. Repsher's contrary opinion is not persuasive because it fails to acknowledge that Claimant continues to suffer from a variety of symptoms that are consistent with the presence of occupational asthma. Based on the persuasive testimony of Dr. Rose, Claimant continues to suffer from the symptoms of well-managed occupational asthma. Because the purpose of a MCT is to determine whether an individual suffers from asthma, the testing is unnecessary and Respondents' request is denied.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. The burden of proof "rests upon the party who asserts the affirmative of an issue." In Re Slattery, W.C. No. 4-728-045 (ICAP, Jan. 29, 2008). Because Respondents seek an order that requires Claimant to undergo and fully cooperate in a second MCT, they must establish their request by a preponderance of the evidence. Whether Respondents have sustained their burden of proof is a question of fact for resolution by the ALJ. In Re Digregorio, W.C. No. 4-614-624 (ICAP, Aug. 15, 2007).

5. As found, Respondents have failed to demonstrate by a preponderance of the evidence that Claimant should be required to undergo and fully cooperate in a second MCT. Dr. Rose persuasively explained that Claimant was initially diagnosed with occupational asthma in the early 1990's and continues to exhibit symptoms that are consistent with occupational asthma. She remarked that Claimant continues to experience wheezing, chest tightness and coughing at the time of irritant exposures. Dr. Rose explained that Claimant's symptoms have been well managed and improve when treated with inhaler medications. She noted that imaging studies, including chest CT scans, show subtle findings of airway disease and bronchial wall thickening. Claimant has also had a positive response to bronchial dilators. Dr. Rose summarized that,

because Claimant continues to suffer from occupational asthma and has had difficulties in completing pulmonary function tests, there is simply no medical reason to require Claimant to undergo a MCT. Dr. Repsher's contrary opinion is not persuasive because it fails to acknowledge that Claimant continues to suffer from a variety of symptoms that are consistent with the presence of occupational asthma. Based on the persuasive testimony of Dr. Rose, Claimant continues to suffer from the symptoms of well-managed occupational asthma. Because the purpose of a MCT is to determine whether an individual suffers from asthma, the testing is unnecessary and Respondents' request is denied.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Respondents' request for an Order requiring Claimant to undergo and fully cooperate in a second Methacholine Challenge Test is denied.

2. Any issues not resolved by this Order are reserved for future determination.

DATED: November 20, 2009.

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Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-740-450

ISSUES

Whether Claimant's 10% lower extremity rating should be converted to a 4% whole person impairment.

FINDINGS OF FACT

1. The above-captioned matter is an admitted claim for a date of injury of October 31, 2007.

2. On February 9, 2009, Respondents filed a Final Admission of Liability admitting to a 19% whole person impairment based upon the injuries Claimant sustained in his October 31, 2007 industrial injury.

3. Claimant timely objected to the Final Admission of Liability, filing an objection as well as a Notice and Proposal to Select an Independent Medical Examiner on February 18, 2009.

4. Respondents' filed a Notice of Failed IME Negotiation on March 3, 2009.

5. Through the Division Independent Medical Examination selection process, Dr. Timothy Hall was identified as the physician to complete Claimant's requested Division Independent Medical Examination.

6. On May 20, 2009, Dr. Hall completed his Division Independent Medical Examination. Dr. Hall opined that Claimant suffered from disc-pathology with radiculopathy and provided Claimant with an impairment rating of 21% whole person for Claimant's spinal impairment based upon Table 53 of the AMA Guides to the Evaluation of Permanent Impairment, Third Edition Revised. In addition to his Table 53 impairment, Dr. Hall opined that Claimant suffered from a 15% range of motion loss directly attributable to Claimant's October 31, 2007 industrial injury. Moreover, Dr. Hall opined that Claimant was suffering from a lower extremity radiculopathy, which entitled Claimant to an additional 10% scheduled impairment of the right lower extremity. Dr. Hall concluded that the 10% scheduled lower extremity impairment equated to 4% impairment of the whole person.

7. On June 3, 2009, Respondents filed a Final Admission of Liability admitting to impairment as referenced in Dr. Hall's Division Independent Medical Examination report equaling 21% whole person impairment for Claimant's spinal condition and 10% scheduled impairment for Claimant's residual radiculopathy.

8. Claimant objected to Respondents' Final Admission of Liability and filed an Application for Hearing on July 2, 2009 endorsing the sole issue of conversion of Claimant's scheduled 10% lower extremity impairment to impairment of the whole person.

9. At hearing, Claimant testified to ongoing pain in his lower extremity, which altered his gait and impaired his functional capability to include ambulation and additional limitation in activities of daily living.

10. In his deposition testimony, Dr. Dwight Caughfield opined that

Claimant was having degraded ability to perform certain activities including standing, walking and climbing stairs.

CONCLUSIONS OF LAW

1. Claimant has failed to establish by a preponderance of the evidence that he is entitled to additional permanent partial disability benefits based upon a conversion of his lower extremity impairment to impairment of the whole person.

2. The question of whether the Claimant sustained a loss of an extremity within the meaning of Section 8-42-107(2)(a), C.R.S. 2008, or a whole person medical impairment compensable under Section 8-42-107(8)(c), C.R.S. 2008, is one of fact for determination by the ALJ. In resolving the question, the ALJ must determine the situs of the Claimant's functional impairment, and the site of such functional impairment is not necessarily the site of the injury itself. See Langton v. Rocky Mountain Healthcare Corp, 937 P.2d 883 (Colo. App. 1996).

3. An impairment rating provided for under the AMA Guides to the Evaluation of Permanent Impairment while relevant to the overall degree of permanent impairment itself is not dispositive of whether the Claimant suffered a functional impairment beyond the schedule as provided for in Section 8-42-107(2)(a), C.R.S. Strauch v. PSL Swedish Healthcare System, 917 P.2d 366 (Colo. App. 1996). Thus, it has been determined that scheduled injuries of the upper and lower extremities may be converted to whole person impairment based upon "functional impairment" which would be considered beyond the schedule. In fact, pain which limits the Claimant's ability to use a portion of the body may be considered functional impairment for purposes of demonstrating whether an

injury is on or off the schedule. Valles v. Arrow Moving and Storage, W.C. No. 4-265-129 (October 22, 1998); Salaz v. Phase II Co., W.C. No. 4-240-376 (November 19, 1997), Aff'd Phase ii Co. v. Industrail Claim Appeals Office, (Colo. App. No. 97CA2009, September 3, 1998) (not selected for publication).

4. The Claimant is attempting to convert the Claimant's 10% lower extremity impairment to a 4% whole person impairment.

5. Respondents rely on Warthen v. Industrial Claim Appeals Office, 100 P.3d 581 (Colo. App. 2004), in which a claimant attempted to have a shoulder impairment converted to a whole person impairment. In that case the claimant received a 48% right upper extremity impairment and a 7% whole person impairment to the neck. The respondents admitted to the 7% whole person impairment and the 48% right upper extremity impairment. The claimant attempted to convert the upper extremity to a whole person. The Administrative Law Judge found that all functional impairment that went beyond the arm was fully compensated by the DIME 7% whole person rating. Therefore, the upper extremity impairment remained as one on the schedule. Warthen, 100 P.3d at 583.

6. Although the Claimant's current case involves one to the lower extremity, the Warthen case is on point. The Claimant has provided no medical or other evidence that he experiences any impairment above the lower extremity that would not be fully compensated with the 21% whole person impairment to the back. The Claimant testified that he had pain and discomfort in his back. However, that would be incorporated in the specific disorder part of the back rating, and any functional limitations would be incorporated with the range of motion deficits provided for with the 21% impairment.

7. The Claimant testified that the radiculopathy caused

his knee to give way. The Claimant testified that it was his belief that the radiculopathy was coming from the back. Nonetheless, pursuant to Strauch v. PSL Swedish Healthcare Sys., 917 P.2d 366 (Colo. App. 1996), it is not the situs of the injury that determines where the impairment is, but what parts of the body that have been functionally impaired. In this case, even though the radiculopathy in the leg may be coming from the back, the functional impairments that the radiculopathy is causing the Claimant are that he had leg pain and that his leg would give way. These are functional impairments to the lower extremity.

ORDER

It is therefore ordered that:

1. Claimant's request to convert his 10% scheduled lower extremity rating to a 4% whole person rating is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATE: November 23, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-788-119

ISSUES

1. Whether Claimant suffered a compensable low back injury in the course and scope of his employment with Respondent/Employer, on January 20, 2009.

2. Whether Claimant is entitled to any and all reasonable and necessary medical benefits for the compensable low back injury suffered on January 20, 2009.

3. A determination of Claimant's average weekly wage.

4. Whether Claimant is entitled to temporary total disability benefits for the January 20, 2009, injury from March 25, 2009, ongoing.

FINDINGS OF FACT

1. At all times relevant to this matter, Claimant was an employee of Respondent/ Employer. Respondent-Employer had employed Claimant for approximately four years prior to January 20, 2009. Claimant worked as an operator, which primarily required Claimant to operate heavy equipment. The operation of heavy equipment in the asphalt business often requires a significant amount of heavy lifting due to maintenance of the equipment and set

up of the machinery.

2. On January 20, 2009, Claimant, in the course of his employment with Avery Asphalt, Inc., was working on an asphalt-paying project. At approximately 10:00 am, Claimant was required to lift a piece of equipment called a walker out of the bed of a pickup truck in preparation to use the piece of equipment in paving process. The piece of equipment weighed approximately 150 pounds. In the process of lifting the piece of equipment out of the truck, Claimant heard a loud pop in his low back and felt an immediate onset of low back pain with burning and numbness in his lower extremities. Claimant reported his injury to his direct supervisor.

3. Claimant continued to work for Respondent-Employer until February 4, 2009. Although Respondent-Employer was aware of Claimant's low back condition, Claimant was asked to perform full duty and required to attempt to lift heavy objects. As of February 4, 2009, Claimant was physically unable to perform his job duties. Respondent-Employer informed Claimant that he should not return until he had a doctor's release. Since that time, Claimant has not been given a doctor's release and has not returned to work for Respondent-Employer.

4. On March 17, 2009, Respondent-Employer issued a designated provider list to Claimant. Claimant selected Dr. Bradley at Emergicare and was seen by Dr. Bradley on March 25, 2009. Claimant reported the mechanism of injury as detailed above and complained of low back pain with bilateral

numbness. Dr. Bradley diagnosed degenerative disc disease with bilateral radiculopathy. Dr. Bradley determined that his objective findings were consistent with the mechanism of injury. Dr. Bradley determined that Claimant had temporary restrictions consisting of a five-pound lift/carry restriction. Dr. Bradley indicated that he would continue to treat Claimant for this work-related injury.

5. Claimant has established that it is more probable than not that on January 20, 2009, he suffered a compensable low back injury arising out of and in the course of his employment with Respondent-Employer.

6. Claimant has established that he is entitled to any and all reasonable, necessary, and related medical benefits for the compensable low back injury suffered on January 20, 2009.

7. Claimant has established that his average weekly wage is $670.00 based upon earning $16.75 per hour for a forty-hour week.

8. Claimant has established that it is more probable than not that he is entitled to temporary total disability benefits for the January 20, 2009, injury from March 25, 2009 and continuing until terminated by operation of law or order.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado”

(Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co.v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil

3:16 (2007).

4. Claimant credibly testified that he was performing duties within the course of his employment on January 20, 2009, when he experienced a severe and immediate onset of pain in his low back with burning and numbness in his lower extremities. Dr. Bradley evaluated the Claimant and determined Claimant's injuries were consistent with the mechanism of injury. Dr. Bradley provided a work-related diagnosis of degenerative disc disease with bilateral radiculopathy. Claimant has established that it is more probable than not that he suffered a compensable low back injury arising out of and in the course of his employment with Respondent-Employer on January 20, 2009.

5. Once a claimant has established a compensable work injury, the claimant is entitled to a general award of medical benefits and respondents are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. Section 8-42-101, C.R.S.; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988); Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo.App. 1990). As such, Claimant has established that he is entitled to any and all reasonable, necessary, and related medical benefits for the compensable low back injury suffered on January 20, 2009.

6. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the

disability, and that the disability resulted in an actual wage loss. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), supra, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. PDM Molding, Inc. v. Stanberg, supra. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. Culver v. Ace Electric, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. Lymburn v. Symbios Logic, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. Ortiz v. Charles J. Murphy & Co., 964 P.2d 595 (Colo.App. 1998).

7. In this case, Claimant was injured on January 20, 2009. He continued to work for Employer-Respondent until February 4, 2009. At that time, Claimant was physically unable to perform his job duties. Respondent-Employer informed Claimant that he should not return until he had a doctor’s release. Dr. Bradley examined claimant on March 25, 2009. At that time, Dr. Bradley determined that Claimant had temporary restrictions consisting of a five-pound lift/carry restriction. This restriction is such that Claimant would not be able to perform the essential requirement of his job with Respondent-Employer.

Since that time Claimant has not been given a doctor's release and has not returned to work for Respondent-Employer. Claimant has established that it is more probable than not that he is entitled to temporary total disability benefits for the January 20, 2009, injury from March 25, 2009 and continuing until terminated by operation of law or order.

8. Claimant earned $16.75 per hour for his work for Respondent-Employer. The number of hours worked varied from week to week and also varied depending on the time of year. Claimant has established by a preponderance of the evidence that his average weekly wage cannot be fairly computed under C.R.S. ß 8-42-102(2).

9. Claimant has established that his average weekly wage is $670.00 based upon earning $16.75 per hour for a forty-hour week.

10. Section 8-42-103(1)(f) states:

In cases where it is determined that unemployment insurance benefits are payable to an employee, compensation for temporary disability shall be reduced, but not below zero, by the amount of unemployment insurance benefits received, unless the unemployment insurance amount has already been reduced by the temporary disability benefit amount and except that temporary total disability shall not be reduced by unemployment insurance benefits received pursuant to section 8-73-112.

11. Claimant has been receiving unemployment benefits at a rate of $390.00 per week since shortly after his employment with Respondent-Employer ceased. Therefore, Respondents are entitled to offset for the unemployment benefits at a rate of $390.00 per week to reduce Claimant's temporary total disability benefits, but not below zero.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits under the Workers' Compensation Act of Colorado is compensable.

2. Claimant is entitled to, and Respondent-Insurer shall pay for, any and all reasonable, necessary, and related medical benefits for the compensable low back injury suffered on January 20, 2009.

3. Claimant's average weekly wage is $670.00.

4. Respondent-Insurer shall pay Claimant temporary total disability benefits March 25, 2009 and continuing until terminated by operation of law or order.

5. Based upon ß 8-42-103(1)(f) Respondents are entitled to offset for the unemployment benefits at a rate of $390.00 per week to reduce Claimant's temporary disability benefits, but not below zero.

6. Respondent-Insurer shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

7. All matters not determined herein are reserved for future determination.

DATE: November 23, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-744-646

ISSUES

Whether the DIME physician determined that Claimant's complex regional pain syndrome (CRPS) is related either to his February 20, 2007, injury or his December 23, 2007 injury;

If the DIME physician determined that Claimant's CRPS is related to his February 20, 2007, injury or his December 23, 2007, injury, whether Respondents have overcome the DIME opinion by clear and convincing evidence;

If the DIME physician determined that Claimant's CRPS is not related to either his February 20, 2007, injury or his December 23, 2007, injury, whether Claimant has overcome the DIME opinion by clear and convincing evidence;

Whether Claimant has established by a preponderance of the evidence that his CRPS is related either to his February 20, 2007, injury or his December 23, 2007, injury;

Whether Claimant has established by a preponderance of the evidence that he is permanently and totally disabled (PTD);

Whether Claimant has proven by a preponderance of the evidence that he is entitled to ongoing maintenance medical care;

Whether Respondents have proven by a preponderance of the evidence that Claimant's entitlement to ongoing maintenance care should be apportioned between his work-related injuries and his pre-existing physical condition;

If Claimant has proven that he is permanently and totally disabled, whether Respondents have proven by a preponderance of the evidence that apportionment of his permanent total disability is appropriate; and

If Claimant is PTD, whether Claimant's indemnity benefits should be offset by Claimant's receipt of Social Security disability benefits as well as his

retirement benefits.

FINDINGS OF FACT

Based on the evidence presented at hearing, in addition to the deposition testimony, the Judge finds as follows:

1. Claimant is currently _ years old with a date of birth of _. Claimant worked as a law enforcement officer for Employer for 22 years until September 2008.

2. Claimant began receiving Social Security disability benefits on May 27, 2009, in the amount of $1,973 per month.

3. Claimant also began receiving retirement benefits through the Employer on May 1, 2009, in the approximate amount of $2600 per month. Employer contributed to Claimant's retirement fund by matching Claimant's contributions.

4. On February 20, 2007, a steel security door closed onto Claimant's left hand. Claimant was able to free his hand.

5. Employer referred Claimant to Arbor Occupational Medicine where he saw Mary Ellen Brandon, a nurse practitioner On examination, Claimant showed significant tenderness and swelling in his hand particularly in the index, fourth and third fingers, distal to the PIP joints. Claimant also exhibited limited range of motion and grip. X-rays were taken and Ms. Brandon questioned whether it showed any kind of avulsion fracture in the left index finger. Ms. Brandon also made an appointment for Claimant to see Dr. Weingarten, the next day at 1:30 p.m. Ms. Brandon gave the x-rays to Claimant

to hand carry to Dr. Weingarten's office and prescribed Vicoden.

6. At approximately 8:39 a.m. on the morning of February 21, 2007, Claimant contacted the Kaiser Permanente clinic to make an appointment to see a Kaiser physician that morning. The appointment note indicated that Claimant gave a history of injuring his left hand when a suitcase fell on it and now his hand was black and blue.

7. Claimant saw Mr. Albu, a physician assistant, on 10:28 a.m. on February 21, 2007. Mr. Albu's clinical note documented obtaining a history from Claimant of Claimant coming home from Texas the day before and that a suitcase slammed down on his left hand. Mr. Albu noted that Claimant had swelling over most of the dorsum of the left hand and pain with grip. Claimant did not report receipt of a prescription of Vicoden from Ms. Brandon the day before, and he obtained 120 tablets of Percocet from Mr. Albu. Claimant also underwent x-rays of his left hand again despite having x-rays completed the day before.

8. Claimant saw Dr. Weingarten on February 21, 2007, and reported that his hand had improved substantially. Claimant pointed to the middle of the third, fourth and fifth metacarpals as the area of maximum tenderness. Dr. Weingarten's exam revealed swelling and tenderness of a moderate degree and full hand mobility. X-rays revealed no fracture.

9. Claimant missed his appointment with Arbor

Occupational Medicine on February 27, 2007.

10. On March 6, 2007, Claimant saw Dr. Watson at Arbor Occupational Medicine. Claimant reported that he had a setback because he struck his hand the week before and has had some swelling in the same location in the area of the long finger. Dr. Watson's report indicates that Claimant had some swelling over the MCP joint of the middle finger and good motion and strength were noted as well as unimpaired pinch and grip. Repeated x-rays were negative. Dr. Watson refilled the Vicoden prescription.

11. On March 9, 2007, Claimant returned to Kaiser and reported ongoing low back and leg pain, for which he was taking six Percocet per day to control. He also reported that his left hand was smashed in a car door by his wife a few days earlier. Dr. Feret noted that the hand was still swollen and painful and had not been evaluated. Dr. Feret also noted soft tissue swelling and tenderness over the third and fourth metacarpals and MCPJs and bruising. Dr. Feret referred Claimant for another x-ray of his left hand and prescribed another 120 tablets of Percocet. The x-rays were negative.

12. Claimant adamantly denied on multiple occasions that any injury to his hand occurred in March 2007 although he reported to Dr. Feret that his wife smashed his hand in a car door and told Dr. Watson that he struck his hand. Claimant later admitted that something happened. He described that his hand was "mashed" in between a car door and the map bucket in the door when he used his right hand to pull the car door shut and his left hand was

dangling between the car door and the seat perpendicular to the seat. Given Claimant's previous description of his wife slamming his hand into a car door, his denials that anything at all occurred, and the general implausibility of this event occurring as Claimant described, the manner in which Claimant injured his left hand in early March 2007 is unknown.

13. Whatever happened to Claimant's left hand in early March 2007 was significant enough to cause a "setback" and contribute to the development of CRPS, but not significant enough to cause a fracture.

14. Claimant saw Dr. Watson on March 14, 2007. Dr. Watson noted continued swelling to his left hand along the dorsum of the hand overlying the third and fourth metacarpal phalangeal joints.

15. Claimant returned to Kaiser on March 19, 2007, and made no mention of his hand injury.

16. On April 3, 2007, Claimant saw Dr. Feret for his left hand injury. The subjective report was ongoing hand pain, dropped a suitcase on it, and it is now stiff. Dr. Feret's objective findings were mild swelling at the second and third MCPs with tenderness. Dr. Feret assessed probable osteoarthritis aggravated by trauma.

17. Claimant missed his April 4, 2007, appointment with Dr. Watson, but did return on April 11, 2007. Dr. Watson noted that Claimant

reports continued swelling and pain in the left hand between the third and fourth metacarpal phalangeal joints. Claimant had not begun hand therapy.

18. Claimant missed another appointment with Dr. Watson on May 4, 2007.

19. On May 21, 2007, Claimant returned to see Dr. Watson and reported continued pain in his left hand. He also reported that his hand had been improving, but had worsened and become tender to the touch. Dr. Watson noted some hyperemia on the dorsum of the hand in the area of the third and fourth MCP joints, and tenderness to light touch which diminishes to firm pressure. Dr. Watson referred Claimant to Dr. Primack for a second opinion.

20. Claimant saw Dr. Primack on May 31, 2007. Dr. Primack referred Claimant for a QSART/EMG analysis and MRI to rule out a sympathetic component and rule out problem with the MCP joints.

21. Claimant underwent EMG testing on August 3, 2007, and saw Dr. Schakaraschwili. The EMG tests were normal with no evidence of nerve injury.

22. The QSART test was performed on August 17, 2007, which Dr. Schakaraschwili interpreted to show that Claimant had a high probability for the presence of CRPS type I.

23. Claimant reported left hand pain again to Kaiser personnel until August 24, 2007, when he saw Dr. Baker. Claimant reported to Dr. Baker that he slammed his hand in a door two to three months earlier and has had some pain. The treatment notes specifically indicate, “8/13/07 lifting a suitcase and fell and landed on hand” and “8/17/07 moving furniture and heard a pop” and since then has had increased pain and swelling. Dr. Baker noted limited extension of fourth phalanx and significant erythema and edema over the left hand extensor surface. Dr. Baker assessed a fracture of the fourth metacarpal, but noted difficulty in determining the timing of the fracture due to repeat traumas.

24. Claimant also reported to Dr. Primack on August 30, 2007, that he felt a pop while lifting a suitcase with his left hand. Dr. Primack noted that x-rays demonstrate a fracture of the hand which is new and not work-related. Claimant, therefore, treated with Kaiser for this fracture.

25. Claimant’s fracture delayed treatment for the CRPS. On October 11, 2007, Claimant returned to Dr. Primack to begin the CRPS treatment. Dr. Primack referred Claimant for stellate ganglion blocks and occupational therapy.

26. Claimant saw Dr. Primack on November 14, 2007. Dr. Primack noted that Claimant’s hand was swollen and puffy. He referred Claimant to Dr. Baralot for a consultation for a dorsal column stimulator. Dr. Primack now noted that Claimant’s CRPS was type II rather than type I as previously

indicated by Dr. Schakaraschwili.

27. On November 19, 2007, Claimant reported to Kaiser that he injured his left hand three days earlier when he was carrying a box and smashed his hand between the door jam and the box. His hand was swollen and painful. The x-rays taken showed a healed fourth metacarpal fracture and no acute fracture.

28. Claimant sustained another work-related injury to his left hand on December 23, 2007, when he was stuffing clothing into a locker at work and felt a pop. Claimant initially sought treatment with Beacon Medical Services where he was diagnosed with a new nondisplaced fracture in the proximal portion of the third metacarpal.

29. By that time, Claimant had already been diagnosed with CRPS and surgery was scheduled for implanting a spinal cord stimulator.

30. Claimant returned to Dr. Watson on December 26, 2007, for treatment of this new fracture, and Dr. Watson referred Claimant to Dr. Davis.

31. Claimant saw Dr. Davis on December 31, 2007. Dr. Davis determined that Claimant had a non-union of the fourth metacarpal and a non-displaced third metacarpal fracture. Dr. Davis suggested that Claimant undergo an open reduction internal fixation of the fourth metacarpal non-union

and internal fixation of the third metacarpal. Dr. Davis noted that the fourth metacarpal non-union was conceivably contributing to the persistent CRPS.

32. Dr. Davis performed the open reduction and internal fixation surgery on January 9, 2008. Thereafter, Claimant attended hand therapy and was making good progress.

33. Claimant also had a spinal cord stimulator implanted by Dr. Barolat in May 2008 to help control the pain caused by CRPS. Dr. Barolat returned Claimant to work on June 30, 2008. On August 13, 2008, Claimant reported to Dr. Barolat that he was obtaining a fair amount of relief from the stimulator, but his pain would return if he used his left upper extremity extensively.

34. Dr. Watson placed Claimant at maximum medical improvement on July 22, 2008. Dr. Watson determined that Claimant should continue to follow-up with Dr. Primack for narcotic pain medications. He also imposed work restrictions as follows: avoid lifting over 10 pounds and no working in safety sensitive positions which involve carrying a weapon or potential altercations with inmates or suspects. Dr. Watson assigned an 11 percent upper extremity impairment rating for loss of motion and a five percent whole person rating for the CRPS, which combined for a 12 percent whole person impairment rating.

35. Claimant requested a DIME which he underwent with Dr. Zuehlsdorff on December 9, 2008. Dr. Zuehlsdorff agreed that Claimant was at MMI as of July 22, 2008, and that Claimant should receive maintenance treatment per Dr. Watson. He opined that Claimant had CRPS type I as a result of multiple injuries between February 20, 2007, and December 23, 2007. Dr. Zuehlsdorff approximated that Claimant's condition was 50 percent attributable to his work-related injuries and assigned a 10 percent whole percent impairment rating.

36. During the DIME, Claimant admitted to Dr. Zuehlsdorff that he lied to Dr. Feret during the appointment on February 21, 2007, when he reported that a suitcase fell on his hand the day before. Claimant asserted that he lied because he felt that Arbor Occupational Medicine had not performed an adequate examination and because he believed he had a fracture that Arbor had failed to diagnose.

37. Dr. Zuehlsdorff also questioned Claimant about any injury in early March 2007. Claimant also denied any injury or event in early March 2007 despite two different medical records indicating that something happened to Claimant's left hand in early March 2007.

38. Dr. Zuehlsdorff testified during his deposition that the December 23, 2007, injury did not accelerate the need for treatment of the CRPS, but that it had some additive effect to the pain complex, but the amount could be quantified. Dr. Zuehlsdorff's opinion is persuasive in this

regard.

39. Dr. Zuehlsdorff disagreed with Dr. Primack's determination that the need for the January 2008 surgery was solely attributable to the work injury on December 23, 2007. Dr. Zuehlsdorff opined that it was a combination of the injuries in August, November and December 2007 that caused the need for surgery in January 2008.

40. Ultimately, Dr. Zuehlsdorff opined, and the Judge finds, that Claimant had five or six injuries to his left hand and that the work injury on February 20, 2007, and the non-work injury in early March 2007 combined to cause Claimant to develop CRPS. He further opined that it is impossible to state that the absence of the first injury, that the second injury alone would have caused Claimant to develop CRPS.

41. The injury on December 23, 2007, did not accelerate the need for treating the CRPS. Claimant's CRPS was already present as was the need for treatment.

42. Prior to his work injury on February 20, 2007, Claimant had a significant history of ongoing medical problems. Specifically, beginning in February 2004, Claimant repeatedly sought treatment through Kaiser for a myriad of complaints that included, right neck pain with radiation into his right arm, right shoulder pain, low back pain, left shoulder pain, and upper thoracic pain. Claimant also sought treatment for non-pain related complaints

such has cardiac issues, elevated cholesterol, and migraine prevention.

43. Throughout 2004, Claimant was consistently prescribed narcotic pain medications with nearly every visit to Kaiser. On December 28, 2004, Claimant was prescribed 120 tablets of Tramadol with three refills available.

44. Claimant's did not seek medical treatment for pain complaints in 2005, until July 25 when Claimant complained of chest pain and left shoulder pain. Claimant was prescribed 30 tablets of Percocet. Claimant returned to Kaiser on August 17, 2005, with complaints of pain in the right scapular and neck area. Claimant asked for Tramadol in place of Percocet due to an upcoming three week vacation. Claimant continued reporting pain complaints on September 23, October 4, October 31, November 21, and December 12, 2005. Claimant was prescribed prescription pain narcotics during each of these visits.

45. Beginning January 3, 2006, Claimant continued to report ongoing pain complaints to both the right and left shoulder. He also complained of low back pain, upper back pain and left hip pain. Throughout 2006, Claimant had no less than 20 encounters with Kaiser personnel to seek treatment for pain complaints and to request prescription narcotics. Claimant received nearly 2000 tablets of prescription pain medication in 2006.

46. Claimant also made one report of his pain

medication being stolen and needing an early refill and twice, Claimant requested early refills due to out-of-town trips one of which was a three week trip to Dallas on July 14, 2006. Claimant also reported to Dr. Feret that certain medications had adverse side effects at which time he asked for a different pain narcotic. During later medical appointments, Claimant accepted prescriptions for the same medications he previously reported were having adverse side effects.

47. On January 10, 2007, Claimant saw Dr. Feret. Claimant requested a refill of his Percocet since he would be leaving for Dallas for six weeks of training. As a result, Dr. Feret prescribed Claimant 90 additional tablets of Percocet. Claimant then returned to see Dr. Feret on February 5, 2007, which is within the six week time period that Claimant said he was going to be in Texas. Claimant reported pain in his left leg which he attributed to martial arts training in Texas. Dr. Feret prescribed another 120 tablets of Percocet. Consequently, Dr. Feret, on January 10, 2007 and on February 5, 2007, prescribed Claimant a total of 210 tablets of Percocet.

48. Claimant's time card records reflect that Claimant actually worked in the Denver area at the Arapahoe County Sheriff's Department jail during the time he represented to Dr. Feret that he either was going to be in Texas, or was in fact in Texas. At hearing, Claimant acknowledged that these time card records reflected the days that he worked at the Arapahoe County Sheriff's Department jail.

49. Claimant's medical records reflect a history of misrepresentations to his medical providers. Claimant admitted to Dr. Zeuhlsdorff that he lied to Kaiser about how he injured himself on February 20, 2007.

50. From March 14, 2007, through December 26, 2007, Dr. Watson had released Claimant to work full duty and Claimant was working full duty. After December 26, 2007, Dr. Watson had released Claimant to work modified duty with the only restriction being no use of the left hand.

51. On June 11, 2008, Dr. Watson reviewed a modified duty job offer made by Employer which involved reviewing files, computer work and answering and making telephone calls. Dr. Watson approved these job duties and Claimant performed this job until September 2008 when the job was no longer available. By then, Claimant had reached MMI and had permanent restrictions per Dr. Watson (see paragraph 34) above. Such restrictions would not allow Claimant to return to his normal job as a deputy sheriff thus Claimant's employment was terminated.

52. Claimant saw John Macurak on January 20, 2009, for a vocational rehabilitation evaluation and he issued a report dated March 13, 2009. Macurak assumed the following physical restrictions: lifting/carrying to 10 pounds maximum occasional lift; repetitive lifting of zero pounds; and no repetitive handling, grasping or use of left hand. Macurak opined that Claimant has limited transferable skills for positions that do not require repetitive

lifting or use of the left hand. Factoring in Claimant's physical limitations, chronic pain, advanced age, limited education and work restrictions, Macurak opined that Claimant's injury has rendered him unable to earn any wages.

53. Macurak also testified by deposition. During his deposition Macurak explained that when determining Claimant's employability, he assumed that Claimant was restricted from crawling, kneeling, squatting or climbing based upon statements made by Claimant. While no physician imposed these restrictions, it is logical to conclude that Claimant would have difficulty crawling or climbing because he would need to use both hands for such activities. However, there is no medical basis related to Claimant's work injuries for the kneeling and squatting restriction. Macurak also assumed that Claimant could not walk more than one hour per day although no physician imposed this restriction either. Macurak's opinions are unpersuasive.

54. On March 5, 2009, Claimant saw Margot Burns for a vocational evaluation. Burns determined that Claimant could perform light duty work such as the clerical work he was performing for the Employer from June to September 2008. Burns also concluded that Claimant could work as a security guard or gate guard because neither position requires lifting anything over five pounds.

55. Burns testified during her deposition that in determining Claimant's employability, she assumed a ten-pound lifting restriction with the left hand and minimal repetitive work with the left hand.

Burns did not consider restrictions of no walking or standing because no physician had imposed such restrictions. Burns opined that Claimant acquired some transferable skills as a result of his employment as a deputy sheriff. Specifically, Burns believed Claimant had acquired the following skills: organizational, problem solving, obtaining information, basic computer, customer service type skills, and record keeping.

56. Burns reviewed the Dictionary of Occupational Titles, which indicates that security guard is considered light work because it requires standing and walking. Burns, however, testified that in reality many security guard positions require minimal or no walking and standing. Burns concluded that with the restrictions imposed by Claimant's physicians and Dr. Ramaswamy, Claimant is capable of working as a security guard. It is the opinion of Burns that working as a security guard would be a "perfect fit" for Claimant given his history in law enforcement.

57. Burns contacted three security guard employers in the Denver area and found that all three had jobs available and would hire someone in Claimant's situation.

58. Claimant has a high school education and completed some college courses. Claimant's entire career has been in law enforcement which required ongoing training in areas such as first aid and safety.

59. Claimant testified that he has no use of his left

hand, and that if he does use it even to lift something light, he will experience pain that takes a day to resolve. He experiences pain approximately 10 to 12 days each month rendering him incapable of leaving the house. He described the pain as a burning, fire, aching-type pain. Claimant takes several medications to control the pain which he testified can interfere with his concentration. Claimant testified that his pain currently (June 15, 2009) was the same as in July 2008 when he was placed at MMI and when he returned to modified work in June 2008.

60. Both Burns and Macurak agreed that no employer would tolerate absences from work in excess of two per month.

61. Claimant testified that when he performed the clerical work, his left hand would swell so he would use only his right hand to type. While this might be true, there was no persuasive evidence that Claimant's left hand pain or swelling caused him to miss work during the summer of 2008 or that he was otherwise unable to perform the job duties.

62. Undoubtedly Claimant suffers from pain in his left hand; however, no persuasive or credible evidence supports Claimant's contention that he suffers from such debilitating pain between 10 and 12 days each month that would render him unable to leave his house. In addition, Claimant's ability to work at his normal job for several years while taking narcotic pain medications directly refutes his reports that such medications interfere with his ability to concentrate.

63. There is no clear and convincing evidence that the opinions of Dr. Zuehlsdorff regarding the causal relationship of Claimant's February 20, 2007, injury and the development of CRPS is incorrect. Dr. Ramaswamy disagrees that Claimant developed CRPS as a result of the February 20, 2007, injury based upon one medical record, a missed medical appointment and Claimant's lack of credibility. Dr. Ramaswamy's opinions and conclusions constitute a difference of medical opinion that is insufficient to overcome Dr. Zuehlsdorff's causation opinion, apportionment or impairment ratings. Claimant concedes Dr. Zuehlsdorff's opinion on apportionment. Consequently, the development of CRPS is 50 percent attributable to Claimant's work injury of February 20, 2007, (WC 4-744-616) and the non-work injury that occurred in early March 2007. Claimant also has a 10 percent whole person impairment.

64. Claimant has established entitlement to maintenance medical benefits for treatment of the work-related CRPS. Respondents have not established that such medical benefits should be apportioned.

65. Claimant has not established that he is permanently and totally disabled. While it is true that Claimant suffers from a medical condition, such condition is limited to his left hand. The opinions of Burns are more credible and persuasive than those of Macurak. Burns persuasively opined that Claimant's career in law enforcement has provided him with transferable skills as described above. She further analyzed specific employment as a security guard for which she felt Claimant was well suited given

his background in law enforcement. Burns contacted three employers and determined that all three had available security guard jobs and would hire someone in Claimant's situation. Macurak's analysis of Claimant's employability included non-existent physical restrictions and his unpersuasive opinion that Claimant has acquired limited transferable skills. Macurak's opinion also considers Claimant's subjective reports of the inability to concentrate due to pain medications. Claimant's testimony in this regard is directly refuted by the Kaiser medical records which reflect years of using narcotic pain medication while continuing to perform his job for Employer.

66. Because Claimant is not found PTD, the remaining issues need not be addressed.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers'

Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

DIME Opinion

4. Section 8-42-107(8)(c) C.R.S. provides that if either party disputes the finding of a DIME the finding of the DIME shall be overcome only by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. Metro Moving and Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and

convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. Id.. The mere difference of medical opinion does not constitute clear and convincing evidence to overcome the opinion of the DIME physician. Javalera v. Monte Vista Head Start, Inc., W.C. Nos. 4-532-166 & 4-523-097 (ICAO July 19, 2004); see Shultz v. Anheuser Busch, Inc., W.C. No. 4-380-560 (Nov. 17, 2000).

5. If the DIME physician offers ambiguous or conflicting opinions concerning MMI or impairment, it is for the ALJ to resolve the ambiguity and determine the DIME physician's true opinion as a mater of fact. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000); Stephens v. North & Air Package Express Services, W. C. No. 4-492-570 (February 16, 2005), aff'd, Stephens v. Industrial Claim Appeals Office (Colo. App. 05CA0491, January 26, 2006) (not selected for publication). The ALJ should consider all of the DIME physician's written and oral testimony. Lambert & Sons, Inc. v. Industrial Claim Appeals Office, 984 P.2d 656, 659 (Colo. App. 1998).

6. Once the ALJ determines the DIME physician's opinion concerning MMI, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. Clark v. Hudick Excavating, Inc., W. C. No. 4-524-162 (November 5, 2004).

7. As found, the DIME physician, Dr. Zuehlsdorff ultimately opined that Claimant had CRPS type I as a result of a combination of two

injuries, one of which occurred at work on February 20, 2007, and a non-work related injury in early March 2007. Dr. Zuehlsdorff concluded that the CRPS was 50 percent attributable to the work injury and 50 percent attributable to the non-work injury. Claimant concedes this apportionment thus, Respondents bear the burden of overcoming such opinion by clear and convincing evidence because Respondents seek a determination that Claimant's CRPS is not related to any work injury.

8. Respondents have failed to overcome the DIME opinion. As found, no clear and convincing evidence demonstrates that Dr. Zuehlsdorff was incorrect. Dr. Ramaswamy disagrees that Claimant developed CRPS as a result of the February 20, 2007, injury based upon one medical record, a missed medical appointment and Claimant's credibility. While it is true that Claimant lacks credibility, it is undisputed that Claimant suffered some kind of non-work related injury in early March 2007. Although the extent of that injury is unknown, it was not severe enough to cause a fracture. Dr. Ramaswamy's opinions and conclusions constitute a difference of medical opinion that is insufficient to overcome Dr. Zuehlsdorff's causation opinion, apportionment or impairment ratings. Claimant concedes Dr. Zuehlsdorff's opinion on apportionment. Consequently, the development of CRPS is 50 percent attributable to Claimant's work injury of February 20, 2007, (WC 4-744-616) and the non-work injury that occurred in early March 2007. Claimant, therefore, has a 10 percent whole person impairment.

Maintenance Medical Benefits & Apportionment

9. Respondents are liable only for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; Grover v. Indus. Comm'n, 759 P.2d 705 (Colo. 1988). Claimant must prove that an injury directly and proximately caused the medical condition for which benefits are sought. Wal-Mart Stores, Inc. v. Indus. Claim Appeals Off., 989 P.2d 251 (Colo. App. 1999); Snyder v. Indus. Claim Appeals Off., 942 P.2d 1337 (Colo. App. 1997), cert. denied September 15, 1997. Claimant bears the burden of proof in showing that medical benefits are causally related to her work-related injury or condition. See Ashburn v. La Plata School District 9R, W.C. No. 3-062-779 (ICAO May 4, 2007).

10. Respondents primary argument is that Claimant's CRPS is not a result of any industrial injury therefore relieving them of the obligation to pay for medical treatment related to the CRPS. Claimant, however, has established that he developed CRPS as a result of his work injury on February 20, 2007, and the non-work injury in early March 2007. Thus, Respondents are required to pay for reasonable and necessary medical treatment related to the CRPS and any other affects of his industrial injuries.

11. Respondents have failed to establish that apportionment of medical benefits is appropriate. Respondents cite to no authority that would permit such apportionment and the Judge is aware of none applicable to the facts found herein.

Permanent Total Disability

12. Section 8-40-201(16.5)(a), C.R.S., defines permanent total disability as the inability to earn “any wages in the same or other employment.” Christie v. Coors Transportation Co., 933 P.2d 1330 (Colo. 1997). Under the statute, the claimant carries the burden of proof to establish permanent total disability by a preponderance of the evidence. The question of whether the claimant proved permanent total disability is a question of fact for resolution by the Administrative Law Judge. Under this statute, a claimant is not permanently and totally disabled if she able to earn some wages in modified, sedentary, or part time employment. McKinney v. Industrial Claim Appeals Office, 894 P.2d 42 (Colo. App. 1995).

13. In ascertaining whether a claimant is able to earn any wages, the Judge may consider various “human factors,” including a claimant's physical condition, mental ability, age, employment history, education, and availability of work that the claimant could perform. Weld County School Dist. RE-12 v. Bymer, 955 P.2d 550, 556 (Colo. 1998); Holly Nursing v. ICAO, 992 P.2d 701, 703 (Colo. App. 1999). The overall objective of this standard is to determine whether, in view of all of these factors, employment is "reasonably available to the claimant under his or her particular circumstances." Bymer, 955 P.2d at 557.

14. Claimant has not established that he is permanently and totally disabled. Based on the credible testimony of vocational expert Margot Burns,

and consideration of a number of “human factors” Claimant has failed to establish that it is more likely true than not that he is unable to earn any wages in other employment. Claimant is 56 years old, has slightly more than a high school education and has acquired sufficient skills throughout his employment history in order to earn wages. Claimant has demonstrated, through his light duty work in the summer of 2008, the mental ability to maintain employment. Furthermore, any determination that Claimant is permanently and totally disabled must necessarily rely upon Claimant’s subjective reports that his pain is so debilitating that he cannot leave his house 10 to 12 days per month. As found, Claimant’s testimony lacks credibility. Claimant’s report that he is unable to concentrate while taking pain medications is also unreliable. Although Claimant has been unable to continue working in law enforcement due to his physical limitations, Burns has identified at least one vocational opportunity that is within the work restrictions provided Dr. Watson. Claimant is, therefore, capable of earning wages in some amount.

Remaining Issues

9. The Judge need not address the remaining issues of apportionment of PTD benefits or offsets.

ORDER

It is therefore ordered that:

1. Respondents have not overcome the DIME opinion of Dr. Zuehlsdorff. Consequently, Claimant’s CRPS is 50 percent attributable to his February 20,

2007, industrial injury and Claimant has a 10 percent whole person impairment.

2. Claimant has established entitlement to maintenance medical benefits.

3. Respondents have not established that apportionment of medical benefits is appropriate.

4. Claimant has not established that he is permanently and totally disabled.

5. Because Claimant is not permanently and totally disabled, the remaining issues need not be addressed.

6. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

7. All matters not determined herein are reserved for future determination.

DATED: November 23, 2009

_____

Laura A. Broniak

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-787-528

ISSUES

ÿ Did claimant prove by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment?

ÿ Did claimant prove by a preponderance of the evidence that she is entitled to temporary disability benefits?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Employer has been operating the parking business at Denver International Airport since October of 2008. Claimant works as a cashier the drive-through booths at DIA. Claimant performed the same cashier job for employer's predecessor from September 2006 through October 2008. Claimant's date of birth is January 1, 1975; her age at the time of hearing was 34 years. On February 1, 2009, claimant reported to employer that she was experiencing right upper extremity and shoulder pain when performing her duties. Claimant continued working as a cashier for employer through May 12, 2009.

2. Claimant testified to the following: While working for her prior employer, claimant would rotate from the slower booths to the higher volume booths from day to day. While working for employer, claimant worked in the busier booths four out of five days. Claimant stated that she began to experience right shoulder and neck problems when employer assigned her to spend more time working in the high volume booths.

3. Claimant's cashier duties involve the following activities: With each customer, claimant opens the window of her booth and reaches for the customer's ticket with her left hand. Claimant receives the ticket from the customer with her left hand, moves her hand back into the booth, and passes the ticket to her right hand to put it into the ticket reader machine. With her right hand, claimant adjusts the video-control stick on a control panel to position the camera to confirm the vehicle's license plate. Claimant again reaches with her left hand to retrieve payment from the customer. Claimant operates the cash register and returns the receipt to the customer using her left hand.

4. Claimant testified to the following: She started having pain in her right shoulder when using her right hand to operate the video-control stick and when moving her extremity to process the ticket into the reader. The majority of her time in the booth, claimant spent sitting. As the pain and discomfort became too much, claimant was no longer able to work from a sitting position.

5. Claimant and her co-worker, Makdes Lemma, testified that, while in a seated position, the reader and the video controls were above shoulder level. Claimant stated that she only performed repetitive activities while working for employer.

6. Employer referred claimant to Concentra Medical Centers, where Alan E. Shackelford, M.D., examined her on February 1, 2009. Claimant reported to Dr. Shackelford that, about 4 months prior, she began having right shoulder discomfort with repeatedly raising and lowering her right arm. Claimant reported that her symptoms began with slight discomfort but

progressively worsening until February 1, 2009, when she reported she was unable to raise her right arm above her shoulder level. Claimant reported pain radiating into her right arm, especially into her biceps area, wrist, and hand. Dr. Shackelford assessed rotator cuff syndrome/strain of the right shoulder, tenosynovitis of the right wrist, and repetitive motion injury of the right upper extremity. Dr. Shackelford recommended an ergonomic evaluation of claimant's workplace. Dr. Shackelford imposed physical activity restrictions of no reaching above the shoulders, no lifting greater than 10 pounds, no pushing or pulling greater than 20 pounds of force, and limited use of the right arm.

7. On March 16, 2009, Tom Vandenbussche, CSP, ARN, a certified ergonomist with 20 years of experience, performed an ergonomic assessment of claimant's cashier job based upon standards from the National Institute of Occupational Safety and Health (NIOSH). Crediting Mr. Vandenbussche's ergonomic opinion as persuasive, the Judge finds: According to NIOSH, there is strong evidence of a positive association between exposure to certain risk factors and a finding of work-related development of tendonitis, tenosynovitis, rotator cuff syndrome or musculoskeletal disorders of the shoulders, neck, and upper extremities. Those risk factors involve repetition, forceful work, and extreme awkward postures. Claimant's upper extremity activities at work fail to involve risk factors for repetition, awkward posturing, or force. The average cycle time per vehicle is 45 seconds, with varying periods of inactivity depending upon traffic. This cycle time fails to meet the ergonomic risk factor for repetition. The force exerted to use the keyboard or other equipment in the booth is extremely low and fails to meet the ergonomic risk factor for force. The cashier workstation is designed for working while standing, but a cashier

may elect to sit or stand. Claimant's physical activities as cashier involve no extreme postures of the shoulders, neck, or arms. Workstation equipment is adjustable and allows for neutral positioning for proper ergonomic postures.

8. Claimant failed to show it more probably true that the physical activities of her cashier work involve the requisite combination of NIOSH risk factors necessary to support the development of tendonitis, tenosynovitis, rotator cuff syndrome, or musculoskeletal disorders of the shoulders, neck, arms, wrists, hand, elbows or back.

9. On March 20, 2009, insurer filed a Notice of Contest, denying liability for claimant's claim. After that, claimant sought medical attention from C.R. White, M.D., at Kaiser Permanente. Dr. White first examined claimant on April 24, 2009. Dr. White testified as an expert in the area of Internal Medicine. Dr. White testified that, upon physical examination of claimant, he found:

[D]ecreased range of motion of the right shoulder, which was more from pain and discomfort, not from a torn ligament or anything of that nature. I also found that the trapezius muscle, which is the large muscle that goes from the corner of the shoulder up to the side of the neck, was very tight.(Emphasis added).

Dr. White diagnosed myospasm (tight muscles) and a sprain of the right shoulder. Based upon the history claimant gave him, Dr. White attributed claimant's symptoms to repetitive motion. Dr. White referred claimant for physical therapy.

10. Dr. White ordered a magnetic resonance imaging (MRI) scan of claimant's right shoulder, which was a normal study. On May 22, 2009, Dr. White placed claimant at maximum medical improvement (MMI), writing:

11. [Claimant] continues to suffer from right shoulder pain which is aggravated with repetitive motion. MRI of the shoulder was normal. There is nothing else I can do for her and she is at MMI from my standpoint. I am not a specialist in musculo-skeletal disorders and if a disability evaluation is needed I would recommend a specialist in that area.

12. At respondents's request, Henry J. Roth, M.D., performed an independent medical examination of claimant on August 3, 2009. Dr. Roth attributed claimant's complaints of discomfort as more likely related to personal anxiety, stress, health status, and sleep disorder. Dr. Roth suspected claimant may have developed idiopathic adhesive capsulitis of the right shoulder, unrelated to her work as a cashier; he reported:

13. [A]n individual developing adhesive capsulitis Ö will be uncomfortable. They will be uncomfortable with any use of motion of the body parts involved. Thus, it is reasonable to anticipate that [claimant] would experience discomfort at work. She experiences the same discomfort at home dressing, attending to personal hygiene, cooking, cleaning, etc.

14. Dr. Roth opined that claimant's work exposure was not the medically probable cause of any sustained musculoskeletal disorder because her work involved neither forceful gripping nor repetitive physical motions that potentially could cause cumulative trauma disorder.

15. Dr. Roth testified as an expert in the area of Occupational Medicine. Dr. Roth disagreed with Dr. White's diagnosis; he testified:

There's no medically probable sprain or strain here. There's nothing consistent with that. There's no diagnostic finding to support that, there's no clinical course that's consistent with that and there's no mechanism of injury for a

sprain or a strain.****

16. There is nothing in Dr. White's notes that would indicate he did a responsible analysis as dictated Ö by the Division of Labor guidelines. He has a history from the patient that, I am hurt by what I do at work, and he then transfers her assessment of her own difficulties to his medical record. He doesn't get the information. If he does, there certainly isn't in his notes what she does, the rate she does it at, the frequency, the duration, the amounts of weight Ö what she has to do.

17. Dr. Roth also observed cashiers at DIA performing their job activity; he stated:

There is nothing in this activity that puts any stress on the persons performing the activity. You couldn't do less physically and still call it work. There is nothing in this design Ö to be the airport cashier parking lot attendant that has the capacity to sprain or strain you.

I don't believe that any amount of this work causes any strain on [claimant's] body or anybody else's body. You know, something that is not stressful and that is well within your range of motion and your physiologic abilities, if it's not a problem physically, then two times the same activity isn't going to be a problem either. It's certainly not going to be injurious.

[T]here's no force involved in the work. There's no strength required to handle an airport ticket or cash. I mean, I don't think that her strength is an issue for the job Ö.(Emphasis added).

18. Dr. White examined claimant on August 17, 2009, when she complained of a flare-up in symptoms after returning to work. Dr. White imposed the following permanent physical activity restrictions: No out-of-body reaches

greater than 12 inches; no work with arms above head; no repetitive gripping or grasping with the right hand; no repetitive right elbow flexion; and no repetitive shoulder motion.

19. The Judge credits Mr. Vandenbussche's ergonomic opinion as persuasive in finding the following: The physical requirements of claimant's cashier work do not require claimant to reach beyond 12 inches with her right arm because she can stand right in front of the equipment she uses. Claimant's work does not involve working with her hands above her head. The work does not involve gripping or grasping, nor does it involve repetitive shoulder or elbow motion.

20. Dr. Roth testified there are no physical activity restrictions associated with adhesive capsulitis:

Restrictions, no. There's no tissue pathology at risk. And, basically, [claimant] can perform and should perform to whatever degree she's able to move her shoulder at this point in time.

And those aren't restrictions. It's really limitations. You're just describing her limitations.

I don't know if there's anything that you can do to [make adhesive capsulitis worse]. What's worse Ö is when you move your shoulder it hurts. It hurts in all directions, so that's the problem that you have to fight. You have to try and maintain mobility and muscle use as much as possible when you're living through [adhesive capuslitis]. (Emphasis added).

21. Dr. Roth disagreed with Dr. White's diagnosis of tendinopathy or tenosynovitis because there is no MRI evidence of an inflamed tendon.

22. Dr. Roth's medical opinion was more persuasive than that of Dr.

White. Dr. Roth is trained in the area of Occupational Medicine and is a Level II accredited physician with training in medical causation analysis. Dr. Roth reviewed claimant's medical records and weighed Mr. Vandenbussche's ergonomic opinion in his causation analysis. Dr. White acknowledged that he based his causation opinion upon claimant's report of pain and discomfort while using her upper extremity at work, with symptoms quiescent when taking periods of time off work. Dr. White's practice in Internal Medicine fails to allow him requisite time to fully analyze causation by obtaining a detailed description of job activities. Dr. White failed to incorporate or weigh Mr. Vandenbussche's ergonomic opinion in his causation analysis.

23. Claimant failed to show it more probably true than not that a hazard associated with her work activities proximately caused, intensified, or, to a reasonable degree, aggravated her right shoulder condition. Although claimant's testimony that she experiences pain with use of her right upper extremity is credible, her opinion concerning causation of her pain was unpersuasive. The Judge credited as persuasive Mr. Vandenbussche's ergonomic opinion in finding that claimant failed to show it more probably true that the physical activities of her cashier work involve the requisite combination of NIOSH risk factors necessary to support the development of tendonitis, tenosynovitis, rotator cuff syndrome, or musculoskeletal disorders of the shoulders, neck, arms, wrists, hand, elbows or back. The Judge credits as persuasive the medical opinion of Dr. Roth in finding it medically probable that claimant has developed idiopathic adhesive capsulitis that is unrelated to work activity involving use of her right upper extremity. Even Dr. White ruled out possible diagnoses of tendinopathy or tenosynovitis based upon MRI evidence.

Crediting the medical opinion of Dr. Roth, claimant likely experiences pain with work and non-work activity requiring her to use her right upper extremity as a result of her underlying adhesive capsulitis. Dr. Roth's medical opinion that claimant needs to use her right upper extremity in order to work through the adhesive capsulitis was persuasive. The Judge thus credits the medical opinion of Dr. Roth in finding that claimant's use of her right upper extremity, including use at work should be encouraged, and not restricted.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues she has proven by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado, ßß8-40-101, et seq., C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant shoulders the burden of proving by a preponderance of the evidence that her occupational disease type injury arose out of the course and scope of her employment. Section 8-41-301(1), supra; see City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of

the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. Campbell v. IBM Corporation, 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by ß8-40-201(14), supra, as:

[A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment. (Emphasis added).

A claimant seeking benefits for an occupational disease must establish the existence of the disease and that it was directly and proximately caused by the claimant's employment duties or working conditions. Wal-Mart Stores, Inc. v. Industrial Claims Office, 989 P.2d 251, 252 (Colo. App. 1999). This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. Anderson v. Brinkhoff, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. Id. A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. Id. Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. Id. Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. Cowin & Co. v. Medina, 860 P.2d 535 (Colo. App. 1992).

Here, the Judge found claimant failed to show it more probably true than not that a hazard associated with her work activities proximately caused, intensified, or, to a reasonable degree, aggravated her right shoulder condition. Claimant thus failed to prove by a preponderance of the evidence

that she sustained a compensable occupational-disease-type injury.

As found, claimant failed to show it more probably true that the physical activities of her cashier work involve the requisite combination of NIOSH risk factors necessary to support the development of tendonitis, tenosynovitis, rotator cuff syndrome, or musculoskeletal disorders of the shoulders, neck, arms, wrists, hand, elbows or back. The Judge found it medically probable that claimant has developed idiopathic adhesive capsulitis that is unrelated to work activity involving use of her right upper extremity. The Judge found that, because of her underlying adhesive capsulitis, claimant likely experiences pain when performing work and non-work activity requiring her to use her right upper extremity. The Judge credited Dr. Roth's medical opinion in finding that claimant should be encouraged to use her right upper extremity, including use at work, in order to work through the adhesive capsulitis.

The Judge concludes that claimant's claim for benefits under the Workers' Compensation Act should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order: Claimant's claim for benefits under the Workers' Compensation Act is denied and dismissed.

DATED: _November 23, 2009__

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Michael E. Harr,

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-571-475

ISSUES

ÿ Did the claimant prove that the motor vehicle accident of July 9, 2005, occurred in the quasi-course of employment because he was engaged in travel to obtain authorized medical treatment?

ÿ Did the claimant prove by clear and convincing evidence that the mental impairment caused by the March 2003 injury resulted from "neurological brain damage" rather than depression so as to negate the twelve week limitation on medical impairment benefits contained in ß 8-41-301(2)(b), C.R.S.?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

On March 4, 2003, the claimant suffered compensable injuries to his left knee and left elbow when he fell down some stairs while working as a heating and air conditioning maintenance person for the employer.

The claimant testified that he also injured his head during the fall, but the respondents dispute this assertion.

On March 4, 2003, the claimant received authorized medical treatment from Dr. Lon Noel, M.D. of Midtown Occupational Medicine. Dr. Noel's records from this visit reflect the claimant's main complaint was left knee pain medially. Dr. Noel's notes do not reflect any complaint of head injury or head pain.

The claimant was subsequently referred to Dr. Martin Senicki, M.D., an orthopedic surgeon, for evaluation and treatment of the left knee injury. On April 14, 2003, Dr. Senicki performed surgery for repair of a medial meniscus tear.

Dr. Noel initially placed the claimant at maximum medical improvement (MMI) on January 6, 2004, and assessed 25% permanent impairment of the left lower extremity. A Final Admission of Liability (FAL) was filed on February 5, 2004, based upon the finding of MMI and permanent impairment.

Following the January 2004 FAL the claimant continued to experience problems with his left knee. He was referred to Dr. James Ferrari, M.D., for further orthopedic evaluation. On April 20, 2005, Dr. Ferrari performed a posterior cruciate ligament (PCL) reconstruction with anterior tibialis allograft.

Dr. Noel remained an authorized treating physician (ATP) following the April 2005 PCL surgery. On May 15, 2005, Dr. Noel noted the claimant was using a crutch and a knee brace. Dr. Noel stated the claimant was to continue physical therapy, home exercises, medications, use of a "custom brace," partial weight bearing, and restrictions to "seated duty only." There was no express restriction against driving.

Dr. Noel maintained an office in Denver, Colorado. At the time of the PCL

surgery the claimant resided in Denver, Colorado. However, in June 2005 the claimant moved to a rural cabin located approximately 20 miles south of Steamboat Springs, Colorado.

On Monday, July 11, 2005, the claimant was scheduled for an authorized medical appointment with Dr. Noel in Denver. At that time the claimant had not yet obtained an ATP closer to his new residence near Steamboat Springs.

At hearing the claimant testified that in July 2005 he owned a truck with a manual transmission, but he was unable to drive it because he was still wearing a knee brace (as a result of the PCL surgery) and because he was in too much pain to operate the clutch. The claimant further testified that his brother, who also resided in the Steamboat Springs area, frequently provided the claimant with transportation. However, the brother was unable to drive the claimant to Denver for the July 11 medical appointment. The claimant stated that in these circumstances arrangements were made with Raymond Whiteshield to drive the truck and the claimant to Denver so he could attend the medical appointment. The claimant stated that Mr. Whiteshield was a friend or acquaintance of the claimant's brother, although the claimant was not familiar with Whiteshield.

The trip to Denver did not begin on July 11, 2009, but instead it began on Saturday, July 9, 2005. According to the claimant this was because Mr. Whiteshield, who lived in Denver, needed to go to work on the morning of Sunday, July 10, 2005. The claimant stated that his intention was to stay at his parents' home until it was time for the appointment with Dr. Noel.

On the afternoon of July 9, 2005, the claimant and Mr. Whiteshield were involved in a rollover motor vehicle accident (MVA). The accident occurred on Colorado 16, a winding dirt and gravel road known as "Lynx Pass." The claimant testified

that there were three possible routes from the cabin to Denver, and he chose the most direct route over Lynx Pass. The claimant stated that this route was 40 miles shorter than driving to Steamboat, but conceded that it was necessary to drive more slowly over the Lynx Pass road because of its surface.

The claimant testified that he has limited memory of the MVA but recalls lying on the side of the dirt road after the accident occurred. The claimant reports some recollection of seeing a deer in the road in front of the truck just before the accident. However, the claimant testified that he is certain that he was not driving the truck at the time of the accident because of the condition of his knee.

The claimant admitted that 4 to 6 hours prior to the accident he drank a couple of beers and maybe a shot of Schnapps.

Corporal Ryan Parker of the Colorado State Patrol testified by deposition. Corporal Parker stated that he responded to the accident scene and prepared the State of Colorado traffic accident report. Corporal Parker testified that he was responsible for investigating an average of 100 accidents per year, and at the time of the accident on July 9, 2005, he had participated in 400-450 investigations. Corporal Parker further testified that he was familiar with the location of the accident; since he worked this road and that he would hunt and fish on the exact same road. Corporal Parker testified that the road starts at the town of Stagecoach, winds back into a national forest area, and extends about 26 or 27 miles from the beginning to County Road 134 near the scene of the accident. According to Corporal Parker, it would “make no sense” why somebody would take that road when traveling back to Denver rather than taking the State highway.

Corporal Parker further testified that he took field measurements, photographs of the scene, and that he spoke to the paramedics at the scene. Corporal Parker recalls taking photographs of alcohol containers that were in and around the vehicle during the accident. He specifically remembers that there were beer cans and, he believes, some other liquor bottles also. He estimates that the pickup truck was traveling between 51-57 miles per hour at the time of the rollover accident. Corporal Parker testified that the speed limit was 35 miles per hour. He testified, "I would say alcohol had (sic) a definite factor along with speed in this accident."

Following the accident, paramedics from Yampa Ambulance responded to the scene. The Colorado EMS Trip Report indicates that the claimant gave a history of a rollover MVA and: "(Pt.) states he was driver . . . (and) had his seatbelt on." The paramedic further reported that claimant was "oriented to person & place." The claimant stated that he had "2 beers & shot of Schnapps."

The paramedics took the claimant to the Yampa Valley Medical Center (YVMC). He was admitted with a history of "multiple trauma." The claimant's blood alcohol level was tested and noted to be "186 mg/dL." According to the emergency department report, the claimant presented as an "alert male" in moderate to marked distress. The claimant gave a history that he was the driver of a "truck that slid on gravel and rolled when he braked to avoid hitting a deer." The claimant further stated that he remained restrained in the vehicle. X-rays taken in the emergency room confirmed multiple left rib fractures, multiple cervical spine fractures, old post-operative changes in the left knee with no evidence of acute injury, and a fracture of the left distal radius.

The claimant was transported to Denver Health Medical Center on July 10, 2005.

He was admitted with a history of having suffered multiple injuries following a rollover accident. The claimant underwent surgery for his cervical spine injuries, including an anterior fusion with vertebral body screws, plate and interbody plug at C6-7, and vertical rods extending from C5 through C7. During his hospitalization the claimant also underwent an MRI scan of the brain that revealed evidence of an acute hemorrhage. A follow-up CT scan was advised in one month.

On August 5, 2005, Dr. Noel examined the claimant at Midtown Occupational Medicine. He recited a history of an intervening "nonworkers compensation related motor vehicle accident" that occurred at Steamboat Springs "when he hit a deer." The claimant reported that he fractured two cervical vertebrae and he was operated upon for this injury. The claimant also reported that he fractured six ribs and fractured his left radius/ulna and that he was released from the hospital last week. According to Dr. Noel, "luckily" he did not "reinsure" [sic] his left knee at the time of his MVA. Dr. Noel indicated the claimant was wearing a knee brace, should continue with home exercise and could return to modified duty with minimal walking and standing. There was no express restriction against driving.

The claimant was again placed at MMI on January 25, 2006. At that time Dr. Marc Steinmetz, M.D., of Midtown Occupational Medicine assessed 35% permanent impairment of the left lower extremity. This rating did not take into account any possible impairment resulting from the July 2005 MVA. On February 10, 2006, the respondents filed an FAL admitting liability for permanent impairment based on the rating of Dr. Steinmetz. The claimant sought a Division-sponsored independent medical examination (DIME) to review the MMI determination and the

impairment rating.

Dr. Joseph Ramos, M.D., was selected to perform the DIME, and he issued a report on July 11, 2006. At the time of the DIME the claimant reported he had been involved in a "major mechanism motor vehicle crash that occurred on his way into town to go to an appointment." The claimant reported that he fractured his cervical spine in two places, requiring surgery, and that he fractured six ribs, his left arm and left wrist as a result of the motor vehicle crash. Dr. Ramos assessed the claimant for his left knee injury, lumbar strain secondary to overuse and antalgic gait, bilateral hip pain secondary to gait changes, and depression with adjustment disorder secondary to the work-related injuries. Dr. Ramos opined the claimant was not at MMI because he needed a psychological workup and follow-up with Dr. Ferrari. Although Dr. Ramos noted that claimant suffered other injuries in connection with the 2005 MVA, his opinion that the claimant was not at MMI was limited to and based on the injuries suffered on March 4, 2003.

Following the 2006 DIME report the claimant resumed medical treatment with Dr. Noel and Dr. Ferrari. Eventually he was referred for psychological evaluation and treatment with Ricardo Esparza, Ph.D. Dr. Esparza examined the claimant on November 9, 2007. Dr. Esparza noted claimant's history of a left knee injury in 2003 when he fell down stairs while working for the employer, and the occurrence of additional injuries in July 2005 when he was involved in an MVA while traveling to a medical appointment related to his occupational injury. The claimant advised Dr. Esparza that he was uncertain whether he lost consciousness in the 2003 fall. The claimant reported symptoms of depression after learning that his knee injury was worse than initially thought and because he could not

return to work. According to Dr. Esparza, the MVA caused injuries to the claimant's neck, back, spine, ribs, wrist, arms and rotator cuff. Further, according to Dr. Esparza, the claimant suffered from amnesia about the events and circumstances following the MVA. Dr. Esparza reported that, "he cannot remember many of the specifics regarding the accident and to date, cannot even recall if he was the driver or passenger." Dr. Esparza assessed the claimant as suffering from a depressive disorder, generalized anxiety disorder, and "rule out cognitive disorder."

On August 28, 2008, Dr. Howard Entin, M.D., examined the claimant for purposes of a neuropsychiatric evaluation. The claimant gave a history that in March 2003 he was working for the employer when he fell down some steps, banged his head, and injured his left knee. He further recited a history of being a restrained passenger in a motor vehicle on July 9, 2005, when the driver lost control and rolled the pickup a number of times. The claimant reported multiple injuries from the rollover accident and a loss of consciousness for hours "perhaps." Dr. Entin noted that cognitively the claimant had significant difficulties since the accident with attention, concentration and difficulties with multitasking. He reported problems with memory and daily headaches. Dr. Entin assessed major depressive disorder, insomnia, post-concussive syndrome with cognitive and emotional effects and alcohol abuse-moderate. Dr. Entin stated he would attribute the claimant's "current difficulties to his injuries."

The claimant returned to Dr. Ramos for a follow-up DIME on January 19, 2009. Dr. Ramos placed the claimant at MMI. Dr. Ramos again noted the history of an accident in July 2005 when the claimant was severely injured as the restrained front seat passenger in a MVA rollover crash that occurred near Steamboat

Springs. Dr. Ramos reviewed medical records pertaining to treatment rendered following MVA, including treatment for multiple cervical spine fractures that required emergency surgery with internal fixation and a fracture of the left distal radius during claimant's hospitalization.

Dr. Ramos provided an impairment rating that assumed all of the injuries reported, including the injuries sustained in the July 2005 MVA, were related to the workers' compensation claim. In his follow-up DIME report, Dr. Ramos found the following: a) left knee: 44% lower extremity impairment, converts to 18% whole person; b) cervical spine: 32% whole person impairment; c) left wrist: 5% upper extremity impairment, converts to 3% whole person; d) lumbar spine: 10% whole person impairment; e) psychological impairment: 9% whole person impairment; f) traumatic brain injury: 10% whole person impairment for emotional disturbance and episodic neurological disorders; g) areas without impairment or inclusive in the above impairment ratings: bilateral hips, thoracic spine, sacroiliac joints, rib fractures, and spleen laceration; and h) total: 60% whole person impairment.

The parties stipulated that Dr. Ramos attributed 6 percent of the mental impairment to the March 2003 injury, with the remainder attributed to the 2005 MVA.

Dr. Ramos credibly testified that he assigned the 6 percent rating for the 2003 injury based on depression. Dr. Ramos further testified that he had no evidence the claimant sustained a closed head injury in 2003, and that he did not believe the claimant sustained a traumatic brain injury in 2003. Dr. Ramos further testified that to the extent the claimant exhibited any cognitive problems after the 2003 injury but prior the 2005 MVA he believes those problems were a

function of the claimant's depression. The ALJ finds that it is the opinion of Dr. Ramos that the claimant did not sustain any "traumatic brain injury" in 2003, and that none of the 6 percent impairment rating for mental impairment assigned by Dr. Ramos was caused by "neurological brain damage."

Dr. Ramos further testified that he frequently sees emergency room records, such as those from the YVMC, where a person has been transported immediately following an MVA. According to Dr. Ramos, the claimant's blood alcohol (BA) test following the MVA revealed the claimant's BA was over twice the legal limit for intoxication. Dr. Ramos testified that two times the legal limit would be 160 milligrams per deciliter and claimant's test result was 186 mg/dL. Dr. Ramos testified that claimant's BA results were not consistent with claimant's testimony that he consumed only two beers between four and six hours prior to the time of the accident. Dr. Ramos also testified the claimant's BA test was not consistent with his testimony that he may have also taken a shot of hard alcohol.

The ALJ finds it is more probably true than not that the injuries sustained in the MVA did not occur in the quasi-course of employment. The ALJ finds the weight of the evidence establishes that the claimant's travel to Denver on July 9, 2009, was not, as he testified, for the purpose of attending the medical appointment with Dr. Noel on July 11, 2009. Rather, the evidence establishes that the travel on July 9 was most probably for the convenience of Mr. Whiteshield, a friend of the claimant's brother. The MVA occurred two days prior to the scheduled medical appointment. The claimant's explanation for this fact is that, because of the condition of his knee, he was unable to drive his truck to Denver and needed Mr. Whiteshield to do it. Further the claimant

explained it was necessary to leave on July 9 so that Mr. Whiteshield could return to Denver in time to be at work on July 10. However, the ALJ finds the claimant's explanation for leaving on July 9, and his testimony that he was a passenger in rather than the driver of the truck, is not credible. First, the claimant admitted at hearing that his recollection of the July 9 MVA is less than clear. This particular aspect of the claimant's testimony is corroborated by the by the report of Dr. Esparza who noted the claimant had amnesia and could not even remember if he was the driver more than two years after the accident. In light of these memory problems the claimant's hearing testimony that he now knows he was a passenger rather than the driver of the truck is not very persuasive. Second, the claimant's testimony that he was not the driver at the time of the MVA is contradicted by evidence that he told the EMS ambulance personnel, while on the way to the YVMC, that he was the driver of the vehicle and had his seat belt on. Significantly, the EMS personnel noted that the claimant was "oriented to person and place." Further, when the claimant reached the YVMC he reported he was "the driver of a truck that slid on gravel and rolled when he braked to avoid hitting a deer." The emergency room described the claimant as "an alert male in moderate to marked distress." Although the ALJ appreciates the claimant sustained a head injury in the MVA, the balance of the evidence demonstrates that his recollections and statements to emergency personnel recorded on the day of the accident are more lucid and credible than his testimony at the hearing. Third, the ALJ is mindful of the fact that the claimant now has substantial financial incentive to testify, despite his unclear recollections, that he knows he was a passenger and was traveling to receive medical treatment. Thus, the ALJ infers the claimant could have driven to

Denver on July 10, 2005, or July 11, 2005 to attend the medical appointment. Instead, the claimant elected to transport his brother's friend to Denver on July 9, 2005, so that Whiteshield could go to work on July 10. The ALJ finds that a preponderance of the evidence establishes the claimant's travel on July 9 was not necessitated by and not for the purpose of attending the authorized medical appointment on July 11, but instead was for the convenience of Mr. Whiteshield.

However, even if the evidence established that the travel was for the ultimate purpose of delivering the claimant to the July 11 medical appointment, the ALJ finds the circumstances of the accident demonstrate that it is more likely than not that at the time of the MVA the claimant was engaged in a personal deviation substantial enough to sever any causal relationship between the travel and the medical appointment. For the reasons described in Finding of Fact 30, the ALJ finds the claimant was in fact the driver of the truck on July 9, 2005. The claimant himself conceded during his testimony that he probably drank two beers and a shot of Schnapps on the morning of the accident. Trooper Parker, the investigating officer, credibly testified that he observed beer and liquor containers in and around the truck. Finally, the medical records from YVMC establish the claimant's BA level, when measured at YVMC, was 186 milligrams per deciliter. Dr. Ramos credibly testified that this is twice the legal limit for operating a motor vehicle in Colorado. He also testified that this level of alcohol in the blood is not consistent with drinking only two beers and a shot of Schnapps long before the MVA. Trooper Parker credibly opined that, based on his investigation of the accident scene, the causes of the accident were excessive speed and driving under the influence of alcohol. Finally, the

accident occurred on a winding, gravel and dirt mountain road where, the ALJ infers, the risks of driving while intoxicated were even greater than would have been the case on concrete or blacktop roads. In this regard the ALJ notes that Trooper Parker was familiar with Colorado 16 and did not think it was suitable for traveling to Denver considering the alternatives. The ALJ finds the circumstances of the MVA including the place of the accident, the time of the accident in relation to the medical appointment, and the consumption of alcohol while driving at a high rate of speed on a dangerous road, occurred so far outside the risks associated with ordinary travel to a medical appointment that the MVA occurred during a personal deviation sufficient to sever any causal relationship to the employment.

The ALJ finds the claimant failed to prove it is highly probable and free from serous doubt that Dr. Ramos was incorrect in finding that the claimant's 6 percent mental impairment rating (attributable to the March 2003 injury) was caused by depression rather than "neurological brain damage." As determined in Finding of Fact 29, Dr. Ramos assigned the mental impairment rating for the March 2003 injury based on his determination that the claimant suffered from depression, not neurological brain damage. Dr. Ramos noted the absence of evidence tending to establish that the claimant sustained a head injury in 2003, and his opinions in this regard are found to be persuasive. The claimant's testimony that he sustained a head injury in March 2003 when he fell down the stairs is not credible and persuasive. The claimant does not point to any medical records establishing that he complained of or sought medical treatment for a head injury as a result of the 2003 fall. No complaint of a head injury or headaches is mentioned in Dr. Noel's report of March 4, 2003. This evidence

corroborates the finding of Dr. Ramos that the claimant did not sustain a traumatic brain injury in 2003.

In contrast to the medical records from 2003, it is clear that the claimant subsequently suffered a closed head injury as a result of the 2005 MVA. The post-MVA MRI scan documents this injury.

Insofar as Dr. Entin's August 2008 report of could be interpreted as suggesting the March 2003 incident caused a head injury that resulted in neurological brain damage, the ALJ finds the report is not sufficiently persuasive and credible to overcome the opinion of Dr. Ramos. The opinion of Dr. Entin appears to be influenced by history given by the claimant that he "banged his head and was dazed" when he fell down the stairs in 2003. As found, this history is not credible. In any event, Dr. Entin appears to attribute the claimant's cognitive problems to the 2005 injury, not the 2003 injury. Therefore, it is not clear that Dr. Entin believes the claimant sustained any "neurological brain damage" as a result of the 2003 injury. In the "Discussion" section of his report Dr. Entin mentions physical injuries caused by the MVA, and in the next sentence states the following: "He certainly had a mechanism of injury to create a mild traumatic brain injury."

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), ß 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without

the necessity of litigation. Section 8-40-102(1), C.R.S. Except as specifically noted below, the claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

COMPENSABILITY OF INJURIES SUSTAINED IN 2005 MVA AND APPLICATION OF QUASI-COURSE

OF EMPLOYMENT DOCTRINE

The claimant contends the evidence establishes the injuries he sustained on July 9, 2005, were incurred while he was en route to seek authorized medical treatment. Therefore, he argues the injuries and resulting impairment are compensable because they ocurred in the "quasi-course of employment." The ALJ disagrees with this argument.

The claimant was required to prove by a preponderance of the evidence that at the time of the injury he was performing service arising out of and in the course of the employment, and that the injury or occupational disease was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S. The question of whether the claimant met the burden of proof is one of fact for determination by the ALJ. City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985); Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844 (Colo. App. 2000).

Colorado courts recognize the quasi-course of employment doctrine. This legal construct holds that injuries sustained while traveling to and from appointments to receive authorized medical treatment are themselves compensable. The rationale for this principle is that because an employer is required to provide medical treatment for injuries arising out of and in the course of employment, and because the claimant is required to submit to the treatment in order to receive benefits, travel to receive authorized treatment is an "implied part of the employment contract." Turner v. Industrial Claim Appeals Office, 111 P.3d 534 (Colo. App. 2004) (applying quasi-course doctrine to injuries sustained while traveling to mandatory vocational evaluation); Excel Corp. v. Industrial Claim Appeals Office, 860 P.2d 1393 (Colo. App. 1993). Thus, the quasi-course of employment doctrine provides "the requisite connection between

the employment and an injury that would not otherwise be considered to have arisen out of and in the course of employment." Price Mine Service, Inc. v. Industrial Claim Appeals Office, 64 P.3d 936 (Colo. App. 2003).

In contrast, if the evidence establishes that the travel resulting in the injuries was not for the purpose of receiving authorized medical treatment, the injuries are not compensable. This is true because travel for purposes other than to receive authorized treatment is not an implied condition or expectation of the employment. Schreiber v. Brown & Root, Inc., 888 P.2d 274 (Colo. App. 1993) (travel to seek unauthorized treatment not compensable under quasi-course doctrine).

Application of the quasi-course is complicated where the evidence demonstrates the claimant engaged in some deviation from the most direct route or method of travel to and from authorized medical treatment. In Kelly v. Industrial Claim Appeals Office, __P.3d__ (Colo. App. No. 07CA0970, March 5, 2009), the court held that the test is whether the "deviation from covered travel is substantial enough to break the chain of causation." The court described this test as "highly fact specific," and therefore one of fact to be determined by the ALJ. However, the court provided guidance in resolving the issue by stating that, as a general rule, "substantial deviations curtail coverage, while minor deviations do not." The Kelly court's citations from other jurisdictions indicate that relevant factors include the distance of the deviation from the most direct route of travel, the duration of the deviation, and the reasons for the deviation.

As determined in Finding of Fact 30, the ALJ concludes that the July 9, 2005, MVA did not occur in the quasi-course of employment. As found, the ALJ is

persuaded that the travel on July 9, 2005, was not for the purpose of transporting the claimant to for an authorized medical appointment scheduled for July 11, 2005, but was instead for the purpose of taking Mr. Whiteshield to Denver so that he could go to work on Sunday, July 10, 2009. The ALJ discredits the claimant's testimony that he was unable to drive and needed Mr. Whiteshield to transport him to Denver. Instead, the ALJ finds the claimant was in fact the driver of the truck at the time of the MVA. Therefore, the ALJ infers the claimant traveled on July 9, 2005, for the purpose of delivering Mr. Whiteshield to Denver, not for the purpose of attending a medical appointment scheduled for 2 days in the future.

In any event, the ALJ concludes that any relationship between the travel on July 9, 2005, and the need for authorized medical treatment, was severed by a substantial deviation from the scope of the travel. As determined in Finding of Fact 31, the claimant was the driver of the truck at the time of the MVA. The claimant was intoxicated and traveling on a dangerous mountain road at a high rate of speed. This route of travel was certainly not the best route of travel considering the winding mountain road and the dirt and gravel surface. The combination of speed and alcohol caused the claimant to roll the truck and sustain the injuries. The ALJ finds there was a substantial deviation from the best route of travel, the date of the travel in relation to the date of the medical medical appointment, and most significantly in the means and methods of travel (driving on mountain road at high rate of speed while intoxicated).

These deviations removed the travel from any causal connection to the industrial injury and the obligation to seek authorized medical treatment for the injury.

Cf. Pacesetter Corp. v. Collett, 33 P.3d 1230 (Colo. App. 2001) (travel status

case involving drinking and driving).

The claim for workers' compensation benefits resulting from the July 2005 MVA, including benefits for the MVA-related medical impairment identified by Dr. Ramos, is denied and dismissed.

OVERCOMING DIME WITH RESPECT TO ALLEGED NEUROLOGIC BRAIN DAMAGE

The claimant alleges that the 6 percent whole person impairment that Dr. Ramos assigned for mental impairment caused by the March 2003 injury is the result of "neurological brain damage." Therefore, the claimant asserts the twelve-week limit for medical impairment benefits caused by mental impairment does not apply. The ALJ disagrees.

Section 8-41-301(2)(b), C.R.S., provides that where a claim is by reason of mental impairment "the claimant shall be limited to twelve weeks of medical impairment benefits: except that this limitation shall not apply Ö to the victim of a physical injury or occupational disease that causes neurological brain damage."

A DIME physician must apply the AMA Guides when determining the claimant's medical impairment rating. Section 8-42-101(3.7), C.R.S.; ß8-42-107(8)(c), C.R.S. The finding of a DIME physician concerning the claimant's medical impairment rating shall be overcome only by clear and convincing evidence. Clear and convincing evidence is that quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. Metro Moving and Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995).

As a matter of diagnosis the assessment of permanent medical impairment inherently requires the DIME physician to identify and evaluate all losses that result from the injury. Mosley v. Industrial Claim Appeals Office, 78 P.3d 1150 (Colo. App. 2003). Consequently, a DIME physician's finding that a causal relationship does or does not exist between an injury and a particular impairment must be overcome by clear and convincing evidence. Cordova v. Industrial Claim Appeals Office, 55 P.3d 186 (Colo. App. 2002); Qual-Med, Inc. v. Industrial Claim Appeals Office, 961 P.2d 590 (Colo. App. 1998). The rating physician's determination concerning the cause or causes of impairment should include an assessment of data collected during a clinical evaluation and the mere existence of an impairment does not create a presumption of contribution by a factor with which the impairment is often associated. Wackenhut Corp. v. Industrial Claim Appeals Office, 17 P.3d 202 (Colo. App. 2000). The questions of whether the DIME physician properly applied the AMA Guides, and ultimately whether the rating was overcome by clear and convincing evidence present questions of fact for determination by the ALJ. Wackenhut Corp. v. Industrial Claim Appeals Office, supra.

As determined in Findings of Fact 28 and 32, Dr. Ramos, the DIME physician, found that the 6 percent mental impairment rating that he assigned for the March 2003 injury was the result of depression, not a "traumatic brain injury." Moreover, as determined in Findings of Fact 32 through 34, the claimant failed to overcome the opinion of Dr. Ramos by clear and convincing evidence. Specifically, the claimant failed to prove it is highly probable and free from serious doubt that he sustained a head injury in March 2003 that caused mental impairment resulting from "neurological brain damage." The ALJ is

persuaded by evidence that the claimant did not prove that he sustained any head injury in March 2003, let alone a head injury that caused neurological brain damage. As found, the medical records from March 4, 2003, do not document that the claimant even complained of any head injury or symptoms. However, the records following the July 2005 MVA document a clear closed head injury. Further, Dr. Ramos persuasively explained that to the extent the claimant suffered cognitive problems after March 2003, such problems were the result of depression, not an alleged head injury and any resulting "neurological brain damage."

The ALJ does not understand the claimant to be challenging any other aspect of the DIME physician's opinion.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

2. The claim for benefits resulting from the motor vehicle accident on July 9, 2005, is denied and dismissed.

3. The claimant failed to overcome the opinion of Dr. Ramos that he suffers 6 percent mental impairment as a result of the March 4, 2003, injury, and that this impairment was caused by depression rather than "neurological brain damage." Therefore, payment for medical impairment benefits associated with the depression is limited to twelve weeks as provided in ß 8-41-301(2)(b), C.R.S.

4. Issues not resolved by this order are reserved for future

determination.

DATED: November 24, 2009

_____

David P. Cain

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-715-282

ISSUES

ÿ Did claimant prove by a preponderance of the evidence that his claim should be reopened based upon a change or worsening of his condition from the injury?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Claimant sustained an injury while working for employer on February 9, 2007. At the time of his injury, claimant was recycling tools and trash when he caught the long finger of his right hand between two large heavy objects.

2. Claimant underwent suture repair and splinting on an emergent

basis. Thomas P. Moore, M.D., provided claimant authorized medical treatment. Dr. Moore evaluated claimant on February 21, 2007, and noted x-ray studies showed a distal tuft fracture. Dr. Moore noted claimant had multiple sutures in the nail matrix in order to hold the fingernail over the traumatized tissue.

3. Dr. Moore referred claimant to Hand Surgeon Charles Hamlin, M.D., who evaluated claimant's finger on April 18, 2007. Dr. Hamlin reported the following physical examination findings:

4. Deformed right long finger with what appears to be an ununited fractrure of the tuft. I am not sure if this [is] old or new but it should not hold him back from gainful employment.

5. Dr. Hamlin provided claimant a back-up splint and scheduled a return appointment for another x-ray study.

6. Dr. Hamlin reevaluated claimant on May 21, 2007, and released him to full-duty work. Dr. Hamlin planned to reevaluate claimant the following July to determine whether excision of the fragment (amputation of the tip of the finger) might be indicated.

7. Dr. Moore reevaluated claimant on May 31, 2007, when claimant complained of pain of the distal aspect of the stump of his finger, especially with any type of impact or percussion of the tip of the finger. Dr. Moore reported:

8. It was discussed with [claimant] that it is unlikely at this point that the distal tuft fracture will heal. It was discussed with him that he can live with his present symptoms and hope they Ö improve over time, or consider excision of the non-union fragment. He states that he is planning to move and would like to consider some treatment of his finger prior to moving. This will

be discussed with his workers' compensation company.

9. Dr. Moore's office indicated that claimant had demanded an appointment, which was scheduled with Dr. Moore for September 19, 2007, but for which claimant no-showed.

10. On November 7, 2007, insurer filed a Final Admission of Liability (FAL) based upon claimant's failure to attend medical appointments on September 4th and 19, 2007. Insurer had mailed claimant a September 20, 2007, letter via certified mail asking him to respond within 30 days regarding his intentions for additional medical treatment. Insurer filed the FAL after claimant failed to respond. Claimant's claim closed by operation of law when claimant failed to preserve his rights by objecting or otherwise responding to the FAL.

11. Claimant could not recall when he last saw Dr. Moore. Claimant believes he last saw a physician in July of 2007. Claimant agrees he reported to Dr. Moore pain when he pressed anything against the tip of the injured finger. Claimant agreed the pain he now experiences is the same pain he reported to Dr. Moore in May of 2007.

12. Claimant failed to show it more probably true than not that the condition of his right long finger has changed or worsened since November of 2007, when his claim closed by operation of law. Crediting claimant's testimony, the condition of his injured finger is substantially the same at the time of hearing as it was at the time insurer filed the FAL. The FAL was filed based upon claimant's failure to comply with medical treatment. Claimant failed to offer any persuasive medical evidence showing any change either in his condition or in the recommendations of his medical providers.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Although claimant failed to articulate a basis for reopening his claim, he would like further medical attention. The Judge however finds claimant failed to prove by a preponderance of the evidence that reopening is warranted.

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201, supra; see Osborne v. Industrial Commission, 725 P.2d 63 (Colo. App. 1986). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

Section 8-43-303(1), supra, provides:

At any time within six years after the date of injury, the director or an administrative law judge may Ö review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition Ö.

Section 8-43-303(1), supra, provides that an award may be reopened on the ground

of, inter alia, change in condition. A change in condition refers either to change in the condition of the original compensable injury or to change in claimant's physical or mental condition which can be causally connected to the original injury. Chavez v. Industrial Commission, 714 p.2d 1328 (Colo. App. 1985). Reopening is appropriate where the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. Richards v. Industrial Claim Appeals Office, 996 P.2d 756 (Colo. App. 2000).

Here, the Judge found claimant failed to show it more probably true than not that the condition of his right long finger has changed or worsened since November of 2007, when his claim closed by operation of law. Claimant thus failed to prove by a preponderance of the evidence sufficient grounds for reopening his claim.

As found, the condition of claimant's injured finger was substantially the same at the time of hearing as it was at the time insurer filed the FAL. Claimant failed to offer any persuasive medical evidence showing any change either in his condition or in the recommendations of his medical providers.

The Judge concludes claimant's petition to reopen his claim should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's petition to reopen his claim is denied and dismissed.

2. Issues not expressly decided herein are reserved to the parties for

future determination.

DATED: _November 25, 2009__

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Michael E. Harr,

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-777-766

ISSUE

Whether Claimant has established by a preponderance of the evidence that she injured her lower back during the course and scope of her employment with Employer on November 21, 2008.

STIPULATIONS

The parties agreed to the following:

1. If Claimant suffered a compensable injury, her medical treatment was authorized, reasonable and necessary to cure and relieve the effects of the injury.

2. For the period November 22, 2008 through May 31, 2009 Claimant earned an Average Weekly Wage (AWW) of $790.00. For the period beginning on June 1, 2009 and continuing Claimant earned an AWW of $884.27.

3. If Claimant suffered a compensable injury, she is entitled to receive Temporary Total Disability (TTD) benefits for the period November 22, 2008 until terminated by statute.

FINDINGS OF FACT

1. Employer is a trucking company. Claimant began working for Employer as a utility driver in late April 2008. Her duties involved driving semi-trucks to deliver Ford and General Motors (GM) automobile parts to various dealers.

2. Claimant testified at the hearing in this matter. She explained that on November 20, 2008 Employer directed her to drive to a GM facility, load two trailers and return to a Ford loading dock.

3. Claimant drove her truck to the GM facility and positioned the trailer at a loading dock. She entered the facility and was greeted by Shane Adams and Lesea McCall. Because Claimant had no previous experience loading trailers, Mr. Adams had been designated to instruct Claimant about how to load the trailer. Mr. Adams was a temporary employee for Kelly Services who worked for Employer. Ms. McCall worked for GM on the loading dock.

4. Claimant and Mr. Adams proceeded to load Claimant's trailer with automobile parts. The parts were in various containers including metal cages and totes. The process lasted approximately one and one-half hours. Claimant subsequently drove the loaded trailer back to the Ford loading dock. She then connected an empty trailer to her truck and returned to the GM facility. Claimant and Mr. Adams loaded carts onto the trailer and Claimant again returned to the Ford dock. Although Claimant's muscles ached after completing her duties, she did not notice any additional symptoms.

5. On November 21, 2008 Claimant was again assigned to load parts at the GM facility and return the loaded trailers to the Ford dock. Because her trailers had been improperly loaded on the previous day, supervisor James Hanna was assigned to oversee Claimant's work. Claimant and Mr. Hanna drove an empty trailer to the GM facility. She loaded the trailer with Mr. Adams and returned to the Ford dock with Mr. Hanna. She dropped off Mr. Hanna, hooked up a new trailer and returned to the GM facility for a second load.

6. Claimant and Mr. Adams began loading the second trailer with various items. Claimant testified that when she had almost finished loading a number of totes, she grabbed a tote that was unexpectedly heavy. The tote weighed approximately 35-40 pounds. As the tote dropped forward, Claimant attempted to catch it, but experienced a pulling sensation in her lower back. Claimant subsequently completed her duties loading the truck.

7. Claimant believed that she had pulled a muscle in her back as a result of the incident but was not very concerned about the event. However, as Claimant drove her truck over approximately 10 miles to the Ford facility, the bumps in the road caused an increase in her lower back pain. When she arrived at the facility, she apprised Mr. Hanna of her injury and notified her mother by telephone that she had injured her back.

8. Claimant did not immediately seek medical treatment after her work shift because she believed she had sustained a muscle pull that would resolve without treatment. However, when she awakened on the following morning she experienced increased pain.

9. On November 22, 2009 Claimant visited a Concentra Medical Facility to obtain treatment for her lower back. Claimant reported that she had

injured her lower back on November 21, 2008 while unloading an approximately 40 pound tote. She denied that she had suffered any previous lower back injuries. Claimant was diagnosed with a lumbosacral strain.

10. Mr. Adams testified at the hearing in this matter. He explained that he worked on the GM dock loading trailers with Claimant on November 20-21, 2008. Mr. Adams commented that Claimant did not complain about any back problems that prevented her from loading the trailers. However, he also remarked that Claimant did not exhibit any symptoms of a back injury or otherwise appear to be injured on November 21, 2008. Mr. Adams finally noted that none of the totes that Claimant moved weighed in excess of 15 pounds.

11. Ms. McCall testified at the hearing in this matter. She stated that she worked on the loading dock at the GM facility on November 20-21, 2008. Ms. McCall commented that empty totes weighed approximately 10 pounds. She explained that the totes would be loaded with a number of automobile parts. The weights of the individual parts were marked, but the total weight of the tote was unknown. Based on her 28 years of experience with GM, Ms. McCall explained that a loaded tote could not weigh less than 15 pounds.

12. Ms. McCall recalled that on November 21, 2008 she noticed Claimant grab a tote and lurch forward while loading the truck. She did not know whether Claimant had been injured. However, after the last trailer had been loaded Ms. McCall observed that Claimant was walking slowly and was obviously suffering discomfort. Claimant also remarked that her back was hurting just before she returned to her cab to drive the load to the Ford facility.

13. David Newcomb testified at the hearing in this matter. He

stated that he worked for Employer shuttling trailers back and forth from the GM facility to Employer's facility. Mr. Newcomb explained that he talked to Claimant between approximately 8:30 p.m. and 9:30 p.m. on November 20, 2008 at the GM facility. He questioned Claimant about why she was standing on a loading dock and not working. Claimant responded that she was waiting for a helper because she had "hurt [her] back the other day." Nevertheless, Mr. Newcomb acknowledged that he was uncertain about the specific evening he had spoken to Claimant. He stated that he heard the evening after he spoke to Claimant that she had been injured on the previous evening.

14. The parties conducted the evidentiary deposition of George Schakaraschwili, M.D. in this matter. He explained that he initially evaluated Claimant on January 12, 2009. She reported that she had been loading a truck and grabbed a bin with one hand that weighed approximately 30 to 40 pounds. When the bin began to fall, she twisted in an attempt to catch it. Dr. Schakaraschwili remarked that the mechanism of injury that Claimant had reported was consistent with her lower back pain. He determined that Claimant's SI joint was the most likely pain generator. Dr. Schakaraschwili concluded that Claimant's lower back injury was caused by her lifting incident at work on November 21, 2008.

15. Claimant has established that it is more probably true than not that she suffered a compensable lower back injury during the course and scope of her employment with Employer on November 21, 2008. Claimant credibly testified that on November 21, 2008 she was loading totes into a trailer at the GM facility when she grabbed a tote that was unexpectedly heavy. As the tote dropped forward, Claimant attempted to catch it, but experienced a pulling

sensation in her lower back. Ms. McCall corroborated Claimant's account. She explained that Claimant grabbed a tote and lurched forward while loading the trailer. Ms. McCall did not know whether Claimant had been injured. However, after the last trailer had been loaded Ms. McCall noticed that Claimant was obviously suffering discomfort and Claimant remarked that her back was hurting. Although Mr. Newcomb testified that Claimant mentioned she "hurt [her] back the other day," his testimony lacks credibility because he was uncertain about the specific evening on which he had spoken to Claimant. Furthermore, Claimant's initial medical report at the Concentra Medical Facility is consistent with her account of the November 21, 2008 incident. Finally, Dr. Schakaraschwili remarked that Claimant's reported mechanism of injury was consistent with her lower back pain and concluded that her injury was caused by the lifting incident at work on November 21, 2008.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. ß8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. ß8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. ß8-43-201, C.R.S.

A Workers' Compensation case is decided on its merits. ß8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. ß8-41-301(1)(c) C.R.S.; In re Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844, 846 (Colo. App. 2000); Singleton v. Kenya Corp., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. Faulkner, 12 P.3d at 846.

5. As found, Claimant has established by a preponderance of

the evidence that she suffered a compensable lower back injury during the course and scope of her employment with Employer on November 21, 2008. Claimant credibly testified that on November 21, 2008 she was loading totes into a trailer at the GM facility when she grabbed a tote that was unexpectedly heavy. As the tote dropped forward, Claimant attempted to catch it, but experienced a pulling sensation in her lower back. Ms. McCall corroborated Claimant's account. She explained that Claimant grabbed a tote and lurched forward while loading the trailer. Ms. McCall did not know whether Claimant had been injured. However, after the last trailer had been loaded Ms. McCall noticed that Claimant was obviously suffering discomfort and Claimant remarked that her back was hurting. Although Mr. Newcomb testified that Claimant mentioned she "hurt [her] back the other day," his testimony lacks credibility because he was uncertain about the specific evening on which he had spoken to Claimant. Furthermore, Claimant's initial medical report at the Concentra Medical Facility is consistent with her account of the November 21, 2008 incident. Finally, Dr. Schakaraschwili remarked that Claimant's reported mechanism of injury was consistent with her lower back pain and concluded that her injury was caused by the lifting incident at work on November 21, 2008.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant suffered a lower back injury during the course and scope of her employment with Employer on November 21, 2008.

2. Claimant's medical treatment for her lower back injury was authorized, reasonable and necessary to cure and relieve the effects of the injury.

3. For the period November 22, 2008 through May 31, 2009 Claimant earned an AWW of $790.00. For the period beginning on June 1, 2009 and continuing, Claimant earned an AWW of $884.27.

4. Respondents shall pay Claimant TTD benefits for the period November 22, 2008 until terminated by statute.

5. All issues not resolved in this Order are reserved for future determination.

DATED: November 25, 2009.

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Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-775-422

ISSUES

Whether the Claimant has proven by a preponderance of the evidence that he sustained compensable injuries to his bilateral ankles on July 29, 2008 arising out of and in the course of his employment with Employer.

If compensable, whether Claimant is entitled to medical benefits for the treatment received from Aurora Medical Center, Dr. Peter Weingarten, M.D. and Dr. Steve Ogden, M.D.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed as a mechanic for Employer. Claimant had been employed for a period of five (5) years as of July 2008.

2. On July 29, 2008 Claimant was working a shift that began at 3:00 PM and was to end at 1:15 AM on July 30, 2008.

3. Claimant testified that around midnight, July 29, 2008 he was clearing jams on the inbound section of bag claim 18 on Level 5 at Denver International Airport. Claimant testified that while doing this his ankles became caught between the rollers of the conveyor belt, causing injury to his ankles.

4. According to Claimant the jam that he was clearing when his injury occurred was due to some luggage tubs that had not cleared a curtain on the conveyor to Level 5 of baggage claim 18. Claimant testified that he pushed the E-stop button at the top of the baggage claim 18 carousel as required

by company procedure and then proceeded to climb onto the conveyor to clear the jam. Claimant testified that the conveyor moved once he cleared the jam causing his ankles to be caught between rollers of the conveyor even though the E-stop had been pushed. Claimant testified that the conveyors continued to run for approximately 10 minutes with his feet caught between the rollers.

5. Claimant testified that when his ankles became caught in the rollers of the conveyor he called a fellow employee, Jason Palmer, on his cellphone for help. Claimant testified that Jason Palmer came to the scene and assisted Claimant in getting his feet and ankles out of the rollers and then brought Claimant a wheelchair and rolled Claimant in the wheelchair to a taxi at Level 5 of the airport so the taxi could take Claimant to the hospital. Claimant further testified that two other co-employees, Jack Klein and Joe Sturgis, arrived on the scene sometime later and assisted in getting Claimant out of the rollers of the conveyor. Claimant specifically testified that Jack Klein assisted Jason Palmer in opening the rollers so that Claimant could be removed from in between the rollers.

6. Claimant testified that prior to the injury occurring he had given Employer his two-week notice that he was resigning his employment and that his last day of work would be August 13, 2008. Claimant completed a Workers' Claim for Compensation on October 6, 2008 alleging that his injury occurred at 11:30 PM on July 29, 2008;

7. Claimant did prepare a letter of resignation address to Michael Stollsteimer at Employer that is dated July 30, 2008. Mr. Stollsteimer testified, and it is found, that this letter was faxed to him on July 30, 2008. An Employee Status Change form was completed by Mr. Stollssteimer on August 15,

2008 that noted that Claimant had turned in his resignation on July 30, 2008 and at that time was asked not to return to work.

8. The baggage conveyor and carousel system at Denver International Airport (”DIA”) is monitored by a computer system that creates a log of system activities or alarms, including jams and activation of an E-stop. This alarm log notes the location of the alarm, the date, the time the alarm is cleared and the total time the alarm was activated for each particular alarm event and location. Vernon Mauzy, Claimant’s supervisor and a former mechanic with Employer, testified, and it is found, that this computer log records every jam that occurs in the system.

9. The computer alarm log shows that a jam occurred on July 29, 2008 at the photo sensor on the conveyor from Level 4 to Level 5 on baggage claim 18 that was cleared at 10:22 PM. The log further shows that this alarm had been tripped for 4 minutes and 4 seconds, placing the time the jam actually occurred at 10:17:54 PM on July 29, 2009. After this jam was cleared, no further jams occurred as reflected by the computer alarm log. The computer log shows that in clearing this jam, the E-stop on Level 5 was not activated.

10. The computer alarm log shows that the E-stop on Level 5 of baggage claim 18 was activated for a total of 43 minutes and 17 seconds and was cleared or reset at 12:13:17 AM on July 30, 2009. Based upon the log entry showing the duration of the activation of the E-stop at Level 5 on baggage claim 18 it is found that the E-stop was activated at 11:29:43 PM on July 29, 2008. The computer log does not reflect a corresponding jam having occurred around that time at the photo sensor between Level 4 and Level 5 of baggage claim 18 as Claimant alleges to have occurred. As found, the jam that did occur at that

location occurred and was cleared one hour before without activation of the E-stop on Level 5.

11. Claimant presented for treatment at the emergency room of The Medical Center of Aurora at 12:41 AM on July 30, 2008. Claimant complained of injuries to his ankles that had “just happened prior to arrival”. Claimant provided the emergency room physician with a history that he had sustained a twisting injury from getting both feet stuck in a conveyor belt that occurred at work. Claimant was diagnosed with bilateral ankle fractures and was then referred to and treated surgically by Dr. Weingarten on July 30, 2008. Claimant subsequently moved to Texas and began treatment with Dr. Steve Ogden, M.D.

12. Claimant called his supervisor, Vernon Mauzy, at 1:19 AM on July 30, 2008 from The Medical Center of Aurora hospital. Claimant told Mr. Mauzy that he had had an emergency and had left work without clocking out. Claimant did not mention an injury at work to Mr. Mauzy in this conversation. Claimant told Mr. Mauzy that he had left work 30 ñ 40 minutes prior. This timeline places the Claimant as having left work at Denver International Airport between 12:39 and 12:49 AM on July 30, 2008, which cannot be accurate because at time approximate time Claimant was already at the emergency room seeking treatment for injuries he claimed occurred at work just prior to his arrival.

13. Jason Palmer is a senior technician for Employer. Mr. Palmer was working on the night of July 29, 2008 on the same shift as Claimant. Mr. Palmer testified, and it is found, that Claimant did not call him on that night about being injured at work. Mr. Palmer did not assist Claimant in getting his feet and ankles out from between the rollers of the conveyor. Mr. Palmer also did not assist Claimant with getting a wheelchair and wheeling

Claimant to a taxi so that he could go to the hospital. Mr. Palmer testified, and it is found, that if the E-stop were activated to allow a jam to be cleared the conveyor would not re-start until the E-stop was reset which requires use of a key at the location of the E-stop.

14. Jack Klein is a technician for Employer. On July 29, 2008 Mr. Klein did not assist in extracting Claimant's feet and ankles from between the rollers of the conveyer. Mr. Klein testified consistent with the testimony of Mr. Palmer that after a jam is cleared and the photo-eye reset the conveyor would not start to move until the E-stop was reset with a key start.

15. Joseph Sturgis is junior technician for Employer. On July 29, 2008 Mr. Sturgis did not assist in removing Claimant's ankles from between the rollers of the conveyor or assist in moving the rollers so that Claimant could extract his feet and ankles from between the rollers. Mr. Sturgis testified consistent with the testimony of Mr. Palmer and Mr. Klein that after a jam is cleared and the photo-eye reset the conveyor would not start until the E-stop is pulled and reset with a key.

16. Claimant was evaluated at the request of Respondents by Dr. John Douthit, M.D. Dr. Douthit opined that Claimant's symptoms or complaints were consistent with the mechanism of injury.

17. The ALJ resolves the conflicts in the testimony of Claimant and that of Jason Palmer, Jack Klein, Joseph Sturgis and Vernon Mauzy in favor of the testimony of Mr. Palmer, Mr. Klein, Mr. Sturgis and Mr. Mauzy as being the more credible and persuasive. Claimant's testimony that he injured his bilateral ankles on July 29, 2008 when they became caught between the rollers of the conveyor that had moved once he cleared a jam, causing his ankles

to become caught, is not credible or persuasive.

18. Claimant has failed to prove by a preponderance of the evidence that he sustained an injury to his bilateral ankles arising out of and in the course of his employment with Employer on July 29, 2008.

CONCLUSIONS OF LAW

19. The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, supra. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

20. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of

evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

21. The claimant was required to prove by a preponderance of the evidence that the conditions for which he seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The claimant must prove a causal nexus between the claimed disability and the work-related injury. Singleton v. Kenya Corp., 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. Duncan v. Industrial Claim Appeals Office, 107 P.3d 999 (Colo. App. 2004); H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990).

22. As found, Claimant has failed to prove by a preponderance of the evidence that he sustained compensable injuries to his ankles on July 29, 2008 while employed with Employer. Dr. Douthit's opinion that Claimant's symptoms and complaints are consistent with the mechanism of injury is not considered sufficient to prove that the mechanism of injury itself actually occurred. Although it is true that Claimant suffered bilateral ankle fractures that necessitated surgical treatment, the specific issue to be determined is whether those injuries occurred at work as alleged by Claimant.

23. Claimant's testimony concerning the occurrences and circumstances surrounding his claim of injury on July 29, 2008 is rebutted by the credible testimony of Jason Palmer, Jack Klein, Joseph Sturgis and Vernon Mauzy. In

addition Claimant's testimony is directly rebutted by the computer log of the alarms occurring in the DIA baggage system on July 29 and 30, 2008. While the memories of Mr. Palmer, Mr. Klein and Mr. Sturgis of the specific day of July 29, 2008 may be somewhat clouded by the passage of time each of them credibly testified that at no time did they assist Claimant in getting his feet and ankles extracted from between rollers of the baggage conveyor, assist in separating the rollers so Claimant could be extracted or obtain a wheelchair and wheel Claimant to a waiting taxi to be taken for medical treatment for his injuries as Claimant has claimed. More importantly, each of these witnesses credibly and consistently testified that the conveyor system would not start automatically, after activation of the E-stop, clearing of a jam and resetting a photo-eye without the E-stop being reset, as Claimant claims to have occurred. The computer alarm log does contain entries of a jam in the area indicated by Claimant and that the E-stop on Level 5 was activated. However, and as found, these two events were separated by over one hour in time and this discrepancy is not persuasively explained. Claimant alleged the injury occurred around 11:30 PM or midnight on July 29, 2008. The computer alarm log establishes that although the E-stop on Level 5 was activated around that time, no corresponding jam had occurred in the area where Claimant claims he went to clear a jam and was then injured when the conveyor suddenly restarted.

24. Claimant bears the burden of proof to show that medical benefits are causally related to a work-related incident. See Ashburn v. La Plata School District 9R, W.C. No. 3-062-779 (ICAO May 4, 2007); Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997). Because Claimant has failed to prove that the medical treatment and surgery for his bilateral ankle fractures

were causally related to a compensable injury at work, Claimant's claims for medical benefits for such treatment and surgery must be denied.

ORDER

It is therefore ordered that:

Claimant's claim for compensation and benefits, including medical benefits for the treatment received from The Medical Center of Aurora, Dr. Weingarten and Dr. Ogden, for an injury to his bilateral ankles on July 29, 2008 is denied and dismissed.

DATED: November 25, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-789-454

ISSUES

The issues for determination were responsibility for termination of

employment and temporary disability benefits.

FINDINGS OF FACT

Claimant was injured in a motor vehicle accident on March 14, 2009. Claimant was stopped at an intersection. He watched a police car approach from one direction. He entered the intersection and was struck by a shuttle bus approaching from the opposite direction. Claimant suffered head, back, and other injuries. Insurer has admitted liability for the accident.

Claimant was performing security duties for Employer on March 14, 2009. It was his second day that he was performing security duties. At the beginning of his shift, Claimant relieved the previous driver, who asked Claimant for a ride to Landside, an employee's parking lot at DIA. The motor vehicle accident occurred as Claimant neared the Landside lot.

Employer alleges that Claimant was not where he was supposed to be when the accident occurred. Employer has a progressive discipline system. Claimant had been disciplined in the past. Employer terminated Claimant's employment on March 14, 2009, because of the alleged violation of company policy at the time of the accident and the prior disciplinary actions taken against Claimant.

Claimant's security duty involved patrolling the east public parking lots at DIA and responding to calls for assistance at both the public lots and the Landside employee lot. The accident did not occur in Claimant's patrol area.

Employer permits an employee to give a co-worker a ride to the Landside lot, but

only after the employee obtains permission from a supervisor. Employer sent a "Read Thru" to all supervisors on December 28, 2008. The message was read to Claimant one or more times in the two weeks following December 28, 2008. The message provided:

At no time will there be any unnecessary transports for no reason, due to the operational needs to have all officers in their assigned areas to answer any and all calls... If the transports continue disciplinary action will follow. These transports have to be approved by a supervisor no exceptions.

Claimant testified that he was not aware that he was required to call dispatch and have supervisor approval prior to taking a co-worker to the Landside lot. The above message would have been read to Claimant in late December or early January. At that time, Claimant was not performing security duties and the message had no relevance to the work he was performing. It is easy to understand why Claimant would not have remembered this policy in March when be began perform the security duties. Claimant's testimony that he was not aware of the requirement that he had to seek the approval of a supervisor before taking a co-worker to the Landside lot is credible and persuasive. Claimant did not reasonably expect his conduct in taking a co-worker to the Landside lot would result in the termination of his employment. Claimant did not perform some volitional act or otherwise exercise a degree of control over the circumstances resulting in termination. Claimant was not at fault for the termination of his employment.

Claimant was first treated for the injuries he sustained from the motor vehicle accident at an emergency room. He was taken off work. Claimant was treated on March 19, 2009, at Concentra. Claimant was “placed at regular duty” and instructed to “gradually increase his work activities as tolerated.”

Claimant was seen again at Concentra on April 3, 2009. Claimant complained of significant pain. Claimant was instructed to engage in “no activity” until additional reports were received. On April 9, 2009, a Concentra physician stated that Claimant should not work until a further evaluation and additional records were obtained. On April 23, 2009, a physician at Concentra restricted Claimant from driving more than short distances and to stand and sit as needed for pain control. Claimant received physical therapy. On May 14, 2009, a physician at Concentra restricted Claimant from lifting, pushing, or pulling over 25 pounds. On June 11, 2009, a physician at Concentra noted that Claimant had been unable to work. Claimant has had other examinations by physicians, but has not been released to return to work.

Claimant attempted to work for a different employer in July. He left that employment after two and one-half days because it was not within his restrictions. He earned $90.00.

Claimant testified credibly that his condition did not significantly change between the accident and the date of the hearing. It is found that Claimant could not perform the regular duties of his employment from the date of the accident through April 3, 2009, and continuing.

CONCLUSIONS OF LAW

Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., (termination statutes) provide that, where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury. Respondents shoulder the burden of proving by a preponderance of the evidence that a claimant was responsible for his termination. See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office, 20 P.3d 1209 (Colo.App. 2000). By enacting the termination statutes, the General Assembly sought to preclude an injured worker from recovering temporary disability benefits where the worker is at fault for the loss of regular or modified employment, irrespective ofwhether the industrial injury remains the proximate cause of the subsequent wage loss. Colorado Springs Disposal v. Martinez, 58 P.3d 1061 (Colo.App. 2002) (court held termination statutes inapplicable where employer terminates an employee because of employee's injury or injury-producing conduct). An employee is "responsible" if the employee precipitated the employment termination by a volitional act that an employee would reasonably expect to result in the loss of employment. Patchek v. Colorado Department of Public Safety, W.C. No. 4-432-301 (ICAO, September 27, 2001). Thus, the fault determination depends upon whether the claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. Padilla v. Digital Equipment Corp., 902 P.2d 414 (Colo.App. 1994), opinion after remand, 908 P.2d 1185 (Colo.App. 1995). That determination must be based upon an examination of the totality of the circumstances. Id.

Claimant did not reasonably expect his conduct in taking a co-worker to the Landside lot would result in the termination of his employment. Claimant did not perform some volitional act or otherwise exercise a degree of control over the circumstances resulting in termination. Claimant was not a fault for the termination of his employment. Respondents have not shown that Claimant was responsible for the termination of his employment. Temporary disability benefits are not precluded by Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S.

Claimant was treated on March 19, 2009, at Concentra. Claimant was "placed at regular duty" and instructed to gradually increase his work activities as tolerated. Since he was told to "gradually increase work activities as tolerated, this was not a release to regular duty under Section 8-42-105(3)(2), C.R.S.

Claimant has established by a preponderance of the evidence that he was temporarily disabled commencing March 15, 2009. Insurer is liable for temporary total disability benefits commencing March 15, 2009, except for one week in July 2009 when Claimant's disability was partial. Sections 8-42-105 and 106, C.R.S. Temporary disability benefits shall continue until terminated pursuant to law. Section 8-42-105(3), C.R.S.

Insurer is liable for interest at the rate of eight percent per annum on all benefits not paid when due. Section 8-43-410, C.R.S.

ORDER

It is therefore ordered that:

Insurer shall pay Claimant temporary total disability benefits from March 15, 2009, to the date of the hearing and continuing until terminated pursuant to law, except for one week in July 2009 when Insurer shall pay temporary partial disability benefits.

Insurer shall pay Claimant interest on all benefits not paid when due.

Issues not determined by this order are reserved.

DATED: November 25, 2009

Bruce C. Friend, ALJ

Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-754-998

ISSUES

ÿ Did respondents overcome by clear and convincing evidence the

determination of Dr. Yamamoto that claimant's depression is related to his industrial injury and that claimant has not reached maximum medical improvement for any psychological component of his injury?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Employer is in the business of manufacturing furniture. Claimant worked for employer as a woodworker and furniture assembler for approximately 8 Ω years until employer laid him off on October 9, 2008. Claimant's date of birth is August 23, 1949; his age the time of hearing was 60 years. Claimant sustained an admitted occupational disease type injury to his right wrist and right thumb, with a date of onset of January 1, 2008.

2. Employer referred claimant to Workwell Occupational Medicine, where he was first evaluated on March 24, 2008, for complaints of right thumb pain. There were no documented complaints by claimant of depression or psychological issues. John P. Mars, M.D., and William Ford, NP, were claimant's primary medical providers at Workwell.

3. Dr. Mars referred claimant to Kenneth Cavanaugh, M.D., who performed an orthopedic evaluation of claimant on March 31, 2008. Following his appointment with Dr. Cavanaugh, claimant presented to Workwell for a follow-up evaluation. Claimant admitted that he did not complain of depression or anxiety to any of his medical providers on March 31, 2008.

4. Dr. Cavanaugh referred claimant to Hand Surgeon Timothy Pater, M.D., who evaluated him on May 28, 2008. Dr. Pater diagnosed flexor

capal radialis (FCR) precipitated by arthritis of the scaphotrapezoid (STT) joint. Dr. Pater performed surgery on claimant's right wrist on July 1, 2008, which involved a synovectomy of the FCR tendon sheath and debridement of arthritis of the STT joint. Claimant admitted that Dr. Pater documented no complaints of depression, anxiety, or psychological issues.

5. On October 6, 2008, Dr. Pater released Claimant to full-duty work, without restrictions, and to follow up as needed. There is no medical record evidence otherwise showing that Dr. Pater documented any complaint by claimant of depression or psychological problems.

6. Dr. Mars placed claimant at maximum medical improvement (MMI) on October 7, 2008. Dr. Mars noted that claimant's primary complaint involved wrist pain. Claimant reported no pain at rest and some mild pain with activity. Claimant had returned to his regular work at employer. Dr. Mars rated claimant's permanent medical impairment according to the American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised) (AMA Guides). There were no documented complaints by claimant of depression, anxiety, or psychological issues. Dr. Mars recommended neither maintenance treatment nor permanent work restrictions.

7. Joel English has worked for employer for some 20 years and currently acts as safety and purchasing manager at the location where claimant worked. Mr. English's job duties include processing and handling workers' compensation claims. Mr. English maintained regular and daily contact with claimant in 2008. Mr. English credibly testified that claimant never expressed to him that he was depressed or anxious because of his work-related injury involving his right wrist and hand.

8. Crediting Mr. English's testimony, employer laid off claimant on October 9, 2008, due to economic reasons completely unrelated to claimant's workers' compensation claim. On October 9, 2008, employer laid off a total of 19 employees for economic reasons, including 12 employees from claimant's location. Mr. English was involved in the analysis of which employees would be laid off at that time. Mr. English credibly and persuasively testified that the decision to lay off claimant and other employees was based strictly on economic reasons and that claimant's work-related injuries and workers' compensation claim played no part in that decision.

9. Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation; the division appointed David Yamamoto, M.D., the DIME physician. Dr. Yamamoto examined claimant on March 23, 2009. Dr. Yamamoto thoroughly documented claimant's medical treatment. Dr. Yamamoto noted the absence of medical record evidence of complaints by claimant of depression, anxiety, or psychological issues. Claimant complained to Dr. Yamamoto of feeling depressed over prior few months because of the loss of his job. Dr. Yamamoto agreed with Dr. Mars's determination that claimant had reached MMI for the physical component of his injury as of October 7, 2008. Dr. Yamamoto however determined that claimant had not reached MMI for any psychological component of the injury because his depression had not been treated. Dr. Yamamoto recommended claimant undergo treatment for the depression by a psychiatrist familiar with workers' compensation. Dr. Yamamoto determined that claimant sustained permanent medical impairment, which he rated at 15% of the right upper extremity. Dr. Yamamoto's determination that claimant's work-related injury has a psychological component and that he has not reached

MMI for that component is presumptively correct unless overcome by clear and convincing evidence.

10. In his April 30, 2009, response to a letter from insurer, Dr. Mars reiterated that claimant had not reported any symptoms of depression up to the time he reached MMI. Dr. Mars stated his opinion that he would not consider claimant's depression work-related unless employer laid claimant off because of inability to perform his work due to functional effects of his injury. Dr. Mars however opined that, were claimant's termination was due to economic reasons, he would not find claimant's symptoms of depression work-related.

11. At respondents's request, Psychiatrist Robert Kleinman, M.D., performed an independent medical examination of claimant on July 31, 2009. Claimant reported to Dr. Kleinman that he was somewhat depressed during his treatment for the injury because he disliked going to doctors and was frustrated dealing with workers' compensation. Claimant reported that he became significantly depressed when employer laid him off. Claimant reported that, after employer laid him off, he became depressed with sleep disturbance, appetite disturbance, weight loss, excessive alcohol use, decreased motivation, decreased initiative, and irritability. Claimant reported that he was worried about money since the lay-off. Claimant explained to Dr. Kleinman that, although he completed all job tasks he was assigned, he was not as fast because of his wrist injury.

12. Dr. Kleinman wrote in his assessment:

Through the entire course of treatment, and through his being placed at MMI and released to work, [claimant] did not complain of depression.

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Though he told me that he was somewhat depressed, this is not indicated in the contemporaneous medical record. Either way, this [depression] was not significant and was manageable and was not impairing.

Complaints of depression did (sic) surface until the division IME. He told Dr. Yamamoto that he became depressed after he was laid off. He confirmed this in his interview with me. This is further confirmed by a review of the medical records.

****

[S]ymptoms of anxiety and worry interfered with his sleep and appetite. These started after he was laid off. He believes they are related to being laid off, lack of income, and worry about his family. He is worried about his future. Though he has issues with alcohol, which seem to remit and relapse over time, alcohol became a major problem after he was laid off.

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He became more irritable wile (sic) drinking and this caused instability with his marriage.

(Emphasis added). Dr. Kleinman diagnosed: Adjustment disorder with depressed mood; alcohol dependency, in partial remission; and pain disorder associated with psychological factors and a medical condition.

13. Dr. Kleinman concluded that claimant's depression started after he reached MMI on October 7, 2008, and after he was laid off. Dr. Kleinman believes that claimant's depression and anxiety were not a problem during the course of his treatment for his occupational injury, prior to being placed at MMI. The first medically documented complaint of depression appeared

in Dr. Yamamoto's DIME report, where Dr. Yamamoto noted that claimant had been feeling depressed for a few months with the loss of his job. Dr. Kleinman concluded, that Dr. Yamamoto incorrectly attributed claimant's depression to the occupational injury. Dr. Kleinman opined that claimant requires no psychological care that is related to his occupational injury.

14. Crediting claimant's testimony, the Judge finds: Claimant's duties assembling furniture at employer involved lifting posts weighing up to 50 pounds when sanding or turning them on a lathe. After claimant was released to return to work, claimant observed that his injury diminished his ability to perform as much work and slowed him down. Claimant became concerned employer would lay him off because he could not work as fast as he worked prior to his injury. Although Dr. Mars and Dr. Pater released him to full-duty work, claimant understood he should wear his wrist brace and exercise more care when lifting items weighing more than 10 pounds. Claimant told Dr. Mars he was concerned he would lose his job because he could not keep up. Claimant told Dr. Mars before he reached MMI that he had lost interest in riding his motorcycle, gardening, and fishing because of the impact of the injury on his functioning.

15. Dr. Mars testified as an expert in the area of Occupational Medicine. Dr. Mars agreed with Dr. Keinman's opinion that claimant is depressed. Dr. Mars agreed with Dr. Kleinman's opinion that claimant's complaints of depression began after Dr. Mars placed him at MMI and after employer laid him off. Dr. Mars opined that Dr. Yamamoto incorrectly attributed claimant's depression to his work-related injury. Dr. Mars testified:

16. I think the note from the employer indicating that

[claimant] was laid off for economic reasons, and the report from Dr. Kleinman indicating the depression started afterwards, and the fact that we have never had any reports of depression during his treatment, I would say that the depression was post layoff, and therefore, not related to his work-related injury.

17. (Emphasis added). Dr. Mars agreed with Dr. Kleinman's opinion that claimant requires no treatment for his depression attributable to his work-related injury and that claimant has no psychological restrictions attributable to his work-related injury.

18. Respondents failed to show it highly probable that Dr. Yamamoto is incorrect in determining that claimant's injury caused his depression and psychological adjustment disorder. Dr. Yamamoto, Dr. Mars, and Dr. Kleinman agree that claimant suffers from depression and from problems adjusting to his situation. Respondents correctly argue that claimant's complaints of depressive symptoms and adjustment problems more likely surfaced after employer laid him off. This is supported alike by the medical records and by claimant's own testimony. Claimant however credibly testified that his wrist injury caused him to feel less secure in his ability to perform his job prior to the time he reached MMI and before employer laid him off. Indeed, claimant was concerned he would be laid off because his functioning in his job had suffered because of his injury. Although the timing of claimant's complaints, surfacing after MMI, might indicate that his psychological problems are more probably related to his lay-off, claimant's date of MMI is only 2 days prior to the date employer laid him off. Claimant's credible testimony shows a causal relationship between his impaired functioning from the effects of his injury and

his depression and adjustment disorder. This nexus was medically sufficient for Dr. Yamamoto to find that claimant's injury caused his psychological problems. There was no persuasive medical evidence showing it highly probable that Dr. Yamamoto incorrectly determined that claimant's injury involves a psychological component that requires treatment before claimant reaches MMI for all components of the injury.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Respondents argue they overcame by clear and convincing evidence the determination of Dr. Yamamoto that claimant's depression is related to his industrial injury and that claimant has not reached MMI for any psychological component of his injury. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, supra. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

Sections 8-42-107(8)(b)(III) and (c), supra, provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. Metro Moving and Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. Metro Moving & Storage Co. v. Gussert, supra. A mere difference of opinion between physicians fails to constitute error. See, Gonzales v. Browning Ferris Indust. of Colorado, W.C. No. 4-350-36 (ICAO March 22, 2000).

The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. Qual-Med v. Industrial Claim Appeals Office, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. Qual-Med v. Industrial Claim Appeals Office, supra. Here, the Judge found that respondents failed to show it highly probable that Dr. Yamamoto was incorrect in determining that claimant's injury caused his depression and psychological adjustment disorder. Respondents thus failed to overcome Dr. Yamamoto's MMI determination by clear and convincing evidence. As found, Dr. Yamamoto, Dr. Mars, and Dr. Kleinman concur that claimant suffers from depression and from problems adjusting to his situation. The Judge agreed with respondents in finding that claimant's complaints of depressive symptoms and adjustment problems surfaced after employer laid him off. This finding was supported alike by the medical records and by claimant's own testimony.
The Judge however credited claimant's testimony in finding that his wrist injury caused him to feel less secure in his ability to perform his job prior to the time he reached MMI and before employer laid him off. Claimant was concerned he would be laid off because his functioning in his job had suffered because of his injury. Although the timing of claimant's complaints, surfacing after MMI, might indicate that his psychological problems are more probably related to his lay-off, claimant's date of MMI was only 2 days prior to the date employer laid him off. That amount of time seems insignificant to show that his injury was

not contributing to his psychological problems.

The Judge found that claimant demonstrated a legally sufficient nexus between his impaired functioning from the effects of his injury and his depression and adjustment disorder. See Martinez v. Mac-Bestos, Inc., W.C. No. 4-291-444 (ICAO October 13, 2000). This nexus was medically sufficient for Dr. Yamamoto to find that claimant's injury caused his psychological problems. There was no persuasive medical evidence showing it highly probable that Dr. Yamamoto incorrectly determined that claimant's injury involves a psychological component that requires treatment before claimant reaches MMI for all components of the injury.

The Judge concludes that Dr. Yamamoto's determination that claimant has not reached MMI for the psychological component of his injury should be upheld.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Dr. Yamamoto's determination that claimant has not reached MMI for the psychological component of his injury is upheld.

2. Claimant has not reached MMI.

3. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _November 25, 2009_

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Michael E. Harr,

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-794-835

ISSUES

Whether Claimant has proven by a preponderance of the evidence that he is entitled to an award of TTD benefits commencing December 11, 2008 and continuing.

At hearing the parties stipulated that Claimant's Average Weekly Wage was $860.90. That stipulation was accepted by the Court.

FINDINGS OF FACT

Based upon the evidence presented in the record, the ALJ finds as fact:

1. Claimant was employed by Employer as the location manager at Brighton Oxygen. Employer's business consists of the delivery of oxygen tanks and other durable medical equipment. Claimant's job duties as the location manager included on occasion substituting for one of the delivery drivers by running their route and handling the receiving of equipment and oxygen through the shipping and receiving area of Brighton Oxygen. When covering for one of the drivers Claimant would be required to handle delivery of an oxygen generator weighing up to 200 pounds. In the shipping and receiving

area Claimant would be required to lift oxygen concentrators weighing 35 pounds.

2. Claimant sustained an admitted compensable injury on May 27, 2008. On that date, Claimant was making a delivery for one of the drivers and was going upstairs with an oxygen generator weighing 200 pounds when he felt a “pop” in his right leg.

3. Claimant continued working after the injury and did not seek medical treatment until July 2008 when he went to his family physician, Dr. Hicks, for treatment. Dr. Hicks treated Claimant and then referred him to Dr. Bagley for further care.

4. During the time that he continued working after the injury Claimant adjusted his job duties to avoid lifting of heavy objects. Claimant avoided lifting over 10 pounds and had one of the drivers, Kevin Schwartz, to the receiving work involving any lifting over that amount. Claimant would also use a cart to move items and make deliveries. Claimant’s testimony is credible and persuasive.

5. Claimant was first evaluated by Dr. Bagley on August 6, 2008. Dr. Bagley is an orthopedic physician specializing in the treatment of knees and shoulders. Dr. Bagley noted a history that Claimant had had pain in his right mid-tibial area for the last 10 weeks. As noted by Respondents independent medical examiner, Dr. Sabin, in his review of the medical records including those of Dr. Bagley, Dr. Bagley advised the Claimant on August 6, 2008 to limit his activities. At a subsequent office visit on August 13, 2008 Dr. Bagley continued to advise Claimant to perform activity and work schedule “as tolerated”.

6. Claimant continued treating with Dr. Bagley as his

primary treating physician through October 2008. Dr. Bagley obtained an MRI of the lumbar spine in September 2008 and began to feel that Claimant's symptoms were spine related. At the office visit of October 1, 2008 Dr. Bagley referred Claimant to a spine surgeon for evaluation. Claimant was subsequently seen by Dr. McPherson on October 10, 2008 who diagnosed right leg radicular pain, L5-S1 spondylosis and severe right L5 foraminal narrowing.

7. Dr. Bagley again evaluated Claimant on December 10, 2008 and recommended an epidural cortisone injection for which Dr. Bagley would refer Claimant out. At this evaluation Dr. Bagley advised Claimant to continue with activities "as tolerated". Dr. Bagley then referred Claimant to Dr. Smolenski. Dr Bagley testified, and it is found, that he does not treat the spine and therefore referred Claimant to Dr. Smolenski who specializes in spinal conditions.

8. When Dr. Bagley used the term "as tolerated" in describing the Claimant's activity level he was indicating that if Claimant was uncomfortable in any way doing something physically then he should not be doing it.

9. Dr. Smolenski initially evaluated Claimant on December 17, 2008. Claimant testified, and it is found, and as discussed in Dr. Smolenski's subsequent office note of July 21, 2009, that Dr. Smolenski placed Claimant on restrictions as of December 17, 2008 of no lifting over 10 pounds.

10. Dr. Bagley would defer to and agrees with the opinions of Dr. Smolenski regarding the need for work restrictions for Claimant.

11. In an office note of February 13, 2009 Dr. Bagley stated that Claimant could continue his normal work. In his deposition testimony Dr.

Bagley retracted this opinion stating that he was in error and further clarifying that he would not have authorized Claimant to lift or move 200-pound oxygen tanks.

12. Claimant was laid off from the Employer effective December 10, 2008. Claimant has not returned to work since that date. At the time of layoff Employer provided Claimant with a severance payment of $3,732.01 representing 4.25 weeks of pay from the date of the separation from employment.

13. Claimant has not been released to return to his regular work since the date of injury, had not been provided an offer of modified work by Employer and has not been placed at maximum medical improvement by an authorized treating physician.

14. Claimant has proven by a preponderance of the evidence that he was disabled and unable to work his regular duty at the time he was laid off from employment by Employer effective December 10, 2008.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the

employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995).

To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), supra, requires claimant to establish a causal connection between a work-related injury and a subsequent

wage loss in order to obtain TTD benefits. PDM Molding, Inc. v. Stanberg, supra. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his/her prior work. Culver v. Ace Electric, 971 P.2d 641 (Colo. 1999), Hendricks v. Keebler Company, W.C. No. 4-373-392 (June 11, 1999). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his/her regular employment. Ortiz v. Charles J. Murphy & Co., 964 P.2d 595 (Colo.App. 1998).

The existence of disability presents a question of fact for the ALJ. There is no requirement that the claimant produce evidence of medical restrictions imposed by an ATP, or by any other physician. Rather, lay evidence alone may be sufficient to establish disability. Lymburn v. Symbios Logic, 952 P.2d 831 (Colo. App. 1997). Where an injured employee loses his job for economic factors and is not at fault for the layoff, the employee is entitled to temporary disability benefits. Schlage Lock v. Lahr, 870 P.2d 615 (Colo. App. 1993), Lunsford v. Sawatsky, 780 P.2d 76 (Colo. App. 1989).

In defense of Claimant's claim for TTD benefits Respondents argue that Claimant was not placed on any work restrictions until July 2009. The ALJ disagrees. Dr. Bagley advised Claimant to limit his activities as early as his first visit of August 6, 2008. Dr. Bagley's advisement to Claimant that he limit his activities or that he engage in activities and work schedule "as tolerated" connotes something less than an unequivocal and unrestricted release of Claimant

to continue the full range of his regular work duties. Claimant has established by his own credible testimony that following his injury he found it necessary to limit his work activities and to have other employees perform certain aspects of his job that required heavier lifting. This testimony is consistent with the testimony of Dr. Bagley that Claimant was not advised to work without limitation. Claimant was disabled as of the time of his layoff on December 10, 2008 as he was restricted in his bodily function and had an impairment of his earning capacity as he was unable to effectively and properly perform his regular employment. Respondents do not argue that Claimant was responsible for his layoff or his separation from employment. Claimant was an injured or disabled worker at the time of his layoff and there is therefore a presumed connection between his subsequent loss of earnings and the compensable injury that establishes an entitlement to TTD benefits. Lunsford, supra. The work injury does not have to be the sole cause of Claimant's loss of wages in order to establish entitlement to TTD benefits. PDM Molding, supra.

Respondents further argue that because Claimant received monies from Employer for severance Claimant should not be entitled to at least some period of the TTD benefits he is claiming as this would amount to a double recovery. The ALJ is not persuaded. The provisions of Section 8-42-103(1)(c), (d), (e) and (f), C.R.S. outline the permissible offsets to TTD benefits established to prevent double recoveries. See generally, Myers v. State, 162 Colo. 435, 428 P.2d 83 (1967); Walker v. City and County of Denver, 870 P.2d 1269 (Colo. App. 1994). The provision of a severance payment to a Claimant does not fall within one of the enumerated types of disability benefits requiring an offset against a

Claimant's entitlement to TTD benefits under Section 8-42-103, C.R.S. and Respondents have not cited to any persuasive authority to the contrary. Thus, the fact that Claimant received some amount of severance payment following his lay off does not eliminate or diminish Claimant's entitlement to TTD benefits.

As stipulated, Claimant's Average Weekly Wage is $860.90. Claimant is therefore entitled to TTD benefits at the weekly rate of $573.93. Section 8-42-105(1), C.R.S.

ORDER

It is therefore ordered that:

Insurer shall pay Claimant TTD benefits at the weekly rate of $573.93 from December 11, 2008 and continuing until terminated in accordance with statute, rule or order of an ALJ.

The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: November 25, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-767-433

ISSUES

The issues determined herein are compensability of an occupational disease, authorization of medical treatment, temporary total disability ("TTD") benefits, late reporting penalty, and penalty for not filing a timely admission or contest. The parties stipulated to an average weekly wage of $395.94. The parties also stipulated that the insurer was entitled to an offset in the amount of $252 per week for short-term disability ("STD") benefits received by claimant for all weeks of TTD through July 26, 2009.

FINDINGS OF FACT

1. In August 2007, the Claimant began work for the employer as a Full Case Filler, which is a material handler or warehouse worker. This work is labor intensive and classified as heavy under the employer's physical requirements job description.

2. The Claimant's job duties were physically demanding, requiring frequent heavy lifting, pushing and pulling, overhead lifting, including reaching above shoulder level and out front lifting. This work required lifting 70 pounds or more on a regular basis, with constant standing and no sitting.

3. During the course of his employment with the employer, the Claimant began experiencing physical problems involving his left shoulder. The Claimant experienced pain and stiffness with lifting and rotation of the shoulder. The Claimant did not immediately report the symptoms to his employer, believing that the symptoms would resolve. The Claimant did not want to create conflict with his employer.

4. The Claimant experienced shoulder pain a few months prior to the point of seeking medical attention. It was approximately one week prior to seeking medical attention for his left shoulder that the symptoms progressed to the point of severe pain, functional limitations and interference with daily activities, including job duties.

5. On July 27, 2008, the Claimant reported to the Memorial Health System Urgent Care with complaints of shoulder pain for one week, with no specific injury. This medical report states that Claimant was unable to “move it this a.m., concerned if caused by work.” The medical personnel at the Memorial Health System Urgent Care provided physical restrictions of no lifting with the left shoulder greater than 10 pounds. The Claimant delivered the physical restrictions provided by Memorial Health System Urgent Care to Mr. Fuchs, one of the Claimant’s supervisors. Claimant did not work on July 27, 2008 and an Attendance Report was completed by Mr. Martinez, another supervisor of the Claimant.

6. On the following day, July 28, 2008, the Claimant presented for evaluation of his left shoulder pain with his family physician, Dr. Zirkle of Dublin Primary Care Family Practice. The Claimant was evaluated by John Bell, Physician's Assistant to Dr. Zirkle. The history provided in this medical report is consistent with the Memorial Health System Urgent Care report of the day before.

7. On July 28, 2008, PA Bell prescribed physical therapy and medications including Skelaxin, Zanaflex and steroids (Depomedrol). The Claimant was also provided an injection to the left shoulder. PA Bell restricted the Claimant from work for the next three days.

8. The Claimant delivered PA Bell's off work statement to his employer. The employer, through Mr. Martinez, completed attendance reports confirming that the Claimant did not work on July 28 and 29, 2008. The attendance reports completed by Mr. Martinez identified either pain in the shoulder or shoulder injury as the reasons for absence. The Claimant advised Mr. Martinez that his left shoulder problems might be work related.

9. On July 31, 2008, the Claimant returned to Dr. Zirkle for continuing evaluation and treatment of his left shoulder. Dr. Zirkle's examination noted that the Claimant had tenderness to the anterior left shoulder with increased pain upon abduction of the arm. Dr. Zirkle identified positive impingement findings on exam. Additional medical notes from Dr. Zirkle dated July 31, 2008 indicate that the Claimant's mother requested a letter stating

that the Claimant's shoulder problems were work related. Dr. Zirkle provided a letter dated July 31, 2008, which stated that claimant's shoulder injury might be related to the heavy lifting he does at work and that a workers' compensation evaluation should be considered. The Claimant delivered this letter to the employer.

10. Dr. Zirkle prepared a letter dated August 8, 2008 on behalf of the Claimant requesting a workers' compensation evaluation. In this letter, Dr. Zirkle concluded that claimant's condition is most likely related to heavy lifting at work.

11. Dr. Zirkle extended the Claimant's off work restriction through August 12, 2008. At all times, the Claimant provided his employer with statements from Dublin Primary Care related to physical and work restrictions, causation, and request for a worker's compensation evaluation.

12. No representatives or supervisors of the employer advised the Claimant that Dr. Zirkle was not an authorized treating physician despite receiving documentation from Dr. Zirkle concerning the Claimant's physical restrictions, restrictions from work, statements requesting a worker's compensation evaluation and opinions that the Claimant's left shoulder problems were work related. The employer did not provide a list of designated physicians for the Claimant. The employer failed to refer the Claimant to a physician. Claimant was impliedly authorized to choose a provider and he chose Dr. Zirkle.

13. The employer had sufficient knowledge that the Claimant presented with a lost time, work related injury. Mr. Martinez and Mr. Fuchs denied that the Claimant made any report of a work related injury in July 2008. This conflict is resolved in favor of the Claimant. Claimant's mother is a paralegal for a law firm that specializes in the defense of workers' compensation claims. The fact of this employment alone does not significantly impact the issue as to whether the Claimant suffered an occupational disease. Claimant's mother's status, however, makes it more likely that Claimant did report his left shoulder injury as work related. His mother requested a physician letter stating whether the injury was due to a work injury. It is unlikely that she obtained this letter and claimant failed to follow through to report a work injury. The evidence establishes that the Claimant provided his physician restrictions to the employer and reported his left shoulder injury to the employer as work related.

14. On August 5, 2008, the Claimant completed a Worker's Claim for Compensation identifying a left shoulder injury resulting from lifting heavy objects and repetitive motion during the course and scope of his employment. The Worker's Claim for Compensation identifies treatment at Memorial Hospital Urgent Care and Dublin Primary Care, Dr. Zirkle.

15. Pursuant to Dr. Zirkle's prescription and referral, the Claimant commenced physical therapy at Joint Effort Rehabilitation on August 8, 2008. The Claimant indicated that he was receiving therapy due to an injury at work with a date of injury identified as July 20, 2008. The Claimant incurred costs in the form of co-payments for treatment with Dr. Zirkle's office, Joint

Effort Physical Therapy and prescriptions.

16. As a result of the physical therapy, a TENS unit, medications, and work excuses, Claimant's left shoulder pain improved. The Claimant requested a release to return to work, which was provided by Dr. Zirkle effective August 13, 2008. Although his left shoulder had improved, the Claimant requested the return to work because he was afraid of losing his job. The Claimant returned to his regular, labor-intensive job duties as a material handler/warehouse worker.

17. On December 19, 2008, the Claimant returned to Dr. Zirkle with severe left shoulder pain. Dr. Zirkle's medical report states that the Claimant previously experienced some improvement in pain with physical therapy, but the pain increased and became constant, particularly with reaching overhead. Dr. Zirkle recommended an orthopedic referral.

18. The Claimant did not experience any new trauma or different symptoms in his left shoulder prior to his evaluation with Dr. Zirkle on December 19, 2008. Rather, the left shoulder pain and functional limitations were a progression of the problems previously noted and treated in July and August 2008.

19. The Claimant self-referred to Dr. Richman for an evaluation. Dr. Richman is an expert in physical medicine and rehabilitation and pain medicine. Dr. Richman is a Level II accredited physician for the State

of Colorado. Dr. Richman evaluated the Claimant on January 9, 2009. Dr. Richman's report of that date notes that the Claimant presented with constant shoulder pain, especially with heavy work. No prior or subsequent shoulder injuries were identified. The Claimant identified no specific incident or acute onset of shoulder pain, but stated that the pain appeared to be a more gradual onset with repeated heavy work and particularly overhead work as part of his job duties.

20. Dr. Richman's physical examination identified positive apprehension in abduction and external rotation. In addition to the apprehension sign, Dr. Richman conducted a relocation test, the results of which were positive. Dr. Richman testified that a positive apprehension and positive relocation test provides a good clinical sign that there is instability. Dr. Richman conducted an O'Brien's maneuver that was also positive. This maneuver isolates the anterior shoulder, directing pressure to the area where the labrum and the biceps followed by a rotation. The O'Brien's maneuver was positive for anterior shoulder pain and some clicking. Dr. Richman's clinical examination was consistent with a probable labral injury, possible rotator cuff injury along with some anterior instability. Specifically, Dr. Richman noted that the Claimant presented with a classic physical examination for a SLAP lesion, an anterior labral tear.

21. Dr. Richman provided a diagnostic impression of chronic left shoulder pain, most likely related to the Claimant's heavy and repetitive work. Dr. Richman stated that claimant's shoulder injury was a work related

condition to a reasonable degree of medical probability. Dr. Richman stated that there was a very high likelihood that claimant's work either directly caused or substantially aggravated this condition. The ALJ finds the testimony of Dr. Richman credible and persuasive.

22. On or about January 12, 2009, the Claimant delivered Dr. Richman's Attending Physician's Return to Work Recommendations to the employer along with the results of the left shoulder magnetic resonance image ("MRI") conducted on January 9, 2009. Subsequently, the employer referred the Claimant to Concentra Medical Center for evaluation.

23. The Claimant was evaluated by Dr. Malis at Concentra Medical Center on January 12, 2009. Dr. Malis' physical examination demonstrated decreased range of motion of the shoulder noted to abduction. The Claimant experienced pain during range of motion testing with positive impingement.

24. The employer prepared an employer's first report of injury and sent it to the insurer, who received it on January 13, 2009.

25. The insurer filed a Notice of Contest on January 16, 2009.

26. On January 20, 2009, the Claimant was evaluated by Dr. Wiley Jinkins, orthopedic surgeon, through Concentra Medical Centers. According

to Dr. Jinkins, the Claimant's left shoulder revealed all provocative testing for impingement to be positive. The diagnostic impression included post-traumatic supraspinatus tenosynovitis secondary to repetitive/cumulative trauma with MRI evidence of a possible labral tear. Dr. Jinkins provided an injection.

27. On January 23, 2009, the Claimant was evaluated by Dr. John Pak, orthopedic surgeon. The referral to Dr. Pak was authorized by Respondent's designated physician, Dr. Malis, per medical report of February 2, 2009. Dr. Pak, upon evaluating the Claimant and reviewing the MRI, provided a diagnostic impression of labral tear. Dr. Pak further concluded that "with the type of work that he does with heavy lifting, it is certainly reasonable with a lot of overhead activity that he could develop this and in all probability that with his activity mostly at work with heavy duty and nothing at home that is contributing to his pain." Dr. Pak recommended diagnostic arthroscopy and labral repair. Dr. Pak provided work restrictions including no overhead lifting for two weeks and no lifting over 25 pounds for two weeks.

28. On February 23, 2009, Dr. Malis reevaluated the Claimant, stating that the shoulder impingement and labral tear were medically probably work related.

29. The Claimant returned to Dr. Pak on March 3, 2009. Dr. Pak indicated that the Claimant's symptoms are not changed and there was still no authorization for surgery from the worker's compensation insurance carrier. Dr. Pak assigned physical restrictions of no more than 10 pounds overhead, no

more than 25 to 50 pounds of lifting.

30. In a letter dated August 29, 2009, Dr. Pak again concluded that the Claimant's injuries resulted from his work, particularly the type of work performed overhead with the use of the biceps tendon.

31. On March 17, 2009, Dr. Steinmetz conducted an independent medical evaluation at the request of Respondents. Dr. Steinmetz concluded that the Claimant's left shoulder problems are not related to his work activity for the employer. In support, Dr. Steinmetz notes that the Claimant had previously been treated at least twice, in 2001 and 2006, for left shoulder injuries and that these injuries could have caused all of the findings identified on the January 9, 2009 left shoulder MRI. Dr. Steinmetz also finds relevant a minor back injury sustained by the Claimant in January 2008 resulting from an episode of lifting carpet.

32. Based upon the testimony of the Claimant, Dr. Richman and the medical records of Dr. Zirkle, the ALJ finds that the Claimant's prior left shoulder injuries are not materially relevant to the current claim. On August 17, 2001, the Claimant reported to Dr. Zirkle left shoulder pain resulting from playing football. The Claimant was 13 years old. This was a one-time evaluation and the diagnosis was muscle injury, left shoulder. The Claimant's left shoulder injury in August 2006 was due to a work related event. Claimant, after two medical visits, was placed at maximum medical improvement with no impairment and no restrictions. The diagnosis was left shoulder strain.

33. An additional prior episode referenced by Dr. Steinmetz concerned a complaint of low back pain for which the Claimant reported to Dr. Zirkle on January 2, 2008. This event did not in any manner involve the Claimant's left shoulder and was a one-time evaluation with Dr. Zirkle with no further follow up for low back complaints.

34. In his medical report of April 15, 2009, Dr. Richman concluded that Dr. Steinmetz's report is "not at all credible." Dr. Richman concluded that the type of injury sustained by Claimant to his left shoulder is commonly caused by heavy and repetitive lifting, particularly that which requires strong contraction of the biceps, and which then leads to bicipital tendinosis and tearing of the labrum that is seen in a SLAP lesion. Dr. Richman noted that this is a common type of mechanism for this type of lesion seen on MRI. Again, Dr. Richman concluded that within a good degree of medical probability the Claimant's SLAP lesion is in fact directly related to the heavy and repetitive lifting that he was performing for the employer. Dr. Richman stated that, if Claimant had ongoing shoulder problems of a pre-existing nature, he would not have been able to work performing the heavy repetitive lifting for the employer.

35. Dr. Richman testified that he has never seen anyone just wake up with a labral tear. Dr. Richman also indicated that he considered the Claimant to be credible.

36. Dr. Malis, in her deposition testimony, concluded that Claimant's left shoulder injury is medically probably related to his work. Dr. Malis had previously made the same conclusion in her medical report of February 23, 2009. Dr. Malis stated that there was no MRI evidence to suggest that the Claimant's left shoulder condition was present prior to the current injury. Dr. Malis has experience in evaluating patients with injuries for which there is no specific trauma, where such patients have initially sought treatment through private physicians before proceeding for a worker's compensation evaluation. Dr. Malis concluded that the Claimant's actions in this regard were reasonable.

37. The Claimant was evaluated by Dr. Hattem through Concentra Medical Centers on June 11 and August 6, 2009. Dr. Hattem reviewed the medical records from Concentra, Dr. Zirkle, Dr. Richman, Dr. Pak, and Dr. Steinmetz. Dr. Hattem agreed with Dr. Richman's conclusion that Dr. Steinmetz's report was not credible and that the Claimant's left shoulder problems are work related.

38. Claimant has proven by a preponderance of the evidence that he suffered an occupational disease to his left shoulder arising out of and in the course of his employment with the employer. Claimant was not the most precise historian, but his testimony is credible that he suffered increasing left shoulder pain due to his heavy lifting and overhead reaching at his job for the employer. The testimony of Dr. Richman is credible and persuasive. The opinions of Dr. Richman, Dr. Malis, Dr. Hattem, and Dr. Zirkle are more persuasive than the opinions of Dr. Steinmetz. Respondents' persistent reference to the occupation of claimant's mother does not significantly impact

whether claimant suffered the occupational disease. Dr. Richman is persuasive that the previous left shoulder injuries are not materially relevant to the current claim. It is highly unlikely that claimant would be able to work for one year in his heavy lifting job with a labral tear without significantly increasing symptoms. It also is highly unlikely that claimant simply "awoke" with a labral tear in July 2008. The most probable explanation is that he suffered gradual tearing and bicep tendinosis due to his work activities. Even Dr. Steinmetz testified that claimant's lifting and reaching overhead would be a possible cause of his shoulder injuries. The claim is compensable.

39. Claimant has proven by a preponderance of the evidence that Concentra, Dr. Zirkle, Joint Effort, Dr. Pak, and their referrals are authorized providers for this work injury. The key issue of disputed fact is whether claimant reported his work injury to the employer in July 2008. Mr. Martinez and Mr. Fuchs both deny any such report. Claimant alleges that he made such a report, although he is extremely vague about the details. Claimant clearly informed Dr. Zirkle on July 28, 2008, that the left shoulder injury might be due to work. On this point, claimant's mother's status is probative and makes it more likely that claimant did report his left shoulder injury as work-related. She obtained an August 1 letter from Dr. Zirkle that the injury might be work related. Claimant clearly filed a workers' claim for compensation on August 5, 2008, although the record evidence does not demonstrate that the employer received a copy. Claimant clearly provided his physician restrictions to the employer and missed work. The most probable fact is that claimant did report his left shoulder injury to the employer on July 28, 2008, and the employer failed to

refer claimant to a physician. Claimant was impliedly authorized to choose a provider and he chose Dr. Zirkle. The insurer is liable for the bills of Dr. Zirkle and his referrals. Respondents agreed that they were liable for the bills of Concentra, Dr. Pak, and their referrals.

40. Claimant has failed to prove by a preponderance of the evidence that Dr. Richman and his referrals are authorized providers for this work injury. Claimant was impliedly authorized to choose Dr. Zirkle. Once he selected Dr. Zirkle, he was not free to change authorized providers without agreement of the respondents or an order. Claimant self-selected Dr. Richman. The fact that the employer did not subsequently object to Dr. Richman does not authorize that physician.

41. Claimant has proven by a preponderance of the evidence that he was unable to return to the usual job due to the effects of the work injury for the periods July 27 through August 12, 2008, and from February 3, 2009, and continuing.

42. Respondents have failed to prove by a preponderance of the evidence that claimant should be penalized for late reporting. Claimant was required to make a written report of the occupational disease within 30 days after the first distinct manifestation in late July 2008. Claimant made a timely report on July 28, 2008.

43. Claimant has failed to prove by a preponderance of the evidence that a

penalty should be imposed against the insurer for not filing a timely admission or notice of contest. Claimant confounds the duty of the employer to file a first report with the duty of the insurer to file an admission or contest. The only penalty at issue was the latter. The record evidence does not demonstrate that the insurer had notice of the report of injury until January 13, 2009. Ms. Sullivan then immediately prepared a notice of contest on January 16, 2009.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; see, Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844 (Colo. App. 2000); City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985); Pacesetter Corp. v. Collett, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office, 989 P.2d 251 (Colo. App. 1999); Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997), cert. denied September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark,

197 Colo. 306, 592 P.2d 792 (1979).

2. In this case, claimant alleges an occupational disease to his left shoulder. Section 8-40-201(14), C.R.S. defines "occupational disease" as:

[A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond that required for an accidental injury. An occupational disease is an injury that results directly from the employment or conditions under which work was performed and can be seen to have followed as a natural incident of the work. Section 8-40-201(14), C.R.S.; Climax Molybdenum Co. v. Walter, 812 P.2d 1168 (Colo. 1991); Campbell v. IBM Corporation, 867 P.2d 77 (Colo. App. 1993). An accidental injury is traceable to a particular time, place and cause. Colorado Fuel & Iron Corp. v. Industrial Commission, 154 Colo. 240, 392 P.2d 174 (1964); Delta Drywall v. Industrial Claim Appeals Office, 868 P.2d 1155 (Colo. App. 1993). In contrast, an occupational disease arises not from an accident, but from a prolonged exposure occasioned by the nature of the employment. Colorado Mental Health Institute v. Austill, 940 P.2d 1125 (Colo. App. 1997). Under the statutory definition, the hazardous conditions of employment need not be the sole cause of

the disease. A claimant is entitled to recovery if he or she demonstrates that the hazards of employment cause, intensify, or aggravate, to some reasonable degree, the disability. Anderson v. Brinkhoff, 859 P.2d 819 (Colo. 1993). As found, claimant has proven by a preponderance of the evidence that he suffered an occupational disease to his left shoulder

3. The insurer is liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988). The insurer is only liable for authorized or emergency medical treatment. See ß 8-42-101(1), C.R.S.; Pickett v. Colorado State Hospital, 32 Colo. App. 282, 513 P.2d 228 (1973). Under ß 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. See Gianetto Oil Co. v. Industrial Claim Appeals Office, 931 P.2d 570 (Colo. App. 1996); Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo. App. 1990). A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." Greager v. Industrial Commission, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. Greager, supra. As found, claimant has proven by a preponderance of the evidence that Dr. Zirkle is impliedly authorized. Consequently, Concentra, Dr. Zirkle, Joint

Effort, Dr. Pak, and their referrals are authorized providers for this work injury.

4. In order to change physicians, claimant has a statutory obligation to request that change in accordance with section 8-43-404(5)(a), C.R.S. Yeck v. Industrial Claim Appeals Office, 996 P.2d 228 (Colo. App. 1999). As found, claimant has failed to prove by a preponderance of the evidence that Dr. Richman and his referrals are authorized providers for this work injury.

5. Claimant was "disabled" within the meaning of section 8-42-105, C.R.S. and is entitled to TTD benefits. Culver v. Ace Electric, 971 P.2d 641 (Colo. 1999); Hendricks v. Keebler Company, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). As found, claimant was unable to return to the usual job due to the effects of the work injury for the periods July 27 through August 12, 2008, and from February 3, 2009, and continuing. Pursuant to the stipulation of the parties, the insurer is entitled to an offset in the amount of $252 per week for STD benefits received by claimant for all weeks of TTD through July 26, 2009.

6. As found, respondents have failed to prove by a preponderance of the evidence that a penalty should be imposed against claimant for late reporting.

Pursuant to section 8-43-102(2), C.R.S., claimant was required to make a written report of the occupational disease within 30 days after the first distinct manifestation in late July 2008. Actual knowledge by the employer is deemed notice to the employer. As found, claimant made a timely report to the employer on July 28, 2008.

7. As found, claimant has failed to prove by a preponderance of the evidence that a penalty should be imposed against the insurer for not filing a timely admission or notice of contest. Claimant confounds the duty of the employer in section 8-43-103(1), C.R.S., to file a first report of injury with either the insurer or the Division of Workers' Compensation with the duty of the insurer in section 8-43-203(1), C.R.S., to file an admission or contest. The only penalty at issue was the latter. Section 8-43-203(1), C.R.S., requires the insurer in this case to file an admission or contest within 20 days after the date that an employer's first report of injury is filed with the Division. The statute expressly provides that any knowledge by the employer is not imputed to the insurer. Consequently, unless the employer is self-insured, the duty to file the admission or contest arises only after the insurer has notice of the report of injury. As found, the record evidence does not demonstrate that the insurer had notice of the claim until January 13, 2009. The insurer then immediately prepared a notice of contest on January 16, 2009.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary

medical treatment from authorized providers for this work injury, including Concentra, Dr. Zirkle, Joint Effort, and Dr. Pak, and their referrals.

2. Claimant's claim for payment of the medical bills of Dr. Richman and his referrals is denied and dismissed.

3. The insurer shall pay to claimant TTD benefits at the stipulated rate of $263.96 for the periods July 27 through August 12, 2008, and from February 3, 2009, and continuing until modified or terminated according to law. The insurer is entitled to an offset in the amount of $252 per week for STD benefits received by claimant for all weeks of TTD through July 26, 2009.

4. Respondents' request for a penalty against claimant for late reporting is denied and dismissed.

5. Claimant's request for a penalty against the insurer for not filing a timely admission or notice of contest is denied and dismissed.

6. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

7. All matters not determined herein are reserved for future determination.

DATED: November 25, 2009 /s/ original signed by:_____

Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-796-763

ISSUES

The issues for determination are responsibility for termination of employment and temporary disability benefits.

FINDINGS OF FACT

1. On June 20, 2009, Claimant sustained an injury to his right ring finger. Respondents filed an amended general admission of liability admitting for temporary total disability benefits commencing June 21, 2009.

2. On June 20, 2009, Claimant provided a urine sample at Emergicare Medical Clinics. On June 24, 2009, the urine drug screen results showed that Claimant had tested positive for "cannaboids/THC".

3. It is the policy of Employer to terminate an employee who tests positive for illicit drugs or alcohol. On June 29, 2009, Employer terminated Claimant's employment because of the positive drug test.

4. Claimant admitted to safety medic Bourgeois that he had been smoking marijuana.

CONCLUSIONS OF LAW

The termination statutes, Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., provide: “In cases where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury.”

Respondents bear the burden of proving by a preponderance of the evidence that Claimant was terminated for cause or was responsible for his separation from employment. Gilmore v. Industrial Claim Appeals Office, 187 P.3d 1129, 1132 (Colo. App. 2008). Respondents must show that Claimant committed a volitional act or exercised control over the circumstances of his termination and that the act precipitating his termination was one he should reasonably expect to result in the loss of employment. Michelle Richardson v. Larimer County, W.C. No. 4-507-367 (ICAO, June 24, 2003); see also Gilmore, 187 P.3d at 1131.

Claimant admitted that he had been smoking marijuana and Claimant tested positive for “cannaboids/THC.” Claimant was terminated on June 29, 2009, pursuant to Employer’s policy to terminate an employee who tests positive for illicit drugs or alcohol.

Claimant’s marijuana use was a volitional act over which he had control. Claimant was aware of Employer’s policy to terminate an employee who tests positive for illicit drugs and should reasonably have expected that using marijuana would result in the loss of employment.

Claimant was responsible for the termination of his employment. Insurer is not liable for temporary total disability benefits. Insurer may credit any temporary disability paid against any temporary or permanent disability benefits admitted or found to be due in the future.

ORDER

It is therefore ordered that Insurer is not liable for temporary disability benefits.

Issues not determined herein are reserved for future determination.

DATED: November 30, 2009

Bruce C. Friend, ALJ

Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-761-724

ISSUES

Whether Claimant has sustained a functional impairment above the level of the arm at the shoulder and should be entitlement to an award of whole

person permanent impairment.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant is employed as a truck driver for Employer. Claimant's job duties involve driving a tractor-trailer truck making deliveries of grocery items to local grocery stores. Claimant's job requires lifting up to 75 pounds. Claimant has worked for Employer for 4 Ω years.

2. Claimant sustained an admitted injury to his right shoulder on June 7, 2008. Claimant was referred by Employer for treatment at Concentra Medical Center where Claimant came under the treatment of Dr. James Fox, M.D. Dr. Fox later referred Claimant to Dr. John Papilion for surgery to his right shoulder.

3. Dr. Papilion performed surgery on August 28, 2008 consisting of an athroscopic right shoulder subacromial decompression and acromioplasty with resection of the distal clavicle and arthroscopic debridement of the glenoid labrum.

4. Following surgery, Dr. Papilion evaluated Claimant on January 8, 2009. Dr. Papilion noted that Claimant had good strength in the rotator cuff and no pain with cross-shoulder stretching of the acromino-clavicular joint. Dr. Papilion further noted that Claimant's examination was rather benign and recommended Claimant return to work at regular duty on a trial basis.

5. Dr. Fox evaluated Claimant on February 9, 2009. Dr. Fox noted that Claimant had been tolerating regular duty since January 9, 2009 with some occasional popping with movement and some minor pain, but otherwise was

doing well. Dr. Fox placed Claimant at maximum medical improvement and released Claimant to return to work with no permanent restrictions. Dr. Fox further commented, and it is found, that Claimant was able to perform his usual job activities with minimal to no discomfort.

6. Dr. Rachel Basse, M.D. performed a Division-sponsored independent medical examination of Claimant on May 20, 2009 at the request of Claimant. Dr. Basse noted that Claimant's primary pain was located primarily on the top of the right shoulder with some pain in the anterior area of the shoulder. Dr. Basse noted that Claimant would occasionally feel a pop in the shoulder with driving. Dr. Basse also noted that Claimant would occasionally get a stiff neck that he was usually able to stretch out and occasional, more rarely than the neck pain, spasm in the interscapular area on the right associated with right shoulder discomfort. On physical examination Dr. Basse found that Claimant was minimally tender in the upper neck midline and far lateral trapezius and upper interscapular area. Dr. Basse also found that Claimant's cervical range of motion was full and pain free. Dr. Basse did not provide opinions on whether Claimant had sustained any functional impairment of the trapezius or interscapular areas due to pain or whether Claimant had sustained any functional impairment above the level of the arm at the shoulder.

7. Dr. Robert Watson evaluated and examined Claimant at the request of Respondents on October 2, 2009. Dr. Watson noted Claimant to have pain in the area of the shoulder around the acromino-clavicular joint and over the distal aspect of the clavicle. Dr. Watson further noted, and it is found, that Claimant has bee able to resume all of his activities without limitation. Dr. Watson opined that Claimant did not have any impairment proximal to the

shoulder.

8. Dr. Watson testified that Claimant has a functional impairment of the shoulder that affects the use of the upper extremity. Dr. Watson stated that no functional limitations have been placed on Claimant's activities and that Claimant does not have any impairment above the shoulder level.

9. Dr. Ronald Swarsen, M.D. was called as a witness by Claimant at hearing and qualified as an expert in Occupational Medicine and as a Level II certified physician by the Division of Workers' Compensation. Dr. Swarsen did not physically examine Claimant. Dr. Swarsen provided testimony and illustration as to the anatomical location of the gleno-humeral joint, shoulder girdle, trapezius and scapular areas and the areas of the shoulder joint addressed by Dr. Papilion in his surgical procedure on Claimant's right shoulder. Dr. Swarsen testified that he defines functional impairment as meaning what is wrong with the anatomy that leads to inability to do something. Dr. Swarsen opined that Claimant has a functional impairment to the shoulder but acknowledge that neither Dr. Fox or Dr. Papilion had placed any functional limitations as to the anatomy he described in his testimony.

10. Claimant testified that he no longer carries objects on his shoulder because it causes pain to the top of the shoulder and has pain in his shoulder with lifting objects weighing 30 pounds overhead. Claimant has pain in between his neck and shoulder with turning his head to the right. Claimant has returned and continues working his full duty as a truck driver for Employer.

11. The ALJ finds the opinions of Dr. Watson to be more

credible and persuasive than those of Dr. Swarsen as to whether Claimant has sustained a functional impairment above the level of the arm at the shoulder under the facts of this case.

12. Respondents filed a Final Admission of Liability dated July 2, 2009 to admit for 15% impairment of the arm at the shoulder consisted with the report of Dr. Basse.

13. Claimant has failed to prove by a preponderance of the evidence that he has sustained a functional impairment above the level of the arm at the shoulder.

CONCLUSIONS OF LAW

14. The purpose of the Workers' Compensation Act of Colorado (Act), ßß8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

15. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece

of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

16. Section 8-42-107(1)(a), C.R.S. limits a claimant to a scheduled disability award if the claimant suffers an "injury or injuries" described in ß 8-42-107(2), C.R.S. 2004. Strauch v. PSL Swedish Healthcare System, 917 P.2d 366 (Colo. App. 1996). The term "injury," as used in ß 8-42-107(1)(a), refers to the situs of the functional impairment, meaning the part of the body that sustained the ultimate loss, and not necessarily the situs of the injury itself. Walker v. Jim Fuoco Motor Co., 942 P.2d 1390 (Colo. App. 1997). The term “injury” refers to the manifestation in a part or parts of the body that have been functionally impaired or disabled as a result of the industrial accident. Warthen v. Indus. Claim Appeals Office, 100 P.3d 581 (Colo. App. 2004). It is not the location of physical injury or the medical explanation for the “ultimate loss” which determines the issue. Blei v. Tuscorora, W.C. No. 4-588-628 (June 17, 2005).

17. Whether a claimant has suffered an impairment that can be fully compensated under the schedule of disabilities is a factual question for the ALJ, whose determination must be upheld if it is supported by substantial evidence. Walker v. Jim Fuoco Motor Co.,supra. That determination is distinct from, and should not be confused with, the treating physician's rating of physical impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (rev. 3d ed.) (AMA Guides). Strauch v. PSL Swedish Healthcare System, supra; see also City Market, Inc. v. Indus. Claim

Appeals Office, 68 P.3d 601, 603 (Colo. App. 2003)("The determination whether a claimant sustained a scheduled or nonscheduled injury is a question of fact or the ALJ, not the rating physician."). Kolar v. ICAO, 122 P.3d 1075 (Colo. App. 2005).

18. An injury involving the glenohumeral joint does not mandate conversion to whole person impairment. The fact that Claimant may have physical injury to structures found proximal to the arm does not compel a finding of functional impairment beyond the arm at the shoulder. Where the injury affected structures proximal to the arm and in the shoulder that resulted in functional impairment affecting the arm but did not extend beyond the shoulder the Claimant has failed to prove entitlement to whole person impairment. Lovett v. Big Lots, W.C. No. 4-657-285 (November 16, 2007), aff'd Lovett v. Indus. Claim Appeals Office, No. 07CA2375 (September 11, 2008) (not selected for publication). Although an impairment of the shoulder is not listed on the schedule of disabilities found at Section 8-42-102(2), C.R.S., damage to the structure of the shoulder may or may not reflect a "functional impairment" which is enumerated on the schedule of disabilities. Maree v. Jefferson County Sheriff's Department, W.C. No. 4-260-536 (August 6, 1998). Thus, the existence of damage to the structures of the shoulder or the glenohumeral joint does not compel a finding of a "functional impairment" in an area of the body not listed on the schedule of disabilities found in Section 8-42-107(2), C.R.S.

19. The mere fact that the shoulder joint does not physically function as it did before the injury or that a claimant experiences pain in the shoulder

joint does not, as a matter of law, establish that a claimant has proven a functional impairment beyond the arm. Ellison v. People's National Bank, W.C. No. 4-449-392 (January 7, 2002). Evidence of pain which restricts a claimant's ability to use a portion of the body located proximal to the arm at the shoulder is a relevant factor in determining whether a claimant has proven a functional impairment above the level of the arm at the shoulder. Guilotte v. Pinnacle Glass Company, W.C. No. 4-443-878 (November 20, 2001).

20. As found, Claimant has failed to prove by a preponderance of the evidence that he has sustained a functional impairment above the level of the arm at the shoulder. Dr. Swarsen's descriptive testimony regarding the anatomy of the shoulder joint and shoulder girdle and its relationship to the arm with specific reference to the areas addressed surgically or described in the physical examinations of other physicians fails to persuasively establish that Claimant has a functional impairment sufficient to entitle Claimant to an award of whole person impairment. As Dr. Swarsen acknowledges, although Claimant has injury or symptoms in areas of the shoulder joint or shoulder girdle that are proximal to the arm, and which were addressed surgically by Dr. Papilion, Claimant does not have any functional impairment on the use of these structures. Claimant is and remains capable to perform his usual full duty work without any limitations on the use of his right arm or any other area of his body, including any area proximal to the arm at the shoulder. While Claimant has some pain in areas of the neck and trapezius, Claimant has not proven by a preponderance of the persuasive evidence that this pain restricts Claimant's abilities to use these areas of the body and amounts to a functional impairment.

Dr. Basse's report contains no express opinion on whether Claimant has a functional impairment above the level of the arm at the shoulder and is therefore unpersuasive to support Claimant's burden of proof. Dr. Watson credibly opined, under the facts of this case, that Claimant does not have a functinonal impairment above the shoulder area that the ALJ infers refers to the level of the arm at the shoulder.

ORDER

It is therefore ordered that:

Claimant's claim for an award of whole person permanent impairment for his right shoulder injury is denied and dismissed.

Respondents admission for 15% impairment of the arm at the shoulder is made the order and award of the Court.

All matters not determined herein are reserved for future determination.

DATED: November 30, 2009

Ted A.

Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-773-953

ISSUES

[As originally framed in the initial order.]

The issues determined herein are compensability, average weekly wage, authorized medical benefits, temporary disability benefits and Claimant's request for penalties for Respondents' violations of C.R.S. 8-43-101, 18-43-203 and W.C.R.P. 5-2.

FINDINGS OF FACT

[As found in the original order with modifications in underline.]

1. Claimant was involved in a motorcycle accident in 1983. He suffered a crush injury to his left foot resulting in a partial amputation of the heel pad and a skin graft being placed directly over the bone.

2. Over the next twenty-five years, Claimant had residual symptoms, including stiffness and soreness in his foot and ankle. These symptoms increased with activity, particularly after a long shift at work. Despite these problems, Claimant was able to perform heavy work, mostly in the construction industry.

3. In July of 2004, Claimant obtained a position with the Respondent-Employer working in the oil fields in Trinidad. His primary duties consisted of operating and maintaining the various types of heavy machinery associated with the oil wells. His job required heavy lifting, as well as frequent standing and walking in rough conditions. He usually worked twelve hour shifts

4. In addition to the soreness and stiffness, Claimant had occasional cuts to the skin graft area. Until 2005, however, the problems with

the graft area were minimal and did not require any medical intervention or cause any disability.

5. In 2005, when he was showering after work, Claimant noticed a cut on his heel. He was unable to pinpoint an exact cause for the cut but he suspected that he had gotten a rock in his boot. This cut was significant and he obtained medical treatment from Dr. Russell De Groote. Claimant consequently missed several weeks from work. The cut healed completely after approximately ten weeks, and Claimant was able to return to work without restrictions. He did not need surgery or any other medical treatment at that time.

6. On May 31, 2008, Claimant volunteered to work an extended shift. At the beginning of the shift, his skin graft was intact without any cuts, ulcers or abrasions. His job duties required significant walking over rough terrain. He worked a total of 42 hours between May 31 and June 1, 2008.

7. After about twenty hours, Claimant began to suffer an increasing discomfort in his foot. After about thirty hours, Claimant removed his boot and discovered an open cut on his skin graft.

8. Dr. De Groote stated in his report that he would not expect Claimant's skin graft to break down without some type of intervening cause. It is Dr. De Groote's opinion that Claimant's work activities on May 31 and June 1, 2008 aggravated or accelerated his pre-existing condition. Dr. De Groote is the physician most familiar with Claimant's condition both before and after the date of injury and his medical evidence is persuasive.

9. Dr. Arnold's opinion to the contrary is not consistent with the factual or medical evidence in the record. It is not persuasive.

10. It is more likely than not that Claimant suffered an aggravation

of his pre-existing foot injury that was caused by his work duties on May 31 and June 1, 2008.

11. The conditions of employment were the direct cause of the injury. Under these circumstances, the "special hazard" rule does not apply.

12. Claimant had the next day off and returned to work on June 3, 2008. He attempted to perform his duties but was unable to do so because of the condition of his foot. He reported the injury to his immediate supervisor and was directed to the onsite clinic.

13. The nurse practitioner, Candice Ferguson, examined Claimant and referred him to Dr. Russell De Groote. When the injury did not heal, Dr. De Groote referred Claimant to Dr. Kessler for a surgical evaluation. Dr. Kessler in turn referred him to Dr. Wade Smith who called in Dr. Kagan Ozer to perform surgery. These providers are all authorized.

14. Ms. Ferguson also completed a Physician's Report of Workers' Compensation injury and submitted it to Claimant's senior supervisor on June 3, 2008. The Respondent-Employer had written notice of the injury and Claimant's physical restrictions on June 3, 2008. The Respondent-Insurer had notice of the lost time claim no later than October 24, 2008 when it received the Application for Hearing as evidenced by its date stamped copy.

15. The Respondent-Employer was unable to accommodate Claimant's physical restrictions. He has not worked since the date of injury. Respondents have stipulated that Claimant is entitled to temporary disability from June 3, 2008 forward.

16. Respondents have further stipulated that Claimant is entitled to the maximum disability rate. The maximum disability rate for the date of

injury is $753.41.

17. Respondents should have filed a First Report of Injury no later than June 16, 2008. They have not done so to date. Respondents have continued to be in violation of CRS 8-43-101 and W.C.R.P. 5-2. up to the date of hearing, February 18, 2009. Respondents were in violation C.R.S. 8-43-101 and W.C.R.P. 5-2 for a period of 247 days.

18. Respondents should have filed an admission or denial of the claim no later than twenty days after the First Report of Injury was filed or due. Since the report was not filed timely, the due date of June 16, 2008 is the starting point. Therefore, the admission or denial was due no later than July 6, 2008. The Notice of Contest was not filed until February 11, 2009. Respondents appear to have been in violation C.R.S. 8-43-203 and W.C.R.P. 5-2 for a period of 220 days. However, based upon the finding above that the Respondent-Insurer had notice no later than October 24, 2008, the Respondent-Insurer's actual violation begins on that date. Thus, the Respondent-Insurer was in violation for a period of 110 days.

19. The Respondents' failure to file a First Report of Injury and failure to file an admission or denial of the claim until February 11, 2009 was not objectively reasonable.

[Additional findings of fact in support of the instant order.]

20. On June 4, 2008 the day after NP Ferguson first saw Claimant, she indicated on a note that the Safety Department had determined that Claimant's condition was not work-related under OSHA standards. The note indicates that Claimant's supervisor was informed and that the supervisor was to

inform the Claimant.

21. A few days later Claimant spoke with his Supervisor Phil Mandrell and there was a discussion over whether or not the condition was work-related. Mandrell verbally notified Claimant that he did not have a "legitimate workers' compensation claim."

22. Much confusion existed concerning Claimant's condition based upon the widespread knowledge by the supervisors of Claimant's previous off-duty injury to his heel.

23. The ALJ finds that neither the Respondent-Employer collectively, or as an entity, or any of the Respondent-Employer's personnel involved in reviewing Claimant's situation, intended to improperly deprive Claimant of benefits under the Workers' Compensation Act of Colorado. However, based upon the totality of circumstances the ALJ finds that an objective Respondent-Employer should have known that Claimant's workers compensation claim should have been properly processed through the system.

24. Respondents have presented credible, but not persuasive evidence, that their inaction in failing to comply with the law was objectively reasonable.

25. Claimant's attorney filed the first claim for Workers Compensation benefits on Claimant's behalf on October 15, 2008.

26. Claimant has suffered a loss of income subsequent to his short-term disability benefits expiring. As a result, he has experienced stress regarding his financial situation.

CONCLUSIONS OF LAW

[As found in the original order.]

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; see, Faulkner v. Industrial Claim Appeals Office, 12 P.3d 844 (Colo. App. 2000); City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985); Pacesetter Corp. v. Collett, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a Workers' Compensation case are not interpreted liberally in favor of either Claimant or Respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (1979). A preexisting condition does not disqualify a Claimant from receiving Workers' Compensation benefits. Rather, where the industrial injury aggravates, accelerates, or combines with a preexisting disease or infirmity to produce the need for treatment, the treatment is a compensable consequence of the industrial injury. H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990). As found, it is more likely than not that Claimant suffered an aggravation of his pre-existing foot injury that was caused by his work duties on May 31 and June 1, 2008.

2. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988). The Respondents are only liable for authorized or emergency medical treatment. See ß 8-42-101(1), C.R.S.; Pickett v. Colorado State Hospital, 32

Colo. App. 282, 513 P.2d 228 (1973). Under ß 8-43-404(5), C.R.S., the Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the Respondents have exercised their right to select the treating physician the Claimant may not change physicians without permission from the insurer or an ALJ. See Gianetto Oil Co. v. Industrial Claim Appeals Office, 931 P.2d 570 (Colo. App. 1996); Sims v. Industrial Claim Appeals Office, 797 P.2d 777 (Colo. App. 1990). A physician may become authorized to treat the Claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." Greager v. Industrial Commission, 701 P.2d 168 (Colo. App. 1985). As found, Candice Ferguson, Dr. Russell De Groote, Dr. Charles Kessler, Dr. Wade Smith, and. Kagan Ozer are authorized providers.

3. Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused Claimant to leave work, and Claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. PDM Molding, Inc. v. Stanberg, 898 P.2d 542 (Colo. 1995). Respondents have stipulated the Claimant is entitled to temporary total disability benefits from the date of injury forward.

4. C.R.S 8-34-101 requires employers to notify the Division of Workers' Compensation within 10 days of knowledge that an employee has suffered an injury that results in lost time in excess of more than three shifts or calendar days using the forms prescribed by the Division. W.C.R.P. 5-2 has a similar requirement but specifies the notification shall be in the form of a First Report of Injury. The Rule also requires such a report to be made within

10 days of notice or knowledge of a claim for benefit that has been denied for any reason. As found, Respondents were required to file the first report of injury by June 15, 2008 and have failed to do so to date.

5. Section 8-43-304(1), C.R.S., 2008, states that an insurer or self-insured employer who “violates any provision” of Articles 40 to 47 of Title 8 “shall . . . be punished by a fine of not more than $500.00 per day for each such offense”. Section 8-43-304(1) also requires punishment when an insurer or self-insured employer “fails or refuses to perform any duty lawfully enjoined within the time prescribed by the Director or panel, for which no penalty has been specifically provided or fails, neglects or refuses to obey any lawful order made by the Director or panel or any judgment or decree made by any court as provided by said articles shall be subject to such order being reduced to judgment by a court of competent jurisdiction and shall also be punished by a fine of not more than five hundred dollars per day for each such offense, seventy-five percent payable to the aggrieved party and twenty-five percent to the subsequent injury fund created in section 8-46-101". In Diversified Veterans Corporation Center v. Hewuse, 942 P.2d. 1312 (Colo. App. 1997), the Court of Appeals determined that failure to comply with the Workers’ Compensation Rules of Procedure has been determined to constitute a failure to perform a “duty lawfully enjoined” within the meaning of section 8-43-304(1). Thus, the Respondents’ violation of the Rules of Procedure fall under ß8-43-304(1).

6. Before penalties may be imposed under ß8-43-304(1), a two-step process must be met. First, the ALJ must determine whether the disputed conduct constituted a violation of the Act, of a duty lawfully enjoined, or of an order. If the Administrative Law Judge concludes that there is such

violation, the ALJ may impose penalties if he also finds that the Respondents' actions were objectively unreasonable. Allison v. Indus. Claim Appeals Office, 916 P.2d 623 (Colo. App. 1995). As found, Respondents are and continue to be in violation of CRS 8-43-101 and W.C.R.P. 5-2 and their actions were not objectively reasonable. The violation began on June 15, 2008 and is continuing.

7. C.R.S. 8-43-203 and W.C.R.P. 5-2 requires the employer or the insurance carrier to file an admission or a denial of the claim within 20 days of the date the first report of injury should have been filed with the Division. Failure to do so may result in a penalty of one day's compensation for each day's failure to notify. As found, Respondents violated these provisions and their actions were not objectively reasonable. The violation began July 5, 2008 and ended February 18, 2009.

[Additional conclusions in support of the instant order.]

8. The moving party for a penalty bears the burden of proving that a party failed to take an action that a reasonable party would have taken. City and County of Denver v. Indus. Claim Appeals Office, 58 P.3d 1162, 1164-65 (Colo.App.2002). Once the prima facie showing of unreasonableness has been made, the burden of persuasion shifts to the party who committed the alleged penalty to show that the conduct was reasonable under the circumstances. Postlewait v. Midwest Barricade, 905 P.2d 21, 23 (Colo. App. 1995).

9. The amount of penalties to be awarded under section 8-43-304(1) are discretionary even if the ALJ finds that there has been a violation of the Act or Rules, and that violation was not reasonable under an objective standard.

10. The ALJ concludes that Respondent-Employer held a good faith

belief that the claim was not a compensable work-related injury, and therefore did not need to be processed as such. This good faith belief does not excuse the failure to follow the law and rules in terms of reporting the injury and with following up with a denial or admission once it is alleged to be a work-related injury. It does however mitigate the amount of penalties to be imposed.

11. Respondents did in fact contest the compensability of the claim and provided medical expert testimony in support of their position. Respondents vigorously defended the position that Claimant's condition arose from a prior injury sustained by the Claimant years before.

12. Additionally, although the Claimant reported orally to a supervisor that he injured himself there was no written claim filed by the Claimant until his attorney filed a Workers Claim for Compensation, which was received by the Division of Workers' Compensation on October 15, 2008. The WC 164 form filled out by NP Ferguson was sufficient however in providing the written notice of injury required by section 8-43-102(1)(a).

13. Claimant argues that it was a deliberate and intentional refusal to follow the law on the part of the Respondent-Employer.

14. C.R.S 8-34-101 requires employers to notify the Division of Workers' Compensation within 10 days of knowledge that an employee has suffered an injury that results in lost time in excess of more than three shifts or calendar days using the forms prescribed by the Division. W.C.R.P. 5-2 has a similar requirement but specifies the notification shall be in the form of a First Report of Injury. The Rule also requires such a report to be made within 10 days of notice or knowledge of a claim for benefit that has been denied for

any reason. The ALJ concludes that the actions required to violate either the statute or the Rule, are substantially the same and thus constitute a single violation.

15. C.R.S. 8-43-203 requires the employer or the insurance carrier to file an admission or a denial of the claim within 20 days of the date the first report of injury should have been filed with the Division. Failure to do so may result in a penalty of one day's compensation for each day's failure to notify. In the instant case, the First Report of Injury should have been filed no later than June 16, 2008. Respondents admit that they failed to file an admission or denial until the Notice of Contest dated February 11, 2009.

16. Claimant argues that it was a deliberate and intentional refusal to follow the law on the part of the Respondent-Employer. Claimant argues that the most important consideration is the nature of the violation. Claimant then points out the Respondent-Employer is an international corporation based out of Texas. Claimant argues that the Respondent-Employer apparently decided that it was above the laws of the State of Colorado. Claimant argues that Respondent-Employer
also decided that it could act as its own ALJ, and make its own determinations as to which claims are compensable. The result is an underreporting of potentially work-related injuries. The other result is that [Respondent-Employer's] employees are not informed of their right to request a hearing on the issue compensability. Doubtless, there are many claims that would ultimately be found compensable. [Respondent-Employer's] employees are being denied benefits because of the Respondent-Employer's refusal to follow the law. This is not a case where there was only a technical error, mistake,

or a short delay. Rather, it was a deliberate and intentional refusal to follow the law on the part of the [Respondent-Employer]. The maximum penalty should be imposed to punish its behavior and deter such conduct in the future.

This is also not a case where the claimant has suffered no harm as a result of the violation. [Claimant] has suffered a loss of income since his short-term disability benefits expired. As a result, he is experience[ing] considerable stress regarding his financial situation. In particular, he was on the verge of losing his house, and he suffered damage to his credit rating. In addition, since he did not have any income when his health insurance expired he was unable to pay the cost of continuing the insurance. He now has no insurance to cover any health problems that are not related to this claim.

Finally, Respondents have made no attempt to mitigate the damages even after the issue of penalties was endorsed. They still have not filed the required First Report of Injury to this day. This again demonstrates their contempt for this Court, the Workers' Compensation system and the laws of the State of Colorado. As stated above, [Respondent-Employer] is a large multinational corporation, with an operating budget of millions of dollars. [Respondent-Insurer] is a wholly owned subsidiary of [an Insurance Company]. It is another large corporation with a long history of violating the statute and rules of procedure. The only means to hold these companies accountable is to impose the maximum penalty of $500 per day from June 15, 2008 and continuing until the date first report of injury is filed.

17. The ALJ concludes that, with little exception, the record does not support the arguments of the Claimant. For example, the record is devoid of sufficient credible evidence as to the size of the Respondent-Insurer and

Respondent-Employer. Assuming arguendo, Claimant is correct about the size of the entities, there is no logical or legal reason to assume ipso facto that because of their size they therefore intentionally violated the law.

18. The ALJ also concludes that sufficient evidence of record is lacking to show that Respondent-Employer engages in a systematic practice of illegally denying workers' compensation claims. The ALJ concludes that if it were shown that Respondent-Employer engaged in such behavior, one of the effects would be that employees would not be told of their right to request a hearing on compensability. However, the ALJ concludes that the evidence making up the house of cards, upon which that argument is dependent, is ill equipped to support the weight of such an argument. The ALJ concludes that the credible evidence of record does not support the notion that Respondent-Employer acted intentionally to deprive Claimant of his benefits under the workers' compensation act. The ALJ concludes that Respondent-Employer acted out of a misguided subjective belief, albeit not objectively reasonable, that the claim was not a workers' compensation injury and that the Claimant was required to obtain his own medical care.

19. Claimant has suffered a loss of income subsequent to his short-term disability benefits expiring. As a result, he has experienced stress regarding his financial situation.

20. Respondents have not filed the required First Report of Injury up to and including the date of hearing.

21. The ALJ concludes that the facts hereunder do not require that the maximum penalty be imposed for the Respondent-Employer's failure to admit or deny liability as required under the statute. Claimant was provided with actual

notice of the denial of the claim through the supervisor. While this does not cure the violation it does mitigate the effects of the failure. By failing to follow the statute's mandate it did deprive Claimant of the appropriate notice that he could file an application for an expedited hearing. The ALJ concludes that that was not the intent of the Respondent-Employer.

22. Section 8-43-203 indicates that it is the insurer's responsibility to admit or deny liability within certain timeframes. However, the section also indicates that the insurer is not charged with knowledge of the Respondent-Employer. Thus, the earliest date that the evidence supports knowledge by the Respondent-Insurer is October 24, 2008.

23. The maximum penalty is one day's compensation for each day's failure to admit or deny. Claimant computes the maximum penalty to be $25,938.83. The ALJ concludes the maximum penalty available is $11,807.40. This is computed by taking the stipulated weekly compensation of $753.41, multiplying it by 52, and dividing that result by 365. The result gives you the daily compensation rate. This is then multiplied by the number of days of violation by the Respondent-Insurer of 110 to give the result of $11,807.40.

24. In arriving at an ultimate penalty for this violation, the ALJ takes into consideration the Claimant's actual knowledge at the time the violation began that his claim was denied and he had retained counsel in the matter. It would appear that an admission or denial at that juncture would serve little purpose. This does not excuse the conduct but does mitigate the conduct. The ALJ concludes that based upon a totality of the circumstances a penalty of twenty dollars ($20.00) per day is appropriate to address the violation of section 8-43-203. $20.00 multiplied by the number of days of

violation amounts to a total penalty of $2,200.00. The ALJ concludes that this is an appropriate balance of the interests of all parties. The penalty is reached in an effort to compensate Claimant for the violation, and to deter future misapplication of the law by the Respondents and other similarly situated employers and insurers.

25. In the ALJ's original order in this matter the ALJ combined all of the penalties into a single unapportioned amount and ordered that the Claimant receive seventy-five percent of the penalties imposed and the subsequent injury fund the remaining twenty-five percent. In doing so the ALJ misapplied that portion of the statute requiring that a penalty under section 8-43-203 be paid fifty percent to the Claimant and fifty percent to the subsequent injury fund. Thus, the ALJ orders that fifty percent of the penalty of $2,200.00, or $1,100.00, be paid to the Claimant and the remaining fifty percent or $1,100.00 be paid to the subsequent injury fund.

26. The maximum penalty for the violation of section 8-43-101, and Rule 5-2 as applied through section 8-43-304 is $500.00 per day. As found the ALJ considers this a single violation. Up to the date of hearing Respondents were in violation for a total of 247 days.

27. The ALJ is cognizant of the fact that section 8-43-304 provides a catchall provision to impose penalties not otherwise specified. Thus, by its nature, not every violation that is penalized through the use of section 8-43-304 is of the same gravity. The ALJ concludes that a violation of section 8-43-101 under the totality of the circumstances herein, is adequately addressed by a penalty of $9.00 per day for a total penalty of $2,223.00 is appropriate to address the violation of section 8-43-101 and Rule 5-2, to compensate Claimant

for the violation, and to deter future misapplication of the law by the Respondents and other similarly situated employers and insurers.

28. The ALJ orders that seventy-five percent of the penalty of $2,223.00 or $1,667.25 be paid to the Claimant and the remaining twenty-five percent, or $555.75, be paid to the subsequent injury fund.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of Claimant's reasonably necessary medical treatment from authorized providers, including Candice Ferguson, Dr. Russell De Groote, Dr. Charles Kessler, Dr. Wade Smith, and Dr. Kagan Ozer

2. Respondents shall pay to Claimant TTD benefits at the rate of $753.41 per week from June 3, 2008 until terminated by law.

3. Respondent-Insurer shall pay a penalty in the amount of $2,200.00 of which $1,100.00 shall be payable to the Claimant and $1,100.00 shall be payable to the subsequent injury fund.

4. Respondents shall pay a penalty in the amount of $2,223.00 of which $1,667.25 shall be payable to the Claimant and $555.75 shall be payable to the subsequent injury fund.

5. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

6. All matters not determined herein are reserved for future determination.

Date: November 30, 2009/s/ original signed by:

Donald E. Walsh

Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

[1] Exhibit 13, p. 3, first paragraph.