OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-799-318

ISSUES

Whether the surgery to the Claimant's right wrist recommended by Dr. Kavi Sachar, M.D. is reasonable, necessary and causally related to an admitted injury to the wrist on July 20, 2009.

FINDINGS OF FACT

1. Claimant was employed by Employer as a field technician. Claimant's job duties included testing of soil, concrete and asphalt for moisture content and densities. In connection with these job duties Claimant used a nuclear gauge that was kept in a containment box. Claimant's job duties required him to load the containment box with the gauge weighing 60# into his company truck at the beginning of each days work shift.

2. Claimant sustained an admitted compensable injury on July 20, 2009. On that date, Claimant was in the process of loading the containment box into the bed of his company pickup truck when he experienced a sudden onset of pain in his right wrist followed by immediate swelling.

3. Claimant was using both hands to load the containment box into the bed of his truck. Claimant's left hand was placed on a handle at the side of the containment box and Claimant's right hand was on a handle on the top of the box. Claimant noticed the pain in his wrist as he was lifting the box and had it within 1 inch of the tailgate to the bed of his truck. When Claimant experienced the pain in his right wrist he then dropped the box to the ground.

4. Claimant reported the injury to Employer and was referred to Concentra Medical Centers for evaluation and treatment. Claimant was initially evaluated by Physicians' Assistant Glenn Petersen on July 20, 2009. Upon physical examination PA Petersen found very limited movement of the right wrist with soft tissue swelling and tenderness in the snuffbox area. PA Petersen also noted on examination that Claimant had an enlarged knuckle at the right 3d MCP joint and the PIP joint of the 3d finger. X-rays were done that showed significant degenerative joint disease in the right wrist.

5. Claimant was referred by physicians at Concentra for an MRI of the right wrist that was done on July 28, 2009. The MRI of the right wrist showed moderate to severe degenerative changes and findings compatible with chronic scapholunate ligament disruption. There was no convincing evidence on the MRI for an acute fracture within the right wrist.

6. Claimant was evaluated for consultation on August 17, 2009 by Dr. Kavi Sachar, M.D., a hand surgeon. Dr. Sachar noted that the diagnostic studies had confirmed advanced arthritis in the right wrist. Dr. Sachar injected the right wrist and opined that if the injection gave some short-term relief consideration could be given for arthroscopic debridement as it was Dr. Sachar's opinion that Claimant had sustained an acute injury "on top of his arthritic wrist".

7. Dr. Sachar evaluated Claimant again on August 31, 2009. Dr. Sachar noted that the injection had not provided relief. However, Dr. Sachar further noted that Claimant had not had an MRI to specifically look at the 3d MCP joint region and Dr. Sachar ordered an MRI of that region.

8. The MRI of the 3d MCP joint region of Claimant's right hand/wrist was done on September 10, 2009. The MRI showed a focal predominantly cystic appearing lesion within the overlying subcutaneous tissue of the third metacarpal joint which the radiologist ready a reflecting a bursal collection or an inclusion cyst. The MRI also showed a prominent osseous protuberance projecting from the dorsal aspect of the third metacarpal head that was thought to presumably reflect an osteophyte given the arthritic changes within the joint.

9. Dr. Sachar again evaluated Claimant on September 14, 2009 and reviewed the results of the recent MRI. Dr. Sachar opined that Claimant had what appeared to be an inclusion cyst over the right middle finger metacarpal. Dr. Sachar further noted that Dr. Kohake had tried to aspirate the dorsal aspect of the middle finger and obtained some whitish fluid. Dr. Sachar felt this was consistent with a possible inclusion cyst that occurred from Claimant's injury on July 20, 2009. Dr. Sachar proposed a right wrist arthroscopy with debridement and mass excision from the middle finger.

10. Claimant was evaluated by Dr. John Burris, M.D. on September 24, 2009. Dr. Burris reviewed the findings from the previous treatment and evaluation by Dr. Sachar. Dr. Burris opined that the recommended surgical intervention was reasonable.

11. Claimant's treatment was then transferred to Dr. Andrew Plotkin, M.D. Dr. Plotkin evaluated Claimant on November 24. 2009. On visual examination Dr. Plotkin noted a focal cystic swelling over the third metacarpalphalngeal joint. Dr. Plotkin's assessment included "cystic mass, right third metacarpalphalangeal joint with extension along the third metacarpal. Dr. Plotkin authored a letter report dated December 7, 2009 to a representative of the Insurer. In this report Dr. Plotkin noted that Claimant had significant, pre-existing degenerative joint disease of the right wrist. Dr. Plotkin also opined that Claimant had had a significant aggravation of his underlying condition. With regard to the recommended surgery, Dr. Plotkin opined that it was not directed at improving the underlying condition but rather to return Claimant to his baseline status. Dr. Plotkin stated that he was in agreement with Dr. Sachar's recommendation for arthroscopic surgery.

12. Dr. Jonathan Sollender, M.D. performed a medical record review at the request of Respondents. Dr. Sollender testified at hearing and was qualified as an expert in the areas of hand and general surgery.

13. In his record review, Dr. Sollender noted the presence of the pre-existing degenerative changes in Claimant's right wrist. Dr. Sollender stated that there was no doubt that Claimant aggravated the existing arthritic process. However, Dr. Sollender felt that the inclusion cyst was not likely to have occurred following the work injury. Dr. Sollender opined that the recommended surgery was not related to the work injury.

14. At hearing, Dr. Sollender testified, and it is found, that inclusion cysts are small growths under the skin that can originate in a joint and work outward and that occur with arthritis. Dr. Sollender testified that he did not believe that the described mechanism of injury would cause the inclusion cyst in Claimant or aggravate or accelerate the underlying degenerative changes in the wrist as it was his opinion that the mechanism of injury placed more torque or force on the left wrist and that there was not sufficient force on the right wrist to cause the inclusion cyst or aggravate the underlying degenerative changes. Dr. Sollender opined that Claimant was a surgical candidate for the underlying degenerative changes in his right wrist before the July 20, 2009 injury and remained a surgical candidate after the injury.

15. Claimant testified that prior to the injury on July 20, 2009 he did not have any pain in his right wrist/hand and was able to perform all activities of his job without limitation. Claimant further testified that the bumps, or protrusions/prominences, on his right middle finger were not present prior the injury. The ALJ finds Claimant's testimony to be credible. Claimant is right hand dominant.

16. The ALJ finds persuasive Dr. Sollender's testimony that the injury of July 20, 2009 did not aggravate or accelerate the significant pre-existing degenerative arthritic changes in Claimant's right wrist. Dr. Sollender's opinion that Claimant was a surgical candidate for these changes before the occurrence of the July 20, 2009 injury and remains so after the injury is also credible and persuasive.

17. The ALJ resolves the conflict between the opinions of Dr. Sachar, Dr. Plotkin and Dr. Sollender with respect to the causation of the inclusion cyst in the right 3d metacarpalphalangeal joint in favor of the opinions of Dr. Sachar and Dr. Plotkin that the occurrence of the inclusion cyst is causally related to the injury of July 20, 2009. The mechanism of injury as described by Claimant would have placed the primary force for lifting the 60-pound containment box on Claimant's right hand/wrist as that was the hand placed on the top handle of the box. The ALJ finds that Claimant would have been using his left wrist primarily to steady the lift of the box into the bed of his truck given that Claimant is right hand dominant.

18. Claimant has proven by a preponderance of the evidence that the

arthroscopic surgery for debridement and mass excision of the inclusion cyst proposed by Dr. Sachar is reasonable, necessary and related to the injury of July 20, 2009. Claimant has failed to prove by a preponderance of the evidence that surgery to address the degenerative arthritic changes in Claimant's right wrist, although reasonable and necessary, is causally related to the effects of the July 20, 2009 work injury. The work injury of July 20, 2009 did not aggravate or accelerate these changes such as to cause the need for medical treatment and surgery for the degenerative changes.

CONCLUSIONS OF LAW

19. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *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*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

20. 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. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. Section 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Appeals Office*, 12 P3d 844, 846 (Colo. App. 2000).

22. The evidence must establish the causal connection with reasonable probability, not medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission, 491 P.2d 106 (Colo. App. 1971)*. Reasonable probability exists if the proposition is supported by substantial evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding. *F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985)*. An award of benefits may not be based upon or denied upon speculation or conjecture. *Deines Bros. v. Indus. Comm'n,* 125 Colo. 258, 242 P.2d 600 (1952); *Indus. Comm'n v. Havens,* 136 Colo. 111, 134 P.2d 698 (1957).

23. Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192

(Colo. App. 2002).

24. The fact that the claimant suffers from a preexisting condition does not, of course, disqualify the 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. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). However, the mere occurrence of a compensable injury does not require an ALJ to find that all subsequent medical treatment and physical disability was caused by the industrial injury. To the contrary, the range of compensable consequences of an industrial injury is limited to those which flow proximately and naturally from the injury. Standard Metals Corp. v. Ball, 172 Colo. 510, 474 P.2d 622 (1970); Section 8-41-301(1)(c), C.R.S. 1997.

25. It is the claimant's burden to prove a causal relationship between the industrial injury and the medical condition for which he seeks benefits. Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997). The question of whether an industrial injury is the cause of a subsequent need for medical treatment is largely one of fact for determination by the ALJ. City of Durango v. Dunagan, 939 P.2d 496 (Colo. App. 1997).

26. As found, Claimant has proven that the arthroscopic surgery recommended by Dr. Sachar is reasonable, necessary and is related to the compensable injury of July 20, 2009 for treatment of the inclusion cyst at the right third metacarpalphalangeal joint. A fair reading of Dr. Sachar's September 14, 2009 report in which he recommends the surgery is that the surgery is not addressing the underlying degenerative changes, but rather, the inclusion cyst. This is further supported by the opinion of Dr. Plotkin that the surgery is not directed at improving the underlying condition but to return Claimant to his baseline status. That baseline status would be an individual who did not have the presence of an inclusion cyst but did have significant degenerative arthritic changes and ligament damage as reflected on the two MRI scans done on Claimant's right wrist and hand areas. Further, as found, the injury of July 20, 2009 did not aggravate or accelerate the underlying degenerative arthritic changes within Claimant's right wrist as credibly and persuasively opined by Dr. Sollender Any surgery to address these degenerative arthritic changes is not causally related to the compensable injury of July 20, 2009. See, *Fairchild v. GCR Tire Center and Old Republic Ins. Co.,* W.C. No. 4-632-507 (February 2, 2006).

ORDER

It is therefore ordered that:

Insurer shall pay according to the Official Medical Fee Schedule of the Division of Workers' Compensation the expenses for an arthroscopic surgery for debridement and mass excision as recommended by Dr. Kavi Sachar, M.D.

All matters not determined herein are reserved for future determination.

DATED: February 1, 2010

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-730-799

ISSUE

Whether Respondents have produced clear and convincing evidence to overcome the opinion of Division Independent Medical Examination (DIME) physician Brian J. Beatty, D.O. that Claimant reached Maximum Medical Improvement (MMI) on June 29, 2009 and suffered a 17% whole person impairment rating.

FINDINGS OF FACT

1. On February 14, 2007 Claimant sustained admitted industrial injuries to his cervical and lumbar spine during the course and scope of his employment with Employer. Claimant was injured when he slipped on ice and fell backwards.

2. Employer directed Claimant to Concentra Medical Centers for treatment. Claimant received care from Authorized Treating Physician (ATP) Rosalinda Pineiro, M.D. He underwent conservative treatment consisting of physical therapy, chiropractic manipulations and medications.

3. Because conservative measures failed, Dr. Pineiro referred Claimant to Jeffrey A. Wunder, M.D. for an examination. On May 17, 2009 Claimant visited Dr. Wunder for an evaluation. Dr. Wunder noted inconsistencies between Claimant's subjective pain complaints and behavioral presentation. Dr. Wunder saw Claimant on May 24, 2009 and again remarked that he demonstrated inconsistent findings. Based on Claimant's presentation, Dr. Wunder concluded that Claimant had reached MMI with no permanent impairment or restrictions. He also commented that Claimant did not require medical maintenance care.

4. On May 31, 2007 Dr. Pineiro also placed Claimant at MMI with no impairment or work restrictions. On August 8, 2008 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Pineiro's determinations.

5. Claimant objected to the FAL and sought a DIME. On February 12, 2008 Dr.

Beatty performed the DIME. Claimant remarked that numerous activities, including driving, bending and lifting, aggravated his neck and lower back pain. Based on a review of Claimant's medical history, a physical examination and range of motion testing, Dr. Beatty diagnosed Claimant with a "cervicothoracic strain with persistent myofacial pain" and a "lumbosacral strain with persistent myofacial pain." He concluded that Claimant had not reached MMI. Dr. Beatty recommended six to eight trigger point injections to the cervical and lumbar areas, massage therapy and physical therapy for eight to twelve visits. He assigned a conditional 17% whole person impairment rating. The impairment consisted of specific disorders and range of motion loss for both the cervical and lumbar spines.

6. Claimant returned to Dr. Wunder for additional treatment during the period March through May 2009. He underwent physical therapy and trigger point injections. Dr. Wunder remarked that Claimant had missed several physical therapy sessions and the trigger point injections had not provided any benefit. On May 15, 2009 Dr. Wunder determined that Claimant had again reached MMI with no impairment. He also concluded that Claimant did not require medical maintenance treatment.

7. On June 29, 2009 Claimant returned to Dr. Beatty for a second DIME. Claimant reported that his symptoms had worsened and reiterated that a variety of activities aggravated his condition. Dr. Beatty noted that Claimant experienced tenderness in the lumbosacral spine over the "paralumbar musculature centrally at the L4-L5 level." He also remarked that Claimant suffered from tenderness in the cervical spine "along the occipital ridge." Dr. Beatty diagnosed Claimant with cervical and lumbar strains accompanied by chronic pain and concluded that Claimant had reached MMI.

8. Dr. Beatty determined that Claimant suffered from a 13% impairment of the cervical spine. The rating consisted of 4% for a specific disorder and 9% for range of motion deficits. Dr. Beatty also concluded that Claimant suffered from a 9% impairment of the lumbar spine. The rating consisted of 5% for specific disorders and 4% for range of motion deficits. Combining the 13% and 9% impairment ratings yields a 21% whole person impairment. However, because the lumbar flexion range of motion testing results were invalid, Dr. Beatty deferred back to his February 12, 2008 examination in which Claimant suffered a 17% whole person impairment. Finally, Dr. Beatty commented that Claimant did not require medical maintenance benefits.

9. Dr. Wunder testified through an evidentiary deposition as an expert in the field of physical medicine and rehabilitation. He explained that pursuant to the AMA Guides of Permanent Impairment (AMA Guides) physicians provide ratings based on objective findings instead of subjective complaints. Because he could not discern a specific pain generator, Claimant had a normal MRI and Claimant exhibited overt pain behavior with nonspecific pain complaints, Dr. Wunder concluded that Claimant was not suffering from any identifiable, ratable medical condition. Based on Dr. Wunder's treatment and diagnosis of Claimant, he determined that Claimant did not suffer from a diagnosable medical condition and had

remained at MMI since May 2007.

10. Dr. Wunder remarked that Dr. Beatty was incorrect in initially determining that Claimant was not at MMI and required additional treatment. He commented that none of the treatment he provided to Claimant in 2009 improved Claimant's condition. In fact, Claimant reported that he was feeling 30% worse after the treatment.

11. Dr. Wunder also explained that Dr. Beatty's assignment of a 17% permanent impairment rating constituted an incorrect application of the AMA Guides. Initially, Dr. Wunder noted that Dr. Beatty observed no specific objective findings on exam, there has been no identifiable medical diagnosis under Table 53 and no specific pain generator could be identified on the basis of an x-ray or MRI. Dr. Wunder also commented that, under the AMA Guides p. 78, Section 3.3a, General Principles of Measurement of the Spine, Dr. Beatty's invalid lumbar flexion range of motion measurements should have been repeated. However, there is no evidence that Dr. Beatty brought Claimant back for repeat measurements. Furthermore, Dr. Beatty did not complete the required set of six measurements at the time Claimant was in his office. Instead, he completed only three sets of measurements. Dr. Wunder remarked that the failure to perform the six sets of measurements constituted an incorrect application of the AMA Guides.

12. Dr. Wunder further explained that Dr. Beatty incorrectly applied the AMA Guides in assigning Claimant's impairment rating when he made findings inconsistent with the clinical record and failed to consult with treating physicians. Notably, AMA Guides Section 2.1 requires the rating physician to determine if his findings are in "substantial accordance" with the other information in a claimant's medical record.

13. Respondents have failed to produce clear and convincing evidence to overcome Dr. Beatty's February 12, 2008 conclusion that Claimant had not reached MMI. Based on a review of Claimant's medical history, a physical examination and range of motion testing, Dr. Beatty diagnosed Claimant with a "cervicothoracic strain with persistent myofacial pain" and a "lumbosacral strain with persistent myofacial pain." He recommended six to eight trigger point injections to the cervical and lumbar areas, massage therapy and physical therapy for eight to twelve visits. In contrast, Dr. Wunder concluded that Claimant had reached MMI in May 2007 and remarked that none of the treatment he provided to Claimant in 2009 improved Claimant's condition. Although Claimant's condition did not improve from the treatment recommended by Dr. Beatty, he nevertheless prescribed the treatment in an attempt to alleviate Claimant's symptoms. After the treatment did not improve Claimant's condition, Dr. Beatty reasonably concluded that no additional treatment would improve Claimant's condition and therefore placed him at MMI. Accordingly, Claimant reached MMI on June 29, 2009.

14. Respondents have not produced clear and convincing evidence to overcome Dr. Beatty's June 29, 2009 assignment of a 17% whole person impairment rating except for his

incorrect application of the AMA Guides in ascertaining Claimant's lumbar range of motion measurements. Initially, at the second DIME Claimant reported that his symptoms had worsened and reiterated that a variety of activities aggravated his condition. Dr. Beatty noted that Claimant experienced tenderness in the lumbosacral spine over the "paralumbar musculature centrally at the L4-L5 level." He also remarked that Claimant suffered from tenderness in the cervical spine "along the occipital ridge." Dr. Beatty diagnosed Claimant with cervical and lumbar strains accompanied by chronic pain. He thus determined that Claimant suffered from specific disorders and range of motion deficits. Respondents have not overcome Dr. Beatty's assignment of impairment ratings for the cervical spine, lumbar spine and cervical range of motion deficits. However, Dr. Wunder commented that, under the AMA Guides p. 78, Section 3.3a, General Principles of Measurement of the Spine, the lumbar flexion range of motion measurements should have been repeated because Dr. Beatty determined they were invalid. There is no evidence that Dr. Beatty brought Claimant back for repeat measurements and Dr. Beatty did not complete the required set of six measurements at the time Claimant was in his office. Instead, he completed only three sets of measurements.

15. Although Respondents have produced clear and convincing evidence to overcome Dr. Beatty range of motion impairment rating for the lumbar spine, Claimant is still entitled to a 17% whole person impairment rating. On June 29, 2009 Dr. Beatty determined that Claimant suffered from a 13% impairment of the cervical spine and a 9% impairment of the lumbar spine. Combining the 13% and 9% impairment ratings yields a 21% whole person impairment. The lumbar spine rating consisted of 5% for specific disorders and 4% for range of motion deficits. However, because the lumbar flexion range of motion testing results were invalid, Dr. Beatty deferred back to his February 12, 2008 and assigned Claimant a 17% whole person impairment. Similarly, eliminating the 4% range of motion impairment for the lumbar spine because Dr. Beatty incorrectly applied the AMA Guides leaves a 5% impairment for a specific disorder of the lumbar spine. Therefore, combining the 13% impairment of the cervical spine with the 5% impairment for the lumbar spine yields a total combined whole person impairment rating of 17%.

CONCLUSIONS OF LAW

1. 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. §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. §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. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits.

§8-43-201, 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).

Overcoming the DIME

4. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). In other words, to overcome a DIME physician's opinion, "there must be evidence establishing that the DIME physician's determination is incorrect and this evidence must be unmistakable and free from serious or substantial doubt." *Adams v. Sealy, Inc*., W.C. No. 4-476-254 (ICAP, Oct. 4, 2001). 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 (ICAP, July 19, 2004); *see Shultz v. Anheuser Busch, Inc*., W.C. No. 4-380-560 (ICAP, Nov. 17, 2000).

5. A DIME physician must apply the AMA Guides when determining the claimant's permanent impairment rating. §8-42-101(3.7), C.R.S. The questions of whether the DIME physician properly applied the AMA Guides and ultimately whether the rating was overcome by clear and convincing evidence constitute factual questions to be determined by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 202 (Colo. App. 2000).

6. As found, Respondents have failed to produce clear and convincing evidence to overcome Dr. Beatty's February 12, 2008 conclusion that Claimant had not reached MMI. Based on a review of Claimant's medical history, a physical examination and range of motion testing, Dr. Beatty diagnosed Claimant with a "cervicothoracic strain with persistent myofacial pain" and a "lumbosacral strain with persistent myofacial pain." He recommended six to eight trigger point injections to the cervical and lumbar areas, massage therapy and physical

therapy for eight to twelve visits. In contrast, Dr. Wunder concluded that Claimant had reached MMI in May 2007 and remarked that none of the treatment he provided to Claimant in 2009 improved Claimant's condition. Although Claimant's condition did not improve from the treatment recommended by Dr. Beatty, he nevertheless prescribed the treatment in an attempt to alleviate Claimant's symptoms. After the treatment did not improve Claimant's condition, Dr. Beatty reasonably concluded that no additional treatment would improve Claimant's condition and therefore placed him at MMI. Accordingly, Claimant reached MMI on June 29, 2009.

7. As found, Respondents have not produced clear and convincing evidence to overcome Dr. Beatty's June 29, 2009 assignment of a 17% whole person impairment rating except for his incorrect application of the AMA Guides in ascertaining Claimant's lumbar range of motion measurements. Initially, at the second DIME Claimant reported that his symptoms had worsened and reiterated that a variety of activities aggravated his condition. Dr. Beatty noted that Claimant experienced tenderness in the lumbosacral spine over the "paralumbar musculature centrally at the L4-L5 level." He also remarked that Claimant suffered from tenderness in the cervical spine "along the occipital ridge." Dr. Beatty diagnosed Claimant with cervical and lumbar strains accompanied by chronic pain. He thus determined that Claimant suffered from specific disorders and range of motion deficits. Respondents have not overcome Dr. Beatty's assignment of impairment ratings for the cervical spine, lumbar spine and cervical range of motion deficits. However, Dr. Wunder commented that, under the AMA Guides p. 78, Section 3.3a, General Principles of Measurement of the Spine, the lumbar flexion range of motion measurements should have been repeated because Dr. Beatty determined they were invalid. There is no evidence that Dr. Beatty brought Claimant back for repeat measurements and Dr. Beatty did not complete the required set of six measurements at the time Claimant was in his office. Instead, he completed only three sets of measurements.

Impairment Rating

8. When the ALJ determines that the DIME physician's rating has been overcome, the question of the claimant's correct medical impairment rating becomes one of fact for the ALJ. The only limitation is that the ALJ's findings must be supported by the record and consistent with the AMA Guides and other rating protocols. Thus, once the ALJ determines that the DIME physician's rating has been overcome in any respect, the ALJ is free to calculate the claimant's impairment rating based upon the preponderance of the evidence. *See Deleon v. Whole Foods Market, Inc.,* W.C. No. 4-600-477 (ICAP, June 6, 2006); *Garlets v. Memorial Hospital,* W.C. No. 4-336-566 (ICAP, Sept. 5, 2001).

9. As found, although Respondents have produced clear and convincing evidence to overcome Dr. Beatty range of motion impairment rating for the lumbar spine, Claimant is still entitled to a 17% whole person impairment rating. On June 29, 2009 Dr.

Beatty determined that Claimant suffered from a 13% impairment of the cervical spine and a 9% impairment of the lumbar spine. Combining the 13% and 9% impairment ratings yields a 21% whole person impairment. The lumbar spine rating consisted of 5% for specific disorders and 4% for range of motion deficits. However, because the lumbar flexion range of motion testing results were invalid, Dr. Beatty deferred back to his February 12, 2008 and assigned Claimant a 17% whole person impairment. Similarly, eliminating the 4% range of motion impairment for the lumbar spine because Dr. Beatty incorrectly applied the AMA Guides leaves a 5% impairment for a specific disorder of the lumbar spine. Therefore, combining the 13% impairment of the cervical spine with the 5% impairment for the lumbar spine yields a total combined whole person impairment rating of 17%.

ORDER

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

1. Claimant reached MMI on June 29, 2009 and suffered a 17% whole person impairment rating.

2. Any issues not resolved in this Order are reserved for future determination.

DATED: January 29, 2010.

_____
Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-612-449

ISSUES

The issues for determination are:

1. Maximum medical improvement (MMI);

2. Medical benefits for treatment for depression, sleep apnea, and low back surgery; and

3. Penalty against Claimant for violation of multiple pre-hearing Orders regarding discovery.

Claimant marked permanent partial and permanent total disability benefits on the Application for Hearing, but those issues were not listed on the Case Information Sheet, were not mentioned at the commencement of the hearing, and were not argued in either party's position statement. Permanent disability benefits and other issues not determined by this order are reserved for future determination.

FINDINGS OF FACT

1. Claimant was injured on February 1, 2004. Dr. Gronseth, an authorized treating physician, placed Claimant at maximum medical improvement (MMI) on May 17, 2007, "unless [Claimant] decides to pursue L4-5 fusion surgery." Dr. Wunder, the Division independent medical exam (DIME) physician, in his report of January 21, 2008, agreed with Dr. Gronseth's MMI determination and stated that Claimant had reached MMI on May 17, 2007. Claimant alleges that he was not at MMI on May 17, 2007, in that he required treatment for his low back condition, depression, sleep apnea, and an ear infection.

2. Claimant had an ear infection that developed after pool therapy for this injury in December 2006. Claimant received treatment for the ear infection in 2006 and 2007.

3. Dr. Wunder, the DIME physician, noted that Claimant had chronic left ear infections that Claimant blamed on pool therapy. He noted that Claimant had a lifelong history of ear infections and Eustachian tube dysfunction. The DIME physician stated that the ear infection was not a work-related condition.

4. Claimant testified that he did have ear infections years ago. He further testified that his left ear was asymptomatic for approximately eighteen years before he underwent the aquatic therapy.

5. Dr. Hartshorn, in his report of April 30, 2007, stated that he was seeing Claimant for repeated ear infections since December 2006. He noted that Claimant had a lifelong history of Eustacian tube dysfunction and problems with ear infections in the left ear. He also stated that he did an eardrum replacement operation on the left ear and that the ear was relatively well until December 2006. He noted that Claimant began to have water therapy in December 2006, and that he continued to have that water exposure. Claimant was directed to keep the left ear clean and dry and to use earplugs with water exposure. He also directed Claimant to avoid water therapy.

6. Dr. Kempers, in her July 9, 2009, report, stated that Claimant's ear infection was directly related to the injury and she noted that Claimant had not had ear problems for over a year. The opinion of Dr. Kempers is credible and persuasive.

7. After he was placed at MMI, Claimant sought additional treatment for his ear. Respondents denied liability for the additional treatment after MMI. Claimant sought care from Dr. Menachof in January 2008. Claimant was not referred to Dr. Menachof by an

authorized treating physician. Dr. Menachof performed a left myringotomy with placement of a ventilating tube on March 6, 2008, 10 months after MMI. The treatment was reasonably needed maintenance care to relieve Claimant from the effects of the compensable injury. The surgery was not justified as an emergency.

8. The ear infection did not require any treatment at the time of MMI. The treatment for the ear after MMI was maintenance care.

9. The DIME physician was incorrect; the ear infections in 2006 and 2007 were related to the industrial injury. However, the ear infection did not require any treatment to improve his condition at the time of MMI. The ear infection was stable and no further treatment was reasonably expected to improve his condition at the time he was placed at MMI.

10. The DIME physician stated that the medical record did not show evidence of depression and that no psychological evaluation or treatment was noted. He stated that psychological factors were not prominently mentioned until Claimant was placed at MMI.

11. Dr. Kempers noted in her report of May 27, 2004, that Claimant was suffering from a depressive disorder. She recommended that Claimant increase his Elavil. Dr. Kempers continued the Elavil prescription on June 29, 2005, October 17, 2005, and June 21, 2006.

12. Dr. Gronseth, on May 19, 2006, noted that Claimant had “possible depression or side effects of medications.” He encouraged Claimant to increase his Lexapro dose, which had been prescribed by Claimant’s primary care physician.

13. Dr. Kempers, on June 28, 2006, noted that Claimant was suffering from a depressive disorder and continued Claimant on Lexapro. On September 7, 2006, Dr. Kempers did not mention a depressive disorder or Lexapro.

14. Dr. Gronseth, in his May 17, 2007, report, stated that Claimant has depression “which is causally related to the work injury.”

15. On August 31, 2007, Dr. Toby noted that Claimant was “very depressed” and rated Claimant’s depression at six percent. Dr. Toby did not recommend any treatment for the depression.

16. Dr. Kempers, on July 9, 2009, stated that Claimant has had mild depression for five years that she related to Claimant’s chronic pain. Dr. Kempers did not recommend any treatment for the depression.

17. The medical record does show evidence of depression and treatment prior to MMI. The DIME physician was incorrect. However, the depression did not require any treatment at the time Claimant was placed at MMI.

18. The DIME physician did not comment on sleep apnea.

19. Dr. Primack recommended that Claimant’s medications be adjusted and then see if Claimant still has ongoing sleep disturbance.

20. Dr. Kempers stated that Claimant has sleep apnea that is caused by or related to the

narcotic pain medications he is taking for his back injury. She stated that Claimant is using oxygen at night “which is not an ideal treatment for this diagnosis.” On March 19, 2009, she recommended a sleep study.

21. Dr. Kempers’ recommendation for a sleep study and Dr. Primack’s recommendation for medication adjustment is maintenance care.

22. The DIME physician noted that Claimant had a long history of chronic pain and disability prior to this injury, and noted that Claimant would not be a good surgical candidate.

23. Dr. Wong examined Claimant on December 9, 2005, and stated that Claimant would not be a good candidate for fusion surgery.

24. On December 14, 2006, Dr. Choi, a neurosurgeon, recommended consideration of L4-L5 decompression and stabilization procedure.

25. Dr. Tice, a neurosurgeon, on April 12, 2007, stated that surgery should be considered in the future. On July 25, 2007, Dr. Tice stated that Claimant had a chronic problem and that “I don’t think there is any urgent surgical treatment.” He stated that he would see Claimant on a yearly basis.

26. Claimant has failed to overcome the opinion of the DIME physician that he was at MMI on May 17, 2007.

27. A discogram on December 10, 2008, showed that “the L4-5 and L5-S1 disc are degenerative and concordantly painful.”

28. Dr. Villavicencio, a neurosurgeon, saw Claimant on January 6, 2009. He recommended conservative care or “a minimally invasive L4-5 and L5-S1 transforaminal lumbar interbody fusion with unilateral pedicule screws and an Aspen device.” Claimant indicated he wished to proceed with surgery. Dr. Villavicencio is waiting for Claimant to set up a surgical date.

29. Dr. Primack examined Claimant on April 16, 2009. He stated that Claimant has multi-level degenerative disk disease not related to this injury. He also stated that Claimant is not a good candidate for surgery because Claimant’s Distress Risk and Assessment Method score was in the distressed somatic category.

30. The discogram and examinations by Dr. Villavicencio and Dr. Primack constitute maintenance care that is reasonably needed to relieve Claimant from the effects of the industrial injury.

31. Dr. Villavicencio and Claimant have not considered Dr. Primack’s opinion and change in Claimant’s condition since January 6, 2009, which may lead either or both of them to decide not to proceed with the recommended surgery.

32. In preparation for hearing, Respondents sent Claimant interrogatories Claimant’s answers to interrogatories were due 20 days later, or on September 22, 2008.

33. Claimant did not timely respond to interrogatories. Respondents filed a motion to

compel Claimant's Discovery Responses on October 2, 2008.

34. In an order dated November 10, 2008, PALJ Jaynes ordered Claimant to respond to discovery within 10 days of the order. Claimant's answers to interrogatories were due on November 20, 2008.

35. Claimant did not provide answers to interrogatories until November 26, 2008. Claimant had failed to comply with PALJ Jaynes' November 10, 2008, Order, and was six days late in filing answers to interrogatories.

36. The parties attended pre-hearing conferences in front of PALJ Eley on December 1, 2008, and December 18, 2008. At those pre-hearing conferences, Respondents argued that Claimant's answers to interrogatories were not adequate. Respondents argued that interrogatories numbers one, five, and ten were either non-responsive or did not contain sufficient information. PALJ Eley agreed with Respondents, position. PALJ Eley ordered Claimant to submit revised responses to interrogatories number one, five and ten within 15 days of the date of his December 18, 2008, Order. PALJ Eley also ordered a 60-day continuance of the December 4, 2008, hearing.

37. In supplemental answers to interrogatories dated January 6, 2009, Claimant, through counsel, provided supplemental discovery responses. In response to interrogatory number one that requested Claimant to describe in detail and with specificity what various witnesses would testify to at hearing, Claimant's answer was "none at this time." Claimant's answers to interrogatories were submitted two days late based on PALJ Eley's Order requiring Claimant to provide supplemental interrogatories by January 4, 2009.

38. The parties attended additional pre-hearing conferences in front of PALJ Eley on February 4, 2009, and February 12, 2009. Issues for determination at those pre-hearing conferences were Respondents' motion to compel Claimant to once again provide sufficient answers to interrogatories as well as sanctions. PALJ Eley issued another pre-hearing order dated February 24, 2009. In his pre-hearing order, PALJ Eley noted that Claimant's avoidance of giving complete summaries of Claimant's witnesses' testimony violated the spirit, but not the letter, of the previous discovery orders. Consequently, he did not grant Respondents' request that Claimant's application for hearing should be struck with prejudice, or that Claimant should not be allowed to call any witnesses. However, PALJ Eley ordered that, as a discovery sanction for the late compliance with the orders of November 10, 2008, and December 18, 2008, Claimant would be required to provide the information sought in Respondents' interrogatory number one within 10 days of the endorsing by Claimant of any witness for hearing, whether that endorsement is made on an application for hearing, a response to application for hearing, or by any other means.

39. Claimant filed a new application for hearing on April 9, 2009. Pursuant to PALJ Eley's Order dated February 24, 2009, Claimant had until April 19, 2009, to submit supplemental answers to Respondents' interrogatories.

40. Claimant did provide supplemental answers to interrogatories, but did not provide them to Respondents until April 22, 2009. Claimant violated the timing requirement of the

February 24, 2009, pre-hearing order by not timely filing supplemental answers to interrogatories after he filed his application for hearing. Claimant was three days late.

41. There was no substantial change in Claimant's answer to interrogatory number one from original answers to interrogatories dated November 26, 2008, to Claimant's supplemental answers to Respondents' interrogatories dated April 22, 2009.

42. The parties attended another pre-hearing conference on June 29, 2009, before PALJ Eley. Judge Eley issued a pre-hearing order dated June 30, 2009. Judge Eley noted that, despite his determination in his December 18, 2008, Order that Claimant's initial response to interrogatory number one was insufficient and lacked detail, Claimant's response to interrogatory number one in his supplemental answers to Respondents interrogatories dated April 22, 2009, had not substantially changed. Judge Eley noted that Claimant's decision to simply repeat the large part of his answers to interrogatory number one almost word for word was a willful violation of PALJ Eley's February 24, 2009, Order. Claimant, knowing that the Court had previously found his response to interrogatory number one to be inadequate, simply repeated them in the April 22, 2009, disclosures. PALJ Eley concluded that Claimant's violation of the February 24, 2009, Order demonstrated a flagrant disregard of discovery obligations. PALJ Eley also found that the fact that a total of three discovery orders were, in one way or another, violated by Claimant constituted a substantial deviation from reasonable care in complying with discovery obligations. PALJ Eley ordered that the testimony of Drs. Tobey, Kempers, and Villavicencio would be precluded at hearing. The striking of those witnesses relieved Claimant of the obligation to answer the interrogatory regarding their expected testimony, since there no longer was any expected testimony.

43. Claimant has violated discovery orders of Pre-hearing Administrative Law Judges. Claimant knew, or should have known, that discovery orders of a Pre-hearing Administrative Law Judge must be followed. Claimant's actions were not predicated on a rational argument based in law or fact and were not objectively reasonable.

CONCLUSIONS OF LAW

1. Law: A claimant is at maximum medical improvement (MMI) when his condition is stable and no further treatment is reasonably expected to improve his condition. Section 8-40-201(11.5), C.R.S.

The MMI determination of the DIME physician may 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 MMI finding must produce evidence showing it highly probable the DIME physician is incorrect. Sections 8-42-107(8)(b)(III), C.R.S.; *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 claimant may be entitled to medical benefits after maximum medical improvement if there

is substantial evidence in record to support determination that future medical treatment will be reasonable and necessary to relieve effects of industrial injury or prevent deterioration of claimant's condition. *Grover v. Industrial Commission,* 759 P.2d 705 (Colo. 1988).

Section 8-43-304(1), C.R.S. is a general penalty provision under the Worker's Compensation Act that authorizes the imposition of penalties up to $500.00 per day where a party violates a statute, rule, or lawful order of a Judge. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 705, 706 (Colo. 2001). An award of penalties shall be paid 75% to the aggrieved party and 25% to the Subsequent Injury Fund. Section 8-43-304(1), C.R.S. The imposition of penalties under Section 8-43-304(1), C.R.S., requires a two-step analysis. *See In Re Hailemichael,* W.C. No. 4-382-985 (ICAO, Nov. 17, 2004). The Judge must first determine whether the disputed conduct violated a provision of the Act or rule. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623, 624 (Colo.App. 1995). If a violation has occurred, penalties may only be imposed if the Judge concludes that the violation was objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 907 P.2d 676, 678-79 (Colo.App. 1995). The reasonableness of a violator's actions depends upon whether the action was predicated on a "rational argument based on law or fact." *In re Lamutt,* W.C. No. 4-282-825 (ICAP, Nov. 6, 1998). The question of whether a person acted in an objectively reasonable manner when violating an order presents a question of fact. *Pioneers Hospital v. Industrial Claim Appeals Office,* 114 P.3d 97 (Colo.App. 2005). The party seeking imposition of a penalty establishes a prima facie showing of unreasonable conduct by proving there was a violation of an order. *Id.* If such a prima facie showing is made, the burden of persuasion shifts to the alleged violator to show that her conduct was reasonable under the circumstances. *Id.; Human Resource Co. v. Industrial Claim Appeals Office,* 984 P.2d 1194 (Colo.App. 1999). In ascertaining an appropriate penalty the Judge may consider a "wide variety of factors." *Adakai v. St. Mary Corwin Hospital,* W.C. No. 4-619-954 (ICAP, May 5, 2006). However, any penalty assessed should not be excessive in the sense that it is "grossly disproportionate" to the conduct in question. *See id.* When determining the penalty a Judge may consider factors including the "degree of reprehensibility" of the violator's conduct, the disparity between the actual or potential harm suffered by a party and the award of penalties, and the difference between the penalties awarded and penalties assessed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office,* 126 P.3d 323 (Colo.App. 2005).

2. Ear Infection: Claimant had an ear infection that developed after pool therapy in December 2006. Claimant received treatment for the ear infection in 2006 and 2007. The DIME physician noted that Claimant had chronic left ear infections that Claimant blamed on pool therapy. He noted that Claimant had a lifelong history of ear infections and Eustachian tube dysfunction. The DIME physician stated that the ear infection was not a work-related condition. However, as stated in Dr. Hartshorn's report and as testified by Claimant, his left ear was asymptomatic for approximately eighteen years until he underwent the aquatic therapy. Dr. Kempers, in her July 9, 2009, report, stated that Claimant's ear infection was directly related to the injury and she noted that Claimant has not had problems for over a year.

The DIME physician is incorrect; the ear infection in 2007 was related to the industrial injury. However, Claimant has failed to show that the 2007 ear infection required any treatment at the time of MMI or at this time.

Claimant did received treatment for his ear infection after MMI. Dr. Menachof performed a surgery on March 6, 2008. The surgery was related to the compensable injury and was maintenance care. However, Dr. Menachof is not an authorized provider, and Claimant has not shown that his care was justified on an emergency basis. Insurer is not liable for the cots of the March 6, 2008, ear surgery.

3. Depression: The DIME physician stated that the medical record did not show evidence of depression and that no psychological evaluation or treatment was noted. He stated that psychological factors were not prominently mentioned until Claimant was placed at MMI. Dr. Kempers noted in her report of May 27, 2004, that Claimant was suffering from a depressive disorder. She recommended that Claimant increase his Elavil. Dr. Kempers continued the Elavil prescription on June 29, 2005, October 17, 2005, and June 21, 2006. Dr. Gronseth, on May 19, 2006, noted that Claimant had “possible depression or side effects of medications.” He encouraged Claimant to increase his Lexapro dose, which had been prescribed by Claimant’s primary care physician. Dr. Kempers, on June 28, 2006, noted that Claimant was suffering from a depressive disorder and continued Claimant on Lexapro. On September 7, 2006, Dr. Kempers did not mention a depressive disorder or Lexapro. Dr. Gronseth, in his May 17, 2007, report stated that Claimant has depression “which is causally related to the work injury.” On August 31, 2007, Dr. Toby noted that Claimant was “very depressed” and rated Claimant’s depression at six percent. Dr. Toby did not recommend any treatment for the depression. Dr. Kempers, on July 9, 2009, stated that Claimant has had mild depression for five years that she related to Claimant’s chronic pain. Dr. Kempers did not recommend any treatment for the depression.

The DIME physician was incorrect. The medical record does show evidence of depression and treatment prior to MMI. However, Claimant has failed to show that the depression required any treatment at the time of MMI or at this time.

4. Sleep Apnea: The DIME physician did not comment on sleep apnea. Dr. Primack recommended that Claimant’s medications be adjusted and then see if Claimant still has ongoing sleep disturbance. Dr. Kempers stated that Claimant has sleep apnea that is caused by or related to the narcotic pain medications he is taking for his back injury. She stated that Claimant is using oxygen at night “which is not an ideal treatment for this diagnosis.” On March 19, 2009, she recommended a sleep study.

Dr. Kempers’ recommendation for a sleep study and Dr. Primack’s recommendation for medication adjustment is maintenance care. Insurer is liable for the costs of such care from authorized providers in amounts not to exceed the Division of Workers’ Compensation fee schedule.

5. Low Back Surgery: The DIME physician noted that Claimant had a long history of

chronic pain and disability prior to this injury, and noted that Claimant would not be a good surgical candidate. Dr. Wong examined Claimant on December 9, 2005, and stated that Claimant would not be a good candidate for fusion surgery. On December 14, 2006, Dr. Choi, a neurosurgeon, recommended consideration of L4-L5 decompression and stabilization procedure. Dr. Tice, a neurosurgeon, on April 12, 2007, stated that surgery should be considered in the future. On July 25, 2007, Dr. Tice stated that Claimant had a chronic problem and that “I don’t think there is any urgent surgical treatment.” He stated that he would see Claimant on a yearly basis. Claimant has failed to overcome the opinion of the DIME physician that he was at MMI on May 17, 2007.

A discogram on December 10, 2008, showed that “the L4-5 and L5-S1 disc are degenerative and concordantly painful.” Dr. Villavicencio, a neurosurgeon, saw Claimant on January 6, 2009. He recommended conservative care or “a minimally invasive L4-5 and L5-S1 transforaminal lumbar interbody fusion with unilateral pedicule screws and an Aspen device.” Claimant indicated he wished to proceed with surgery. Dr. Villavicencio is waiting for Claimant to set up a surgical date.

Dr. Primack examined Claimant on April 16, 2009. He stated that Claimant has multi-level degenerative disk disease not related to this injury. He also stated that Claimant is not a good candidate for surgery because Claimant’s Distress Risk and Assessment Method score was in the distressed somatic category.

The discogram and examinations by Dr. Villavicencio and Dr. Primack constitute maintenance care that is reasonably needed to relieve Claimant from the effects of the industrial injury. Insurer is liable for the costs of such tests and examinations from authorized providers, in amounts not to exceed the Division of Workers’ Compensation fee schedule.

Dr. Villavicencio and Claimant have not considered Dr. Primack’s opinion and change in Claimant’s condition since January 6, 2009, which may lead either or both of them to decide not to proceed with the recommended surgery. If Dr. Villavicencio and Claimant decide to proceed with the surgery, the issue of worsening of condition and whether or not Claimant remains at MMI as of the date of the surgery may be determined then. No determination is made at this time as to liability for the back surgery should it be recommended.

6. Claimant has not overcome the MMI determination of the DIME physician by clear and convincing evidence. Claimant is at MMI.

7. Penalties: Insurer has established by a preponderance of the evidence that Claimant has violated discovery orders of Pre-hearing Administrative Law Judges. Claimant knew, or should have known, that discovery orders of a Pre-hearing Administrative Law Judge must be followed. Claimant’s actions were not predicated on a rational argument based in law or fact and were not objectively reasonable. Claimant was severely sanctioned by expert witness preclusion at the August 5, 2009, hearing. The sanction of witness preclusion imposed by Judge Eley was severe and further sanctions should be minimal. However, some sanctions must be levied. Section 8-43-304(1), C.R.S.

Claimant was in violation of orders to respond to discovery for six days (Finding No. 35), two

days (Finding No. 37) and three days (Finding No. 40), a total of eleven days. Considering all the factors in aggravation and mitigation, it is determined that the penalty should be assessed at the rate of $10.00 per day, for a total penalty of $110.00. Seventy-five percent is payable to Insurer ($82.50) and twenty-five percent is payable to the Subsequent Injury Fund of the Division of Workers' Compensation ($27.50). Section 8-43-304(1), C.R.S.

Under the facts in this case, it is concluded that attorney fees should not be awarded.

8. Liability for surgery should that be recommended after review of Claimant's present condition and Issues not determined herein are reserved for future determination.

ORDER

It is therefore ordered that:

1. Claimant has not overcome the MMI determination of the DIME physician. Claimant reached maximum medical improvement on May 17, 2007.

2. Insurer is liable for the costs of a sleep study, medication adjustment, discograms, and further tests and evaluations as maintenance care. The costs may not exceed the Division of Workers' Compensation fee schedule. No determination is made by this Order as to liability for back surgery should that be recommended following further tests and evaluations.

3. Insurer is not liable for the surgery performed by Dr. Menachof on March 6, 2008.

4. Claimant shall pay a penalty of $82.50 to the Insurer and $27.50 to the Subsequent Injury Fund. Respondents' request for attorney fees is denied.

5. Issues not determined by this order are reserved.

DATED: *February 1, 2010*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-803-833

ISSUES

The issues for determination are compensability, medical benefits, average weekly

wage (AWW), and temporary disability benefits. Respondents have raised the affirmative defense of responsibility for termination.

The parties stipulated that the medical care that Claimant received from Dr. Miller and Dr. Ellis at Exempla Healthcare, and other care pursuant to their referrals, was authorized. Claimant is not seeking coverage for any care he may have received from his personal physicians. The parties stipulated that, at the time of the injury, Claimant was also working at a second job at FR. The parties have stipulated that Claimant's AWW from FR is $658.17. The parties further stipulate that Claimant's AWW should be increased as of October 29, 2009, by $55.37 to reflect the cost of replacement of the health insurance Claimant had with Employer. The appropriate calculation of Claimant's AWW from Employer remains at issue. It is Claimant's position that his AWW from Employer (not including the cost of replacing his health insurance) is $295.34. Respondents calculate the AWW from Employer to be $225.93. All other issues are reserved.

FINDINGS OF FACT

1. Claimant worked for Employer as a customer assistance sales associate. He had worked for Employer for approximately one and one-half years at the time of the injury. Claimant's job included assisting customers and stocking product. On Saturday, August 8, 2009, at approximately 4:30 p.m., Claimant was instructed to stock dog food stored in a back room. The product was stacked three high on a dolly called a "U-boat." While Claimant was pushing the U-boat down an aisle in the store, some of the product fell off and Claimant tripped on one of the bags. Claimant fell, hitting the floor with his left outstretched hand. He turned his head to avoid striking his face.

2. Claimant initially felt pain in his left hand. He immediately reported the injury to his supervisors. Later that day, Claimant went to the authorized provider, Exempla Healthcare. At that time Claimant's neck was hurting in addition to his left wrist. Claimant was diagnosed with a cervical muscle strain and a left wrist sprain. He was placed on restrictions of no use of the left hand. On August 10, 2009, Claimant's hand was very visibly swollen and FR sent him home as Claimant could not perform the job or perform it safely in his condition.

3. On August 11, 2009, Dr. Miller placed Claimant on a twenty pound lift, carry, push and pull restriction and further restricted him from use of a forklift or driving work vehicles. Claimant has remained on similar restrictions since that time with the exception that the restriction against driving work vehicles was lifted on August 25, 2009. Claimant has not yet been discharged from treatment. Insurer has paid for Claimant's medical care so far. However, additional treatment has been denied pending the determination on compensability.

4. On June 30, 2009, Claimant had a previous work-related injury to his back

and knee while working for Employer. Claimant was put on restrictions as a result of this injury until sometime in July 2009 when he was released to full duty. Prior to the June 30, 2009 injury, commencing with pay period ending February 7, 2009, when Claimant's hourly rate was increased, Claimant had been working on average over twenty-five hours per week. After the June 30, 2009, injury, Claimant averaged significantly fewer hours per week. Claimant worked fewer hours after June 30, 2009, as a result of that injury. Claimant's AWW from Employer is fairly calculated by averaging his earnings from January 25, 2009 (payperiod ending February 7, 2009) through June 27, 2009, so as not to include wages after the date of the June 30, 2009, injury. The AWW from Employer is $295.34, not including the cost of replacing his health insurance.

5. After the subject injury, Claimant was offered light duty work by Employer. Claimant left early from time to time, and occasionally called in sick due to pain and headaches he had from the injury. Claimant lost wages from his employment at Employer as a result. From August 9, 2009, through October 28, 2009, the date Claimant was terminated by Employer, he earned a total of $1,336.89. Based on an AWW of $295.34 as calculated above, Claimant would have earned $3,417.51 but for the subject injury. This reduction in earnings was all due to missed work related to the subject injury.

6. Claimant was not offered light duty by his employer at FR. Claimant did not earn any wages from FR after the injury.

7. Claimant was terminated by FR on September 17, 2009, for "voluntary job abandonment." A letter addressed to Claimant dated September 17, 2009, relates the termination to Claimant's supposed failure to "call" as required by company policy. However, a review of the written policy shows that Claimant was not, in fact, in violation. As set forth in the first paragraph of the FR policy entitled "Notification of Calling Off Sick," a distinction is made between those employees who miss work due to sickness and those who have extended absences. An employee who is sick is required to call in everyday. This is not required of employees, like the Claimant, who will be out for an extended period of time. "In the case of extended absences, the employee must keep management aware of your expected date of return."

8. Claimant notified FR of his restrictions as they were given to him by his medical providers and FR informed him that he was not allowed to return to work with his restrictions. The FR file notes document that Claimant kept FR informed of his status. On August 10, 2009, two days after the subject injury, Claimant attempted to work at FR. FR records state, "On 8/10/09, you arrived at work with an arm injury preventing 'any use' of that arm. By any reasonable thinking, we simply cannot believe that you reported for work considering the work demands and safety considerations mandated by your position at FR." Claimant was sent home. Claimant called FR on August 12, 2009, to provide his restrictions and apologized for putting FR in a bad spot. Claimant also communicated with FR on August

14, 22, 25, and September 3, 15, and 17. On August 25, 2009, when Claimant informed FR that the driving restriction had been lifted but that he still had a thirty pound weight limitation, Claimant was told that he must have less restrictive limitation before he would be allowed to report to work. This has not yet happened.

9. According to the records of FR, Claimant was sent a letter terminating his employment on September 17, 2009. The termination letter concludes with the comment that Claimant's absence had "caused much difficulty at the company during the busiest season of the year." At the time of this termination, Claimant still had weight restrictions that precluded him from returning to this job. Claimant was given no warning by FR that he was in violation of any company policy. Claimant did nothing volitional to bring about his termination from his employment at FR.

10. Effective October 28, 2009, Claimant was terminated by the Employer, pursuant to Employer's no-fault absentee policy. Under the policy, Employer assessed points for missing work. Based on his tenure with Employer, an accumulation of 11 points in a 12-month period would result in termination for attendance. On October 22, 2009, Claimant accrued in excess of the points allowed and he was terminated effective October 28, 2009.

11. Claimant accrued many of these points for reasons related to the subject injury. It is Employer's policy that once light-duty within an employee's restrictions is offered, attendance points are assessed against an injured employee regardless of the cause of the absence, including missed work due to reasons related to a work injury. On October 22, 2009, Claimant did present to Employer an excuse from Dr. Ellis explaining that Claimant's missed day on the previous Sunday was related to the subject injury. The excuse was misdated because it applied to a date when the Claimant was not scheduled to work. However, even if the excuse had been properly dated for a date the Claimant was scheduled to work, it would not have mattered. As explained by Hilverding, the General Manager, Claimant would have been assessed points for missing work regardless of whether or not he presented a work excuse from the authorized provider. Hilverding testified that on October 22, 2009, when Claimant came in with the excuse and told her that he could not work that evening due to pain from the subject injury, she informed him that if he missed work, it would put him over the allowed points and he would be terminated. When Claimant did not work that evening, he was terminated.

12. Although not all the points assessed against Claimant under the attendance policy related to the subject injury, Claimant was not terminated for any individual event, but for having accrued too many points under the policy. Hilverding testified that, but for Claimant having exceeded the points, he would not have been terminated. Claimant's termination from Employer was not based on his volitional conduct and he was not at fault for the termination.

13. On November 1, 2009, Claimant obtained employment as a janitor making $9.00 per hour, forty hours per week. Claimant is able to work at this job within his restrictions.

CONCLUSIONS OF LAW

1. A claimant in a worker's compensation case has the burden of proving entitlement to benefits by a preponderance of the evidence. *City of Boulder v. Streeb*, 706 P.2d 786, 789 (Colo. 1985). This standard is met when the "existence of a contested fact is more probable than its nonexistence." *Industrial Commission of Colorado v. Jones*, 688 P.2d 1116, 1119 (Colo.1984). Claimant's testimony regarding the injury is supported by the medical evidence and his report of the injury to Employer. Claimant had a previous injury to the same part of his body. However, that does not prevent the current injury from being compensable. *Peter Kiewit Sons' Co. v. Industrial Commission*, 124 Colo. 217, 236 P.2d 296 (1951). Claimant has met his burden of proving entitlement to benefits for this injury.

2. Claimant's AWW must be calculated based on his earnings from both FR and Employer. *St. Mary's Church & Mission v. Industrial Commission of Colorado*, 735 P.2d 902 (Colo.App.1986). The parties have stipulated that Claimant's AWW from FR was $658.17. They have also stipulated that $55.37 should be added to the AWW as of October 29, 2009, to reflect the cost of replacing the health insurance. The parties differ in their calculations of the appropriate AWW that should be attributed to Claimant's job at Employer. Claimant calculates this AWW to be $295.34. He bases this figure on his average earnings between pay period ending February 7, 2009, and pay period ending June 27, 2009, which is prior to his previous injury on June 30, 2009, when he sustained an injury at Employer and was placed on temporary restrictions. The wage records after June 30, 2009, demonstrate a reduction in weekly hours worked as compared to average hours worked before this injury. Claimant testified that this loss in hours was a result of the June 30, 2009, injury. Claimant's calculation more accurately reflects his AWW at Employer than the formula employed by Respondents that was based on earnings during the twelve weeks prior to the subject injury and included the period during which Claimant was on restrictions as a result of this prior injury.

3. The objective of wage calculation is to reach a fair approximation of a claimant's actual wage loss and diminished earning capacity. *Campbell v. IBM Corp.,* 867 P.2d 77 (Colo.App.1993). Pursuant to Section 8-42-102(3), C.R.S., the ALJ has broad discretion in determining a fair computation of the AWW. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo.App.2001); *Avalanche Industries, Inc. v. Clark*, 198 P.3d 589 (Colo. 2008). A fair computation of Claimant's average wages from Employer is $295.34 per week, resulting in a total AWW of $953.51, increased to $1,008.88 as of October 29, 2009.

4. Claimant has shown a causal connection between the compensable injury and his subsequent wage loss, and is entitled to temporary disability benefits from the date of the injury. *Horton v. Industrial Claim Appeals Office*, 942 P.2d 1209 (Colo.App. 1996). The medical records show that Claimant was placed on restrictions following the injury and these restrictions are continuing. Claimant has not been released to regular duty. Although Claimant does not have a doctor's excuse for each time he left early or called in sick to Employer, this is not required if the evidence shows a wage loss as a result of the injury. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo.App. 1997).

5. Claimant is entitled to temporary disability benefits as follows:

TPD for lost wages from Employer from 8/9/09 through 10/17/09 (10 weeks) based on an AWW from Employer of $295.34. Actual earnings for this period were $1,336.89-- **$1,077.67**.

TTD for lost wages from Employer from 10/18/09 through 10/28/09 (11 days) based on an AWW from Employer of $295.34 (weekly rate of $196.89). The records do not reflect that Employer paid any wages to Claimant during this period. – **$309.40.**

"TTD" (technically TPD) for lost wages from FR from 8/9/09 through 10/31/09 (84 days) based on an AWW from FR of $658.17 (weekly rate of $438.78) –**$5,265.36.**

TTD for lost wages from Employer from 10/29/09 (the day after the termination) through 10/31/09 (3 days) based on an AWW from Employer of $350.71 (adding the cost of health insurance) (weekly rate of $233.81) – **$100.20**.

TPD for lost wages from both jobs from 11/1/09 through 1/7/10 (68 days) based on a AWW of $1,008.88 minus $360.00 per week from Claimant's current job (weekly rate of $432.59) – **$4,202.30**.

TPD for lost wages after 1/7/10 is ongoing.

6. Respondents claim that Claimant should be denied temporary disability benefits after his terminations from employment pursuant to Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., ("the termination statutes"). However, for the termination statutes to apply, there must be a finding that Claimant performed some volitional act or otherwise exercised a degree of control over the circumstances leading to the termination in light of the totality of the circumstances. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo.App. 1994). In determining whether Claimant engaged in volitional conduct, it is appropriate to look at cases in the unemployment insurance context applying the same principal. *Padilla, supra*. The burden of proof is on Respondents. *Witherspoon v. Metropolitan Club*, W.C. No. 4-509-612 (ICAO, Dec. 16, 2004).

7. With respect to Claimant's termination at FR, as set forth above, Claimant was not in violation of the company policy as written. Nor was he given any prior warning that more was expected of him with respect to keeping the employer apprised of his restrictions. As such, Claimant's conduct was not volitional and he was not responsible for his termination. *See Zelingers v. Industrial Commission*, 679 P.2d 608 (Colo.App. 1984) (Claimant in unemployment case who was given "tacit" permission to miss work and had no knowledge her employment would be jeopardized for doing so was not at fault for her termination).

8. Claimant was also not responsible for his termination from Employer that was based on Claimant having exceeded the allowable points under the Employer's no-fault absentee policy. An employer's policy, particularly a "no-fault" attendance policy that does not consider whether the absences were justified or unavoidable, is not determinative of whether a claimant acted volitionally with regard to his termination. *See, Gonzales v. Industrial Commission of State of Colorado*, 740 P.2d 999 (Colo. 1987). Furthermore, in this case, many of the absences were related to the subject injury. *See, e.g. Morales v. Wal Mart Stores, Inc.,* W.C. No. 4-770-910 (ICAO, Sept. 21, 2009).

9. Respondents have failed to establish by a preponderance of the evidence that Claimant was responsible for his termination from either of his jobs.

Order

It is therefore ordered that:

1. Claimant sustained a compensable injury on August 8, 2009, while working for Employer;

2. Claimant's average weekly wage at the time of the injury was $953.51 from both his jobs. The AWW increased to $1,008.88 as of October 29, 2009, to include the cost of replacement of his health insurance;

3. Insurer shall pay for Claimant's medical care from his authorized providers for this compensable injury; and

4. Insurer shall pay Claimant temporary disability benefits as set forth in the above Conclusions.

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

DATED: *February 1, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-784-552

ISSUES

- Whether Claimant is entitled to temporary total disability (TTD) from April 1, 2009, and ongoing;
- Whether Claimant was responsible for termination of her employment;
- If TTD is awarded, whether any TTD should be suspended due to failure to attend medical appointments; and
- Whether Claimant would not be entitled to TTD on the dates described in the Stipulated Facts below.

STIPULATED FACTS

The parties stipulated that Claimant was hospitalized for reasons unrelated to her work injury on April 19 and 20; May 2, 4, 13-16; July 18-20; and December 12 and 13, 2009.

The parties stipulated that Claimant's average weekly wage is $378 rather than $360 as indicated in the General Admission of Liability. The parties stipulated that Respondents are entitled to a credit of $875 due to overpaid temporary partial disability.

FINDINGS OF FACT

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

1. Claimant worked as a dental assistant for the Employer. On January 13, 2009, Claimant injured her right knee while assisting a patient transfer from one chair to another. Employer referred Claimant to Concentra for medical treatment.

2. On January 15, 2009, a Concentra physician restricted Claimant from standing and indicated she should be sitting 95 percent of the time. Concentra continued these restrictions through June 2009 when Claimant's restrictions were changed to: No prolonged standing and/

or walking longer than tolerated and no squatting and/or kneeling.

3. Claimant's job duties included setting up the rooms for each patient, assisting the dentists with treatment of patients, taking impressions, x-rays and polishing patients' teeth. Claimant's job required her to stand about 50 percent of her normal shift which was usually 12 hours long. Employer accommodated Claimant's restrictions by reducing her hours and allowing her to alternate standing and sitting throughout her work shift.

4. Claimant's work injury required her to attend appointments with her treating physicians. Claimant also had physical therapy (PT) two times each week. Claimant missed a PT appointment and one of the managing dentists, Dr. Moncayo, directed Claimant never to miss her medical appointments in the future. Claimant tried to coordinate her work schedule to accommodate her medical appointments and to obtain coverage by other staff when she needed to be away from work.

5. On March 31, 2009, Claimant was scheduled to work. She also had an appointment with Concentra. Claimant attended the appointment with Concentra then reported to work. Upon arrival, Claimant was directed into an office to meet with Dr. Rotolo. He terminated Claimant's employment for missing work that day and issued Claimant her final paycheck.

6. The Employer did not have a written policy regarding absences from work although the Employer expected an employee to find someone to cover a shift if that employee intended to be absent for any reason, including illness. The Employer's witness, Dr. Mardis, testified that Claimant failed to adhere to this unwritten policy. Dr. Mardis, however, did not provide testimony about when, other than on March 31, 2009, Claimant failed to adhere to the policy. No persuasive evidence shows that Employer counseled or reprimanded the Claimant about excessive absenteeism or failing to obtain coverage for her missed shifts.

7. Dr. Mardis also testified that Claimant's work performance was somewhat poor, and that Claimant did not progress as a dental assistant like the other assistants in training. Employer provided ongoing counseling about job performance to all of the employees, but no persuasive evidence shows that Claimant was counseled or reprimanded for poor work performance. In addition, no persuasive evidence shows that Claimant committed any volitional act that could be construed as poor work performance.

8. Claimant performed an x-ray on a patient after her personal physician had previously prohibited her from such activity. Employer reprimanded Claimant as evidenced in the memo to Claimant dated March 21, 2009. There is no persuasive evidence that Claimant ignored the Employer's directive rather she ignored her personal physician's directive.

9. Based upon the totality of the circumstances, Claimant did not commit a volitional act that led to the termination and did not exercise a sufficient degree of control over the

circumstances of her termination. Thus, Claimant was not responsible for the termination of her employment. According to Dr. Mardis, Employer terminated Claimant's employment primarily due to Claimant's failure to ensure coverage of her shifts during her absences from work. Employer also cited as other reasons for Claimant's termination that Claimant ignored Employer's directives such as missing Concentra appointments after being directed not to miss appointments. Employer, however, cited only one instance when Claimant missed work without obtaining shift coverage and that was the day Employer fired her for going to her Concentra appointment. If Claimant had missed the Concentra appointment because she could not find coverage, she would have violated Employer's directive. Here, Claimant went to the appointment in compliance with another Employer directive and was terminated.

10. Claimant was unable to perform her normal job within the restrictions imposed by Concentra in January 2009 and was on modified duty when Employer terminated her employment on March 31, 2009. No evidence reflects that Claimant has reached maximum medical improvement. Accordingly, Claimant has established entitlement to TTD commencing on April 1, 2009.

11. Claimant missed a Concentra appointment on April 7, 2009. Insurer issued a notice dated April 10, 2009, that advised the Claimant she was expected to attend a "second demand appointment" on April 20, 2009. The notice warned Claimant that if she failed to attend the appointment, her future benefits might be denied. Claimant attended the appointment on April 20.

12. Claimant missed a Concentra appointment on April 27, 2009. The Insurer issued no notice to the Claimant rather Concentra wrote a letter to Claimant advising her that it was medically important for her to keep appointments and to call to reschedule.

13. As the parties stipulated, Claimant was hospitalized for issues unrelated to her work injury on the dates described above. Claimant was still under physical restrictions imposed by Concentra physicians on the dates of her hospitalizations. Accordingly, Claimant would have been unable to perform her normal job duties regardless of the hospitalizations.

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).

Responsibility for termination

4. 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 claimant was responsible for his or her termination. *See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P.3d 1209 (Colo. App. 2000). An employee is "responsible" if the employee precipitated the employment termination by a volitional act, which 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 (September 27, 2001). Thus, the fault determination depends upon whether claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *See Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995).

5. As found, Claimant did not commit a volitional act that led to the termination and did not exercise a sufficient degree of control over the circumstances of her termination. Thus, Claimant was not responsible for the termination of her employment and §§ 8-42-103(1)(g) and 8-42-105(4), C.R.S., do not bar Claimant from receiving temporary disability benefits.

Entitlement to TTD benefits

6. To prove entitlement to 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), C.R.S., requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. The work-related injury, however, need not be the sole cause

of the wage loss, but must contribute to some degree. *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 her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 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 to perform her regular employment effectively and properly. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

7. Claimant has established that she is entitled to TTD commencing on April 1, 2009, and ongoing. As found, Claimant was unable to perform her normal job within the physical restrictions imposed by her physicians, and was on modified duty when Employer terminated her employment. No evidence reflects that Claimant has reached maximum medical improvement.

8. Respondents contend that Claimant should not be entitled to TTD on dates she was hospitalized for reasons unrelated to her work injury. Respondents urge the Judge to consider the hospitalizations as intervening events sufficient to sever the causal connection between Claimant’s work injury and her subsequent wage loss. However, benefits are precluded only when the work-related injury plays no part in the subsequent wage loss. If the injury contributed in part to the wage loss, temporary partial disability benefits can be denied only if one of the statutory conditions is satisfied. *PDM Molding, Inc. v. Stanberg, supra*; *see also Horton v. Industrial Claim Appeals Office,* 942 P.2d 1209 (Colo. App. 1996). Because Claimant was still restricted from standing due to her work injury when she was hospitalized, she still could not have performed her regular job regardless of the hospitalizations.

Suspension of TTD

9. As found, Claimant missed a medical appointment on April 7, 2009, and the Insurer scheduled an appointment for April 20, 2009. The notice issued by Insurer warned Claimant that if she failed to attend the appointment, her benefits might be denied. Under § 8-42-105(2)(c), C.R.S., if a claimant fails to attend an appointment with his or her attending physician the employer is required to notify the claimant that his or her temporary total disability benefits may be suspended if the claimant fails to attend a rescheduled appointment. If a claimant fails to attend the rescheduled appointment, then the employer is permitted to suspend payment of temporary total disability benefits until the claimant attends a subsequent rescheduled appointment. Here, there is no evidence that Claimant missed the “rescheduled” appointment. The rescheduled appointment was for April 20 and according to the medical records, Claimant attended her appointment at Concentra on April 20. Accordingly, the suspension provisions of § 8-42-105(2)(c), C.R.S., are inapplicable.

10. Claimant missed another appointment on April 27, 2009, however neither the

Insurer nor the Employer issued a notice in compliance with § 8-42-105(2)(c), C.R.S., and Respondents presented no evidence that Claimant failed to attend a subsequent "rescheduled" appointment. The suspension provisions of § 8-42-105(2)(c), C.R.S., are also inapplicable to the missed appointment on April 27.

ORDER

It is therefore ordered that:

1. Claimant has established that she is entitled to TTD at the AWW rate of $378 commencing April 1, 2009, and continuing uninterrupted until terminated pursuant to statute.

2. Respondents are entitled to a credit in the amount of $875 due to overpaid temporary partial disability benefits.

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

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

DATED: February 2, 2010

_____
Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-517-260

ISSUES

The issue determined herein is the appeal from the prehearing administrative law judge ("PALJ") order dismissing this case with prejudice.

FINDINGS OF FACT

1. Claimant suffered an admitted industrial injury on September 4, 2001.

2. On January 27, 2005, respondents filed an amended final admission of liability for permanent partial disability benefits and for reasonably necessary medical benefits after maximum medical improvement.

3. In September 2007, counsel for claimant entered his appearance in the claim. In December 2007, claimant applied for hearing, which was set for March 25, 2008. The parties resolved the issue for hearing by agreeing that Dr. David Richman would become the authorized treating physician.

4. On May 14, 2008, respondents sent claimant's counsel requests to execute medical releases and to provide a list of providers for the past five years for the injured body parts. Claimant's attorney provided medical records from Dr. Richman, but did not provide any list of providers. On June 6, 2008, respondents again requested that claimant provide the list of providers for the past five years. Claimant did not respond.

5. On June 17, 2008, respondents moved to compel claimant to provide the list of medical providers. Claimant did not file a response. On July 1, 2008, PALJ Jaynes granted the motion to compel the list of providers within five days. Claimant did not respond.

6. On July 2, 2008, respondents wrote to Dr. Richman to ask if claimant needed additional treatment, noting that Dr. McMahon had said that claimant's cataracts were "senile."

7. On July 7, 2008, respondents requested that claimant provide the list of providers. Claimant did not respond. Respondents indicated that they would file a motion to dismiss the claim.

8. On July 11, 2008, respondents moved to dismiss the claim for failure to obey the order compelling the list of providers. Claimant did not file a response. At the February 2, 2010 hearing, claimant indicated that his office staff received the motion to dismiss, but did not route it to him. On July 29, 2008, PALJ de Marino granted the motion, dismissing the case with prejudice.

9. On August 26, 2008, claimant moved to set aside the order of dismissal. Claimant's attorney at that time alleged that he had not received the motion to dismiss or the order of dismissal until after he showed up for a deposition that had been canceled. He alleged that the request for a list of medical providers was unnecessary because claimant had no other doctors. He argued that WCRP 5-4 only allowed a request for a list of providers for five years before the injury and there was no authority to request a new list of providers covering the last five years before a new request. Finally, claimant also argued that the PALJ lacked jurisdiction to dismiss the claim, resulting in a denial of medical benefits. On August 27, 2008, respondents responded to the motion and noted that the motion and the order of dismissal had been served on claimant's attorney.

10. On September 12, 2008, PALJ de Marino denied the motion to set aside the order, noting that claimant had not responded to the motion to dismiss, had waited 28 days after the order of dismissal to file the motion to set aside, and did not cite any authority in his motion.

11. On February 6, 2009, claimant filed an application for hearing on the issue of medical benefits. Respondents moved to strike the application. Claimant did not file any response. On March 24, 2009, this Judge granted the motion to strike the application.

12. On May 18, 2009, claimant filed another application for hearing on medical benefits. Respondents moved to strike the application for hearing and for a protective order against claimant filing any further pleadings in this claim. Claimant responded and insisted that he would continue to apply for hearings even if a protective order were entered. He argued that the PALJ had no authority to dismiss the claim and that claimant had no obligation to answer interrogatories without a pending hearing.

13. On June 2, 2009, this Judge granted the motion to strike the application for hearing and issued a protective order against claimant filing any additional pleadings in this claim except for a petition to reopen the claim pursuant to statute.

14. Claimant petitioned for review. On September 9, 2009, the Industrial Claim Appeals Office set aside the protective order and held that claimant always has the right to apply for a hearing to appeal a previous PALJ order.

15. On October 13, 2009, claimant applied for hearing on the issue of medical benefits and the appeal of the PALJ order. On December 17, 2009, PALJ de Marino entered a prehearing order limiting the issue for hearing to appeal of the July 29, 2008, PALJ order.

16. Claimant, through counsel, has repeatedly and willfully failed to comply with a PALJ order compelling provision of a list of medical providers.

CONCLUSIONS OF LAW

This hearing once again involved the issue of “appeals” of PALJ orders to OAC Judges. The workers’ compensation act establishes no procedure for such appeals. The courts have inferred such a procedure and the law governing such appeals is still unsettled. In *Industrial Claim Appeals Office v. Orth*, 965 P.2d 1246 (Colo. 1998), the Supreme Court held that a PALJ may approve a settlement agreement and the order approving the settlement is a final order subject to appeal rather than an interlocutory order. The Court also noted, “a PALJ's order relating to a prehearing conference is interlocutory (i.e., not immediately appealable) because a prehearing conference, by definition, is followed by a full hearing before the director or an ALJ. . . . Thus, the propriety of a PALJ's prehearing order may be addressed at the subsequent hearing.” The Court distinguished the interlocutory nature of the prehearing order from the order approving a settlement, which was at issue in *Orth*.

Dee Enterprises v. Industrial Claim Appeals Office, 89 P.3d 430 (Colo.App. 2003)

affirmed the conclusion that the hearing ALJ could alter prehearing orders by the PALJ. The PALJ had ordered that depositions must be completed before the hearing. Some last minute circumstances caused claimant to request the opportunity to allow a post-hearing deposition of a witness. Respondent argued that the prehearing orders were “binding on all parties” pursuant to section 8-43-207.5(3), C.R.S., and the hearing ALJ could not alter them. The Court noted that the statute does not confer exclusive jurisdiction in the PALJ to determine discovery matters or evidentiary disputes. A party may request a prehearing conference only up to 10 days before the hearing and it would have been impractical, if not impossible, for claimant to request a prehearing conference. The Court concluded:

> Employer has presented no authority which convinces us that an ALJ lacks authority to override the ruling of a PALJ, and we conclude that the circumstances occurring here after the prehearing order lessened its binding effect. Not only was the ALJ presented with claimant's renewed request at the hearing, but that request was necessitated by time constraints arising immediately prior to the hearing, and the request involved evidence having the potential to affect the outcome. Thus, the ALJ did not abuse his discretion in granting claimant's motion.

Szot v. U.S. Security Associates, Inc., W.C. No. 4-714-229 (ICAO, October 2, 2007) held that a PALJ order dismissing a claim for refusing to comply with orders compelling discovery was subject to appeal to an OAC Judge. The OAC Judge had held that the PALJ order dismissing the claim was analogous to the PALJ order approving a settlement, as in *Orth*, *supra*. In *Szot*, ICAO relied on *Orth* and held that only one exception existed to the categorization of all PALJ orders as interlocutory and that exception was orders approving settlements. All other PALJ orders are interlocutory and, by definition, subject to review by an OAC Judge. *Orth*’s assumption that a hearing would always follow a PALJ order, while erroneous, becomes self-effectuating. The *Orth* progeny now clearly defines the proper appeal for all PALJ orders is to an OAC Judge. The ICAO opinion in the current matter noted that the protective order was overly broad. An order precluding claimant from filing any additional applications for hearing on the issue of medical benefits until he complied with discovery orders would have been permissible. Because claimant retained a right to file an application for hearing to appeal the July 29, 2008, PALJ order of dismissal, the protective order could not prohibit an application for hearing on that issue. The application for hearing was also on the issue of medical benefits, but the December 17, 2009, PALJ order limited the issue for hearing only to the appeal of the PALJ order.

Claimant argues that the original PALJ order compelling the provision of the lists of medical providers was incorrect and that the order of dismissal for violating the order to compel was outside the jurisdiction of the PALJ. Respondents argue that the PALJ had jurisdiction to issue the order of dismissal, which pursuant to the *Orth* progeny, is interlocutory and subject to appeal to the OAC Judge.

Respondents persuasively cite *Rencoret-Rodriguez v. The Chemins Co., Inc.,* W.C. No. 4-691-205 (ICAO, May 7, 2008), a case remarkably similar to the instant matter. In *Rencoret-Rodriguez,* a PALJ order compelled claimant to answer interrogatories. Claimant did not respond to the interrogatories and a PALJ order dismissed the claim with prejudice for willfully failing to comply with the discovery orders. Claimant applied for hearing before an OAC Judge to appeal the PALJ order of dismissal. The OAC Judge held that the PALJ did not have statutory authority to enter an order that could be construed as final, except for settlements. The Judge construed the PALJ order of dismissal as interlocutory and subject to his review. The Judge determined that dismissal of the claim was an appropriate sanction because of claimant's repeated and willful failure to comply with discovery orders. ICAO affirmed the order. Claimant argued that the OAC Judge had no authority to consider the motion to dismiss the claim and that the issue before OAC was limited to the narrow question of whether the PALJ could dismiss the claim. ICAO disagreed and held that that claimant had an opportunity to be heard on the "central issue" of dismissal of the claim.

Similarly, in the current case, claimant has had multiple opportunities to be heard on the issue of dismissal of the claim. It strains credulity to argue that claimant should not have to discuss the merits of the motion to dismiss the claim. The *Orth* progeny makes clear that the PALJ orders are interlocutory, except for approval of settlements, <u>because</u> they <u>will</u> be reviewed by the OAC Judge. The analysis is not that a PALJ may only enter certain types of orders that would be interlocutory and an order of dismissal is a "final" order that is not interlocutory. That analysis was rejected in *Szot, supra*. Consequently, the issue presented at the hearing is whether the claim should be dismissed and not just whether a PALJ had authority to enter an order of dismissal.

The Judge concludes that claimant's claim should be dismissed with prejudice, subject only to the statutory petition to reopen, due to claimant's multiple, willful failures to comply with the order compelling provision of the list of medical providers. The conduct of claimant's counsel is difficult to explain. He refused to comply with WCRP 5-4. He failed to respond to the motion to compel. He refused to comply with the motion to compel. He failed to respond to the motion to dismiss, allegedly because his office staff mishandled the motion. The only logical conclusion is that claimant has obstinately and willfully failed to comply with the PALJ order. Dismissal of the claim is the reasonable remedy for the repeated willful failure to comply. *Sheid v. Hewlett Packard*, 826 P.2d 396 (Colo. App. 1991). The unfortunate fact is that claimant might have a meritorious claim for additional medical benefits in this claim. We will never know because his attorney has steadfastly refused to comply with the order compelling the information.

Claimant also argues that the underlying motion to compel was unmeritorious because WCRP 5-4 only allows a one-time request for medical releases and a list of providers over a five-year period. Consequently, claimant had no duty to respond to the request for updated information. That argument, while not obviously correct, at least would have been an

appropriate response to the motion to compel. Claimant made no response. The order compelling the information was entered. Claimant had to obey it, even if he thought it was wrong. *Kennedy v. Industrial Claim Appeals Office*, 100 P.3d 949 (Colo. App. 2004) affirmed a penalty against a claimant for violating a PALJ order to attend a Division Independent Medical Examination. The Court held that the statute provides for no automatic stay of a PALJ order pending review by a hearing ALJ, stating: "Under the circumstances, we agree with the Panel that a party may not elect, without fear of consequences, to ignore a ruling of the PALJ in the hope of obtaining a more favorable ruling before the ALJ. Any change in the current procedure must come from the General Assembly." Once again, *Rencoret-Rodriguez, supra*, is on point. Claimant had argued that the discovery rules did not apply because no hearing was pending on the date that the PALJ dismissed the claim. ICAO held that no authority supported claimant's argument. ICAO noted that the PALJ had authority to address discovery without any limitation that a hearing must be pending. Similarly, in the current matter, the PALJ could address the WCRP 5-4 provision of requests and information, even if no hearing was pending before OAC.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits other than those already admitted and paid is hereby dismissed with prejudice, subject only to any statutory petition to reopen.

DATED: February 3, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-740-233

ISSUES

Ø Did claimant prove by a preponderance of the evidence that she sustained a compensable injury on May 23, 2007 (W.C. No. 4-740-233)?

Ø Did claimant prove by a preponderance of the evidence that she sustained a compensable injury on November 19, 2007 (W.C. No. 4-785-999)?

- Did claimant prove by a preponderance of the evidence that she is entitled to medical benefits?

FINDINGS OF FACT

0. Employer operates a soup-kitchen type facility, where claimant is employed as a head cook. On May 23, 2007, claimant tripped and fell while walking downstairs at one of employer's facilities. Claimant contends the fall down stairs on May 23, 2007, resulted in a lower back injury. Claimant's May 23, 2007, claim is denominated W.C. No. 4-740-233. Claimant's testified that she re-injured her lower back when moving a 40-pound container of laundry soap while crawling on her knees in the back of employer's van on November 19, 2007. Claimant's November 19, 2007, claim is denominated W.C. No. 4-785-999.

1. According to the Employer's First Report of Injury (E-1) for W.C. No. 4-740-233, claimant stated that she simply tripped while descending the stairs on May 23, 2007. Claimant declined medical treatment and continued working.

2. While claimant testified at hearing that she tripped on carpet on May 23, 2007, her testimony is inconsistent with what she reported to employer's workers' compensation coordinator, Jodi Warner, that same day. When Ms. Warner discussed claimant's fall down stairs with her on May 23rd, claimant neither mentioned that she tripped on carpet nor that she injured her back. Claimant's testimony about tripping on carpet similarly is inconsistent with the history she provided to her physicians, with what she reported to the insurer's investigator, and with what she reported in her discovery responses. The investigator reported that he and claimant looked at the steps together and found nothing wrong with the steps nor any type of hazard that may have caused claimant to trip.

3. Claimant's testimony that she tripped on carpet on May 23rd also is inconsistent with what she reported to Dr. Bisgard. Claimant reported to Dr. Bisgard that she is not sure what happened, only that she tripped and fell down the stairs. Claimant acknowledged on cross-examination that, prior to testifying at hearing, she had not previously mentioned tripping on a carpet.

4. Claimant's testimony that she tripped on carpet is inconsistent with what she reported to her own independent physician, John S. Hughes, M.D. The history Dr. Hughes obtained from claimant contains nothing about claimant tripping on a carpet.

5. Claimant's testimony about tripping on carpet lacks credibility. Claimant's testimony that she tripped on carpet is inconsistent with what she reported to employer at the time of her injury, with the history she provided to medical providers, with what she reported to insurer's investigator, and with her discovery responses. The Judge instead credits the more consistent story claimant told in finding it more probably true that claimant's fall on the stairs

is unexplained.

6. On August 4, 2007, claimant sought urgent treatment at Exempla St. Joseph Hospital, complaining of an acute onset of right leg pain 3 days earlier. James Martin, M.D., noted that claimant had experienced similar symptoms from an episode in January of 2007. Dr. Martin noted claimant's leg pain of unclear etiology. On August 9, 2007, claimant underwent surgery to her lower back, a right L5-S1 miscrodiskectomy.

7. Claimant failed to disclose in her answers to interrogatories her pre-existing injury in January 2007, where she reported right leg pain for three weeks after striking her thigh on a metal table. When questioned about the January 2007 incident by Dr. Bisgard, claimant stated that the contemporaneous medical documentation was incorrect and that she actually injured her left leg in January of 2007.

8. According to Dr. Bisgard, it is medically improbable that claimant's fall down stairs on May 23, 2007, proximately either caused her lower back condition or resulted in her need for low back surgery in August of 2007. Dr. Bisgard opined that it is common for individuals with back problems to initially experience leg pain like that claimant reported to her physicians in January 2007. Dr. Bisgard opined that claimant's lower back symptoms were more likely caused by her injury in January 2007. Dr. Bisgard's medical opinions are credible and persuasive.

9. Claimant failed to show it more probably true than not that she injured her lower back when she fell down employer's stairs on May 23, 2007. As found, it is medically improbable that claimant's fall down stairs on May 23, 2007, caused her lower back condition or resulted in her need for lower back surgery in August of 2007. In addition, there was no persuasive evidence otherwise showing claimant's fall resulted in an injury caused by a hazard of her employment. Stairs are ubiquitous and are not a special hazard of employment.

10. Claimant testified that she re-injured her low back at work on November 19, 2007, when unloading supplies from a van. Claimant failed to report this alleged injury to employer until February 27, 2009, over 15 months later. Dr. Bisgard opined that claimant's story about this alleged injury is inconsistent with the absence of any contemporaneous injury described in the medical records. Additionally, Dr. Bisgard testified that an individual in claimant's particular condition could have re-injured her back in a myriad of ways unconnected to her employment with employer. Dr. Bisgard's opinions are more persuasive than those of Dr. Hughes.

11. While claimant testified that she immediately reported the alleged November 19, 2007, incident to employer's representatives, claimant's testimony lacks credibility when weighed against testimony of her supervisor, Sherry Kern, and Ms. Warner. Both Ms. Kern, and Ms. Warner testified that they were unaware of claimant's claim until some 15 months later, on February 27, 2009, when she filed a Workers' Claim for Compensation. In addition, Ms.

Warner stated that she is trained to promptly file an E-1 whenever an employee reports an injury. Ms. Warner's testimony here was supported by her conduct in promptly filing an E-1 as soon as claimant reported her initial fall down the stairs in May 2007. Neither Ms. Kern nor Ms. Warner prepared or filed an E-1 for claimant's alleged injury on November 19, 2007, until she reported an injury on February 27, 2009. The Judge credits the testimony of Ms. Warner and Ms. Kern as more persuasive than claimant's testimony.

12. Claimant's failure to report her alleged injury for some 15 months is inconsistent with her claim that she injured herself while unloading the employer's van on November 19, 2007. Claimant's story about injuring herself on November 19, 2007, is uncorroborated by medical-record evidence of what she reported to her physicians. Crediting the medical opinion of Dr. Bisgard, claimant's story is medically improbable because she failed to report any history of a November 2007 injury to her medical providers. The first record evidence of claimant reporting this history occurred at her independent medical examination with Dr. Hughes on March 2, 2009, some 15 months after the alleged injury.

13. Claimant failed to show it more probably true than not that that she sustained an injury arising out of the course and scope of her employment on November 19, 2007. Because of inconsistencies between claimant's story and the totality of the evidence, the Judge is unable to credit claimant's testimony.

CONCLUSIONS OF LAW

Claimant argues she has proven by a preponderance of the evidence that she sustained compensable injuries on May 23, 2007, and on November 19, 2007. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Workers' Compensation Act), §§8-40-101, *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 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).

An injury occurs “in the course of” employment where the claimant demonstrates that the injury occurred within the time and place limits of her employment and during an activity that had some connection with her work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The “arising out of” element is narrower and requires the claimant to show a causal connection between the employment and the 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 Triad Painting Co. v. Blair*, *supra*. The mere fact that an injury occurs at work does not establish the requisite causal relationship to demonstrate that the injury arose out of the employment. *Finn v. Industrial Commission*, 437 P.2d 542 (1968).

An unexplained fall is not a compensable injury. *Irwin v. Industrial Commission*, 695 P.2d 763 (Colo. App. 1984) (unexplained fall in a lobby of a building is not compensable); *Tidwell v. Department of Corrections*, W.C. No. 3-975-154 (ICAO, June 24, 1994) (unexplained fall from a stool is not compensable); *Aguilar v. Checks Unlimited*, W.C. No. 4-761-110 (ICAO, April 30, 2009) (there is no presumption that a fall is compensable and an unexplained fall at the workplace is not compensable).

Here, the Judge found claimant failed to show it more probably true than not that her fall down employer’s stairs on May 23, 2007, proximately caused her need for low back surgery on August 9, 2007. The Judge further found that claimant failed to show it more probably true than not that that she sustained a work-related injury on November 19, 2007. Claimant thus failed to prove by a preponderance of the evidence that she sustained compensable injuries on May 23, 2007 and November 19, 2007.

The Judge concludes that claimant’s claim for workers’ compensation benefits under W.C. No. 4-740-233 for an injury May 23, 2007, should be denied and dismissed. Claimant’s claim for workers’ compensation benefits under W.C. No. 4-785-999 for an injury November 19, 2007, should be denied and dismissed. Because claimant failed to carry her burden of proof in showing that she suffered compensable injuries, the remaining issues endorsed for hearing are moot.

ORDER

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

1. Claimant’s claim for workers’ compensation benefits under W.C. No. 4-740-

233 for an injury May 23, 2007, is denied and dismissed.

2. Claimant's claim for workers' compensation benefits under W.C. No. 4-785-999 for an injury November 19, 2007, is denied and dismissed.

DATED: _February 2, 2010___

Michael E. Harr,
Administrative Law Judge
Office of Administrative Courts

This matter comes before the undersigned Administrative Law Judge ("ALJ") of the Office of Administrative Courts ("OAC") upon Respondents' Unopposed Motion for Corrected Order dated February 4, 2010. Having reviewed said Motion, and any Response thereto, the ALJ enters the following Corrected Order:

1. The Order portion of the Findings of Fact, Conclusions of Law and Order dated February 1, 2010 is corrected as follows:

Insurer shall pay according to the Official Medical Fee Schedule of the Division of Workers' Compensation the expenses for surgery for mass excision of the inclusion cyst at Claimant's right middle finger as recommended by Dr. Kavi Sachar, M.D. Insurer is not liable for arthroscopic debridement surgery for Claimant's right wrist.

2. The remainder of the Findings of Fact, Conclusions of Law and Order of February 1, 2010 remain as stated and are incorporated as if fully set forth herein.

All matters not determined herein are reserved for future determination.

DATED: February 4, 2010

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-733-328

ISSUES

Ø Did Respondents prove by a preponderance of the evidence that Claimant's benefits should be apportioned pursuant *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 199 (Colo. App. 2004)?

FINDINGS OF FACT

1. Claimant was employed with employer as a delivery driver. Claimant was involved a motor vehicle accident ("MVA") on August 16, 2007 when he was driving a delivery van on County Road 501. A deer ran out in front of the van. Claimant caused the van to swerve to avoid hitting the deer. Claimant lost control of the van and the van went off the road, traveling through a fence and into a field. As a result of this accident, Claimant suffered injuries to his head, low back, upper back, neck, shoulder and thigh. Claimant was taken from the scene of the accident to the emergency room by ambulance and subsequently came under the care of Dr. Jernigan.

2. Respondents originally contested Claimant's injury, but the claim was found compensable by ALJ William Martinez by virtue of an order dated February 15, 2008. ALJ Martinez found that as a result of Claimant's compensable injury, Claimant needs and will need in the future medical care. Respondents were ordered to pay for temporary total disability ("TTD") benefits and reasonable and necessary medical benefits to cure and relieve the Claimant from the effects of the industrial injury. The order became final after Respondents withdrew their Petition to Review.

3. Claimant has an extensive medical history prior to his August 16, 2007 MVA, including a work related injury in 2002. Claimant underwent two microdiscectomy surgeries for his lower back injury after complications with the first surgery led to nerve root impingement at the L5 level. Claimant was eventually placed at maximum medical improvement on January 21, 2004 with a 28% whole person impairment rating and a permanent lifting restriction of forty (40) pounds.

4. Claimant suffered a second injury to his lower back on August 25, 2005 when he injured his back in a roll over MVA. Claimant was employed with DHL when the right front tire dropped off the pavement and caused Claimant's delivery truck to flip over. Claimant was eventually placed at maximum medical improvement ("MMI") for the August 25, 2005 injury by Dr. Jernigan on January 29, 2007 and was provided with a 16% whole person impairment rating.

5. Claimant also has various complaints with regard to his cervical spine pre-existing the present claim. However, the cervical spine complaints are not relevant to the consideration of apportionment for purposes of this hearing.

6. Claimant suffered an admitted work related injury on December 22, 2006 to his bilateral knees when he slipped on ice while walking up a customer's walk. A magnetic resonance image ("MRI") of the left knee taken on March 8, 2007 showed osteoarthritis with

an extensive tear of the medial meniscus. Claimant eventually underwent left knee arthroscopy with partial medial menisectomy and partial lateral menisectomy on September 18, 2008 under the auspices of Dr. Blevins. Claimant received workers' compensation benefits for the knee injury claim at the same time Claimant received benefits for the August 16, 2007 back injury, with Respondents offsetting any TTD benefits Claimant was receiving for the knee injury against benefits that would have been owed Claimant for the back injury in addition to any other statutory offsets allowed by Respondents for unemployment or social security benefits.

7. Following Claimant's August 16, 2007 injury, Claimant reported to Dr. Jernigan on August 21, 2007. Dr. Jernigan provided Claimant with a diagnoses of left medial thigh contusion, minor closed-head injury with scalp abrasions, cervical strain and significant lumbar strain. Dr. Jernigan noted that he had treated Claimant previously for his prior occupational injuries. Dr. Jernigan noted that Claimant had a prior low-back injury with residual S1 radicular symptoms and "right radicular pain and low back pain has been aggravated by this bouncing-type injury that occurred with the car wreck." Dr. Jernigan noted Claimant had significant soreness in his low back, particularly on the right lower lumbar area and an increase in his S1 parathesias on his right lateral calf and foot and had a 20 to 25 centimeter in diameter contusion to the left medial thigh, distally just above the knee. Dr. Jernigan recommended an MRI of the cervical and lumbar spine to determine the extent of the new injury, as opposed to aggravation of his old injury.

8. Claimant returned to Dr. Jernigan on September 11, 2007 with complaints of bilateral numbness in the web space between his first and second toes, and some right lateral leg paresthesias. Due to Claimant's injuries from the August 16, 2007 MVA, the proposed knee surgery for his prior work related injury was delayed. During this time, Claimant continued to receive medical treatment for both his December 22, 2006 slip and fall injury and his August 16, 2007 MVA.

9. Claimant returned to Dr. Jernigan on October 16, 2007. Dr. Jernigan noted that Claimant's MRI of his lumbar spine showed a fairly marked L4-5 left disk bulge that may not have been present on the June 27, 2003 MRI and, therefore, Dr. Jernigan wondered whether Claimant had some degree of new L4-5 disk problems from the MVA. Claimant returned to Dr. Jernigan on November 5, 2007 with continued complaints of persistent low back pain and pain in his knees. Dr. Jernigan opined that his left sided lumbar problems were new compared to his old MRI's, but indicated that Claimant was not presently a surgical candidate and recommended Claimant proceed with conservative treatment, including medications and physical therapy.

10. Claimant was referred to Dr. Youssef in January 2008. Dr. Youssef noted Claimant was an old, established patient who had undergone two surgeries including an L4-5 microdiscectomy on the right for right-sided radiculopathy and recurrent disc herniation with right-sided revision microdiscectomy and epidural scar neurolysis. Dr. Youssef noted that

after an August 16, 2007 MVA, Claimant had right-sided and left-sided low back pain and middle back pain, radiating to his leg and foot. Dr. Youssef noted Claimant had an MRI scan of his lumbar spine performed on August 27, 2007 that showed a left forminal far lateral eccentric disc bulge and osteophytic complex at L4-5, resulting in moderate left lateral recess stenosis, partial medial facetectomy and foraminotomy at L4-5, and some mild peri-facet inflammation at L4-5 that were unchanged from his previous MRI. Dr. Youssef diagnosed Claimant with right-sided radicular features, status post previous L4-5 microdiscectomy without evidence of recurrent herniation and some mild epidural scar formation with evidence of previous foraminotomy on the right.

11. By November 12, 2008, Claimant had undergone L5 transforaminal epidural injections under the auspices of Dr. Isser-Sax. Claimant reported to Dr. Isser-Sax that he no longer had left sided pain, but continued to experience right sided pain that were aggravated by the epidural injections before returning to baseline level. Dr. Isser-Sax opined that Claimant was having an exacerbation of his radicular pain and recommended Claimant continue with his physical therapy.

12. Claimant underwent another MRI of the lumbar spine on December 18, 2008 that showed a right sided extruded disc at the L5-S1 level, centered at the right lateral recess, without extension into the neural foramen, as well as postsurgical changes at L4-L5 with evidence of hemilaminectomy and severe degenerative disc disease at that level with hypertrophic facet degenerative changes causing mild anterolisthesis of L4 on L5, with bulging discs extending to both neural foramen, left greater than right. Dr. Youssef examined Claimant on March 5, 2009. Claimant presented with complaints of back pain and right greater than left leg pain. Dr. Youssef noted Claimant had an MRI on December 18, 2008 and diagnosed Claimant with a (1) postlaminectomy syndrome status post previous microdisectomy in 2003 with increasing back pain, (2) degenerative sponylolisthesis with hyperdynamic features at L4-5, (3) osteoarthritis of both knees, and (4) disc herniation of L5-S1 on the right with bilateral radicular features, right greater than left, all of which are failing nonoperative efforts. Dr. Youssef acknowledged that Claimant's situation was quite complex, and recommended Claimant proceed with surgical intervention in the form of a revised decompression and fusion at L4-5 and posterior spinal fusion of L4-5 with transforminal lumbar interbody fusion of L4-5, pedicle screw instrumentation of L4-5, as well as an L5-S1 microdisectomy on the right, hemilaminectomy and medial facetectomy.

13. Dr. Jernigan issued a letter to Claimant's counsel on April 17, 2009 that acknowledged this case was one of mixed causality. Dr. Jernigan opined, however, that because Claimant was functional and doing well up until the time of his August 16, 2007 MVA that caused the aggravation of his underlying problems, he opined that the August 16, 2007 MVA was the primary causation for his need of surgery at this time. Dr. Jernigan noted that the MVA aggravated Claimant's back condition to the point that he was no longer responding to conservative measures and was the primary causation for the need for surgery.

14. Claimant was referred by Respondents to Dr. Douthit on April 27, 2009 for an independent medical examination ("IME"). Dr. Douthit noted Claimant had a long history of prior back injuries before the present claim. Dr. Douthit noted Dr. Jernigan had found on July 7, 2008 that Claimant was having sever pain in his low back and an MRI after the MVA showed a significant L4-5 left disc protrusion which was not there previously along with his right arachnoiditis that was chronic. Dr. Douthit noted that the MRI actually showed a disc protrusion at the L5-S1 level. Dr. Douthit also reported that Dr. Youssef had indicated in his March 5, 2009 report that Claimant had symmetric disc collapse with severe spondylolysis at L4-5 with a slight spondylothesis of L4 and 5 measuring 4 mm.

15. Dr. Douthit diagnosed Claimant with (1) degenerative spondylisthesis of the lumbar spine, with possible disc herniation at L5/S1 with right-sided sciatica, (2) degenerative arthritis of both knees, (3) advanced aging with degenerative disease, generalized, (4) history of injury to upper back, neck and shoulder with impairment, (5) depression, (6) hypertension and fluid retention with edema of the legs and (7) history of oral narcotic dependency and chronic pain. Dr. Douthit noted Claimant, from his history, has a symptomatic aggravation of his lumbar spine with sciatica of his right leg with clinical evidence of a herniated disc at L5-S1 that was not present on earlier MRI's. Dr. Douthit noted that, allowing benefit of the doubt, this appeared to be related to the August 16, 2007 MVA. Dr. Douthit opined that all the other problems of Claimant's lumbar spine were related to previous problems with degenerative changes throughout the lumbar spine. Dr. Douthit opined that Claimant had not returned to his baseline for the injury to his lumbar spine and noted that claimant gave a history that he was fully active for two years prior to his MVA. Dr. Douthit opined that while the herniated disc at L5-S1 was the result of the accident, the disc deterioration with narrowing, listhesis at L4-L5 was present before the accident and 80% of Claimant's treatment is related to his pre-existing problems with 20% related to the aggravated symptomatology and the possible new injury of the L5-S1 disc with sciatica. Dr. Douthit opined that a microdiscectomy at L5-S1 would be related to the August 16, 2007 MVA and opined that the proposed extensive surgery involving the fusion of L4-L5 would be unlikely to relieve Claimant from his back pain.

16. Dr. Youssef reviewed the IME from Dr. Douthit and issued a letter to Respondents' counsel on May 14, 2009 that agreed that the MRI showed chronic changes that were not caused by the MVA of August 16, 2007. Dr. Youssef noted Claimant had an exacerbation and aggravation of the L4-5 disc space. Dr. Youssef indicated that any surgery done at the L4-5 level would be based on Claimant's pre-existing disease. Dr. Youssef noted from a surgical standpoint that it is hard to recommend a surgical intervention under one anesthetic to treat an MRI finding in isolation. Dr. Youssef believed Claimant required both procedures, but recommended an apportionment be obtained related to the L4-5 level. Dr. Jernigan noted on May 20, 2009 that he disagreed with the opinions of Dr. Douthit. Dr. Jernigan noted that Claimant's injury at the L5-S1 level was related to the new injury and believed that there was an aggravation of the L4-L5 injury that had activated significant problems that had not been prevalent for a number of years. Dr. Jernigan noted that Claimant had not had

significant problems his back for several years prior to the accident and had been working, driving 200 miles per day, and carrying up to an 80 pound package. Dr. Jernigan opined that two-thirds of Claimant's current symptomatology was related to the MVA while one-third was related to his pre-existing condition.

17. Dr. Jernigan testified at the hearing in this matter. Dr. Jernigan testified he is board certified in emergency medicine and was qualified as an expert. Dr. Jernigan noted he was not an expert and not an orthopedic surgeon. Dr. Jernigan testified he had treated Claimant since 2002. Dr. Jernigan testified that when he placed Claimant at MMI for his 2002 injury in January 2004, his only recommendations for ongoing treatment included physical therapy and psychological treatment. Dr. Jernigan testified that while it was medically probable that Claimant would develop some degree of arthritic changes in his lumbar spine over the next 15-20 years, surgery was not inevitable. Dr. Jernigan testified he treated Claimant for injuries following a MVA in 2005. Dr. Jernigan testified it was his opinion Claimant would continue to work for employer if not for the August 16, 2007 MVA. Dr. Jernigan noted that Claimant could possibly have needed a fusion in 10-15 years and had a 50-50 chance of needing a fusion at the L4-5 level in 20 years.

18. Dr. Douthit testified in rebuttal for Respondents. Dr. Douthit has practice for 40 years and was qualified as an expert in orthopedic surgery. Dr. Douthit quit performing surgeries a year ago, and quit performing back surgeries 15 years ago. Dr. Douthit opined that the proposed fusion surgery was not related to the August 16, 2007 injury as the fusion surgery is designed to address the arthrodesis that was present before the August 16, 2007 MVA. Dr. Douthit opined he relied heavily on the objective evidence contained in the medical records, including the MRI's of Claimant's lumbar spine. On cross-examination, Dr. Douthit testified that based on his review of the medical records, prior to August, 2007, no physician was recommending surgery for Claimant's low back. Dr. Douthit also provided no opinion as to whether a future back surgery was inevitable as of January 2004, when Claimant was put at MMI by Dr. Jernigan for his prior back injury. Dr. Douthit noted that it is not inevitable for a patient to have to undergo a future surgery following two microdiscectomies. Dr. Douthit also testified that surgery was appropriate pursuant to the medical treatment guidelines, but Claimant would not recommend surgery for Claimant because of the prior issues Claimant has had with surgeries.

19. In this case, the physicians appear to agree that the August 16, 2007 MVA caused Claimant's herniated disk at the L5-S1 level, and that herniated disk requires surgery, although Dr. Douthit testified he believes that based on Claimant's prior responses to surgical intervention, another surgery may not be appropriate for Claimant's issues with his lumbar spine. The physicians offer differing opinions as to whether the proposed fusion at the L4-5 level is related to the August 16, 2007 MVA, or related to Claimant's prior industrial injuries. The ALJ finds from a review of the medical records that Claimant was not under active treatment for his low back injury immediately prior to the August 16, 2007 MVA. The ALJ finds that Claimant's low back condition had essentially stabilized, but was aggravated by the

August 16, 2007 MVA. The ALJ finds that Claimant was working full time prior to the August 16, 2007 MVA, and that Respondents were ordered to pay TTD benefits to Claimant as a result of the August 16, 2007 MVA by virtue of ALJ Martinez' February 15, 2008 order beginning August 16, 2007 and continuing until terminated by law.

20. The ALJ finds the testimony and opinions of Dr. Jernigan more credible and persuasive than the opinions of Dr. Douthit. The ALJ credits that opinion of Dr. Jernigan that despite Claimant's prior back surgeries, Claimant continued to be employed on a full time basis for employer prior to the August 16, 2007 MVA. The ALJ finds that Dr. Jernigan has treated Claimant for his prior injuries, including his prior back injury from May 2005 and May 2002, and is in a better position to determine whether Claimant's surgery was caused, aggravated or accelerated by the August 16, 2007 MVA, or whether apportionment is appropriate in this case than Dr. Douthit.

21. The ALJ finds the testimony and opinions of Dr. Jernigan more credible and persuasive than the opinions of Dr. Youssef regarding apportionment. The ALJ finds that while the prior microdiscectomies Claimant had undergone may have weakened his low back, Claimant was not under active treatment at the time of his August 16, 2007 MVA for his low back injury. The ALJ credits the testimony of Dr. Jernigan that Claimant's back surgery was not inevitable and, relying on the opinions of Dr. Jernigan, finds that apportionment is not appropriate 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. If a negligent tortfeasor's actions cause trauma to be superimposed upon a Plaintiff's pre-existing condition, so that a disability results, and no apportionment can be made between the extent to which the pre-existing contributed to the disability and the extent to which the trauma resulting from the tortfeasor's negligence played its part, the tortfeasor is responsible for the entire disability. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992) *citing Newbury v. Vogel*, 151 Colo. 520, 379 P.2d 811 (1963). And, in such circumstances, the injured party does not have the burden of proving that the party's disability can not be apportioned between the two causes; it is, rather, the tortfeasor's burden to prove that it can

be. *Cowin, supra., citing Brittis v. Freeman*, 34 Colo. 348, 527 P.2d 1175 (1974).

3. The court, in *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999 (Colo. App. 2004), decided that apportionment of medical and temporary disability benefits is appropriate where claimant's condition is caused by successive industrial injuries and where both industrial injuries contribute to the need for medical treatment and temporary disability. In this case, the physicians agree that Claimant's herniated disk at the L5-S1 level was caused the work injury involving this claim.

4. In this case, the ALJ finds that despite his prior injuries, including 2 microdiscectomy surgeries to his lower back, Claimant was back to work full time with employer and was able to drive over 200 miles per day and carry an 80 pound package. Claimant was not under active treatment for his low back condition that Respondents seek to apportion at the time of his August 16, 2007 MVA.

5. The ALJ credits the testimony of Dr. Jernigan that another lumbar spine surgery was not inevitable in this case and finds that Respondents have failed to prove by a preponderance of the evidence that apportionment of medical and temporary disability benefits is appropriate in this case.

ORDER

It is therefore ordered that:

1. Respondents shall not apportion Claimant's temporary disability or medical benefits. This order does not affect a claim for apportionment of permanent disability.

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.

DATED: January 29, 2010

_____
Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-796-185

ISSUES

Ø Whether Claimant established by a preponderance of the evidence that he suffered a compensable injury arising out of and in the course and scope of his employment with Respondent-employer?

Ø If Claimant did establish that he suffered a compensable injury arising out of and in the course and scope of his employment, whether Claimant has proven by a preponderance of the evidence that the medical treatment he received was reasonable and necessary to cure and relieve the Claimant from the effects of the industrial injury?

FINDINGS OF FACT

1. Claimant was employed with employer as a carpenter. Claimant was hired by employer on June 15, 2009 and paid $30 per hour. Claimant underwent a pre-employment physical on June 16, 2009 that included an examination of his low back that revealed normal range of motion and a negative straight leg test and was cleared to begin work. Claimant testified that on June 18, 2009 he reported to work just before 7:00 a.m. and began working on a project from the previous day. Claimant testified he injured his back while lifting a slide miter saw out of his toolbox. Claimant testified the miter saw weighs approximately forty five (45) pounds and was hung up on a tray as he attempted to lift the saw, causing additional resistance. Claimant testified he experienced a sharp burning pain in his low back after he lifted the saw.

2. Claimant admittedly has a prior history of prior low back pain, including a prior injury to his low back in 1986 while employed with B&H Construction and a pars fracture to his low back in 1995.

3. After Claimant's injury, Claimant completed his work for employer. Claimant did not report his injury to his employer, instead choosing to wait until after the weekend to determine if his back felt better. Claimant testified the injury occurred on a Thursday, and that he did not work Friday, Saturday or Sunday. Claimant reported that his back pain remained the same during the course of the day and over the weekend, he tried to loosen up his back by riding his bicycle. Otherwise, Claimant took Aleve pain medication and took it easy over the weekend.

4. On Monday, after Claimant arrived at work, Claimant was informed that his employment was not working out, and Claimant's employment was terminated. Claimant testified he did not report his injury to employer prior to being terminated. After being informed that he was being let go, Claimant told employer "yeah, you can fire me" and turned and walked away. Claimant had a number of tools still on the job site and eventually got a neighbor to help him move the tools. Claimant testified that the crew working on the job site also helped Claimant move the tools. Claimant testified that he did not report his work injury

immediately because he felt if he reported a minor injury to his employer it would expose his employer to workers' compensation claims and was fearful that he would be fired.

5. Claimant later reported to his employer's place of business to receive his paycheck. Claimant testified that the paycheck included money in excess of what he had earned, as he was being paid as a contractor, and not an employee. Claimant testified he refused the check because the check paid him as a contractor and not an employee. After Claimant was allegedly injured at work, he performed some work on his truck, that was broken down at the time, including removing a four cylinder head, using long wrenches for leverage. Claimant testified that while working on his truck he did not lift anything over thirty to forty (30-40) pounds.

6. Claimant reported to Dr. Brokering on June 23, 2009, the day after he was terminated from employer. Claimant reported to Dr. Brokering that he was employed as a carpenter for employer for one week before being terminated. Claimant reported to Dr. Brokering that he was picking up a miter saw on June 18 when he injured his lower back. Claimant reported to Dr. Brokering that he had a history of low back pain. Dr. Brokering noted Claimant had fairly good range of motion on flexion and extension but experienced tenderness in his back with lateral flexion and twisting. Dr. Brokering diagnosed Claimant with a low back strain and referred Claimant for physical therapy with Peak Performance and provided Claimant with a prescription for Celebrex and cyclobenzaprine. Dr. Brokering provided Claimant with work restrictions of no lifting greater than ten (10) pounds. Claimant returned to Dr. Brokering on June 24, 2009 and advised Dr. Brokering that he was unhappy with the Celebrex prescription after reading the warnings. Claimant requested a prescription for Vicodin, which was provided by Dr. Brokering to the Claimant.

7. Claimant reported for physical therapy with Mr. Weidemann on June 24, 2009. Claimant reported an onset of pain with lifting a miter saw out of a toolbox on June 18, 2009. Claimant also reported right lower extremity pain. Claimant reported to the physical therapist that his pain level was a 9.5/10 at it's maximum. Claimant reported to the physical therapist that the pain interfered with his personal care, kept him from sleeping, made it so he was unable to work and made it so he relied on pain medications for him to be comfortable. Claimant returned to the physical therapist on June 26, 2009 and reported an increase in his left lower extremity weakness. Claimant reported his left leg gave out when he was standing at lunch.

8. Claimant reported to Dr. St. John on July 15, 2009 with complaints of lower back pain and right leg/foot pain with bilateral weakness and numbness of his lower extremities. Dr. St. John performed a magnetic resonance image ("MRI") of the lumbar spine that revealed an L2-3 mild to moderate central disc protrustion and a very mild central disc protrusion at the L3-4 level. The subarticular space and neural formina were normal at the L4-5 and L5-S1 levels.

9. Claimant underwent an independent medical examination ("IME") with Dr. Brodie on

September 15, 2009. Dr. Brodie noted reported injuring his back when he was lifting a miter saw from a toolbox. Claimant reported to Dr. Brodie that his pain worsened on June 19, 2009 (the day after the incident) to a 9/10 that continued through the weekend. Claimant reported to Dr. Brodie that riding his bicycle reduced his low back pain over the weekend. Claimant reported to Dr. Brodie that by Monday, June 22, 2009, his back pain had been reduced to a 3/10 with no lower extremity symptoms at that time. Claimant reported to Dr. Brodie that his back pain worsened between June 22 and June 26, 2009 without interval trauma or return to work or other unique exposure. Claimant reported to Dr. Brodie that his back pain was constant, but with variable intensity that ranged from 4-9/10. Claimant reported episodic sharp sensations on the left low back, primarily with motion and extension that rated at 9/10 on intensity. Claimant also reported to Dr. Brodie that his back pain was increased with walking, sitting and riding a bike, although he reported riding a bike resulted in less pain immediately after the accident. Dr. Brodie eventually concludes that it is medically reasonable to conclude that it is not probable that Claimant suffered an injury to his low back on June 18, 2009.

10. Dr. Brodie testified in this matter at hearing. Dr. Brodie noted that Claimant's medical records from before his alleged injury reveal a description of chronic pre-existing pain that Claimant experienced on a daily basis. Dr. Brodie noted this was inconsistent with the Claimant's history as reported during his examination. Dr. Brodie noted that Claimant's neurological exam was normal although Claimant presented as substantially impaired during his examination. On cross-examination, Dr. Brodie acknowledged that the MRI performed on July 15, 2009 showed end plate edema, or fluid at the edge of the disk, that could be evidence of an acute injury and documents abnormalities of the back.

11. Respondents obtained video surveillance of Claimant on July 1, and 2, 2009 and August 18, 20 and 21, 2009. The video surveillance demonstrate Claimant moving in what appears to be a non-limited fashion, but will not be considered by the ALJ in determining whether Claimant suffered an injury on June 18, 2009.

12. Claimant argues that the incident in which the Claimant lifted the miter saw out of his toolbox caused an aggravation to his pre-existing low back condition and represents a compensable workers' compensation injury. The ALJ is not persuaded. The ALJ finds the testimony of Claimant that he suffered an injury while lifting a miter saw out of his toolbox to be not credible. According to Claimant's testimony, he felt immediate pain in his low back, but continued working the day of the injury without reporting the injury to his employer because he felt his injury was minor. Claimant reported to Dr. Brodie that his pain worsened over the weekend to a 9/10. Upon reporting to work on Monday, Claimant was immediately terminated, but still did not report the work injury to his employer. Instead, Claimant left the work site, only to report the injury later that afternoon. Despite reportedly experiencing pain on a 9/10 scale over the weekend, Claimant reported to Dr. Brodie that his pain on Monday morning when he reported to work was only a 3/10. Claimant then reported to his physical therapist two days later that his pain was back up to a 9.5/10. The ALJ finds that Claimant's

testimony with regard to his fluctuating pain level to be not credible and finds that Claimant has failed to show that it is more probable than not that he suffered an injury arising out of and in the course and scope of his employment with employer. Moreover, during this time in which Claimant's pain was at a 9/10, Claimant was capable of riding his bike and working on his truck. Claimant reported to work on June 22, 2009 prepared to proceed with his job as a carpenter until he was terminated. It was only after Claimant's termination that he decided to report his injury to his employer.

13. Despite the fact that Claimant underwent a pre-employment physical that demonstrated good range of motion of his lumbar spine, this finding is not conclusive to the determination of whether Claimant suffered an injury arising out of his employment on June 18, 2009. The ALJ notes that Claimant's examination with Dr. Brokering on June 23, 2009 revealed good range of motion of the lumbar spine on flexion and extension with limitations on subjective complaints of tenderness on lateral bending and twisting. Moreover, the ALJ notes Claimant's complaints to his physical therapist on June 24, 2009 and June 26, 2009 are significantly higher than the pain Claimant was purportedly experiencing on June 22, 2009, according to his reports to Dr. Brodie.

14. Due to the fact that Claimant's testimony in this matter is not credible, the ALJ determines that Claimant has failed to show that it is more probably true than not that he suffered a compensable injury arising out of and in the course and scope of his employment with employer. The ALJ finds Claimant's testimony inconsistent with the anticipated progression of a back injury insofar as Claimant's pain apparently was present immediately, but Claimant did not believe that the claim was reportable because it was a minor injury. Claimant's pain then increased over the weekend, but decreased prior to Claimant reporting to work on Monday morning, so Claimant again did not report his injury to his employer upon reporting to work on Monday morning. Then, after being fired by his employer, Claimant's pain again increased over the next two days when Claimant was examined by Dr. Brokering (the day after his termination) and the physical therapist (two days after the 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, 2008. 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., 2008. 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., 2008. 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.*

3. 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).

4. As found, the ALJ finds the testimony of Claimant that he suffered an immediate onset of pain after lifting a miter saw out of his toolbox not credible. Claimant's testimony that his pain increased over the next several days is found to be not credible. Based on the fact that Claimant's testimony is not credible, Claimant has failed to prove by a preponderance of the evidence that he suffered a compensable injury arising out of and in the course and scope of his employment with employer.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits is denied and dimissed.

All matters not determined herein are reserved for future determination.

DATED: January 20, 2010

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Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-794-519

ISSUES

Ø Whether the Claimant has proven by a preponderance of the evidence that he suffered a compensable injury arising out of and in the course and scope of his employment with employer?

Ø Whether Claimant has proven by a preponderance of the evidence that his medical treatment is reasonable, necessary and related to cure and relieve the Claimant from a compensable workers' compensation injury?

FINDINGS OF FACT

1. Claimant began his employment with employer as a technical support representative in January 2008. Employer runs a facility handling a call-in center for merchants if they are having problems with their credit card machines. Claimant's job duties involved handling calls from customers who were having trouble with their credit card machines, and providing technical support by means of trouble shooting the issues the customer was experiencing. Claimant usually worked from 10:00 a.m. until 7:00 p.m. on Tuesdays through Fridays with one hour for lunch. Claimant also worked from 7:30 a.m. until 4:30 p.m. on Saturdays with one hour for lunch.

2. Claimant previously served in the Navy before receiving an honorable discharge in 2002 after being diagnosed with a sleep apnea and being disqualified for going back to sea. While in the Navy, Claimant was exposed to deck coating fumes that caused Claimant to experience extreme nausea and a runny nose.

3. On May 19, 2009, while at work for employer, Claimant noticed an odor that caused Claimant to experience a bad taste in the back of his mouth and burning eyes. Claimant worked until 6:00 p.m. on May 19, 2009 before being allowed to leave one hour early due to the noxious odor. Claimant testified that when he got home he had a headache, felt anxious and did not sleep much. Claimant returned to work on May 20, 2009, despite not feeling well, and noticed the same odor that caused the same affects on Claimant including burning eyes and experiencing his voice going hoarse. Claimant complained of the odor to his supervisor, Mr. R, and was told the odor was being addressed and he should go back to work. Claimant testified that he noticed after work on May 20, 2009 that his headaches were worse.

4. Claimant returned to work on May 21, 2009 and noticed the same odor. Claimant was told that the fumes were coming from a remodel taking place on the first floor of the building in which Claimant worked. Claimant testified he went to speak with the workers on

May 21, 2009, but none of the workers spoke English. Claimant testified the area where the workers were performing the remodel was cordoned off with heavy plastic with no ventilation except out a door directly beneath Claimant's work area. Claimant's work area was directly next to a pair of doors that led to a balcony. Beneath the balcony was a hallway and the area where the remodel work was being performed. Claimant worked an entire day on May 21, 2009.

5. Claimant returned to work on May 22, 2009. Claimant testified his eyes were still burning and when he returned home that evening, he felt extremely tired like he had the flu. Claimant worked on Saturday, May 23, 2009 and testified the odor was much less. Nonetheless, Claimant testified he became nauseous and vomited while at work. Claimant testified he had waves of headaches and began to experience a migraine above his eye. Claimant testified he was scheduled to work until 4:30 on May 23, 2009, but left work because of the migraine he developed. Claimant testified he went home, took medications for his migraine, and went to bed. Claimant had experienced migraine headaches in the past and had migraine medication available at home.

6. Claimant testified he returned to work on May 26, 2009, and as he entered the building area, a breeze blew fumes towards Claimant and, upon smelling the recurrent odor, Claimant began suffering a panic attack. After arriving at work, Claimant could not concentrate and was approached by his supervisor to a private office. Claimant met with the human resources director, C, in the office, and requested to see a doctor.

7. C testified that he is the director of Human Resources for employer. C testified he was aware of the odor complaints from the remodel work being performed on the first floor. On May 26, 2009, C met with Claimant and testified Claimant was quite upset and believed he had been harmed by the vapors from the remodel work. C testified he encouraged Claimant to seek help from the veterans administration hospital ("VA") and to take time off.

8. Claimant testified he left work on May 26, 2009 and drove home, although he does not recall the drive home. Claimant's father testified that when Claimant arrived at home he told his father "I think I'm losing my mind." Claimant's father contacted his physician and was instructed to take Claimant to the emergency room.

9. Claimant was examined at Valley View Hospital Emergency Room on May 26, 2009 with a chief complaint of anxiety. Claimant reported he had been exposed to fumes at work from a remodeling project taking place on the floor below him and developed a headache, decreased attention and trouble concentrating over the previous 48 hours. Claimant denied nausea, vomiting or diarrhea, but reported feeling slightly dizzy and stated he can't quite concentrate. Claimant underwent a head computerized axial tomography scan that showed mild parenchymal volume loss, but was otherwise normal. Claimant was diagnosed with anxiety and homicidal ideation and discharged home. Claimant followed up with Dr. Abernathy on May 29, 2009 on referral from employer. Dr. Abernathy diagnosed Claimant as

having reaction hypersensitivity and prescribed supplemental oxygen. Claimant was advised to stay away from the aggravating chemicals for one week. Claimant called Dr. Abernathy on Monday and reported he was crying most of the weekend and unable to “get it together”. Dr. Abernathy noted Claimant’s etiology was likely due to pain.

10. Claimant continued to follow up with Dr. Abernathy on June 5, 2009 and reported the use of oxygen seemed to clear his head, but complained that he still couldn’t focus on anything and reported a poor attention span. Claimant returned to Dr. Abernathy on June 18, 2009 with continued complaints of headaches. Dr. Abernathy recommended Claimant undergo counseling and provided Claimant with a referral to Dr. Birnkrandt.

11. Claimant reported to the Valley View Hospital Emergency Room on June 20, 2009 with complaints of feeling somewhat anxious with shortness of breath and tingling in his hands. Claimant was diagnosed with anxiety with hyperventilation syndrome and provided with Ativan and his symptoms improved rapidly. Claimant was discharged home and instructed to follow up with his primary care physician in the next 2-3 days.

12. Claimant returned to Dr. Abernathy on June 25, 2009 with reports of having trouble walking. Claimant was evaluated on that occasion by Dr. Niebur. Claimant complained that the prescription for Effexor may be worsening his symptoms. Claimant’s pulse oxygen level was noted to be 96% at room air, but dropped to 87% after a slow walk for one block. Dr. Niebur diagnosed Claimant with a tension headache brought on by noxious fumes and provided Claimant with a prescription for Ativan and portable oxygen.

13. Claimant was subsequently evaluated by Dr. Burnbaum on July 1, 2009. Dr. Burnbaum noted Claimant was exposed to fumes at work through an open balcony door that resulted in Claimant experiencing difficulty breathing, significant headache, dizziness, and difficulty concentrating. Claimant reported to Dr. Burnbaum that his symptoms had gotten worse in that he was having more anxiety attacks and his depression was worse. Dr. Burnbaum noted that Claimant had an essentially non-focal neurologic examination but had significant difficulty with concentration, with production of information, and with recent memory. Dr. Burnbaum noted Claimant had no premorbid psychiatric history and recommended Claimant undergo an EEG.

14. Claimant was examined by Dr. Birnkrant, a psychiatrist, on July 21, 2009. Dr. Birnkrant noted Claimant had no prior psychiatric history and was doing well previously emotionally. Claimant reported a prior history of migraine headaches and diabetes. Dr. Birnkrant noted Claimant’s symptoms developed after being exposed to some sort of chemical smell. Dr. Birnkrant noted that the time course of the onset of symptoms and significant debilitation was rapid. Dr. Birnkrant diagnosed Claimant with mood disorder due to medical illness – in particular, depressive disorder due to exposure to chemicals and anxiety disorder with panic due to chemical exposure. Dr. Birnkrant opined that based on the temporal nature of his presentation, Claimant had a toxic exposure that resulted in his current

psychiatric presentation and inability to function. Dr. Birnkrant opined that the exposure to the toxic odor was clearly related and causative with relation to Claimant's psychiatric symptoms. Dr. Birnkrant noted that it would be important for Claimant to be treated for his current symptoms despite the etiology being routed in a medical issue as his current symptoms were significantly affecting his functioning. Dr. Birnkrant modified Claimant's medications and recommended Claimant begin seeing a therapist to discuss his current situation, that Dr. Birnkrant described as a significant, sudden and sever change from his prior level of functioning.

15. Claimant returned to Dr. Abernathy on August 28, 2009. Dr. Abernathy provided Claimant with the name of an environmental sensitivities specialist in R, Washington and noted Claimant was experiencing anxiety and depression that was improving, but not controlled. Dr. Abernathy noted Claimant's pulse oxygen levels were 95%, but with ambulation, Claimant's pulse oxygen levels dropped to 83%. Claimant was diagnosed with hypoxemia, reaction hypersensitivity and mild cognitive impairment. Dr. Abernathy also increased Claimant's nighttime oxygen levels.

16. Claimant was referred for an independent medical examination ("IME") with Dr. Waxman on September 16, 2009. The ALJ notes that Dr. Waxman was recommended as a referral by Dr. Burnbaum. However, based upon the deposition testimony of Dr. Waxman, along with the report in this matter, the ALJ determines that Dr. Waxman's role in this case was of an examining physician, and not a treating physician.

17. Dr. Waxman noted Claimant reported neurological symptoms that included dizziness, vertigo, deceased concentrating ability, memory lapses or loss, decreased sense of smell, speech difficulties, a tremor, gait abnormality, difficulty with balance and poor coordination. Dr. Waxman measured Claimant's pulse oxygen level at 95% while resting and 91% after a six (6) minute walk. Dr. Waxman performed a physical examination and diagnosed Claimant with tinnitus, hypertension, esophageal reflux, dyslipidemia, obesity, type II diabetes mellitus, rotator cuff tendonitis, migraine headache, vertigo, depression and obstructive sleep apnea. Dr. Waxman opined that Claimant's complaints were of a psychiatric, neurocognitive and respiratory nature, including anxiety, depression, hyperventilation and shortness of breath. Dr. Waxman opined that Claimant's shortness of breath manifested itself without an identifiable cause, noting that Claimant's July 9, 2009 spirometry results were normal.

18. Dr. Waxman noted that although the term "fumes" appears in a number of places in Claimant's medical records, including reports from his co-workers that they "smelled fumes", Dr. Waxman was not able to find any evidence that Claimant was exposed to fumes as opposed to simply smelling odors. Dr. Waxman noted that while other employees also felt the odor, none developed continuous symptoms as Claimant did. Dr. Waxman found that there was no evidence supporting the assertion that Claimant's current psychological and medical condition resulted from "toxic fume exposure" or "toxic encephalopathy". Dr. Waxman opined that following odor perception, Claimant developed headache, irritation of

both eyes, and change is his voice. Dr. Waxman opined that these symptoms were not related to a toxic fume exposure. Dr. Waxman opined that Claimant was in need of intensive psychiatric care that is for Claimant's psychiatric condition that was not the result of a toxic fume exposure. Dr. Waxman noted Claimant sustained a temporary mental and physical impairment with a good chance of recovery with appropriate care. Dr. Waxman opined Claimant's temporary impairment was related to his mental condition that was not associated with "toxic exposure to fumes".

19. Dr. Waxman provided testimony in this matter by deposition. Dr. Waxman noted in his deposition, and consistent with his report, that Claimant was complaining of odors over a period of several days. Dr. Waxman testified that there was no objective explanation for Claimant's shortness of breath. Dr. Waxman based that opinion on the fact that Claimant's oxygen saturation did not drop while in Dr. Waxman's office for examination and his pulmonary function tests were completely normal. Dr. Waxman agreed that Claimant suffered from depression and anxiety, but opined that the depression and anxiety were not related to chemical damage to his brain.

20. Claimant was also referred for a psychiatric IME with Dr. Moe on September 21, 2009. Claimant provided Dr. Moe with a consistent accident history, consisting of Claimant working a Tuesday through Saturday schedule and noticing an offensive odor in the office when arriving at work on Tuesday, May 19, 2009. Claimant reported to Dr. Moe that the fumes cause his eyes to burn and experienced an unusual taste in his mouth. Claimant reported that after being allowed to leave work approximately one hour early on May 19, 2009, he went home and experienced a significant headache. Claimant reported to Dr. Moe that he returned to work the remainder of the week and continued to experience the same effects from the fumes as he had on the first day of his exposure. Claimant reported to Dr. Moe that he considered the fumes to represent a safety issue and was frustrated that nothing about the situation was changing. Claimant reported to Dr. Moe that by Saturday, his work exposure triggered a migraine headache and he felt unable to concentrate and perform his job. Claimant asked permission to leave work and his request was granted. Claimant reported to Dr. Moe he developed a headache and dizziness over the weekend and felt horribly sick.

21. Claimant reported to Dr. Moe that on Tuesday morning, he reported to work and while walking into the building, smelled the fumes and had a sudden and marked surge of anxiety that Claimant characterized as a panic attack. Dr. Moe noted that Claimant's sense of being unable to find a solution to his predicament (expected to work, but feeling unable to work) appeared to represent a significant trigger to Claimant's acute emotional reaction that morning. Claimant reported that he sought out his supervisor (M) and the human resources director (C) and that both M and C determined that Claimant's current condition was not work related and Claimant should seek treatment at the VA in Grand Junction. Claimant reported to Dr. Moe that he left work and returned home, where he broke down and collapsed on the driveway. Claimant reported to Dr. Moe he was taken to the emergency room by his father

where he was instructed not to return to work for the following week and given a prescription for anti-anxiety medications.

22. Claimant reported to Dr. Moe that his most significant current complaints involved headaches and balance problems. Claimant reported he was prone to stumble if he walked more than a brief distance along with symptoms suggestive of vertigo. Claimant also reported very little improvement in his symptoms from the time of his original exposure. Dr. Moe noted that none of Claimant's co-workers suffered the extent of symptoms Claimant experienced after being exposed to the fumes and reported that Claimant had three theories as to why his symptoms were so much worse, including (1) that other co-workers were afraid of being fired, (2) that he had greater exposure to the toxic chemicals, and (3) that he had a greater vulnerability for idiosyncratic reasons than his co-workers. Dr. Moe noted that Claimant did not believe that his symptoms were significantly influenced by psychological factors, and described himself as a person who does not get scared, and does not "freak out," in response to stress. Dr. Moe noted, however, that Claimant described himself on the morning of May 26, 2009 by using the terms "hysterical" and "breakdown" and noted that Claimant's condition became significantly worse on the morning after being away from work for three days, especially after his complaints were not validated by his supervisor.

23. Dr. Moe noted Claimant's co-workers (with the exception of one woman who reportedly had a longstanding history of general sensitivity) denied developing any sustained problems, although a number of employees reported transient symptoms that were attributed to the exposure to fumes. Dr. Moe diagnosed Claimant with a Somatorm Disorder and that Claimant's exposure to the disturbing fumes at his work resulted in symptoms in Claimant's case only because of idiosyncratic risk factors.

24. Dr. Moe testified at hearing in this matter that his diagnosis of a Somatoform Disorder had two legs: (1) a set of symptoms that strongly suggest they are not medically explainable and (2) psychological factors that feed the condition. Dr. Moe testified that the first leg of the diagnosis included Claimant's symptoms of headaches, cognitive problems, tremors, etc. Dr. Moe testified that there was not a good correlation to the smell exposure and Claimant's symptoms in that his exposure was worst on Saturday, May 23, 2009, then Claimant was home for 2 ½ days, then after a short exposure, Claimant's symptoms spiked, followed by Claimant's symptoms not getting better. Dr. Moe testified that Claimant's symptoms are not due to his being physically harmed by the fumes, but instead represent a psychological reaction to his perceived harm and how he was treated. Dr. Moe also testified that Claimant believes he was poisoned, but that there was no evidence of this on tests and questioned Claimant's use of oxygen. Dr. Moe further testified that Claimant's reaction was not one you would expect by similarly situated employees and was unique to the individual, or in this case, the Claimant.

25. Claimant returned to Dr. Birnkrant on October 7, 2009. Claimant reported he continued to be anxious and depressed on a daily basis, although he had some mild relief

from some anxiety with the use of medications. Dr. Birnkrant noted that treatment was focused on symptomatic issues of anxiety, sadness and cognitive functioning. Dr. Birnkrant found Claimant suffering from depression and anxiety with only a slight improvement since his initial psychiatric exam. Dr. Birnkrant diagnosed Claimant as suffering from mood disorder due to medical illness, in particular, a depressive disorder due to exposure to chemicals and an anxiety disorder with panic due to chemical exposure. Dr. Birnkrant noted that the rapidity of onset supported a diagnosis of an organic etiology to Claimant's problems that could not be discounted. Dr. Birnkrant noted Claimant had no history of psychiatric illness, nor was there evidence of any psychiatric problems in any medical reports.

26. Dr. Abernathy noted on October 8, 2009, in response to Claimant's counsel's inquiry, that she did not believe Claimant's symptoms were the product of stress and anger. Dr. Abernathy noted that Claimant's symptoms were most severe following the exposure and repeated exposure and therefore, differed from Dr. Moe's opinion regarding the cause of Claimant's symptoms. Dr. Abernathy noted Claimant's treatment should be focused on validating Claimant's stress and anxiety and treatment should follow the recommendations of Dr. Birnkrant.

27. Dr. Burnbaum opined on October 20, 2009 that he disagreed with Dr. Waxman and Dr. Moe's conclusions. Dr. Burnbaum noted Claimant had no premorbid psychiatric history and opined that Claimant's symptoms were related to a hypoxic brain injury or metabolic encephalopathy. Dr. Burnbaum noted that the odor Claimant experienced was noted by his co-workers and found that with the odor, there is a chemical stimulating the olfactory nerve endings. Dr. Burnbaum noted that he didn't know if the odor was toxic, but there was certainly some chemical in the environment.

28. Respondents presented the testimony of K, a co-employee with employer. K testified she performed the same job duties as Claimant. K testified that during the remodel of the restaurant below their office, she noticed a chemical odor on an off and the employees were allowed to leave early. K testified that on Saturday May 23, 2009 the fumes were strong and pungent. K testified that the fumes smelled like "airplane glue" and were strong enough to burn her nasal passages. K testified the fumes gave her a metal taste in her mouth, caused a headache and nausea. K testified the fumes made her feel not like herself and she complained of the odor to her supervisors. K testified that she had some continued problems after May 26, 2009, but is no longer having problems. K told an investigator in June 2009 that she had light headedness related to the fumes, but she was no longer having these problems.

29. H, another co-employee also testified in this matter. H also testified that she recalled the odor being present on Saturday May 23, 2009. H testified that the odor smelled "turpentineish" or "painty". H testified she had previously undergone surgery, so she was already dizzy and light headed. H testified that she had requested the window be opened to vent fumes as early as May 21, 2009. H testified the odor caused a headache but she

doesn't' know if others were effected by fumes. On cross-examination, H testified that her symptoms may have been a combination of the fumes and her pain medication from her surgery.

30. Claimant argues that he has shown by a preponderance of the evidence that the exposure to the noxious odor caused a compensable workers' compensation injury. The ALJ agrees. The undisputed facts as set forth in this case are that Claimant was working in an area where he was exposed to a chemical odor that caused symptoms of headaches and nausea. These symptoms were not only experienced by Claimant, but also experienced by his co-workers. The symptoms manifested themselves to the point that Claimant felt the need to seek medical treatment. When Claimant first sought treatment with his employer, the employer did not refer him for medical treatment, but sent him home and instructed Claimant to seek treatment on his own. After treating with the emergency room, employer referred Claimant for treatment with Dr. Abernathy.

31. The ALJ credits the reports from Dr. Abernathy, Dr. Burnbaum and Dr. Birnkrant over the testimony of Dr. Moe and Dr. Waksman. The ALJ notes that the opinions from Dr. Moe and Dr. Waksman were based on the presumption that the symptoms experienced by co-employees quickly resolved after no longer being exposed to the fumes. The ALJ credits the testimony of K that her symptoms persisted until June 2009 before resolving. While the testimony of the other employees establish that their symptoms eventually resolved without medical treatment, Claimant's symptoms may have some psychological component to them, as opined by Dr. Moe and Dr. Birnkrant.

32. Moreover, while Dr. Moe and Dr. Waksman questioned Claimant's use of the portable oxygen tank in their reports, the use of oxygen was recommended by Dr. Abernathy, Claimant's treating physician, after his pulse oxygen levels dropped into the 84% range with some mild exercise. The ALJ notes that Dr. Moe and Dr. Waksman did not credibly explain why the use of portable oxygen would be unreasonable in light of these findings by Dr. Abernathy.

33. The ALJ notes that Respondents physicians questioned why Claimant's physical symptoms did not resolve over the weekend when he was no longer exposed to the irritant. However, K noted that her symptoms likewise did not resolve immediately after she was no longer exposed to the irritants, and continued into June 2009 (although the symptoms did eventually resolve). While K testified she felt better after not being exposed to the chemical smell after the weekend, K admitted she still felt the effects over the weekend.

34. Further complicating matters in this case, Claimant apparently developed a depressive disorder based upon the fact that he did not believe employer was taking his subjective complaints seriously enough. The ALJ notes that the employer has the right to question the Claimant's alleged injuries in this case. Moreover, if Claimant's alleged injuries are based solely on a mental impairment with no corresponding physical injury, Claimant

faces an increased burden of showing that the psychologically traumatic event is outside the worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances.

35. Respondents argue that Claimant has failed to prove a compensable psychological claim pursuant to Section 8-41-301(2), C.R.S. The ALJ is not persuaded. The ALJ finds that Claimant's psychological injuries are related to a physical injury, as the effects of the odors manifested themselves in physical symptoms as reported by Claimant and his co-employees. Therefore, Claimant's psychological injuries are compensable as a consequence of a physical injury pursuant to Section 8-41-301(2)(a.5), C.R.S. The ALJ credits the reports from Dr. Birnkrant and finds that Claimant is suffering from depression. The ALJ finds that based upon Claimant's lack of psychiatric treatment prior to the injury, Claimant's depression is related to the effects of the industrial injury and is compensable under Section 8-41-301(2)(a.5), supra.

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., 2008. 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., 2008. 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., 2008. 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. "Accident" means an unforeseen event occurring without the will or design of the person whose mere act causes it; an unexpected, unusual, or undersigned occurrence; or the effect of an unknown cause or, the cause, being known, an unprecedented consequence of it. Section 8-40-201(1), C.R.S. 2008. 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.*

3. 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).

4. As found, Claimant was exposed to odors[1] while in the course and scope of his employment that caused Claimant to experience physical symptoms such as headaches, nausea, and dizziness. Claimant experienced these symptoms beginning on May 19, 2009. As of May 26, 2009, Claimant reported to his employer that his symptoms were severe enough that he needed medical treatment. The ALJ finds that Claimant's request for medical treatment was related to the physical symptoms he was experiencing from the odors and that the treatment Claimant received from the emergency room and Dr. Abernathy and Dr. Burnbaum were reasonable, necessary and related to his physical symptoms from the odor exposure. The ALJ credits the reports from Dr. Abernathy and Dr. Burnbaum and the opinions set forth therein and finds that the testimony of Claimant is consistent with the reports from Dr. Abernathy and Dr. Burnbaum in finding that the treatment from Dr. Abernathy and Dr. Burnbaum is reasonable, necessary and related to his exposure to the odors at work and the related physical symptoms the odors caused.

5. Section 8-41-301(2), C.R.S. states in pertinent part:

> (a) A claim of mental impairment must be proven by evidence supporting the testimony of a licensed physician or psychologist. For purposed of this subsection (2), "mental impairment" means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accident injury involves no physical injury and consists of a psychologically traumatic event that is generally outside a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, lay-off, demotion, promotion, termination, retirement or similar action taken in good faith by the employer. The mental impairment that is the basis of the claim shall have arisen primarily from claimant's then occupation and place of employment in order to be compensable.
>
> (a.5) For purposes of this subsection (2), "mental impairment" also includes a disability arising from an accidental injury that leads to a recognized permanent psychological disability.

6. Section 8-41-301(2)(a), supra, was first enacted in 1991 in an effort to eliminate frivolous "stress" claims by establishing a stricter standard for injuries resulting from an *emotional* stimulus. *See* 1991 Colo. Sess. Laws, Ch., 219, at 1294, *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004); *Tomsha v. City of Colorado Springs*, 856 P.2d 13 (Colo. App. 1992); *City of Thornton v. Replogle*, 888 P.2d 782 (Colo. 1995). The General Assembly subsequently amended the statute in 1999 by adding Section 8-41-301(2)(a.5), supra, which provides that the term "mental impairment" includes a disability arising from an accidental physical injury that leads to a recognized permanent psychological disability." *See* 1999 Colo. Sess. Laws, Ch. 103 at 299. The effect of the amendment was to expand the scope of the mental impairment statute. *See Briles v. Montrose Memorial Hospital*, W.C. No. 4-522-095 (Industrial Claim Appeals Office, April 30, 2004). The ALJ notes, however, that Claimant is not alleging that the depression in this claim is a permanent psychological disability. *See Id.*

7. Regardless, the ALJ credits the reports from Dr. Birnkrant and finds that the treatment for Claimant's depression is a compensable component of Claimant's industrial injury.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the reasonable and necessary medical treatment provided by Dr. Abernathy, Dr. Burnbaum and Dr. Birnkrant that is designed to cure and relieve the effects of Claimant's industrial injuries, including his psychological treatment.

All matters not determined herein are reserved for future determination.

DATED: January 28, 2010

_____
Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-573-129

ISSUES

Whether Claimant has proven by a preponderance of the evidence that his carpal tunnel syndrome is causally related to the admitted industrial injury of February 10, 2003.

FINDINGS OF FACT

1. Claimant suffered an admitted work-related injury on February 10, 2003, while working for W. The injury on February 10, 2003, occurred while Claimant was working as a lineman for W. Claimant was on top of a building where electrical work was occurring. An assistant working in a crane bucket attempted to hand Claimant a spool of fiber optic cable, which weighed about 200 pounds. Claimant was standing on the corner of the building where utility wires attached to the building. These utility wires prevented Claimant from stooping or kneeling down when lifting the spool of cable. The assistant who was handing the spool of wire to Claimant had half of the spool on the side of the crane bucket and half on the top of the building. The spool then began to slip, and Claimant had to catch it and rotate his spine while transporting the spool to a spot on the roof. Claimant felt pain in his spine from his neck to his buttocks. As the day progressed Claimant experienced numbness and tingling in his upper extremities.

2. The next day Claimant awoke with severe pain in his cervical spine, lumbar spine and upper extremities. Claimant reported his injury to his employer and was directed to chiropractor Michael Treinen, D.C., at Mountain Chiropractic. On February 13, 2003, Claimant began treating with Dr. Treinen. Dr. Treinen examined Claimant's cervical and lumbar spine. Dr. Treinen treated Claimant for low-back pain with radiation of pain into the leg and upper-back pain with radiation of parasthesias bilaterally to his arms and hands. Claimant again received treatment with Dr. Treinen on February 20, 2003. At that time Claimant related that he felt he could do is job safely and Dr. Treinen released Claimant to full duty.

3. On February 24, 2003, Claimant again received treatment from Dr. Treinen. On that day Claimant related to Dr. Treinen that he had done all right with being released to full duty until the end of the day when he felt bilateral hand parasthesias. Claimant also complained of ongoing low-back symptoms and numbness in his left leg. On March 5, 2003, Claimant returned to Dr. Treinen and stated that he had done a lot of pole climbing and work with his hands, which resulted in bilateral hand tingling and numbness. On March 6, 2003, Claimant had similar complaints in regard to his hand and arm symptoms. On March 10, 2003, and March 14, 2003, Claimant reiterated his complaints concerning parasthesias in his arms and hands when working for prolonged periods. On March 17, 2003, Claimant reported to Dr. Treinen that his symptoms were improved, but that he was not "pushing it" at work. On March 31, 2003, Claimant reported to Dr. Treinen that he had increased low-back symptoms. Dr. Treinen referred Claimant to Cortez Chiropractic for radiographs of Claimant's spine, and Dr. Treinen placed Claimant on "100%" disability.

4. On April 2, 2003, Dr. Treinen noted Claimant's left arm symptoms were improved, but that Claimant's low back and leg symptoms persisted. Dr. Treinen referred Claimant to Dr.

Doug Bagge for an orthopedic consultation.

5. Claimant ceased treating with Dr. Treinen for over a year while he underwent treatment for his low back.

6. Claimant was seen by Cyril Bohachevsky, M.D., on April 11, 2003. Dr. Bohachevsky noted Claimant's mechanism of injury and also noted that Claimant had complaints of low-back pain, neck pain and arm numbness the day after the work-related injury. It was noted that the chiropractic treatment was helpful for the neck symptoms and bilateral arm numbness, but it did not help with his low back and leg symptoms. Dr. Bohachevksy assessed lumbar spondylosis and secondary spondylolisthesis, lumbar disk degeneration and lumbar spinal stenosis.

7. Claimant then received epidural steroid injections in the lumbar spine. Jim Youssef, M. D., evaluated Claimant for a surgical consultation on June 25, 2003. Dr. Youssef noted that in addition to his ongoing back complaints, Claimant had developed neck and arm pain as a result of his work-related injury. Dr. Youssef eventually performed a lumbar fusion on August 4, 2003.

8. On or about March 2, 2004, Claimant participated in a functional capacity evaluation (FCE) at Southwest Physical Therapy. In the FCE Claimant's "current complaints" included "decreased flexibility, pain, numbness in hands."

9. On April 21, 2004, Claimant was assessed by Randal Jernigan, M.D., for an impairment rating. Dr. Jernigan noted that Claimant had complaints of parasthesias and numbness in his upper extremities at the time of the original work-related injury. Dr. Jernigan also noted that Claimant continued to have "occasional bilateral hand numbness and aching in between his shoulder blades every night. He has had no continued workup of his upper back...." Dr. Jernigan assessed a 28% whole person permanent impairment rating for Claimant's lumbar spine and associated leg symptoms.

10. Respondents filed a Final Admission of Liability ("FAL") on August 16, 2004 admitting for ongoing future medical care after maximum medical improvement ("MMI"). Respondents have continued to accept liability for Claimant's low back condition, but deny liability for Claimant's carpal tunnel claim. Claimant did not object to the FAL and his case was closed as a matter of law.

11. On April 6, 2005, Claimant returned to Dr. Youssef. Claimant complained of bilateral hand numbness. Dr. Youssef referred Claimant to Dr. Bohachevsky.

12. On May 5, 2005, Claimant presented to Kim Fairley, M.D., complaining of upper extremity numbness. On June 2, 2005, Dr. Fairley referred Claimant back to Dr. Treinen.

13. On June 10, 2005, Claimant returned to Dr. Treinen. Dr. Treinen noted that cervical spine x-rays taken on June 19, 2005, and June 21, 2005, revealed degenerative changes at C4-5, C5-6, and C6-7 with mild to moderate bilateral neuroforaminal stenosis due to hypertrophy at the C5-6 and C6-7 levels. Dr. Treinen noted that these x-rays were substantially the same as the x-rays taken on April 1, 2004. Dr. Trienen noted positive Phalen's Test, Volar

compression and positive Tinel's sign. Dr. Trienen opined that Claimant's complaints of neck pain, bilateral upper extremity pain and bilateral upper extremity numbness were similar to the complaints that Claimant made in the beginning of his worker's compensation claim.

14. Claimant indicated in a questionnaire dated May 13, 2005, that he had the following symptoms: severe difficulty with using small objects such as pens; severe weakness and tingling in his hands and wrist; and "very severe" pain in the wrists and hands as well as "very severe" numbness in the hands. Dr. Treinen authored a letter to Dr. Kim Fairly, M.D. Dr. Treinen indicated in the letter that Claimant's complaints of bilateral arm and hand parasthesias were the same kinds of complaints Claimant had when he presented to Dr. Treinen in February 2003.

15. On July 12, 2005, Dr. Jernigan authored a letter to an insurance adjuster. Dr. Jernigan indicated in the letter that he felt Claimant's neck and upper back symptoms were related to his original work-related injury. However, Dr. Jernigan stated that Claimant's bilateral wrist symptoms were due to carpal tunnel syndrome, which was not related to the original work-related injury. Dr. Jernigan opined Claimant's hand symptoms were not caused by the work-related injury at Wesodi because they were casused by non-work-related Carpal Tunnel Syndrome; however, he did not discuss the possibility of cervical radiculopathy causing the symptoms in the hands.

16. On January 11, 2006, Claimant filed a Petition to Reopen his claim against Respondents.

17. Dr. Treinen continued to treat Claimant until February 13, 2006. On March 13, 2006, Dr. Treinen authored a letter to David Silva, D.O., concerning Claimant's case and his course of treatment. Dr. Treinen noted Claimant's hand symptoms had not abated despite 36 chiropractic visits. Dr. Treinen noted he had requested nerve conduction studies for a differential diagnosis of Claimant's hand numbness, but that this had been refused by the insurance carrier. Dr. Treinen asked Dr. Silva to evaluate Claimant's condition and comment on possible treatments.

18. On April 5, 2006, Dr. Silva evaluated Claimant. Dr. Silva recommended an MRI of the cervical spine to evaluate a suspected disc protrusion at the C5-6 level projecting leftward, which may be causing Claimant's left sided symptoms. Dr. Silva also recommended an EMG of the upper extremities. Dr. Silva noted that Claimant had symptoms consistent with a C6 distribution of the nerve root.

19. On July 12, 2005, Dr. Jernigan opined that Claimant's condition on his upper back and neck are related to Claimant's original work-related injury with employer.

20. On October 12, 2006, pursuant to the request of one of Claimant's subsequent employers, Claimant was evaluated by Carlton Clinkscales, M.D. At the examination Dr. Clinkscales noted "significantly diminished" cervical range of motion. Dr. Clinkscales also noted that some of Claimant's spine motions reproduced parasthesias in his upper extremities. Dr. Clinkscales also noted the following results from the examination: positive Tinel's on the right and negative on the left; positive Phalen's test; positive median nerve compression test; positive Tinel's sign on the right, but negative on the left; and positive

flexion test on the elbows. Dr. Clinkscales concluded that Claimant most likely has cervical radiculopathy. Dr. Clinkscales noted that Claimant's diagnosis of carpal tunnel syndrome was not confirmed by EMG studies, and that both an EMG and MRI were warranted. Dr. Clinkscales opined that Claimant's activities at his subsequent employers did not contribute to Claimant's present condition. Dr. Clinkscales concurred with Dr. Jernigan's opinion that Claimant's condition on his upper back and neck were related to Claimant's original work-related injury with employer. Dr. Clinkscales also opined that a cervical spine workup should be done.

21. At the request of employer, Dr. Henry J. Roth examined Claimant on January 16, 2007. Dr. Roth testified at hearing. Dr. Roth indicated that Claimant could have carpal tunnel syndrome or cervical radiculopathy. Dr. Roth indicated that Claimant's mechanism of injury could have caused a cervical strain and possible aggravation of underlying degenerative disc disease. Dr. Roth agreed that an MRI and EMG would probably determine whether Claimant suffers from Carpal Tunnel Syndrome or cervical radiculopathy.

22. Claimant testified at hearing that he did not have any preexisting problems with his hands, arms or neck prior to his February 10, 2003, injury with employer. Claimant testified that he has not worked since April 2007 and his upper extremities still go numb.

23. Claimant's testimony was credible and to the extent there are conflicts between Claimant's testimony and the testimony of respondents' witnesses the ALJ credits the Claimant's testimony. Claimant's testimony was plausible, consistent and supported by the persuasive opinions of Dr. Clinkscales and the persuasive part of the medical record.

24. Claimant worked for two other employers after his injury with employer. Claimant eventually filed a petition to reopen his claim against Respondents and included claims against his two subsequent employers in that Petition to Reopen. ALJ Martinez issued Findings of Fact, Conclusions of Law and Order on June 20, 2007 reopening Claimant's claim against Respondents and dismissing Claimant's claims against his subsequent employers. ALJ Martinez ordered Respondents to provide treatment to Claimant's neck and upper extremities including an MRI of Claimant's cervical spine and an EMG of the upper extremities.

25. Claimant subsequently moved to Texas and his care was transferred to Charles Hinman, M.D. beginning on November 27, 2007. Dr. Hinman noted Claimant suffered an injury on February 13, 2003 involving a traction of his arm followed by pain in his low back as well as his neck. Dr. Hinman noted Claimant eventually underwent an L4-5, L5-S1 fusion for radiculopathy, spondylolisthesis and L5-S1 annular tear with 18 months of post op recovery that resulted in a good overall outcome. Dr. Hinman noted Claimant's case was reopened because of neck and upper extremity symptoms. Dr. Hinman diagnosed Claimant with (1) spondylolisthesis of the lumbar spine status post lumbar fusion, (2) cervicothoracic pain with features suggestive of cervical radiculopathy and (3) narcotic analgesic dependence. Claimant returned to Dr. Hinman on December 10, 2007 after undergoing a cervical MRI. Claimant continued to complain of pain, tingling and weakness of both arms. Examination

revealed positive Phalens sign and negative Tinels sign with positive median nerve compression bilaterally. Dr. Hinman noted that Claimant's cervical MRI revealed mild left foramenal stenosis at the C6-7 level with cord indentation, mild right foramenal stenosis at the C5-6 level with cord indentation and minimal disk protrusion at C2-3. Dr. Hinman diagnosed Claimant with cervical radiculopathy, cervical strain, lumbar radiculopathy, lumbar strain and possible median neuropathy.

26. Claimant underwent an EMG study on December 12, 2007 that revealed evidence of a moderate right median neuropathy at the wrist consistent with carpal tunnel syndrome. Claimant returned to Dr. Hinman on January 10, 2008. Dr. Hinman noted Claimant complained of pain in both arms with intermittent weakness of grip causing him to drop objects. Dr. Hinman diagnosed Claimant with carpal tunnel syndrome and advised Claimant to cease smoking. Dr. Hinman testified in this matter that it was his opinion that claimant's carpal tunnel syndrome was not related to the industrial injury of February 13, 2003. Dr. Hinman noted that Claimant's mechanism of injury was not consistent with the development of carpal tunnel syndrome because carpal tunnel syndrome almost always requires a predisposing problem with the actual carpal tunnel. Dr. Hinman opined that for carpal tunnel syndrome to result from a traction injury would be unusual and would not last this long. Dr. Hinman explained that a traction neuropathy would almost always resolve within a matter of six (6) to twelve (12) months. On cross-examination, Dr. Hinman testified that Claimant did suffer an injury to his upper extremities as a result of the February 10, 2003 injury and testified that Claimant's mechanism of injury could have precipitated symptoms of carpal tunnel syndrome and could have aggravated the anatomy to the point of causing carpal tunnel syndrome. Dr. Himan testified on redirect examination that his opinion that the injury could have aggravated Claimant's predisposed anatomy was given in terms of possibilities.

27. Dr. Hinman referred Claimant to Dr. S. Matthew Schocket, M.D. Dr. Schocket has provided Claimant with treatment including cervical epidural steroid injections. Dr. Schocket noted Claimant had carpal tunnel syndrome, but stated that because he did not examine Claimant at the time of his injury, he could not say if Claimant's injury caused, aggravated, accelerated or combined with a pre-existing condition to cause Claimant's need for carpal tunnel release surgery.

28. Dr. Roth provided a second report on June 13, 2008. Dr. Roth noted that Claimant's diagnoses and presentation were confounded by bilateral carpal tunnel and bilateral knee complaints. Dr. Roth noted in his follow up report that Claimant's employment after his injury included repetitive overhead materials handling without functional limitation or complaint. Dr. Roth noted that Claimant was not complaining of right shoulder problems before 2008.

29. Claimant proceeded to hearing in December 2008 on the issue of the compensability of his right shoulder complaints. ALJ Michael E. Harr, in an opinion dated January 22, 2009 found that Claimant's right shoulder complaints were not related to the industrial injury of February 10, 2003.

30. Dr. Roth issued another supplemental report dated April 12, 2009. Dr. Roth noted that he

evaluated Claimant on January 16, 2007 and had since that time reviewed additional documentation. Dr. Roth noted that in his initial examination, he opined that Claimant's bilateral carpal tunnel syndrome was independent and unrelated to the February 10, 2003 industrial injury. Dr. Roth opined that there was no change in his previous opinion insofar as the February 10, 2003 claim provided no mechanism of injury for an acute or sustained anatomic, biochemical or physiologic aggravation of an underlying carpal tunnel syndrome.

31. Claimant was evaluated by Douglas Fox, M.D. on May 12, 2009 with reports of numbness into his hands that was worse with activity and at night. Dr. Fox noted Claimant had an EMG that showed evidence of moderate right median neuropathy at the wrist consistent with carpal tunnel syndrome. Dr. Fox's examination revealed a positive Tinel's on the right with negative Phalen's bilaterally. Dr. Fox diagnosed Claimant with carpal tunnel syndrome on the right side and recommended decompression.

32. Claimant testified at hearing that he experienced pain and numbness in his hands following the February 10, 2003 industrial injury. Claimant testified he continued to experience these symptoms in his hands following his industrial injury. Claimant testified that the cervical epidural steroid injection relieved the burning in his upper extremities, but not the numbness in his hands. The ALJ finds the testimony of Claimant credible and persuasive insofar as it is supported by the medical records.

33. As noted by ALJ Martinez in his June 20, 2007 order, during the time Claimant was treating with Dr. Youseff and Dr. Jernigan, Claimant's neck and arm complaints were not referred to much and neither of these physicians tested claimant for sensory nerve loss of the upper extremities or reviewed the x-rays of Claimant's neck. ALJ Martinez granted the Petition to Reopen and ordered Respondents to provide Claimant with treatment for the upper extremity complaints including an MRI of the cervical spine and an EMG of the upper extremities. The EMG confirmed, and the medical providers agree that Claimant suffers from carpal tunnel syndrome. The ALJ finds that symptoms related to the carpal tunnel syndrome have been present since Claimant's compensable industrial injury, and therefore finds that the carpal tunnel syndrome is related to the February 10, 2003 injury.

34. The ALJ credits the testimony of Dr. Hinman that Claimant's injury could have aggravated the underlying anatomy thereby causing the carpal tunnel syndrome. The ALJ finds this testimony more persuasive than the testimony of Dr. Roth that Claimant's carpal tunnel complaints were unrelated to the February 10, 2003 industrial injury.

35. The ALJ finds that the carpal tunnel syndrome is related to Claimant's February 10, 2003 injury. The ALJ further finds that Respondents are liable for the reasonable, necessary and related medical treatment intended to cure and relieve the Claimant from the work related carpal tunnel syndrome. The ALJ finds that the right carpal tunnel release surgery proposed by Dr. Fox is reasonable and necessary to cure and relieve Claimant from the effects of the industrial injury.

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*. 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).

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.* 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.; *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

3. 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).

4. As found, the ALJ credits the testimony of the Claimant and finds that the proposed right carpal tunnel release surgery recommended by Dr. Fox is reasonable and necessary medical treatment designed to cure and relieve the claimant from the effects of the industrial

injury.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the proposed right carpal tunnel release surgery recommended by Dr. Fox.

All matters not determined herein are reserved for future determination.

DATED: January 5, 2010

_____
Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-799-445

ISSUES

Ø Whether Claimant established by a preponderance of the evidence that he sustained an injury arising out of and in the course and scope of an employment relationship with Respondent-employer?

Ø Whether Claimant established by a preponderance of the evidence that the medical care Claimant received was authorized medical treatment reasonably necessary to cure and relieve the Claimant from the effects of the injury?

Ø Whether Claimant established by a preponderance of the evidence that he is entitled to temporary total disability ("TTD") benefits from June 24, 2009 through September 6, 2009?

Ø What is Claimant's established Average Weekly Wage ("AWW")?

FINDINGS OF FACT

1. Claimant testified that he began working for employer in April 2009 after he was laid off from his previous job hanging dry wall. Employer is an auto-salvage business that provides auto parts to the public. Claimant testified that customers will come into the employer's business and request a part. If the customer pulls the part off the vehicle, the

customer pays a lower price for the part than if the customer has an employee of employer pull the part from the vehicle for the customer. Claimant testified his job duties included obtaining parts from automobiles pursuant to the direction of M, the owner, or B, his supervisor. Claimant testified he was paid $80 per day that he worked for employer and would work six days per week. Claimant testified he was paid in cash for his work for employer. Claimant became acquainted with employer when he purchased parts for his personal automobile at Claimant's salvage yard.

2. Claimant testified that on June 23, 2009 he appeared at employer's business at 9:00 a.m. Claimant testified that he was not very busy, so he went to the front desk and was talking to B. Claimant testified that B took a phone call at approximately 9:15 a.m. from a customer looking for a steering column. Claimant testified B sent him to the second floor of the building to get the steering column. Claimant further testified that a cat had given birth to a litter of kitting in the air conditioner duct on the second floor and B told Claimant to get the cats out of the air conditioner duct while he was upstairs. Claimant testified that the litter of new kittens had caused the building to smell of urine.

3. Claimant testified that after trying to get the wires of the air conditioner cover, he pulled on the cover, slipped and fell and cut his thumb open. Claimant was taken to St. Mary's Hospital by Victor, a co-employee for emergency medical treatment. Upon being admitted to the hospital, Claimant reported to the hospital that he was self-employed. Claimant was treated at the hospital for a right thumb laceration and instructed to follow up with Dr. Rooks on June 26, 2009.

4. Claimant followed up with Dr. Rooks on June 26, 2009 when Dr. Rooks performed an exploration of the wound with repair of flexor pollicis longus, radial and ulnar digital nerves to the right thumb. Claimant reported to Dr. Rooks upon examination that he was a self employed construction worker. Claimant testified he had a cast on hand after the surgery and Dr. Rooks did not recommend he return to work after the surgery.

5. Claimant testified that after the surgery he did not return to work for employer. Claimant testified he eventually returned to work for another employer hanging dry wall on September 7, 2009 in Gunnison, Colorado. Claimant testified that after his injury, M told Claimant he would help him with his medical bills and lost wages. Claimant testified M paid him for a full week of work ending June 27, 2009, but did not pay his medical bills, or any other money with regard to this claim.

6. Respondent acknowledged at hearing that Claimant was hired as an employee to "pick parts" for customers. Respondent acknowledged that Claimant was paid in cash because Claimant did not have a valid social security number. However, Respondent argued at hearing that Claimant was not scheduled to work on the day that he was injured.

7. Respondent presented the testimony of B, Claimant's supervisor. B has been

employer off and on with employer for twenty-five (25) years. B testified employer does not hire mechanics, and that if an employer wants a mechanic to install a part from the salvage lot onto their car, that is an arrangement between the customer and the mechanic. B testified that Claimant talked M into hiring him to work for 1-2 days a week. B testified that employer had several individuals who would work on various days pulling parts for employer. According to B, employer had a calendar, and if the employee was scheduled to work B would write down the name of the employee on the date the employee was supposed to work.

8. B testified that on June 23, 2009, Claimant was at the salvage yard but was not scheduled to work. B testified that he was told by M on the evening of June 22, 2009 that Claimant would not be working the next day. B testified that Claimant asked him about a steering column for a Chevy truck or a Suburban. B told Claimant that if they had a steering column for that make and model of car it would be upstairs. B also testified that as Claimant went to go upstairs, he told Claimant to watch out for cats because they might be in the heating duct. B denied instructing Claimant to go upstairs to get a steering column or to get the cats out of the heating duct.

9. B testified that when employees were scheduled to work, he would document the hours the employee worked and M would pay the employees. B further testified that if M was not at work, and Claimant were working, it would be B's responsibility to tell Claimant what work to perform.

10. B testified that after the Claimant's injury, a representative from the hospital called employer and asked if Claimant was employed there. B testified he told the hospital Claimant was not an employee (even though B admitted at the hearing that Claimant was employed with employer, although he denied Claimant was acting within the scope of his employment when he was injured).

11. M testified that he is the owner of employer business. M testified that employer is a parts business and they do not perform mechanic work. M testified that if the customer asks for an employee to pick the part off the vehicle, the customer is charged a higher price. M admitted he hired Claimant a couple of months prior to the injury in this case to work at picking parts requested by customers. M testified that when he hired Claimant, he requested Claimant's social security number so he could pay Claimant by check. Claimant advised M that he did not have a social security number and didn't want to pay taxes, so he requested to be paid in cash. M agreed to this arrangement. M testified his other employees are paid by check. M testified that when he hired Claimant, Claimant wanted to work full time. M testified Claimant was paid ten dollars ($10) per hour and would work on average 4 days per week and up to 6 days per week.

12. M testified that in addition to Claimant's work with his business, Claimant was also a mechanic. M testified that Claimant informed him on the Saturday before his injury that he would not be working on Tuesday (June 23, 2009). M testified Claimant did not inform him

why he would not be working on that next Tuesday.

13. M admitted he did not carry workers' compensation insurance at the time of Claimant's injury. M testified that Claimant informed him he had his own insurance at the time he was hired through his prior employment hanging dry wall. M testified that he thought he had workers' compensation insurance at the time of the injury, but it turned out Claimant did not have coverage. M testified that he now has workers' compensation coverage for his employees.

14. M testified that he was not at work when Claimant was injured, but was at work later that day when Claimant came back to employer and asked M to tell the hospital he worked for employer. M testified he told Claimant, "No, I can't do that." The ALJ notes that if M believed he had workers' compensation coverage at the time of Claimant's injury, and acknowledged that Claimant was, at least at times, an employee of employer, M would have performed an investigation into whether Claimant was acting within the course and scope of his employment with employer on June 23, 2009 when Claimant returned from the emergency room and asked for employer to have the injury covered by workers' compensation. However, there is no credible evidence that M inquired as to what activities Claimant was engaged in when the injury occurred. Likewise, when contacted by the hospital, B denied Claimant was employed with employer, without any credible evidence that the hospital was inquiring as to whether the injury was work related, but merely confirming employment. These facts undermine the testimony of employer's witnesses in this case.

15. Notably, while B testified that employer kept a calendar with a list of the employees who were scheduled to work each day, a copy of the calendar was not presented as an exhibit by employer at hearing. Additionally, while Claimant testified that he was paid for an entire week's work at the end of the week he was injured, M denied paying Claimant any money that week, even though he acknowledged on examination that Claimant worked on Monday, June 22, 2009 and was owed for that day's work. M provided no credible explanation for why he would refuse to pay Claimant after his injury for work Claimant performed prior to his injury.

16. Respondents presented the testimony of E, a customer of employer. E testified that she would hire Claimant to perform work on her vehicles. E testified that Claimant performed some work on her Jeep Cherokee in the last week of May, 2009. E testified that in June 2009 she was looking for an oil pan for a 2002 Ford Taurus. Claimant told E to pay M for the oil pan and he would install in on her car. E testified that she made arrangements with Claimant to have the work performed on her car on June 23, 2009. E arrived at employer at approximately 11:00 a.m. and asked for Claimant, but he was not there. E testified she called employer later that evening and was advised that Claimant was injured earlier that day.

17. Respondents also presented the testimony of D, another customer of employer. D testified Claimant performed mechanical work on her cars, including a 1996 Chevy pick up

truck. D testified that the work performed on her car was completed by Memorial Day weekend and denied Claimant performed any work on her car after Memorial Day weekend.

18. The ALJ finds the testimony of M and B internally conflicting. M testified Claimant worked on average four days per week, while B testified Claimant worked only 1-2 days per week. The ALJ finds that Claimant likely worked at least four days per week and up to 6 days per week, as M was in charge of paying Claimant in cash, and would likely have a better memory of how much he was paying Claimant per week.

19. Respondents allege that Claimant was not performing work at the time of his injury because he was at employer's place of business to perform work as a mechanic pursuant to his agreement with D that was independent of Claimant's arrangement with employer. The ALJ is not persuaded.

20. Although a great deal of facts in this case are in dispute, the following appears to be agreed upon by both Claimant and Respondent. Claimant was employed as a parts picker for employer on various occasions. Claimant appeared at employer's premises on the morning of June 23, 2009 at 9:00 a.m. Claimant spoke with B about a steering wheel column and was advised that the steering wheel column was upstairs. Claimant and B had a conversation about the cats in the heating duct, although the context of that conversation is disputed. Claimant injured his thumb when he attempted to take a cover off of a heating/air conditioning duct cover. The evidence further shows that the work employer alleges Claimant was going to perform on June 23, 2009 was for E. But E testified that her job did not involve a steering wheel column, nor did it involve the type of make and model B testified Claimant was working for.

21. For these reasons, and in the inconsistencies of B's testimony, the ALJ credits the testimony of Claimant over the testimony of B and finds that Claimant had gone to the second floor at the request of B to look for a steering wheel column. The ALJ further credits the testimony of Claimant over B and finds that B told Claimant to get rid of the cats in the heating/air conditioning duct. The ALJ notes that the Claimant and B testified Claimant did not like cats. As such, Claimant's actions in taking off the cover where the cat and kittens were staying would only be pursuant to instructions from his employer or for some nefarious purpose. However, M testified Claimant was a good employee who was one of his few employees who was reliable. Therefore, the ALJ finds the testimony of B that Claimant independently sought out the kittens after having received a direct order from B to leave the kittens alone incredible.

22. The ALJ finds the testimony of D and E credible and finds that Claimant also performed work on the side as a mechanic. However, the work performed for D was completed approximately three weeks prior to Claimant's injury. Moreover, the work Claimant was to perform for E on June 23, 2009 had not commenced and the undisputed evidence at the hearing was that Claimant was upstairs to retrieve a steering wheel column,

which was not a part of the work E had asked Claimant to perform on June 23, 2009. Therefore, the testimony of D and E does not compel a different finding by the ALJ in this matter.

23. The ALJ further finds that Claimant's testimony that he was paid for an entire week's worth of work on June 27, 2009 more credible than the testimony of employer that he didn't pay Claimant any money for that week, despite acknowledging that Claimant was owed money for at least the work he performed on Monday. Therefore, the ALJ finds that Claimant has proven that the injury happened during normal business hours on a day when he was regularly scheduled to work while performing duties at the express request of his supervisor. Based upon Claimant's credible testimony, the ALJ finds Respondent has paid Claimant $480 on June 27, 2009 for the week of June 22, 2009 through June 27, 2009 and Respondent is entitled to a credit for monies paid to Claimant against any TTD owed.

24. Claimant presented medical bills as evidence at hearing in the amount of approximately $17,533.62 for services performed on June 23, 2009, June 26, 2009 and for occupational therapy performed in September 2009. The ALJ finds that the medical bills from June 2009 are reasonable, necessary and related to Claimant's injury. The ALJ finds that the occupational therapy performed in September 2009 is not accompanied by corresponding therapy records and declines ordering Respondent to pay for the occupational therapy performed in September 2009 at this time. Therefore, the medical bills establish approximately $17,343.12 in medical bills that are reasonable necessary and related to Claimant's injury.

25. The ALJ credits the testimony of Claimant and M and finds that Claimant was working as many as six (6) days per week at $80 per day. The ALJ notes that the establishment of how much Claimant earned each week is made more difficult by the fact that Claimant was paid in cash by employer. However, the evidence establishes that Claimant worked on occasion up to six (6) days per week at $80 per day and finds that Claimant's AWW is properly set at $480.00.

26. The ALJ finds that Respondent was not carrying workers' compensation insurance at the time of Claimant's injury in violation of Section 8-43-408(1), C.R.S. While Respondent alleged at hearing that any failure to carry workers' compensation insurance was unintentional, such mens rea analysis is not allowed under the clear language of the statute. Due to the fact that Respondent failed to carry appropriate insurance, any award for benefits in this case is subject to a 50% increase pursuant to Section 8-43-408(1), C.R.S.

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.*

3. 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).

4. As found, the ALJ finds the testimony of Claimant more credible than the testimony of B or M and finds that Claimant was engaged in activities related to his employment with employer at the time of his injury. Therefore, the ALJ finds that Claimant has proven by a preponderance of the evidence that he suffered an injury arising out of and in the course and scope of his employment with employer.

5. The ALJ finds that the medical treatment performed by St. Mary's Hospital and Dr. Rooks was reasonable and necessary to cure and relieve the Claimant from the effects of the industrial injury. The ALJ finds Respondent-employer is liable for the cost of the medical treatment from St. Mary's Hospital and Dr. Rooks.

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), C.R.S.,

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. As found, Claimant's testimony that he has been unable to work as a result of his injury is found to be credible and Claimant has established by a preponderance of the evidence that he is entitled to TTD benefits beginning June 24, 2009 through September 7, 2009. As found, Respondent is entitled to an offset against TTD owed to Claimant for the $480.00 he paid to Claimant on June 27, 2009, pro rated for the time Claimant worked during the week of June 21, 2009 through June 27, 2009.

8. Section 8-43-408(1) states in pertinent part:

> In any case where the employer is subject to the provisions of articles 40 to 47 of this title and at the time of an injury has not complied with the insurance provisions of said articles, or has allowed the required insurance to terminate, or has not effected a renewal thereof, the employee, if injured, … the amounts of compensation or benefits provided in said articles shall be increased by fifty percent.

8. As found, employer admitted that at the time of Claimant's injury he did not have in effect workers' compensation insurance as required by statute. Therefore, Claimant's compensation in this case shall be increased by fifty percent pursuant to Section 8-43-408(1).

ORDER

It is therefore ordered that:

1. Respondent-employer shall pay for all reasonable necessary and related medical treatment designed to cure and relieve the Claimant from the effects of his industrial injury, including but not limited to his treatment with St. Mary's Hospital and Dr. Rooks, pursuant to the Colorado Medical Fee Schedule.

2. The ALJ finds that the treatment provided by St. Mary's Hospital and Dr. Rooks is authorized as the treatment from St. Mary's Hospital constituted emergency treatment and

Respondent failed to designate a physician willing to treat the Claimant pursuant to Section 8-43-404(5)(a).

3. Respondent-employer shall pay Claimant temporary total disability benefits beginning June 24, 2009 and continuing through September 6, 2009. Respondent-employer is entitled to an offset for any monies previously paid to Claimant for the periods of time Claimant was disabled.

4. Claimant's AWW is determined to be $480.00.

5. Respondent-employer shall increase compensation payable to Claimant by 50% pursuant to Section 8-43-408(1) for failure to carry workers' compensation insurance.

6. In lieu of payment of the above compensation and benefits to the claimant, the Respondent-Employer shall:

a. Deposit the sum of $20,543.12 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Sue Sobolik/Trustee; or

b. File a bond in the sum of $20,543.12 with the Division of Workers' Compensation within ten (10) days of the date of this order:

(1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or

(2) 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 the Respondent-Employer 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 the employer of the obligation to pay the designated sum to the trustee or to file the bond. §8-43-408(2), C.R.S.

7. 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: January 8, 2010

_____
Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-790-385

ISSUES

Ø Whether Claimant established by a preponderance of the evidence that she suffered a compensable injury arising out of and in the course of her employment with employer on or about March 11, 2008?

Ø Whether Claimant established by a preponderance of the evidence that she suffered a compensable injury arising out of and in the course of her employment with employer on or about April 8, 2008?

Ø If Claimant has established that she suffered an injury arising out of and in the course of her employment with employer, whether Claimant has proven by a preponderance of the evidence that the medical treatment she received was reasonable and necessary to cure and relieve the Claimant from the effects of her industrial injury?

Ø If Claimant has established that she suffered an injury arising out of and in the course of her employment with employer, whether Claimant has proven by a preponderance of the evidence that she is entitled to temporary total disability ("TTD") benefits?

Ø If Claimant has established that she suffered an injury arising out of and in the course of her employment with employer, what is Claimant's average weekly wage ("AWW")?

Ø If Claimant has established that she suffered an injury arising out of and in the course of her employment with employer, whether Respondents have proven by a preponderance of the evidence that Claimant was responsible for her termination of employment pursuant to Section 8-42-103(g), C.R.S.?

Ø If Claimant has established that she suffered an injury arising out of and in the course of her employment with employer, whether Respondents have proven by a preponderance of the evidence that Claimant is subject to penalties for failure to timely report her injury

pursuant to Section 8-43-102(1)(a), C.R.S.?

Ø Whether Respondents' Exhibit "HH" is a self authenticating document?

Ø Whether the ALJ can take judicial notice of Claimant's Exhibit 26, a map of the state of Colorado reflecting the elevations of communities?

FINDINGS OF FACT

1. Claimant was hired by employer in August 2005 as a part-time hourly worker to do cleaning at the business and detailing cars. Claimant continued to be employed by employer until June 6, 2008, her final day of work. Based upon the wage records and the testimony of Claimant, by January 18, 2008, Claimant was being paid $8.00 per hour. According to wage records entered into evidence for the full pay periods from January 18, 2008 through the final day of Claimant's employment, Claimant earned $5,701.84, for an AWW of $271.52.

2. Claimant testified that her job duties included performing inventory for the employer, ordering stock, returning parts as well as occasional detailing and cleaning. Claimant also assisted at the parts counter when co-employees needed assistance. After H, a co-employee, left employer, Claimant was given the opportunity by employer to be in charge of the parts department, beginning in November 2007. Claimant testified that after H left in November 2007, her hours increased, but she continued to be a part time employee. Claimant's job duties involved carrying and lifting items weighing up to fifty to one hundred (50-100) pounds, bending, climbing stairs, stepstools and ladders, reaching, standing walking and sitting. Claimant testified she was physically able to perform the functions of her employment until Spring 2008 when she developed symptoms in her hands and arms and later her legs. Claimant testified that after she developed these symptoms, her work performance began to deteriorate.

3. Claimant continued to work for employer until June 6, 2008 when she was provided with a termination letter from her employer dated May 28, 2008. According to the letter provided Claimant by her employer, her job replacing H was not working out because she was not working 8:00 to 5:00 and Saturday mornings and the employer was never sure if she would be showing up to work. Employer also noted that Claimant eats while she works, her phone skills left something to be desired and she had a negative attitude about work. Claimant testified that she believed she was doing a good job as a part time flexible hours employee, although she believed her work performance was affected by her symptoms in the last months of her employment. Employer did not provide evidence of any written warnings to Claimant prior to being terminated.

4. Claimant testified that on March 11 or March 12, 2008, she was working in an area under shelves pulling a box out beyond the shelving unit. Claimant was bent over at a ninety (90) degree angle when a metal rod that was stacked up on her right side fell and hit

Claimant on the back of the neck/shoulder area. Claimant testified that the rod hit her across the right shoulder, neck and head. Claimant testified that the rod is two (2) inches in circumference. Claimant did not feel injured at that time, but testified she reported the incident to B, the assistant manager and son of the employer. Claimant testified that B inquired as to whether she was hurt, and Claimant responded that she was too busy to get hurt and continued working. B testified at hearing that he did not recall Claimant ever reporting to him that she was struck by a rod across the back of the neck and shoulders.

5. Claimant testified that on or about April 8, 2008, she was walking out of the garage door at the employer's business when ice fell off the roof and struck Claimant on the head. Claimant testified that the piece of ice was twelve (12) inches by twelve (12) inches in size. Claimant testified that she reported this incident to C, the owner, and C sent two other employees to break up the ice on the roof. Testimony was presented from D and E, co-employees of Claimant. Both D and E testified that there is a slight slope on the roof of employer's building on which ice would accumulate and they would on occasion break the ice off the roof. Neither D or E recalled Claimant reporting she was injured by ice falling off the roof.

6. Claimant presented the testimony of Dr. Bloink, Claimant's personal physician. Dr. Bloink noted Claimant is not well organized and often will come in with one complaint, then remember a separate complaint while in the office. Dr. Bloink testified that he evaluated Claimant on April 9, 2008 when Claimant made an appointment for issues with her right eye. During that appointment, Claimant also complained of feelings of numbness in her hands and feet. Claimant was asked by Dr. Bloink if she had any head or neck injury and Claimant denied any recent injury. Dr. Bloink referred Claimant for blood work to determine if Claimant was suffering from a neuropathy. Dr. Bloink referred the Claimant for a consultation with Dr. Rivets.

7. The medical records from Dr. Bloink's clinic begin in 2005 and document Claimant's treatment for a variety of non-work related maladies, including gout, allergies, shortness of breath, asthma, warts and hives. Dr. Bloink's report from the April 9, 2008 visit indicate Claimant presented complaining of suspected pink eye, and noted that her hands and feet felt numb. Claimant reported that six months ago her left hand went numb, then four (4) months ago the right hand went numb, with her legs going numb the previous week. Claimant denied any head or neck injuries and reported she had treated in 2005 with Dr. Patterson for somewhat similar complaints of paresthesias, numbness and pain in the extremities. Claimant reported that workup revealed cervical spondylolysis and lumbar degenerative disk disease. Medical records from September 2005 reveal Claimant complaining of a great deal of back pain with radicular symptoms to both legs. X-rays demonstrated degenerative disk disease at numerous levels, including significant degenerative changes at C5-6 level with no instability, fractures or lytic lesions revealed on flexion-extension x-rays . Claimant testified at hearing that she did not report to Dr. Bloink that she experienced pain and numbness for four and six months, but instead claimed she

told Dr. Bloink she had these symptoms for four and six weeks.

8. Claimant returned to Dr. Bloink's office on April 14, 2008 with continued complaints of issues with her right eye. Claimant was referred to Dr. Petty for consultation.

9. Claimant was evaluated on April 29, 2008 by Dr. Hainey, a chiropractor, at which time she complained of numbness/burning/throbbing in all four extremities with minimal neck and moderate low back pain that was getting worse. Claimant reported that her upper extremity symptoms had been present for approximately 5-7 months and her lower extremity symptoms had been present for approximately 3 weeks. Claimant denied any recent trauma. Dr. Hainey noted Claimant had possible cervical spine discopathy and recommended an MRI study and neurological consultation.

10. Claimant returned to Dr. Bloink on May 12, 2008 with continued complaints of feeling "foggy" with a lightheaded type feeling. Dr. Bloink noted Claimant's physical examination was normal, her EKG was normal and he blood glucose was normal. Claimant called Dr. Bloink on June 18, 2008 with complaints that she was paralyzed with both hands being numb and noted she had been in bed for several days. Claimant was referred by Dr. Bloink to the hospital.

11. Claimant was evaluated by Dr. Turpen on June 19, 2008 with reports of generalized body numbness and unsteady gait. Claimant reported she had seen the chiropractor yesterday and denied any new trauma. Claimant was instructed to return the next day for an MRI of the cervical spine. Claimant reported to the emergency room on June 20, 2008 with a four week history of progressively worsening weakness in her hands from her nipple line to her feet. Claimant also reported sensory disturbance with tingling in her hands and hypersensitivity in her legs. Claimant reported being struck on the neck and right shoulder by falling pipe and even though she was hurt, she shrugged it off and went back to work. Claimant underwent an MRI of the cervical spine that revealed a "disc herniation located posterior and centrally of disk protrusion type at C5-6 level with cord compression and edema."

12. Claimant was taken by ambulance to Dr. Rivet on June 20, 2008. Claimant reported to Dr. Rivet that her history went back to 2005 when she had a tingling sensation in the second through the fifth digits on both hands and since that time she progressed very slowly and the tingling became more progressive in her body that it began to involve the lower extremities as well. Claimant also complained of a generalized sensation of weakness with the recent inability to ambulate. Claimant also reported that she was able to continue to work until recently and reported that three and a half weeks ago she suddenly was unable to walk and when she did walk, it was with poor equilibrium and holding onto walls. Dr. Rivet performed an anterior cervical diskectomy and fusion with epidural decompression with application of plates at the C5-6 and C6-7 level. Dr. Rivet provided a postoperative diagnosis of cervical myelopathy due to severe compression of the spinal cord at the C5-6 level due to

a herniated nucleus pulposus with severe spondylosis with narrowing of the canal at the C6-7 level and neurological deficits due to the cord compression. Claimant subsequently reported to Dr. Rivet on December 10, 2008 that she was well until March 12, 2008 with the exception of some "tingliness" of her fingers that had been around since 2005 when she was in the course of her work bending forward and a gust of wind pushed an iron rod that was on a shelf that hit her across the cervical and scapular areas. Claimant reported that while she did not immediately notice anything wrong with her, over the next several days she began to have increasing symptomatology. Claimant also reported that some time later, while outside the warehouse, a chunk of ice a foot squatted fell on her neck resulting in serious symptoms that progressively increased with tingling on the arm, weakness of the legs and difficulty with gait. Dr. Rivet opined that Claimant's herniation of the disk which caused the acute myelopathy was probably the result of the neck injuries that the Claimant sustained as described in her history.

13. Claimant filed a workers claim for compensation on March 28, 2009 for both claims. Respondents filed a notice of contest on May 6, 2009.

14. Respondents referred Claimant for an independent medical examination ("IME") with Dr. James Ogsbury on August 18, 2009. Dr. Ogsbury performs reviews for Respondent-Insurer. Dr. Ogsbury reviewed Claimant's medical records in connection with his examination. Dr. Ogsbury provided the opinion that Claimant's disk herniation was the result of the natural sequelae of the cervical degenerative disk disease. Dr. Ogsbury noted that it was possible for a cervical myelopathy to develop in the absence of an injury and opined that Claimant's pre-existing history of severe cervical degenerative disk disease led to the development of the herniation. Dr. Ogsbury also testified in this matter and noted that the medical records do not contain a history of Claimant's symptoms developing as a result of her work until she was examined by Dr. Rivet in June, 2008. Dr. Ogsbury noted that if the treatment Claimant received from Dr. Rivet was first rate and reasonable and necessary to treat the myelopathy in Claimant's cervical spine. The ALJ finds the testimony of Dr. Ogsbury credible and persuasive and supported by the medical records.

15. At hearing, Respondents sought to introduce a copy of weather records from www.wunderground.com setting forth the weather temperatures for the Cortez area. Claimant objects to the consideration of the weather data set forth in the printout. Respondents argue that the court can take judicial notice of the weather records pursuant to Colorado Rule of Evidence ("C.R.E.") 201. For the court to take judicial notice, the fact must be one not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned. Because the court finds that the weather records are not generally know within the territorial jurisdiction and are not capable of accurate or ready determination, the court will not take judicial notice of Respondents' Exhibit HH.

16. The court also finds that the copy of the weather records do not fall under the self authentication exception for official publications pursuant to C.R.E. 902(5) as the weather records are not issued by a public authority. Therefore, the court does not consider Respondents' Exhibit HH.

17. Claimant submitted an "Official Map to Colorado" with elevation levels of Cortez and Dove Creek, Colorado as an exhibit post hearing. Respondents do not object to the court taking judicial notice of the elevation levels of Cortez being 6,200 feet above sea level and Dover Creek being 6,843 feet above sea level.

18. The ALJ credits the reports from Dr. Bloink and Dr. Hainey and the testimony of Dr. Ogsbury over the reports from Dr. Rivet and the testimony of Claimant. The ALJ notes that Claimant reported to both Dr. Bloink and Dr. Hainey that her symptoms had been present for several months when she first sought treatment in April 2008. The ALJ finds that if Claimant's herniated disk was the result of the traumatic event of either March 12, 2008 or April 8, 2008, Claimant would have reported these incidents to her treating physicians. Instead, Claimant did not report her symptoms as being related to her employment until after she was terminated on June 6, 2008.

19. The ALJ finds that Claimant consistently denied any trauma to her neck to her medical providers in the records with the most temporal relationship to Claimant's alleged injuries, including the examination that occurred the day after Claimant allegedly was struck by ice. The ALJ finds that if Claimant had suffered an injury while employed with employer, Claimant likely would have reported some kind of trauma resulting in her increase in symptoms. Instead, Claimant consistently reported to her treating physicians that her symptoms began worsening some six to seven months earlier, and five months prior to the alleged injuries. The ALJ finds that the medical opinions expressed by Dr. Rivet that Claimant's injury is related to her work injury is based upon the history provided by Claimant that is inconsistent with the medical history Claimant provided immediately after the alleged incidents and is therefore not reliable.

20. Claimant argues that the inconsistencies in the medical records are the result of other people rather than Claimant giving the medical history to the medical personnel (such as the emergency room at Southwest Memorial Hospital), or the result of the physician misreporting the history provided by Claimant (Dr. Bloink). The ALJ is not persuaded. The ALJ notes that the medical history reported by Dr. Bloink is consistent with the medical history reported by Dr. Hainey, the chiropractor Claimant first saw on April 29, 2008. According to Dr. Hainey's records, Claimant's upper extremity symptoms had been present for 5-7 months, while her lower extremity symptoms were present for three weeks. Moreover, Claimant denied recent trauma that would have corresponded to her development of the symptoms.

21. Regardless of the elevations of Dove Creek as compared to Cortez, or the weather in Dove Creek on the April 8, 2008 alleged accident, Claimant must still reach her burden of

proving that she was struck by snow and ice on the date of that incident causing her cervical injury. The ALJ notes that the testimony from the witnesses at hearing established that it was not uncommon for ice to build up on the roof at employer's business, and for co-employees of Claimant to break up the ice to keep it from falling. However, the fact that Claimant reported to Dr. Bloink the day after this alleged incident and failed to note any trauma to her head/neck consistent with being struck by a piece of ice is the most compelling evidence that either the incident did not happen, or was not the cause of Claimant's cervical injury.

22. Likewise, with regard to the incident in which Claimant was allegedly struck by a steel bar on March 11 or 12, 2008, assuming the incident did in fact occur, Claimant did not seek medical attention for an entire month after the incident. Claimant then only sought medical attention when she developed pain in her right eye, unrelated to the effects of this incident. Moreover, according to the reports to Dr. Bloink and Dr. Hainey, the symptoms Claimant alleged were related to this incident were present for several months prior to the March 12, 2008 incident.

23. Based upon the medical records that do not document Claimant associating her onset of symptoms to an accident occurring at work until June 20, 2008 (over two months after the most recent alleged work injury) and the fact that Claimant's reporting of the symptoms as being work related corresponded to her loss of employment with employer, the ALJ finds that Claimant has failed to show that it is more likely than not that her cervical condition is related to an accident arising out of and in the course and scope of her employment.

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.*

3. 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).

4. As found, the ALJ credits the medical report from Dr. Ogsbury and finds that Claimant's myelopathy is likely the result of the natural progression of Claimant's degenerative disk disease and not the result of any work related injury. The ALJ finds that Claimant has failed to prove by a preponderance of the evidence that her medical treatment for her cervical spine condition is the result of either a work related injury occurring on March 12, 2008 or April 8, 2008.

ORDER

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits for an injury arising out of and in the course of her employment on March 12, 2008 is denied and dismissed.

2. Claimant's claim for workers' compensation benefits for an injury arising out of and in the course of her employment on April 8, 2008 is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: January 19, 2010

_____
Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-698-452 & WC 4-760-753

FINDINGS OF FACT

The ALJ entered FFCL on October 1, 2009. The claimant filed a petition to review and brief in support. This Supplemental Order addresses certain issues raised in the claimant's petition to review and supporting brief.

The October 1, 2009, FFCL are amended to reflect that the independent medical examination and deposition testimony of Dr. F. Mark Paz, M.D. were obtained by the "Arlo respondents" rather than the "MC respondents." This correction in no way alters the ALJ's October 1, 2009, FFCL insofar as they address the credibility of the opinions expressed by Dr. Paz.

The claimant seeks another hearing to present additional evidence concerning whether or not the MC respondents may relitigate the issue of the cause of the claimant's back condition. With respect to this issue the ALJ finds that at the commencement of the hearing the ALJ sought to clarify the issues. Claimant's counsel represented that the issues included "compensability of occupational disease *in either claim* for – beyond medical benefits." (Emphasis added). (Tr. p. 4). Claimant's counsel further noted that MC was held liable for medical benefits in a prior order issued by ALJ Jones. Counsel for the MC respondents stated that the issues before ALJ Jones were restricted to medical benefits, did not include indemnity benefits, and were "very limited." Counsel for the MC respondents also took the position that the issues for hearing included the "responsibility of" the MC respondents "after the order of ALJ Jones." Finally, counsel for the MC respondents stated that "if it is an occupational disease that you find, it would then be our argument that there was a -- either substantial permanent aggravation that occurred with Arlo, or under *Royal Globe*, at least medical benefits would continue with his work at Arlo." (Tr. 6-7). Counsel for the claimant did not object to this recitation of the issues by MC's counsel.

The ALJ further finds that in the claimant's position statement he took the position that if the Arlo respondents were not found liable that, "despite any arguments to the contrary, [the MC respondents are] bound by ALJ Jones' findings and conclusions with respect to the compensability of this occupational disease" because the "matter has already been resolved by ALJ Jones and subject to two appeals to ICAP." Conversely, the MC respondents' position statement argues that, based on the opinions of Dr. Paz, the claimant's "problems are not work-related at all." The MC respondents' position also cites to *Sunny Acres Villa, Inc. v. Cooper,* 25 P.3d 44, 47 (Colo. 2001), although this reference appears to have been made in response to the Arlo respondents' assertion that MC had "waived" the issue of shifting liability to Arlo.

CONCLUSIONS OF LAW

A. The ALJ concludes that the FFCL shall be amended to reflect that the Arlo respondents rather than the MC respondents obtained the medical examination and

deposition testimony of Dr. F. Mark Paz, M.D. This correction of the October 1, 2009, FFCL in no way influences or changes any other findings, including the ALJ's previous findings concerning the credibility of the opinions expressed by Dr. Paz.

B. The findings of fact and conclusions of law contained in the FFCL dated October 1, 2009, are otherwise incorporated in this Supplemental Order as if fully set forth.

C. Insofar as the claimant is requesting that the ALJ conduct another hearing to take additional evidence concerning the legal consequences of ALJ Jones's order, the request is denied. Section 8-43-207(1)(i), C.R.S., permits the ALJ for good cause shown to "grant reasonable extensions of time for the taking of any action contained in this article." Section 8-43-207(1)(j), C.R.S., permits the ALJ, for good cause shown, to adjourn any hearing to a later date for the taking of additional evidence. Factors that may be considered in determining whether to adjourn a hearing to a later date for the taking of additional evidence include, but are not limited to, whether the evidence could have been timely presented at the hearing through the exercise of due diligence, the cost and inconvenience to the opposing party if a further hearing is granted, and whether the evidence has the potential to be outcome determinative. *See Dee Enterprises v. Industrial Claim Appeals Office,* 89 P.3d 430 (Colo. App. 2003); *Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo. App. 2000); *IPMC Transportation Co. v. Industrial Claim Appeals Office,* 753 P.2d 803 (Colo. App. 1988).

D. The ALJ concludes, based on the proceedings at the commencement of the hearing, that good cause has not been shown to conduct another hearing. At the commencement of the hearing claimant's counsel was fully aware that the issue of the "compensability" of both claims was before the ALJ for determination. Further, although the claimant's counsel took the position that the MC respondents were "bound" by ALJ Jones's prior causation finding, the proceedings make clear that claimant's counsel was also aware that the MC respondents disagreed with this assertion. In these circumstances, the ALJ concludes that it came as no surprise to claimant's counsel that the legal effect of ALJ Jones's order was in dispute, and that resolution of that question turned on whether "issue preclusion" prevented the MC respondents from relitigating the causation question underling the "compensability" issue. Thus, the ALJ concludes that if claimant's counsel had desired to present any additional evidence concerning issue preclusion he had ample opportunity to do so at the time of the initial hearing. The ALJ sees no reasonable argument that there is any newly discovered evidence that could not have been presented at the time of the original hearing through the exercise of due diligence. Further, the ALJ is mindful of the additional cost and expense to the respondents if another evidentiary hearing is held.

ORDER

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

1. The Findings of Fact, Conclusions of Law, and Order entered on October 1, 2009, are amended as set forth in this Supplemental Order. Otherwise, that order is incorporated herein as if fully set forth

2. The claim for benefits in WC 4-760-753 is denied and dismissed.

3. The claim for additional benefits in WC 4-698-452 is denied and dismissed.

4. The claimant's request for an additional hearing is denied.

DATED: February 8, 2010

_____
David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-799-667

ISSUES

1. Whether Respondents have demonstrated by a preponderance of the evidence that Claimant willfully failed to obey a safety rule in violation of §8-42-112(1)(b) C.R.S.

2. Whether Respondents have proven by a preponderance of the evidence that Claimant is precluded from receiving Temporary Total Disability (TTD) benefits because he was responsible for his termination from employment under §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. (collectively "termination statutes").

FINDINGS OF FACT

1. Claimant worked for Employer as a mixer truck operator. His job duties were limited to driving large cement mixer trucks to various job sites. Claimant earned an Average Weekly Wage (AWW) of $780.00.

2. On July 29, 2009 Claimant was injured during the course and scope of his employment with Employer. Employer directed Claimant to drive a mixer truck from its place of business to a location in Boulder, Colorado. The mixer truck was carrying ten yards of cement and weighed approximately 75,000 pounds. On the way to the Boulder site,

Claimant received a call that the order had been cancelled. Employer thus directed Claimant to return to its facility with the cement load. Claimant was traveling north of the Boulder Turnpike on State Highway 224. He stopped at a stop sign prior to continuing forward on State Highway 224 to merge into I-25. While turning right onto a lane continuation area, the mixer truck tipped over. Most of the truck landed at an angle entirely off the roadway. Claimant injured his head, neck and arms during the accident.

3. Employer's Area manager F testified at the hearing in this matter. He explained that Employer provides extensive safety training for its mixer truck operators. The training includes annual mixer operator certification and a related defensive driving quiz. Training also includes riding with experienced operators. Moreover, Employer conducts monthly toolbox meetings to discuss any safety issues that have arisen. The safety issues discussed included preventing mixer truck rollover accidents.

4. Mr. F detailed the dangers associated with operating a mixer truck. He specifically addressed the high-profile nature and weight distribution of the truck when it is in operation and carrying cement. Mr. F thus commented that Employer has a zero-tolerance policy towards rolling-over a mixer truck. If Employer determines that a mixer truck rolled over because of operator error, the driver is terminated. The only exceptions to the zero-tolerance policy involve equipment failure or some reason other than operator error. Mr. F specifically noted that, on June 18, 2007, a tire failure produced a mixer truck rollover and the driver was not discharged.

5. Mr. F explained that he has investigated prior accident scenes for Employer involving mixer trucks. He noted that Claimant's mixer truck did not have a blown tire. He also considered the nature of the curve and skid marks. Mr. F examined the GPS located in Claimant's mixer truck and determined that Claimant was traveling at 22 miles per hour immediately prior to the rollover accident. He concluded that speed and overcorrection caused the mixer truck to rollover. Mr. F noted that employees are aware that they will be discharged if they are responsible for a rollover accident. Although acknowledging that Claimant had always been a safe driver, he terminated Claimant based on Employer's zero-tolerance policy for rollover accidents.

6. Claimant testified at the hearing in this matter. He explained that he was driving approximately five miles per hour when his truck tipped over. He noted that he heard a load noise and unsuccessfully attempted to apply the brakes when he lost control of the cement mixer while rounding a curve. Claimant maintained that he did not willfully or intentionally violate a safety rule and cause the rollover accident.

7. Claimant acknowledged that he had received safety training about how to safely operate cement mixer trucks. He specifically remarked that the safety training involved a discussion of safe cornering speeds and avoiding distractions. Claimant noted that Employer had always regarded him as a safe driver. He commented that he was unaware

that he would be terminated if he tipped a cement mixer truck. Claimant specifically stated that other employees had been involved in rollover accidents while driving mixer trucks but had not been discharged by Employer.

8. Respondents have failed to establish that it is more probably true than not that Claimant acted with deliberate intent in violating a safety rule and rolling-over his cement mixer truck on July 29, 2009. Mr. F explained that Employer provides extensive safety training for its mixer truck operators. Claimant also acknowledged that he has received extensive safety training regarding the proper operation of cement mixer trucks. However, Claimant credibly maintained that he did not willfully or intentionally violate a safety rule and cause the rollover accident. He explained that he unsuccessfully attempted to apply the brakes when he lost control of the cement mixer while rounding a curve. Claimant may thus have negligently failed to properly operate the cement mixer truck while cornering on July 29, 2009. However, Respondents have not demonstrated that Claimant willfully or deliberately violated a safety rule.

9. Respondents have failed to demonstrate that it is more probably true than not that Claimant precipitated his termination by committing a volitional act that he would reasonably expect to cause the loss of employment with Employer. Mr. F detailed Employer's zero-tolerance policy for rollover accidents involving mixer trucks. He explained that he examined Claimant's accident scene and determined that speed and overcorrection caused the mixer truck to rollover. Mr. F therefore terminated Claimant based on Employer's zero-tolerance policy for rollover accidents. However, Claimant explained that he was unaware that he would be terminated if he tipped his truck because other employees had been involved in rollover accidents while driving mixer trucks but not been discharged by Employer. He noted that he had always been regarded as a safe driver and Mr. F acknowledged that Claimant had been a safe driver for Employer. Claimant explained that he unsuccessfully attempted to apply the brakes when he lost control of the cement mixer while rounding a curve. He thus credibly maintained that he did not commit a volitional act. Considering the totality of the circumstances, Claimant was thus not responsible for his termination from employment.

CONCLUSIONS OF LAW

1. 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. §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. §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. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, 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).

Safety Rule Violation

4. Section 8-42-112(1)(b) C.R.S. authorize a fifty percent reduction in compensation for an employee's "willful failure to obey any reasonable rule adopted by the employer for the safety of the employee." A safety rule does not have to be either formally adopted or in writing to be effective. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d 715, 719 (Colo. App. 1995). To establish that a violation of §8-42-112(1)(b) has been willful, a respondent must prove by a preponderance of the evidence that a claimant acted with "deliberate intent." *In re Alverado,* W.C. No. 4-559-275 (ICAP, Dec. 10, 2003). Willful conduct may be proven by circumstantial evidence including "evidence of frequent warnings, the obviousness of the risk, and the extent of deliberation evidenced by claimant's conduct." *Id.*

5. Respondents need not establish that an employee had the safety rule in mind and decided to break it. *In re Alverado,* W.C. No. 4-559-275 (ICAP, Dec. 10, 2003). Rather, it is sufficient to show the employee knew the rule and deliberately performed the forbidden act. *Id.* However, willfulness will not be established if the conduct is the result of thoughtlessness or negligence. *In re Bauer*, W.C. No. 4-495-198 (ICAO, Oct. 20, 2003). "Willfulness" also does not encompass "the negligent deviation from safe conduct dictated by common sense." *In re Gutierrez,* W.C. No. 4-561-352 (ICAP, Apr. 29, 2004). Whether an employee has deliberately violated a safety rule is a question of fact to be determined by the ALJ. *Lori's Family Dining, Inc.*, 907 P.2d at 719.

6. As found, Respondents have failed to establish by a preponderance of the evidence that Claimant acted with deliberate intent in violating a safety rule and rolling-over his cement mixer truck on July 29, 2009. Mr. F explained that Employer provides extensive safety training for its mixer truck operators. Claimant also acknowledged that he has received extensive safety training regarding the proper operation of cement mixer trucks.

However, Claimant credibly maintained that he did not willfully or intentionally violate a safety rule and cause the rollover accident. He explained that he unsuccessfully attempted to apply the brakes when he lost control of the cement mixer while rounding a curve. Claimant may thus have negligently failed to properly operate the cement mixer truck while cornering on July 29, 2009. However, Respondents have not demonstrated that Claimant willfully or deliberately violated a safety rule.

Responsible for Termination

7. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). Respondents assert that Claimant is precluded from receiving TTD benefits because he was responsible for his termination from employment pursuant to §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. Under the termination statutes a claimant who is responsible for his termination from regular or modified employment is not entitled to TTD benefits absent a worsening of condition that reestablishes the causal connection between the industrial injury and the wage loss. *In re of George,* W.C. No. 4-690-400 (ICAP July 20, 2006). The termination statutes provide that, in cases where an employee is responsible for his termination, the resulting wage loss is not attributable to the industrial injury. *In re of Davis*, W.C. No. 4-631-681 (ICAP Apr. 24, 2006). A claimant does not act "volitionally" or exercise control over the circumstances leading to his termination if the effects of the injury prevent him from performing his assigned duties and cause the termination. *In re of Eskridge,* W.C. No. 4-651-260 (ICAP Apr. 21, 2006). Therefore, to establish that Claimant was responsible for his termination, Respondents must demonstrate by a preponderance of the evidence that Claimant committed a volitional act, or exercised some control over his termination under the totality of the circumstances. *See Padilla v. Digital Equipment*, 902 P.2d 414, 416 (Colo. App. 1994). An employee is thus "responsible" if he precipitated the employment termination by a volitional act that he would reasonably expect to cause the loss of employment. *Patchek v. Dep't of Public Safety,* W.C. No. 4-432-301 (ICAP, Sept. 27, 2001).

8. As found, Respondents have failed to demonstrate by a preponderance of the evidence that Claimant precipitated his termination by committing a volitional act that he would reasonably expect to cause the loss of employment with Employer. Mr. F detailed Employer's zero-tolerance policy for rollover accidents involving mixer trucks. He explained that he examined Claimant's accident scene and determined that speed and overcorrection caused the mixer truck to rollover. Mr. F therefore terminated Claimant based on Employer's zero-tolerance policy for rollover accidents. However, Claimant explained that he was unaware that he would be terminated if he tipped his truck because other employees had been involved in rollover accidents while driving mixer trucks but not been discharged by Employer. He noted that he had always been regarded as a safe driver and Mr. F acknowledged that Claimant had been a safe driver for Employer. Claimant explained that he unsuccessfully attempted to apply the brakes when he lost control of the cement mixer

while rounding a curve. He thus credibly maintained that he did not commit a volitional act. Considering the totality of the circumstances, Claimant was thus not responsible for his termination from employment.

ORDER

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

1. Respondents have failed to demonstrate by a preponderance of the evidence that Claimant willfully failed to obey a safety rule in violation of §8-42-112(1)(b) C.R.S.

2. Respondents have failed to prove by a preponderance of the evidence that Claimant was responsible for his termination from employment pursuant to the termination statutes.

DATED: February 8, 2010.

_____
Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-668-175

ISSUES

- Did respondents prove by a preponderance of the evidence that claimant should repay insurer the overpayment of workers' compensation benefits at the weekly rate of $100.00?

FINDINGS OF FACT

The Judge adopts the stipulation of the parties in finding: The Social Security Administration awarded claimant a lump sum of $26,714.00 in Social Security Disability Insurance (SSDI) benefits. Claimant receives a monthly SSDI benefit of $1,530.00, or $353.08 per week ($1,530.00 x 12 = $18,360 per year, divided by 52 weeks = $353.08). Insurer has admitted liability for permanent total disability (PTD) benefits, in the weekly amount of $249.41.

Because of statutory offsets against the lump sum SSDI award of $26,714.00, insurer has overpaid claimant benefits in the amount of $12,824.80.

Claimant receives combined SSDI and PTD benefits in the weekly amount of $602.49 ($353.08 + $249.41 = $602.49), or $2,590.71 per month.

Claimant received a check in the amount of $26,714.00 from the Social Security Administration due to the back payment of SSDI benefits. At the time he received that check, claimant failed to repay insurer any of the workers' compensation benefits it had overpaid him.

Claimant has not exercised his statutory right to have insurer pay him a lump sum against his award of PTD benefits. Claimant may apply for a lump sum pursuant to statute, which claimant could use to repay insurer the overpayment of $12,824.80.

Crediting the testimony of claimant's wife, the couple's household expenses run approximately $2,160.00 per month, which includes grocery bills of $600.00 per month, clothing expenses of $50.00 per month, and lawn care of $50.00 per month. Claimant's household thus has some $430.00 per month ($99.00 per week) to use for discretionary spending.

The parties have stipulated that claimant owes insurer the overpayment of $12,824.80. At the rate of $50.00 per week, claimant can repay insurer the overpayment in some five years. The Judge finds that, since claimant has chosen not to apply for a lump sum, it is reasonable for insurer to recoup the overpayment at the rate of $50.00 per week until the overpayment of $12,824.80 has been recouped. The $50.00 is reasonable because it is under the weekly range of claimant's $99.00 discretionary spending allotment.

CONCLUSIONS OF LAW

Respondents argue they have proven by a preponderance of the evidence that claimant should repay insurer the overpayment of workers' compensation benefits at the weekly rate of $100.00. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado, §§8-40-101, *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*. 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 8-43-207(1)(q), *supra*, authorizes the judge to require repayment of overpayments.

Here, the Judge found it reasonable for insurer to recoup the overpayment at the rate of $50.00 per week until the overpayment of $12,824.80 has been recouped. The Judge found the $50.00 offset reasonable because it is under the weekly range of claimant's $99.00 discretionary spending allotment.

The Judge concludes that insurer should be awarded an offset at the rate of $50.00 per week against claimant's PTD benefits until such time as insurer has recouped the overpayment of $12,824.80.

ORDER

1. Insurer shall offset claimant's PTD benefits at the rate of $50.00 per week until such time as insurer has recouped the overpayment of $12,824.80.

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

DATED: __February 8, 2010___

Michael E. Harr
Administrative Law Judge

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OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-751-781

ISSUES

The issues to be determined by this decision concern whether were the Division Independent Medical Exam (DIME) opinions of John T. Sacha, M.D., have been overcome by clear and convincing evidence; and, if so, temporary total disability (TTD) benefits from September 10, 2008 through September 14, 2009.

FINDINGS OF FACT

Preliminary Findings

1. Clamant received an admitted injury to his left ankle in the course and scope of his employment on December 27, 2007

2. Authorized treating physicians (ATPs) treated the Claimant, and he received temporary TTD benefits.

3. Steven Danahey, M.D., an occupational medicine specialist, initially saw and evaluated the Claimant, giving him medication, splinting his ankle, and prescribing physical therapy for two months.

4. Next, David Hahn, M.D., an orthopedic surgeon, saw the Claimant and rendered an opinion that Claimant was exhibiting signs of ankle instability. Dr. Hahn recommended surgical intervention.

5. Respondents sent the Claimant to Eric Lindberg, M.D., an orthopedic surgeon, for a second opinion. Dr. Lindberg also recommended surgical intervention on Claimant's ankle.

6. Dr. Danahey agreed with the recommendation for surgical intervention which had been made by Drs. Hahn and Lindberg.

7. Thereafter, Respondents approved and authorized the surgery.

Maximum Medical Improvement and the Hiatus

8. Subsequent to this, Claimant experienced chest pain. He presented on an emergency basis to Swedish Hospital, where a cardiac stint placement was performed. At that time, Claimant was placed on blood thinning medication.

9. Claimant's cardiac issues were not caused by or related to his worker's compensation injury.

10. On or about July 2, 2008, Claimant's cardiologist, Edward Havranek, M.D., indicated that Claimant could safely undergo the ankle surgery which was being proposed, provided it be done after the one year anniversary of the coronary stint implantation. According to Dr. Havranek, the one-year waiting period would be up on August 8, 2009.

11. On September 10, 2008, Claimant returned to his primary authorized treating physician, Dr. Danahey.

12. In a report, dated September 10, 2008, Dr. Danahey placed the Claimant at maximum medical improvement (MMI). He also provided Claimant with an impairment rating and permanent work restrictions.

13. In his report of September 10, 2008, Dr. Danahey stated as follows: "If at some point the patient has clearance from his cardiologist, and would like to proceed with surgery, then he should return to reopen his case. At this point, however, I am recommending case closure and an impairment rating as noted above." The ALJ infers and finds that the sole reason for Dr. Danahey's placement of the Claimant at MMI was because of the one-year hiatus for the left ankle surgery and not because the Claimant was actually at MMI for his left ankle injury, especially, because Dr. Danahey continued to adhere to the proposition that surgery for the Claimant's left ankle was appropriate. Based on the totality of the evidence, the ALJ infers and finds that the contemplated surgery was for the purpose of improving and relieving the Claimant's left ankle condition. Based on the face of Dr. Danahey's MMI determination, the ALJ finds that such determination was clearly erroneous, the error was unmistakable, and it was free from serious and substantial doubt.

14. On October 3, 2008, and based upon Dr. Danahey's report of September 10, 2008, the Respondents filed a Final Admission of Liability (FAL).

15. The FAL terminated temporary disability benefits as of September 9, 2008, based upon Dr. Danahey's report of September 10, 2008.

<u>The Division Independent Medical Examination</u>

16. Claimant timely objected to the FAL, and requested a DIME.

17. The DIME was performed John T. Sacha, M.D., performed the DIME on December 30, 2008.

18 .In his DIME report, Dr. Sacha agreed with the September 10, 2008 date of MMI that was assigned by Dr. Danahey. In his report, Dr. Sacha stated as follows: "In reviewing this patient's case, unfortunately this patient could not have treatment mainly because of coronary artery disease and being medically unstable. Based on this, I would agree with the date of maximum medical improvement." Based on Dr. Sacha's reliance on Dr. Danahey's opinion of MMI and the intervening coronary artery disease rendering the Claimant medically unstable, the ALJ finds that Dr. Sacha's DIME opinion of MMI, on its face, is clearly erroneous, the error is unmistakable and the error is free from serious and substantial doubt.

19. There is no credible or persuasive opinion from any physician involved in this case

that the proposed ankle surgery is **not** reasonably necessary to cure and relive Claimant from the effects of his industrial injury, nor is there any credible or persuasive opinion from any physician that disagrees with surgical intervention.

20. There is no persuasive evidence of the exact period of time that the attainment of MMI was delayed due to Claimant's cardiac issues, other than the one-year delay caused by Claimant's coronary disease.

21. Claimant was eventually cleared for ankle surgery by his cardiologist within the anticipated time frame. August 2009.

22. Claimant's ankle surgery was scheduled for, and actually took place on September 15, 2009. The purpose of the surgery was to improve Claimant's condition. There ios no persuasive evidence to the contrary.

23. On November 11, 2009, the Respondents filed a General Admission of Liability (GAL) placing Claimant back on TTD benefits, with those benefits commencing on September 15, 2009 (the date of surgery) and continuing.

24. Claimant filed an Application for Hearing challenging the DIME opinion of Dr. Sacha concerning the date of MMI. Claimant also requested TTD benefits from the date it was discontinued by the carrier (September 9, 2008, based upon Dr. Danahey"s erroneous September 10, 2008 MMI date) until the date the ankle surgery was actually performed (September 15, 2009).

Temporary Disability Benefits

25. At the time of his injury, Claimant was employed as a janitor. His job duties were rigorous, and required lifting, carrying, climbing ladders, and spending prolonged periods of time on his feet.

26. At no time from the date of his injury and continuing, has Claimant been physically able to perform the job duties which he was performing on the date of his injury.

27. During the time period for which TTD is now being sought, the Claimant had no employment and he was under physical restrictions from his ATPs. Claimant's work-related injury and work-related disability contributed to his wage loss during this period of time.

28. The Employer terminated the Claimant on April 1, 2008, due to his injury. Claimant was not at fault for his termination. He was not offered modified employment.

Credit to Respondents for Permanent Partial Disability (PPD) Payments

29. As of September 8, 2009, Respondents have paid the Claimant $13, 342. 97 in aggregate PPD benefits. Therefore, Respondents are entitled to a net credit of $2,925.36 against aggregate TTD benefits of $10, 417. 61, representing overpaid PPD benefits.

Ultimate Findings

30. Claimant is not at MMI, nor has he ever reached MMI status in this case.

31. The Claimant has proven that it is highly probable, free from serious and substantial doubt and unmistakable that DIME Dr. Sacha's opinion of MMI is erroneous on its face and contradicted by the totality of the evidence.

CONCLUSIONS OF LAW

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

Credibility

a. 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,

The Hiatus

b. In *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995), the Colorado Supreme Court concluded that the claimant's burden to establish a causal connection between a work-related injury and a subsequent wage loss is established when the work-related injury

contributes “in some degree” to the temporary wage loss.
In *Gallegos v. Owens Corning,* W.C. 4-221-098 [Industrial Claim Appeals Office (ICAO), October 25, 1995], the panel held that the work-related injury need not be the “sole” or “immediate” cause of the wage loss, and that the claimant is entitled to temporary disability benefits unless the work-related injury plays no part in the subsequent wage loss. In *Gallegos,* the Respondents sought to terminate temporary disability benefits based upon Claimant’s pregnancy. The Respondents argued that the pregnancy constituted a sufficient intervening condition that severed the causal connection between the claimant’s temporary disability and the occupational disease. Both the ALJ and the Industrial Claim Appeals Office denied Respondents’ Petition to Suspend Benefits, reasoning that Claimant was receiving temporary disability benefits at the time she became pregnant, and that she was not precluded from receiving temporary disability benefits since the industrial injury contributed, at least in part, to the Claimant’s wage loss during her pregnancy. The situation in this case is closely analogous to the situation presented in the pregnancy cases, where the courts have generally refused to suspend temporary disability benefits of a disabled worker based upon the pregnancy of the Claimant.

Maximum Medical Improvement

c. Maximum Medical Improvement is defined as the point in time when any medically determinable physical or medical 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. (2009). *Donald B. Murphy Contractors, Inc. V. ICAO*, 916 P.2d 611 (Colo. App. 1995). As found, Claimant was clearly not at MMI with the pendency of left ankle surgery for the purpose of improving Claimant’s condition.

d. The party seeking to overcome a DIME physician’s opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office***,** 5 P.3d 385 (Colo. App. 2000). It is well established that the DIME physician's determination of MMI is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(b)-(c), C.R.S. (2009). Also, a DIME physician’s conclusion that an injured worker’s medical problems were components of the injured worker’s overall impairment constitutes a part of the diagnostic assessment that comprises the DIME process and ,as such the conclusion must be given presumptive effect and can only be overcome by clear and convincing evidence. *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). "Clear and convincing evidence" is evidence, which is stronger than preponderance, is unmistakable, makes a fact or facts highly probable or the converse, and is free from serious or substantial doubt. _*Metro Moving & Storage Co. v. Gussert, supra.* In other words, a DIME physician's finding may not be overcome unless the evidence establishes that it is "highly probable" that the DIME physician's opinion is incorrect. *Postelwait v. Midwest Barricade,* 905 P. 2d 21 (Colo. App. 1995). The question of whether the DIME physician has placed a

claimant at MMI or not, and whether that determination has been overcome is a factual determination for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, supra. As found, Claimant overcame the DIME opinion of Dr. Sacha, concerning MMI, by clear and convincing evidence. Therefore, the Claimant is not at MMI as of the present time.

Temporary Disability Benefits

e. To establish entitlement to temporary disability 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. Section 8-42-103(1), C.R.S. (2009); *PDM Molding, Inc. v. Stanberg*, *supra*. 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 (ICAO, December 18, 2000). As found, Claimant's termination in this case was not his fault. 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 in modified employment or modified employment is no longer 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. *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 proven that he was temporarily and totally disabled from September 10, 2008 through September 15, 2009, both dates inclusive, a total of 370 days.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant has never been at maximum medical improvement.

B. Respondents shall pay the costs of all work-related medical benefits herein, including the left ankle surgery of September 15, 2009.

C. Respondents shall pay the Claimant temporary total disability benefits at the admitted rate of $197.09 per week, or $28.155 per day, from September 10, 2008 through September 15, 2009, both dates inclusive, a total of 370 days, in the aggregate amount of $10, 417. 61. Respondents overpaid permanent partial disability benefits in the amount of $13, 342.97, when zero was due. Therefore, Respondents are entitled to a credit on the differential

between the temporary benefits due and the permanent disability benefits paid. Because the credit exceeds the temporary disability benefits due by $2,925.36, Respondents may recover this credit from any permanent disability award.

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

DATED this_____day of February 2010.

_____

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-758-499

ISSUES

Ø Did the respondents overcome the DIME physician's impairment rating for cervical and thoracic impairment by clear and convincing evidence?

Ø Did the claimant present sufficient evidence to overcome the DIME physician's impairment rating by demonstrating entitlement to a rating for her shoulder and low back?

FINDINGS OF FACT

1. On May 1, 2008, the claimant sustained admittedly compensable injuries in a motor vehicle accident (MVA) when the vehicle that she was driving was "T-boned" on the passenger's side. The claimant was taken to the Medical Center of Aurora where she was diagnosed with: (1) lumbar sprain strain, (2) neck sprain strain, (3) sprain and strain of unspecified site of shoulder and upper arm.

2. The claimant came under the care of the Rocky Mountain Medical Group (RMMG) as the primary provider for the worker's compensation injury. Dr. Brian Beatty, D.O., first saw the claimant on May 2, 2008. Dr. Beatty noted tenderness of the paracervical and thoracic spine, as well as the paralumbar muscles bilaterally. Range of motion was minimal in the regions of the cervical and lumbar spine. Diagnoses included cervical strain, lumbar strain, left knee contusion and myofascial pain. Dr. Beatty prescribed Ibuprofen and took the claimant off of work.

3. Commencing May 6, 2008, Dr. Annu Ramaswamy, M.D. (Dr. R), a RMMG physician,

assumed responsibility for the claimant's treatment. On May 6, the claimant's primary complaints were headaches located at the "posterior occiput" and neck pain. There were no complaints of low back pain or shoulder pain. Dr. R diagnosed probable suboccipital neuralgia and headaches. Dr. R referred the claimant for osteopathic manipulative therapy (OMT) and acupuncture, and prescribed a Medrol Dosepak for inflammation.

4. On May 9, 2008, Dr. R noted the claimant was primarily complaining of headaches. He diagnosed suboccipital neuralgia and added the diagnosis of cervical strain. On May 29, 2009, Dr. R noted primary complaints of neck pain and headaches. Dr. R then prescribed "massage therapy."

5. Upon referral by Dr. R the claimant underwent acupuncture and OMT treatments from May 14, 1008, through June 20, 2008. The acupuncture treatments were performed by Dr. Rosalie Bondi, D.O., and the OMT treatments by Dr. Thomas Vavrek, D.O. In the early stages of this treatment the claimant reported headaches, neck pain, mid back pain, and lumbar pain. On June 16, 2008, the claimant advised Dr. Bondi that her mid and low back pain was "better" and Dr. Bondi noted the lumbar spine range of motion was "within normal limits." On June 18, the claimant advised Dr. Bondi that her low back pain was mild. Dr. Bondi observed that the claimant exhibited full ROM in both shoulders and that the upper extremities demonstrated full ROM. On June 20, 2008, Dr. Vavrek noted "somatic dysfunction" in the cranial, suboccipital, cervical and thoracic regions. There was no mention of the lumbar region. Dr. Vavrek stated that he performed manipulation on the "areas of somatic dysfunction."

6. On June 30, 2008, the claimant complained to Dr. R of low back pain. She expressed concern that her MVA might have injured a kidney and aggravated pre-existing interstitial cystitis. Laboratory work was done and no abnormality was detected. Dr. R concluded that injury to the claimant's kidney was unlikely "from a historical standpoint given that her back pain appeared to have resolved and one would suspect issues with the kidneys would not improve, especially in a traumatic situation."

7. The claimant underwent "tissue release treatment" (TRT) at the Dorn Group from June 24, 2008, through September 11, 2008.

8. On August 11, 2008, Dr. R suggested a referral to a physiatrist and possible injections, but the claimant declined because she did not want to undergo any injections. At the request of Dr. R, the claimant also underwent a cervical MRI scan. The MRI showed mild degenerative changes but no acute disc herniation.

9. On August 22, 2008, the claimant reported to Dr. R that she was doing "a lot better," and stated that she had "only soreness" but "no pain at this time." Dr. R noted only "minimal trigger point activity now present in the right trapezius and levator regions."

10. In a letter dated September 11, 2008, Dr. R stated that he had reviewed some additional medical records of the claimant's treatment prior to the MVA, and records of some treatment after the MVA. Dr. R opined, based on the pain diagrams completed at the Dorn

Group, that the claimant had improved, although her headaches had returned. Dr. R opined, in light of the fact that the claimant sought treatment from Dr. Starritt for occipital headaches on March 6, 2008 (approximately 2 months before the MVA) that the return of the headaches was not related to the MVA. Dr. R opined the claimant was back to "baseline" for her work-related conditions based on history and the Dorn Group records. Dr. R also opined the claimant's work-related conditions had resolved.

11. On October 20, 2008, Dr. R opined the claimant was back to "baseline" and did not qualify for "permanency." Dr. R noted some trigger points in the left trapezius region but minimal activity on the right. He further noted the claimant was seeking treatment at an "integrated medical center."

12. On November 3, 2008, the respondents filed a Final Admission of Liability based upon Dr. R's 0% impairment rating. The claimant objected and requested a Division Independent Medical Examination (DIME).

13. On April 16, 2009, Dr. Renee Shenoi, M.D., performed the DIME. She issued her report on May 6, 2009. Dr. Shenoi noted that she was asked to review body parts including, "cervical, thoracic, and lumbar spine, shoulder." Dr. Shenoi opined the claimant reached MMI on August 22, 2008, when Dr. R noted, "she was improving." Dr. Shenoi stated that her impression, based on her review of records and examination, was that the following conditions were "identified;" (1) cervical pain/strain; (2) thoracic pain/strain; (3) headaches of multifactorial origin; (4) low back pain; (5) shoulder pain; (6) left knee pain.

14. In her report Dr. Shenoi noted the claimant had a complicated medical history prior to the MVA including headaches, TMJ, neck soreness, thyroiditis, hypothyroidism, dysmenorreha, anemia and interstitial cystitis. Dr. Shenoi also stated that although the medical records she reviewed showed a number of complaints after the MVA, the "most consistent" were neck pain, upper back, and headaches," while the complaints of middle back, shoulders, knee and low back problems were "not consistently reported in my review of the records." Dr. Shenoi observed that there were "limited records provided" regarding the claimant's "baseline." Nevertheless, Dr. Shenoi stated the following:

15. Based on the information presented thus far, it is impossible to fairly assess 1) whether there is permanent physical impairment as a result of the MVA and 2) whether there is apportionment for the impairment secondary to pre-existing conditions.

16. Dr. Shenoi stated it would be helpful to review more records from before and after the MVA, and that her impairment rating was based on "insufficient information." Dr. Shenoi then assigned a 15 percent whole person impairment rating based on the effects of the MVA. This included 4 percent for cervical "strain/sprain," 9 percent for reduced cervical ROM, and 2 percent for thoracic pain.

17. The medical records document that the claimant had a significant medical history prior to the May 1, 2008, MVA. Among many problems the claimant had a lengthy history of suffering from headaches. Her thyroid was removed in 2007. Nevertheless, her headaches did not disappear. As reflected in the notes of Dr. Debra Alspector, M.D., the claimant was

taken off of work because of severe headaches from February 5, 2008, to March 17, 2008. The claimant also had a lengthy history of seeking chiropractic treatment. In 2004 and 2005 she treated with Dr. C Forbes, D.C. Dr. Forbes is presumably located in Michigan. Her complaints variously included headaches, neck pain, shoulder pain and soreness in her back. She also treated with Dr. Flansburg, D.C., in Colorado. On March 14, 2008, she reported to Dr. Flansburg with symptoms of headache and neck pain.

18. On June 19, 2009, Dr. R authored a report after reviewing Dr. Shenoi's DIME report. Dr. R opined that under the "Level II Curriculum, it would have been more appropriate [for Dr. Shenoi] to assign a 0% whole person rating with possible revision, pending receipt of prior medical records," and that "it would be inappropriate to assume permanency from the work-related motor vehicle accident." Dr. R further stated that based on the results of his August 22, 2008, evaluation of the claimant and considering her "history of chronic headaches and neck pain," he believed she "was back to her baseline condition." He further stated that to the extent any of the claimant's symptoms worsened after the industrial injury he did not believe that the worsening was related to the May 1, 2008, MVA. Rather, he opined the claimant's injury-related symptoms resolved as is the expected course for a diagnosis of cervical strain and soft-tissue injury. For these reasons Dr. R did not change his prior opinion that the claimant was not entitled to an impairment rating.

19. On August 28, 2009, Dr. R testified by deposition. Dr. R opined that Dr. Shenoi erred in assigning permanent impairment ratings for the claimant's cervical and thoracic spine. Dr. R was asked to explain his opinion in light of the AMA Guides and his certification as a Level II physician authorized to rate impairment. Dr. R testified that in the Level II accreditation course he was taught that if a rating physician is unable to assess an impairment rating for a particular condition the physician should not rate the condition, and should explain why it cannot be rated. Dr. R explained that if Dr. Shenoi determined it was "impossible" to infer a causal connection between the MVA and the medical impairments she should not have assigned the ratings.

20. Dr. R further testified that in order to rate the thoracic spine it was necessary to determine a specific diagnosis based on objective findings, and that the claimant did not display such findings. With respect to the cervical spine, Dr. R opined that the claimant did not evidence any permanent impairment that could be attributed to the industrial injury. Dr. R explained that in his opinion the claimant did not exhibit any permanent condition of the cervical spine at the time of MMI because her ROM had significantly improved, there were minimal objective findings of any muscular condition, and his records showed a continual decline in the claimant's pain complaints.

21. The respondents proved it is highly probable and free from serious doubt that the DIME physician, Dr. Shenoi, violated the principles for rating impairment established by the AMA Guides when she determined that the claimant sustained permanent impairment of the cervical and thoracic spines caused by the industrial injury of May 1, 2008. In her report Dr. Shenoi admitted that it was "impossible" for her to determine whether the claimant sustained any permanent impairment caused by the industrial injury, and that she would need

additional documentation to make such a determination. The ALJ finds that Dr. Shenoi's remarks amount to a concession that she is unable to state affirmatively that there is causal relationship between the industrial injury and the cervical and thoracic impairment that she reported. Therefore, Dr. Shenoi's report is equivocal and indefinite with respect to whether or not the MVA caused any cervical or thoracic impairment, and is not persuasive concerning the cause of the impairment that she rated. In contrast, Dr. R's testimony concerning the requirements of the AMA Guides concerning proof of causation, as illuminated by his training as a Level II accredited physician, is highly persuasive and credible. Dr. R credibly explained that the rating physician is required to establish and document a causal relationship between impairment and the industrial injury. He further credibly testified that the rating physician is not permitted to rate impairment where the physician cannot explain the relationship between the impairment and its alleged cause. Further, Dr. R credibly opined that the claimant's injury-related symptoms and conditions returned to baseline by MMI and did not warrant an impairment rating. In this regard the medical records establish the claimant has complained of and been treated for neck pain and headaches for many years prior to the MVA. In fact, Dr. Flansburg treated the claimant for neck pain on March 14, 2008, less than two months *prior to* the MVA. This evidence adds further weight to Dr. R's opinion that the medical evidence does not support the inference of a causal relationship between the MVA and the impairment found by Dr. Shenoi. The ALJ finds that Dr. R's testimony is sufficiently credible and persuasive to overcome the rating of Dr. Shenoi by clear and convincing evidence.

22. The claimant failed to prove that it is more probably true than not that she has any ratable impairment of the shoulder and low back, or that if such impairments exist that the May 2008 MVA caused them. In this regard, the ALJ finds there is no credible or persuasive evidence from any physician that the claimant sustained impairment of the shoulder or low back as a result of the MVA. Neither Dr. Shenoi nor Dr. R rated the low back or the shoulder. Dr. Shenoi explained that, based on her review of the records made available to her, reporting of shoulder and low back symptoms was not consistent enough to support an impairment rating. Dr. Shenoi's opinion on this question is persuasively corroborated by the testimony and reports of Dr. R, which fail to document steady complaints of shoulder and low back pain. To the extent the claimant reported shoulder and low back symptoms to other providers during 2008, the claimant has not shown that any of these physicians opined that the complaints warrant an impairment rating, or that if a rating is warranted that the MVA was the cause of such impairment. In this regard the ALJ finds that there is evidence in the record that the claimant sought chiropractic treatment for shoulder and back pain long before the MVA.

23. Evidence and inferences inconsistent with these findings are not found to be credible and persuasive.

CONCLUSIONS OF LAW

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

RESPONDENTS' ATTEMPT TO OVERCOME DIME RATING FOR THORACIC AND CERVICAL IMPAIRMENT

The respondents seek to overcome Dr. Shenoi's impairment rating with respect to the cervical and thoracic regions. The ALJ concludes that the respondents have succeeded.

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.; §8-42-107(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).

As determined in Finding of Fact 20, the respondents proved that it is highly probable and free from serious doubt that Dr. Shenoi, the DIME physician, erred in finding that the claimant sustained any ratable cervical and thoracic impairment caused by the industrial injury of May 1, 2008. As found, Dr. Shenoi herself admitted that, based on the available information, it was "impossible" for her to determine that the impairments of the cervical and thoracic spine were causally-related to the industrial injury. Further, the ALJ finds that Dr. R's opinion that under the AMA Guides and Level II Curriculum Dr. Shenoi incorrectly attributed the impairment to the industrial injury is highly persuasive and credible.

The respondents have overcome the DIME physician's impairment rating by clear and convincing evidence. The respondents are not obligated to pay any permanent partial disability benefits based on impairment of the cervical and thoracic spines.

CLAIMANT'S ATTEMPT TO OVERCOME DIME PHYSICIAN'S FAILURE TO ISSUE A RATING FOR THE SHOULDER AND LOW BACK

The claimant contends the evidence establishes that she is entitled to impairment ratings for the shoulder and low back. The ALJ disagrees with this assertion.

As an initial matter, the ALJ notes that the ICAO has issued a ruling concerning the applicable burden of proof when a portion of a DIME physician's rating has been overcome by clear and convincing evidence. In *Deleon v. Whole Foods Market, Inc.,* W.C. No. 4-600-477 (ICAO, November 16, 2006), the ALJ determined the respondents overcame by clear and convincing evidence a DIME physician's finding that the claimant sustained 5 percent impairment for lost range of motion in the lumbar spine. However, the ALJ also found that the respondents failed to overcome by clear and convincing evidence the DIME physician's finding that the claimant sustained 5 percent impairment for a specific disorder of the lumbar spine. Consequently the ALJ upheld the specific disorder portion of the rating. The ICAO ruled that once an ALJ determines "the DIME's rating has been overcome in any respect" the ALJ is "free to calculate the claimant's impairment rating based upon the preponderance of the evidence" standard. The ICAO further stated that when applying the preponderance of the evidence standard the ALJ is "not required to dissect the overall impairment rating into its numerous component parts and determine whether each part or sub-part has been overcome by clear and convincing evidence." Because the *Deleon* case represents the most current authority concerning this issue, the ALJ finds it persuasive and will apply it to this case.

It is unclear from the *DeLeon* decision whether in a fact pattern such as this (where

the respondents have overcome the DIME physician's rating by clear and convincing evidence) the claimant must separately overcome the DIME physician's rating by clear and convincing evidence, or may simply prove the existence of ratable impairment by a preponderance of the evidence. However, the ALJ concludes there is no need to reach this legal issue because the claimant failed to prove by even a preponderance of the evidence that she sustained permanent impairment of the low back or shoulder that was caused by the May 1, 2008, MVA.

As determined in Finding of Fact 21, the claimant failed to prove that it is more probably true than not that she has any ratable impairment of the shoulder and low back, or that if such impairments exist that the May 2008 MVA caused them. As found, there is no credible or persuasive medical evidence to establish that the claimant sustained ratable impairment of the shoulder and low back caused by the MVA. However, there is significant evidence tending to establish that the claimant had shoulder and back problems prior to the MVA.

The respondents are not obligated to pay any permanent partial disability benefits based on the claimant's contention that she sustained ratable impairment of the shoulder and low back caused by the May 1, 2008, MVA.

ORDER

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

1. The respondents are relieved of any liability to pay permanent partial disability benefits as a result of the May 1, 2008, industrial injury. All claims for permanent partial disability benefits as a result of this injury are denied and dismissed.

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

DATED: February 9, 2010

_____
David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-809-449

ISSUES

The issue determined herein is compensability.

FINDINGS OF FACT

1, Claimant was diagnosed with hypertension in the 1970's and had controlled it with medications. He had never suffered any previous episodes of dizziness or nausea.

2. On September 14, 2009, claimant began work as a telemarketer for the employer. He had one week of training and was paid in full for his hourly wages. Claimant then began work as an hourly employee at $10 per hour plus commissions based upon the percentage of telephone calls that led to sales as well as the number of hours worked each week.

3. From the first week of work as a telemarketer, claimant was not paid in full for the commissions he earned. He complained to supervisors on several occasions.

4. On October 31, 2009, claimant submitted a letter of resignation effective two weeks later, but the employer persuaded him to remain on the job.

5. On November 13 and 14, 2009, claimant had great success in sales, including selling 54% of his calls on November 14. He was looking forward to earning commissions at the highest rate under the employer's commission structure.

6. On November 16, 2009, claimant returned to work and found that he was given a "tier 3" assignment to handle customer service calls, leading to a very low sales success rate that would not qualify him for commissions. Claimant complained to his supervisor, who asked him to return to work. Claimant insisted that the problem with the commission payment needed to be solved immediately or he was leaving. Claimant stood up and immediately became dizzy and nauseous. He drank a bottle of water, but vomited and became incoherent.

7. The employer called paramedics, who transported claimant to Penrose Hospital. Physicians at the emergency room ran an electrocardiogram, gave claimant an aspirin, and observed him for two or three hours. He was discharged with a set of written instructions and was told to follow up with his personal physician.

8. The discharge instructions from Penrose Hospital addressed high blood pressure, headache, and stress reaction in general terms. The instructions did not address any specific aspects of claimant's condition and did not provide any opinions or discussion about causation of claimant's condition.

9. In a couple of days, claimant sought examination by his personal physician, Dr. Crawford. She performed a physical examination, but administered no tests.

10. Claimant has failed to introduce medical expert testimony or written report that

supports the claim that he suffered a recognized disability arising from a psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. Claimant did not even prove his medical condition. He is quite credible: he was stressed at work and he had an episode of dizziness and nausea. He has provided no medical support that ties the two events together and shows that a reasonable worker in similar circumstances would have significant symptoms of distress.

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). 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. At the close of claimant's case, respondents moved for a directed verdict or dismissal. The OACRP and WCRP are silent on such motions. The Colorado Rules of Civil Procedure may apply if there is no conflict with the act or the OACRP and WCRP. CRCP 50 provides for a motion for directed verdict. CRCP 41(b)(1) also provides for dismissal at the close of the plaintiff's case in a matter tried without a jury if, "upon the facts and the law the plaintiff has shown no right to relief." The court may grant the motion at that time or may defer ruling until all of the evidence is presented by the defendant. In the current matter, respondents are entitled to dismissal of claimant's claim at the close of claimant's case.

3. This is a "mental-physical" case. Consequently, claimant must meet the requirements of section 8-41-301(2), C.R.S., for a claim of mental impairment. The 1999 amendments made § 8-41-301(2), C.R.S., applicable to claims for permanent disability from mental impairment resulting from a physical injury. *Briles v. Montrose Memorial Hospital*, W. C. No. 4-522-095 (ICAO, April 30, 2004); *Chavarria v. Dayton Hudson Corporation*, W.C. No. 4-492-078 (June 5, 2003); and *Herbertson v. Arch Coal Inc*., W.C. No. 4-533-791 (January 8, 2004) held that the additional proof requirements were not applicable to claims for medical and temporary disability in these "physical-mental" cases. Nevertheless, *Felix v. City & County Of Denver*, W.C. Nos. 4-385-490 & 4-728-064 (ICAO, January 6, 2009) recently reaffirmed application of the mental impairment statute to "mental-physical" cases:

> The focus is now on the cause of the impairment and the mental impairment statute remains applicable where the stimulus was purely mental, even if the mental stimulus caused a mental impairment, which exhibited physiological

> symptoms or "injuries." *Esser v. Industrial Claim Appeals Office*, 8 P.3d 1218 (Colo. App. 2000); *Hughes-Choyce v. The Childrens Hospital*, W.C. No. 4-444-713 (October 24, 2002); *aff'd sub nom. Hughes-Choyce v. Industrial Claim Appeals Office* No. 02CA2274 (Colo. App. September 11, 2003)(not selected for publication). In *Hughes-Choyce v. The Childrens Hospital*, the Panel noted that the General Assembly did not intend to exempt cases from the reach of the mental impairment statute simply because the mental impairment causes some physiological manifestation or injury.

Claimant argues that his claim is not one of “mental impairment.” Pursuant to *Felix, supra*, claimant’s claim is covered by the mental impairment statute. Claimant’s claim is one based upon the physical effects that mental stimuli caused. One has to reason through claimant’s mental state in order to find any plausible work injury: the physical symptoms of dizziness and nausea. Consequently, claimant must satisfy the proof requirements in § 8-41-301(2), C. R.S.

4. Section 8-41-301(2), C.R.S., provides, “A claim of mental impairment must be proven by evidence supported by the testimony of a licensed physician or psychologist.” Claimant need not provide actual “testimony” and can provide supporting medical evidence by written report. *Esser v. Industrial Claim Appeals Office*, 9 P.3d 1218 (Colo. App. 2000), *aff’d. Colorado Dept. of Labor v. Esser*, 30 P.3d 189 (Colo. 2001). The medical expert must provide supporting evidence on the matters within his expertise, namely whether claimant suffered a recognized disability arising from a psychologically traumatic event. Claimant can prove the other required elements of the claim of mental impairment through other lay evidence. *Davison v. Industrial Claim Appeals Office,* 84 P.3d 1023 (Colo. 2004). “Mental impairment” is defined in part in § 8-41-301(2)(a), C.R.S.:

> [A] recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is generally outside of a worker’s usual experience and would evoke significant symptoms of distress in a worker in similar circumstances.

5. As found, claimant has failed to introduce medical expert testimony or written report that supports the claim that he suffered a recognized disability arising from a psychologically traumatic event that is generally outside of a worker’s usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. Claimant is understandably upset at the employer for not paying him his earnings. He may have a valid claim for breach of employment contract and for wage and hour violations by the employer. What he has not demonstrated is that he suffered a work injury by virtue of the mental stress from the conditions of employment. His claim must be dismissed.

ORDER

It is therefore ordered that:

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

DATED: February 10, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-775-399

ISSUES

The issues to be determined by this decision are:

1) Whether the Respondents have overcome the division independent medical evaluation (DIME) physician's opinion on impairment;

2) whether temporary total disability benefits are due after March 4, 2009; and,

3) whether medical benefits are required.

FINDINGS OF FACT

1. Claimant is a 52-year-old laborer who worked as a seasonal employee for the Respondent-Employer located in Canon City, Colorado. On September 8, 2008, Claimant injured his back and right shoulder in the course of his employment while working for the Respondent-Employer.

2. Claimant treated at CCOM located in Canon City on September 9, 2008 with Physician Assistant (PA) Steve Quakenbush, who diagnosed Claimant with a right shoulder injury, and cervical and lumbar strain. Claimant continued treatment at CCOM through March 2, 2009. The authorized treating physician, Dr. Julian Venegas, stamped and signed the WC M164 form dated February 20, 2009 and March 2, 2009.

3. Prior to and after the injury, Claimant was also receiving treatment from Dr. Christopher Jones for his shoulder and Dr. Michael Gehrke for his lower back.

4. Dr. Jones evaluated Claimant on February 2, 2009 for a surgical consultation. Dr. Jones recommended an arthroscopic decompression and distal clavicle resection.

5. Surveillance video was taken of the Claimant on February 4th and 5th, 2009 and March 5th and 6th, 2009. The video shows Claimant driving in his blue Chevrolet pick-up truck, smoking cigarettes, lifting small children, and bending over to pick up his hat.

6. On March 4, 2009, Dr. Venegas reviewed the video of Claimant and opined he was at MMI and had no impairment. Dr. Venegas also indicated Claimant exhibited signs of symptom magnification and that Claimant's activities in the video exceeded his physical presentation in Dr. Venegas' office.

7. A copy of the letter from Dr. Venegas was sent to Dr. Jones on March 9, 2009 asking him whether he agreed with the opinion of Dr. Venegas. Dr. Jones signed the letter and stated he agreed with Dr. Venegas' opinion of MMI and no impairment.

8. A final admission of liability (FAL) was filed on March 16, 2009, based on the findings of Dr. Venegas. Claimant timely objected and requested a DIME.

9. On June 3, 2009 Dr. Kenneth Finn evaluated Claimant for purposes of a DIME.

10. Dr. Finn assigned a seventeen percent whole person impairment rating and stated these may be due to age related changes and he should seek care under his group health insurance, but his hypertension needs to be adequately controlled. Dr. Finn indicated he counseled Claimant on his hypertension given his significantly elevated pressure.

11. Based on the seventeen percent impairment rating in Dr. Finn's June 3, 2009 report, Respondent-Insurer filed an application for hearing to overcome the DIME physician's finding of impairment on June 15, 2009.

12. On June 19, 2009, a letter was sent from Claimant's counsel asking Dr. Finn to review the surveillance video and opine whether his opinion changed in any way regarding impairment and/or MMI.

13. On August 7, 2009, Dr. Finn authored a letter stating he had reviewed the video. Dr. Finn stated that Claimant appeared to be performing activities and moving his back and right shoulder more than what he was able to obtain in the office by direct measurements, and would have to agree with Dr. Venegas and Dr. Jones that Claimant has no impairment functionally as it related to his back and right shoulder injury.

14. Respondents' deposed Dr. Finn on September 9, 2009. Dr. Finn recognized Claimant to be the individual in the surveillance video. Dr. Finn testified the DIME report he authored dated June 3, 2009 was incorrect. Dr. Finn testified in his deposition that Claimant had no impairment, rather than seventeen percent as he reported on June 3, 2009.

15. Dr. Finn testified he agreed with the opinions of Dr. Venegas and Dr. Jones that Claimant was at MMI as of March 4, 2009 and had no permanent impairment. Dr. Finn testified Claimant presented differently on his exam of June 3, 2009, than what he saw on the surveillance video. The ALJ finds that this is the DIME's ultimate findings.

16. On September 23, 2009, Respondents' counsel sent a letter to Dr. Venegas asking him whether the letter dated March 4, 2009 in regards to MMI and impairment was his true opinion. Dr. Venegas signed the letter affirming his prior opinion that Claimant was at MMI on March 4, 2009 and had no impairment.

17. On October 29, 2009, Dr. Jones affirmed his prior opinion that Claimant was at MMI as of March 4, 2009 and had no impairment. Dr. Jones also stated no further medical treatment is needed for Claimant.

18. The opinions of Dr. Finn, Dr. Jones and Dr. Venegas are credible, and accepted by the ALJ. The ALJ does not find the Claimant credible.

CONCLUSIONS OF LAW

1. The DIME physician's findings concerning the date of MMI and the degree of medical impairment are binding on the parties unless overcome by clear and convincing evidence. Sections 8-42-107(8)(b) (III) & (8)(c), C.R.S. 2007. 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 matter 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). In so doing, 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). A DIME physician's finding of MMI and permanent impairment consists not only of the initial report, but also any subsequent opinion given by the physician. *See Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005)(ALJ properly considered DIME physician's deposition testimony where he withdrew his original opinion of impairment after viewing a surveillance video); *see also, Jarosinski V. Industrial Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002)(noting that DIME physician retracted original permanent impairment rating after viewing videotapes showing the Claimant performing activities inconsistent with the symptoms and disabilities she had reported).

2. In testimony during his deposition Dr. Finn provided his findings, which differed from his original report, that the Claimant was at MMI as of March 4, 2009 and the Claimant has no permanent impairment. The ALJ concludes that this is the DIME physician's true opinion

in this matter. Dr. Finn further affirmed the zero percent rating in his deposition when asked by Respondents' counsel. Dr. Finn stated the zero percent rating would take the place of the seventeen percent rating he gave on June 3, 2009, and that his true opinion is that Claimant has no impairment. The burden then shifted to Claimant to overcome that opinion by clear and convincing evidence. Claimant failed to do so.

3. It is the ALJ's province to determine the DIME physician's true opinion as a matter of fact. Once the ALJ determines the DIME physician's opinion concerning impairment, 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). In *Fera v. Resources One, LLC, D/B/A Terra Firma*, W. C. No. 4-589-175 (May 25, 2005) *aff'd, Resources One, LLC v. Industrial Claim Appeals Office* 148 P.3d 287 (Colo. App. 2006) the panel found that when the ALJ determined the DIME physician's true opinion on MMI, the ALJ did not err in assigning the respondents the burden of proof to overcome by clear and convincing evidence the DIME physician's finding that MMI had not been attained. *See also Viloch v. Opus Northwest*, LLC, W. C. No. 4-514-339 (June 17, 2005); *Gurule v. Western Forge*, W. C. No. 4-351-883 (December 26, 2001). The deposition testimony of the DIME physician is properly considered as part of the DIME physician's overall "finding." *Stephens v. North & Air Package Express Services*, *supra*.

4. Based upon the DIME physician's opinion as found herein, the Respondents have established that the DIME physician has found Claimant has no impairment. In order to change that impairment rating the Claimant must overcome the DIME opinion by clear and convincing evidence. Claimant failed to do so.

5. Sections 8-42-107(8)(b)(III) and (c), C.R.S. provide that the finding 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 Indus. of Colorado,* W.C. No. 4-350-36 (ICAO March 22, 2000).

6. Section 8-42-105(3) C.R.S. 2009 provides that upon the occurrence of one of four enumerated conditions TTD benefits shall cease. The termination of TTD benefits under any one of the four enumerated conditions is mandatory. *Burns v. Robinson Dairy, Inc., 911 P.2d 661* (Colo. App. 1995). In relevant part 8-42-105(3) provides that temporary total disability benefits shall continue until the attending physician gives the employee a written release to return to regular employment or the employee reaches MMI.

7. The ALJ concludes that Claimant's MMI date is March 4, 2009 as stated by the DIME physician, Dr. Venegas, and Dr. Jones. The ALJ finds their opinions to be credible and persuasive. Pursuant to statute, Claimant is not entitled to additional temporary total disability benefits after his MMI date of March 4, 2009. The ATP opined that Claimant reached MMI on March 4, 2009 and that he has no permanent impairment. Claimant has failed to prove he was not at MMI on March 4, 2009 and that additional TTD benefits should be awarded. The termination of TTD benefits on March 4, 2009 was proper under C.R.S. 8-42-105(3).

8. Pursuant to 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. Claimant failed to prove by a preponderance of the evidence that he is entitled to additional medical benefits. Dr. Jones and Dr. Venegas opined that no further medical care is required for Claimant and the ALJ finds their opinions credible.

9. MMI exists when the impairment as a result of injury becomes stable and no "further treatment is reasonably expected to improve the condition." Section 8-40-201(11.5), C.R.S. 2004. Determination of MMI is primarily a medical issue for physicians to determine. *Monfort Transportation v. Industrial Claim Appeals Office*, 942 P.2d 1358 (Colo. App. 1997). The surveillance video taken of Claimant is compelling. Dr. Venegas opined there were discrepancies in how Claimant presented in the office and how he presented in the video. Determination of MMI is a medical issue for physicians to determine. Dr. Venegas and Dr. Jones are physicians; their opinion of MMI is credible. Claimant's opinion about his MMI status and medical condition are not credible.

ORDER

IT IS, THEREFORE, ORDERED THAT:

1. Claimant's impairment rating is zero.

2. Claimant's MMI date is March 4, 2009 and he is not entitled to additional TTD benefits after that date.

3. Claimant's claim for additional medical benefits is denied and dismissed.

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

DATE: February 9, 2010 /s/ original signed by:
Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-780-380

ISSUES

- Whether Claimant sustained an injury to his left knee on December 5, 2008, while in the course and scope of his employment;
- Whether Claimant is entitled to medical treatment for such injury, including payment for treatment already received;
- Authorized provider; and
- Whether Claimant is entitled to temporary total disability (TTD) benefits from December 7, 2008, through May 6, 2009.

STIPULATIONS

- The parties stipulated that Claimant's average weekly wage is $840.

FINDINGS OF FACT

Based on the evidence presented, the Judge finds as fact:

1. On April 11, 2008, an automobile struck Claimant while he was walking. Claimant suffered a left tibial plateau fracture, left medial orbital wall fracture, complex facial lacerations, concussion, and blunt abdominal trauma. X-rays of the Claimant's left knee showed lateral tibial plateau and proximal fibula fractures. Claimant underwent open reduction internal fixation of his left knee on April 11, 2008 with Dr. Bharat Desai. A CT scan of the left knee from April 12, 2008 revealed an undisplaced left fibula head fracture and mildly depressed lateral tibial plateau fracture. A repeat left knee x-ray on April 13, 2008 showed multiple screws transverse and lateral with a good appearing tibial plateau fracture, alignment, and fixation.

2. Claimant testified that as a result of the April 11, 2008 accident he broke his knee in two or three places, went through multiple surgeries lasting for a total of 8 hours, had two plates and five screws placed in his knee, and had over 300 stitches sewn on his face.

3. Following surgery, Dr. Desai examined the Claimant again on May 23, 2008. Dr. Desai noted that the Claimant was improving and had mild-moderate tenderness in the proximal lateral tibial plateau. Dr. Desai recommended that Claimant continue with physical therapy.

4. On June 23, 2008, Dr. Desai noted that the Claimant was partially weight-bearing but had complaints of left ankle pain and pain in the medial aspect of his left knee. Dr. Desai noted tenderness in the proximal tibia and trace effusion of the knee joint.

5. On August 4, 2008, the Claimant stated that his knee pain was improving. Dr. Desai noted left knee tenderness along the medial joint line and medical meniscal area and mild to moderate knee joint swelling. Dr. Desai concluded that Claimant was orthopedically stable from the fracture and referred the Claimant to Dr. Douglas Foulk for evaluation of the medial knee pain. Dr. Desai released Claimant to work without restrictions.

6. Dr. Foulk examined the Claimant on August 11, 2008. Claimant reported that his left leg has improved since surgery, but that he still has pain in the medial aspect of the knee. Claimant also reported instability and popping. Claimant was wearing a knee brace daily at that time. Dr. Foulk noted tenderness along the patellofemoral joint and the medial joint line, a normal gait and no crepitation in the left knee and a negative valgus stress test. Claimant was also still taking prescription narcotic pain medications. Dr. Foulk opined that the Claimant had a MCL sprain that should resolve with time.

7. Claimant began seeing Dr. Joseph Ramos and his physician's assistant, James Peterson, sometime after August 11, 2008, however, the first records of those visits were not offered into evidence. It appears from the record of November 10, 2008, described below, that Dr. Ramos or Mr. Peterson had imposed work restrictions.

8. On September 29, 2008, Mr. Peterson prescribed additional physical therapy for 12 weeks to treat Claimant's left knee and low back pain.

9. Claimant continued physical therapy until November 4, 2008. Physical therapy records from November 4, 2008 show that Claimant complained of medial left knee pain with lateral/rotational motions. Claimant also complained of low back pain and stiffness although he also reported 40 percent overall improvement.

10. On November 10, 2008, Claimant saw Mr. Peterson. Claimant continued to complain of left knee pain, but also reported that he felt it was getting better. Claimant reported that

the pain was mostly on the inside of his knee. Claimant also felt that his low back was improving. Mr. Peterson noted that Claimant had tenderness to left knee medial joint line, but noted no crepitus or instability. He also noted that Claimant had a normal gait and was able to heel-toe walk without difficulty. Mr. Peterson referred the Claimant for a left knee x-ray and an orthopedic consultation, recommended that Claimant continue with his current rehabilitation plan and prescribed ibuprofen. Mr. Peterson noted that Claimant's work restrictions were continued, and added that Claimant should not go up and down stairs.

11. Claimant was working in the maintenance department for Employer when on December 5, 2008, Claimant felt a pop or a twinge in his knee as he was standing on a ladder lifting a heavy pressure release valve over his head in an attempt to install it. Claimant believed that he twisted his knee while on the ladder.

12. Claimant testified that it was necessary for him to use a ladder because the valve was 10 feet off the floor. Photos of the area indicate that the valve at the connection site was approximately seven feet above the ground. Claimant testified that he is 5'10" tall. Risenhoover testified that he is 6'3" tall and that the top of his head reached the bottom of the valve. This testimony is consistent with the photographs that show the bottom of the valve approximately 76 inches (6'4") from the ground. If Claimant is 5'10" tall as he testified, his head would be six inches away from the bottom of the valve and approximately 13 inches away from the connection site. Claimant could probably have reached the valve at the connection site with his arms stretched above his head, but not to comfortably replace the valve. Claimant's testimony concerning his use of the ladder to install the valve is more credible and persuasive than the testimony of Claimant's supervisor, Proksch, or Claimant's coworker, Risenhoover.

13. Claimant also testified that the valve weighed between 60 and 70 pounds. Proksch contacted the valve's manufacturer and determined that the valve in question weighed 52 pounds. The valve Claimant lifted was a different type than the one photographed and it had pipes attached to it when he lifted it. Proksch did not consider whether the valve had pipes connected to it when determining the weight.

14. Claimant worked the following day on December 6, 2008, but his left knee pain made working difficult. Claimant ultimately put his knee brace on about two hours before the end of his shift.

15. On December 7, 2008, Claimant called in to Employer and spoke to someone named, Kevin. Kevin advised Claimant to call Proksch at home to report the injury, which Claimant did. Claimant advised Prokch that he was not returning to work until he saw his doctor to find out what happened to his knee.

16. Claimant asked Employer for a referral to a physician. Claimant wrote a note and

provided it to the Employer's human resource department on December 10, 2008. The note informed the Employer that Claimant injured himself on December 5, 2008, while lifting the valve. The note specifically asked which doctor Claimant should see.

17. Employer did not refer Claimant to a physician so Claimant returned to Dr. Ramos at Premier Care.

18. Claimant went to Dr. Ramos's office and saw Mr. Peterson on December 10, 2008. Claimant reported that he had been doing better and had been walking without significant difficulties until December 5, 2008, when he felt a pop and immediate pain in his knee after being on a ladder lifting a valve at work. Claimant used crutches and was wearing a brace on his knee at the time of the appointment. Mr. Peterson noted tenderness to the medial and lateral joint line and reduced range of motion yet no significant instability or crepitus. Mr. Peterson prescribed narcotic pain medication, took Claimant off work and continued physical therapy. Mr. Peterson opined that Claimant's left knee pain was exacerbated by the work injury of December 5, 2008.

19. Claimant saw Dr. Ramos on December 17, 2008. Dr. Ramos noted that Claimant had been doing well until December 5, 2008, and required a knee brace and crutches again. Dr. Ramos noted tenderness along the medial and lateral joint lines of Claimant's left knee. Dr. Ramos decided to hold off on further diagnostic testing at that time, but recommended that Claimant continue with physical therapy. Dr. Ramos directed Claimant to remain off work until January 10, 2009.

20. Claimant returned to physical therapy on December 22, 2008. He reported to the therapist that he had shooting pain down the left lateral thigh/knee. The therapist noted that Claimant had reached point where he was no longer limping and was feeling pretty good. Claimant continued to complaint of left lateral knee pain throughout the physical therapy visits.

21. On January 5, 2009, the Claimant completed a "Knee Outcome Survey Activities of Daily Living Scale." Claimant previously completed this same survey on November 4, 2008 prior to the alleged industrial injury. The results of the January 5, 2009 were very similar to the November 4, 2008 survey, with some increases in the inability to perform certain tasks. Dr. Watson testified that based on this record, the Claimant was functionally and symptomatically unchanged from November 4, 2008.

22. Dr. Ramos examined the Claimant on February 16, 2009. Dr. Ramos noted that the Claimant's left knee had tenderness in the lateral medial joint lines and his left ankle had laxity to inversion. The CT scan showed a plate along the lateral proximal tibia that was healing satisfactorily with no acute injuries. Claimant continued to treat with physical therapy.

23. On April 20, 2009, the Claimant stated that he was feeling good with physical therapy and it was noted that his range of motion was significantly improved.

24. Dr. Ramos placed the Claimant at MMI on May 6, 2009. Dr. Ramos recommended maintenance treatment of a home exercise program, a gym membership, and office visits every three months. Dr. Ramos assessed the Claimant with 18 percent permanent impairment of the left lower extremity.

25. On August 20, 2009, Dr. Watson examined the Claimant for an independent medical examination. Claimant told Dr. Watson that he was installing a pump mechanism at work when he felt pain and what he described as a loosening of the hardware in his left leg.

26. Dr. Watson opined that the Claimant's complaints at the time of the alleged industrial injury were identical to the symptoms he was reporting to his physicians for the automobile accident prior to the alleged industrial injury. Dr. Watson also testified that there is no evidence that Claimant suffered an aggravation of his pre-existing condition. Dr. Watson, however, agreed that Claimant had an increase in his symptoms, but concluded that no objective findings supported a new injury.

27. Dr. Ramos testified that the CT scan "didn't show anything substantial, as far as discrete notable tear, or loosening of his hardware on his fracture site." Dr. Ramos testified that the Claimant as of November 10, 2008, "for all intents and purposes, he was done with care."

28. Claimant admittedly had additional physical therapy visits scheduled which he missed. The record is not clear as to how many sessions he had remaining, but it appears that he missed two after November 4, 2008.

29. Dr. Ramos concluded that the Claimant suffered an injury to his left knee between November 10, 2008, and December 10, 2008.

30. At a rebuttal deposition, Dr. Watson essentially reiterated his previous testimony. Dr. Watson added that a pain diagram completed on February 16, 2009, was similar to a pain diagram completed by the Claimant on September 30, 2008.

31. Dr. Watson testified that the Division issued an interpretive bulletin dated June 2005 addressing when medical care is due to a work-related conditions. The bulletin, attached to Dr. Watson's deposition, outlines three criteria when the medical treatment is work-related: 1. the work exposure causes a new condition, or 2. the work exposure causes the activation of a previously asymptomatic or latent medical condition, or 3. the work exposures worsens a pre-existing symptomatic condition.

32. Dr. Watson testified that the Claimant's injury did not fall into any of these three categories and thus the medical treatment was not work-related. Specifically, Dr. Watson opined that the Claimant's work exposure did not cause a new injury based on the medical records. Dr. Watson also testified that the work exposure did not cause the activation of a previously asymptomatic condition because the Claimant was still in treatment at the time of the injury. Third, Dr. Watson opined that the work injury did not worsen a pre-existing symptomatic condition based on the treatment the Claimant received following December 5, 2008, being identical to the treatment prescribed on November 10, 2008. Dr. Watson felt that the only change in treatment was that Claimant began taking Vicodin instead of ibuprofen for pain. Dr. Watson testified that this could be due to a flare up in pain and does not indicate a new injury.

33. Dr. Watson's opinions are less persuasive than those of Dr. Ramos. Dr. Watson's opinion that Claimant's work injury did not worsen Claimant's pre-existing symptomatic condition is not persuasive. The evidence shows that Claimant's pre-existing symptoms significantly increased after the incident on December 5, 2008. Claimant was not taking prescription pain medications prior to December 5, 2008, nor was he using crutches or having lateral pain complaints in his left knee. Claimant was tapering the physical therapy visits and Dr. Ramos testified that he was getting ready to discharge the Claimant from care. Moreover, after December 5, 2008, Claimant had new pain complaints in the lateral aspect of his left knee. Claimant's work exposure, therefore, worsened his pre-existing symptomatic left knee condition.

34. Based on the foregoing, Claimant has established that he sustained a compensable injury to his left knee on December 5, 2008.

35. Employer eventually referred Claimant to a physician, but not until January 29, 2009. By that time, Employer's right to select a physician had passed to the Claimant. Accordingly, Dr. Ramos and Premier Care are authorized providers for Claimant's workers' compensation claim.

36. Claimant has established entitlement to medical treatment for his left knee aggravation, including treatment he previously underwent at Premier Care and any referrals made by Premier Care.

37. The treatment Claimant received through Premier Care between December 10, 2008, and May 6, 2009, regarding his left knee was reasonable, necessary and related to Claimant's work injury of December 5, 2008. Accordingly, as to Claimant's left knee, Respondents are liable for payment of any outstanding medical bills arising from care the Claimant received at Premier Care and for any bills related to referrals made by Premier Care.

38. Claimant has also established entitlement to temporary total disability benefits. Claimant was unable to work after December 5, 2008, due to the pain in his left knee and his inability to walk without crutches. Moreover, Mr. Peterson restricted Claimant from working at all after he examined the Claimant on December 10, 2008.

39. The medical records reflect that in February 2009, Claimant was released to work with physical restrictions that included no crawling, squatting or kneeling, frequent change in position and no pushing or pulling greater than 40 pounds and no lifting more than 20 pounds. Claimant reported to Premier Care staff that Employer would not allow him to work until he had no physical restrictions and was able to pass a physical examination. No evidence was introduced to rebut Claimant's statements to his treatment providers regarding his work situation.

40. On April 29, 2009, Employer notified Claimant that it had placed him on a medical layoff and that once a physician declared him fit for duty, he should contact Employer so it could attempt to reinstate his job.

41. At some point after Claimant's work injury, he applied for and received unemployment compensation in an unknown amount for an unknown duration.

42. Respondents offered no credible or persuasive evidence that Claimant was responsible for the termination of his employment.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge enters the following 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).

Compensability

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). The mere experience of symptoms at work does not necessarily require a finding that the employment aggravated or accelerated the pre-existing condition. Resolution of that issue is also one of fact for the ALJ. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

6. As found, Claimant has established that he sustained an industrial aggravation of his pre-existing knee condition. Dr. Watson's opinions are less persuasive than those of Dr. Ramos. Dr. Watson's opinion that Claimant's work injury did not worsen Claimant's pre-existing symptomatic condition is not persuasive. It is true that Claimant may not have suffered a new injury nevertheless the evidence shows that Claimant's symptoms significantly increased after the incident on December 5, 2008. Claimant was not taking prescription pain medications prior to December 5, 2008, nor was he using crutches or having lateral pain complaints in his left knee. Claimant was tapering the physical therapy visits and Dr. Ramos testified that he was getting ready to discharge the Claimant from care. Claimant's work exposure, therefore, worsened his pre-existing symptomatic left knee condition.

Authorized Provider

7. The employer or insurer has the right to select a physician in the first instance to attend an injured employee. If the employer does not provide the services of a physician at the time the injury, the employee has the right to select a physician. Section 8-43-404(5)(a)(I)(A), C.R.S. Claimant provided written notice of his injury to the Employer, but the Employer failed to provide the services of a physician until approximately eight weeks later. The Employer's right to select a physician passed to the Claimant making Premier Care and Dr. Ramos authorized providers.

Medical Benefits

8. Respondents are obligated to provide medical benefits to cure or relieve the effects of the industrial injury. Section 8-42-101(1), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Respondents, however, retain the right to dispute liability for specific medical treatment on grounds the treatment is not authorized or reasonably necessary to cure or relieve the effects of the industrial injury. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Williams v. Industrial Commission*, 723 P.2d 749 (Colo. App. 1986).

9. Claimant established that, as a result of the industrial aggravation of his left knee injury, he required additional medical treatment. Dr. Ramos persuasively opined that the treatment Claimant received through Premier Care was reasonable, necessary and related to his work injury. Accordingly, as to Claimant's left knee, Respondents are liable for payment of any outstanding medical bills, subject to the fee schedule, arising from care the Claimant received at Premier Care and for any bills related to referrals made by Premier Care.

Temporary Total Disability Benefits

10. To prove entitlement to 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), C.R.S., requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. The work-related injury, however, need not be the sole cause of the wage loss, but must contribute to some degree. *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 her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 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 to perform her regular employment effectively and properly. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

11. Claimant has established entitlement to TTD payments beginning on December 7, 2008, through May 6, 2009. Claimant was unable to work on December 7, 2008, due to his left knee pain and inability to walk without crutches. Claimant was then restricted from working on December 10, 2008. In February 2009, Dr. Ramos released Claimant to return to work with restrictions which the Employer could not accommodate. Dr. Ramos placed Claimant at maximum medical improvement on May 6, 2009, which would result in termination of TTD benefits pursuant to § 8-42-105(3)(a), C.R.S. Respondents are entitled to offset the amount of unemployment compensation Claimant received pursuant to § 8-42-103(1)(f), C.R.S. Respondents have not established that Claimant was responsible for termination of his employment.

ORDER

It is therefore ordered that:

1. Claimant sustained a compensable injury to his left knee on December 5, 2008.

2. Premier Care's personnel are authorized providers.

3. Claimant is entitled to reasonable and necessary medical treatment related to his work-related knee injury, including treatment previously received.

4. Respondents are liable for payment of outstanding medical bills from Premiere Care and its referrals that are related to Claimant's work-related knee injury, subject to the fee schedule.

5. Respondents shall pay TTD benefits to Claimant commencing on December 7, 2009, through May 6, 2009, at the stipulated AWW of $840.

6. Respondents are entitled to an offset for any unemployment compensation Claimant have received during the relevant time period.

7. Claimant was not responsible for termination of his employment.

8. The 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.

DATED: February 10, 2010

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Laura A. Broniak

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-664-891

ISSUES

1. Whether Claimant has proven by a preponderance of the evidence that she is incapable of earning any wages and is entitled to receive Permanent Total Disability (PTD) benefits as a result of admitted injuries that she sustained during the course and scope of her employment with Employer.

2. Whether Claimant is entitled to a disfigurement award pursuant to §8-42-108, C.R.S.

FINDINGS OF FACT

1. Claimant worked for Employer as a hair stylist and manager. On August 28, 2005 she slipped and fell on water during the course and scope of her employment with Employer. Claimant injured her neck, mid-back and left arm.

2. Employer admitted the industrial injuries and Claimant underwent a left ulnar nerve transposition on October 20, 2005. She subsequently received conservative treatment including a chronic pain program and biofeedback. On September 20, 2006 Authorized Treating Physician (ATP) Justin D. Green, M.D. determined that Claimant had reached Maximum Medical Improvement (MMI) and assigned an 8% upper extremity impairment rating.

3. On May 5, 2007 Claimant was performing modified duty when she began experiencing pain in her mid-back. Instead of treating the incident as a separate Workers' Compensation claim, Respondents voluntarily reopened the August 28, 2005 claim.

4. Claimant underwent conservative medical treatment with Dr. Green. Dr. Green referred Claimant to Daniel S. Bennett, M.D. for a determination of whether she would benefit from the implantation of a spinal cord stimulator. Because Claimant continued to experience persistent pain symptoms, she underwent diagnostic testing. Doctors Bennett and Green considered whether Claimant was suffering from Chronic Regional Pain Syndrome (CRPS).

5. On February 16, 2009 Claimant underwent the implantation of a spinal cord stimulator to relieve her continued pain symptoms. Medical records reveal that Claimant's subjective pain levels decreased after the implant procedure. Nevertheless, on May 5, 2009 Dr. Green

determined that Claimant was suffering from CRPS of the left arm.

6. At Dr. Green's request Claimant underwent a Functional Capacity Evaluation (FCE) with Shari Barta at OccMed Colorado on June 2, 2009. Claimant performed a number of tasks including pushing and pulling tests, the Blankenship Blind Box Lift test, a frequent lift test, carrying tests and the Complete Minnesota Dexterity Test. Ms. Barta testified at the hearing in this matter that she had to stop Claimant at various points during the FCE because she feared Claimant might injure herself. She explained that Claimant worked hard during the FCE and gave her maximal effort. Ms. Barta noted that working too hard might cause inconsistencies in testing.

7. On June 9, 2009 Dr. Green determined that Claimant had again reached MMI. He assigned Claimant a "15% whole person impairment for the left upper extremity for complex regional pain syndrome." Dr. Green also imposed the following work restrictions:

> No repetitive lifting of the left upper extremity. No lifting greater than 5 pounds on an intermittent basis with the left upper extremity. No prolonged standing greater than 30 minutes, no working greater than 90 minutes continuous sitting without a 15-minute rest break. I would recommend no greater than 1-2 hours of work per day.

Respondents filed a Final Admission of Liability (FAL) acknowledging Dr. Green's June 9, 2009 report.

8. Dr. Green testified at the hearing in this matter that he has treated Claimant since August 2005 and has attempted to manage her pain as a result of her ulnar nerve condition. He noted that Claimant exhibited non-specific pain in her left upper extremity into her scapular region. Dr. Green explained that he based Claimant's permanent work restrictions on her June 2, 2009 FCE and his clinical judgment. He specified that he based Claimant's work restrictions on her functional abilities and not specifically her CRPS diagnosis.

9. On September 1, 2009 Claimant underwent a second FCE as part of a vocational assessment with occupational therapist Doris J. Shriver. Claimant completed over 30 different tests to assess the consistency of her performance. There was a high correlation between subjective and objective measures of testing. Claimant exhibited significant physical limitations during the FCE. The vocational report stated that Claimant's physical limitations did not "qualify her for the full definition of sedentary work." The vocational assessment concluded that "when the combination of [Claimant's] education, academic ability, strength, coordination and ability to sustain work postures [are] considered, [Claimant] is not able to do any work as it is customarily defined."

10. On September 9, 2009 Claimant underwent an independent medical

examination with Nicholas K. Olsen, D.O. Claimant reported significant pain in her left arm, constant tingling in both legs and tingling in her right arm. After reviewing Claimant's medical history and performing a physical examination, Dr. Olsen determined that Claimant's ulnar neuropathy resolved following her ulnar nerve transposition. He also remarked that there was little objective data to support a CRPS diagnosis.

11. Dr. Olsen also testified at the hearing in this matter. He defined CRPS as a chronic severe pain syndrome involving one or more of the limbs. CRPS typically results in atrophy, skin changes, alterations in sweat patterns, loss of nail beds and severe pain.

12. Dr. Olsen testified that, according to the Workers' Compensation Treatment Guidelines (Guidelines), there are certain diagnostic tests that are recognized in diagnosing CRPS. The tests include a plain x-ray, a bone scan, stellate ganglion blocks, QSART testing and a thermogram. The Guidelines provide that the presence of two positive diagnostic tests are sufficient to constitute objective criteria to support a diagnosis of CRPS. Furthermore, even if there are not two positive diagnostic tests, a clinician can still make the diagnosis of CRPS if clinical findings are strongly present. Dr. Olsen explained that his physical examination of Claimant did not reveal any objective findings that would support a diagnosis of CRPS. He noted that Claimant's QSART testing reflected a low probability of CRPS and a triple-phase bone scan was negative. Dr. Olsen also commented that Dr. Green's medical records for 2008 and 2009 did not document any objective findings to support a CRPS diagnosis.

13. On October 1, 2009 Ms. Shriver issued an employability assessment for Claimant. Ms. Shriver also testified at the hearing in this matter. She commented that Claimant is required to alternate positions throughout the day in order to manage her neck, left shoulder, left arm, right arm, left leg and right leg pain. Ms. Shriver specifically commented that, because Claimant must lie down for up to four hours each day, it is unlikely that an Employer would accommodate her condition. She also remarked that Dr. Green had limited Claimant to working 1-2 hours each day. Ms. Shriver thus noted that Claimant was unable to tolerate a job requiring productive performance on a consistent or sustained basis. She remarked that Claimant could no longer perform the job requirements of a hair stylist or return to any of her previous work. Considering the combination of Claimant's education, academic ability, strength, coordination and ability to sustain work postures, Ms. Shriver concluded that Claimant was unable to perform any work as it is customarily defined.

14. At Dr. Olsen's request Claimant underwent a third FCE on October 7, 2009. Vickie Mallon was the occupational therapist who performed the evaluation. Ms. Mallon testified through an evidentiary deposition in this matter. She noted that she administered a number of tests to Claimant including the Jamar Dynanometer test, static lifting test, Minnesota Rate of Manipulation test, Crawford Small Parts test, Blind Box Lift test and pushing and pulling tests. Ms. Mallon concluded that Claimant's "overall demonstrated abilities are most consistent with the light work category for occasional work and the medium

work category for frequent work."

15. On October 12, 2009 Dr. Olsen considered the appropriate physical restrictions that should be assigned for Claimant's industrial injuries. After reviewing Claimant's FCE's he determined that her function demonstrated in the FCE's could be considered minimum rather than maximum capabilities. Based on Claimant's level of function, Dr. Olsen remarked that she could perform light duty work. He recommended restrictions of 20 pounds maximum lifting and 10 pounds repetitive lifting. Dr. Olsen emphasized that the restrictions likely demonstrated Claimant's minimum capabilities because of her submaximal performance and inconsistencies during her October 7, 2009 FCE.

16. On October 13, 2009 vocational expert Margot Burns conducted a vocational evaluation of Claimant and prepared a report. Ms. Burns also testified at the hearing in this matter. She acknowledged that, if she accepted Dr. Green's restriction of Claimant's inability to work in excess of 1-2 hours each day, Claimant would be unable to obtain employment or earn wages. However, assuming Claimant could work an eight-hour day and could not engage in repetitive lifting with her left arm, Ms. Burns concluded that Claimant was capable of obtaining employment and earning wages. She specifically identified the following positions that were available to Claimant: greeter/hostess; receptionist; ticket taker/usher; lot attendant; lobby attendant; and gate guard. Ms. Burns remarked that the preceding positions are readily available in the Denver labor market.

17. Claimant testified at the hearing in this matter. She noted that her pain has worsened and spread since her industrial injuries. Claimant explained that she performed modified duty after her injury and initially worked for four hours each day. However, her hours were subsequently reduced to two hours per day. Claimant testified that she worked up to the time that she received a spinal cord stimulator and was not subsequently allowed to return to work. She remarked that she experiences pain and aching in her arms, legs and back. She also suffers numbness and tingling in her hand. Claimant commented that daily activities aggravate her symptoms.

18. Claimant submitted photographs showing a 2.5 inch scar on her shoulder blade, a 2.5 inch scar on her back where the battery for her stimulator is located, a 3 inch scar on her back where the stimulator is connected, and a 4 inch scar on her left arm from the ulnar nerve surgery. The disfigurement is serious, permanent, and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $1,000.00.

19. Claimant has demonstrated that it is more probably true than not that she is unable to earn any wages in the same or other employment. Considering a variety of "human factors" Claimant has proven that there is no employment that is reasonably available under her particular circumstances. ATP Dr. Green assigned Claimant significant work restrictions as a result of her industrial injuries. The restrictions included not working in

excess of 1-2 hours each day. Dr. Green explained that he based Claimant's permanent work restrictions on her June 2, 2009 FCE and his clinical judgment. He specified that he based Claimant's work restrictions on her functional abilities and not specifically her CRPS diagnosis. On September 1, 2009 Claimant underwent a second FCE as part of a vocational assessment with Ms. Shriver. In conducting an employability assessment Ms. Shriver considered Claimant's education, academic ability, strength, coordination and ability to sustain work postures. Ms. Shriver persuasively concluded that Claimant was unable to perform any work as it is customarily defined. After a third FCE vocational expert Ms. Burns acknowledged that, if she accepted Dr. Green's restriction of Claimant's inability to work in excess of 1-2 hours each day, Claimant would be unable to obtain employment or earn wages.

20. In contrast, Dr. Olsen performed an independent medical examination of Claimant and determined that objective criteria under the Guidelines did not support a diagnosis of CRPS. After a third FCE, Dr. Olsen determined that Claimant could perform light duty work because her only restrictions were 20 pounds maximum lifting and 10 pounds repetitive lifting. In assuming Claimant could work an eight-hour day and could not engage in repetitive lifting with her left arm, Ms. Burns concluded that Claimant was capable of obtaining employment and earning wages. However, because Dr. Green was Claimant's ATP and two out of three of Claimant's FCE's reflected consistent results, Dr. Green's work restrictions are appropriate. Furthermore, regardless of Claimant's diagnosis of CRPS, her functional limitations prevent her from earning wages in any capacity.

CONCLUSIONS OF LAW

1. 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. §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. §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. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, 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).

Permanent Total Disability

4. Prior to 1991 the Act did not define PTD. *Weld County School Dist. RE-12 v. Bymer*, 955 P.2d 550, 553 (Colo. 1998). Under the prevailing case law standard the ability of a claimant to earn occasional wages or perform certain types of gainful work did not preclude a finding of PTD. *Id.* at 555. A PTD determination prior to 1991 "turned on the claimant's loss of earning capacity or efficiency in some substantial degree in a field of general employment." *Id.*

5. In 1991 the General Assembly added a definition of PTD to the Act. *See* §8-40-201 (16.5)(a), C.R.S. Under §8-40-201(16.5)(a), C.R.S. PTD means "the employee is unable to earn any wages in the same or other employment." The new definition of PTD was intended to tighten and restrict eligibility for PTD benefits. *Bymer*, 955 P.2d at 554. A claimant thus cannot obtain PTD benefits if she is capable of earning wages in any amount. *Id.* at 556. Therefore, to establish a claim for PTD a claimant shoulders the burden of proving by a preponderance of the evidence that she is unable to earn any wages in the same or other employment. *See* §8-43-201, C.R.S.

6. A claimant must demonstrate that her industrial injuries constituted a "significant causative factor" in order to establish a claim for PTD. *In Re Olinger,* W.C. No. 4-002-881 (ICAP, Mar. 31, 2005). A "significant causative factor" requires a "direct causal relationship" between the industrial injuries and a PTD claim. *In Re of Dickerson,* W.C. No. 4-323-980 (ICAP, July 24, 2006); *see Seifried v. Industrial Comm'n,* 736 P.2d 1262, 1263 (Colo. App. 1986). The preceding test requires the ALJ to ascertain the "residual impairment caused by the industrial injury" and whether the impairment was sufficient to result in PTD without regard to subsequent intervening events. *In Re of Dickerson,* W.C. No. 4-323-980 (ICAP, July 24, 2006). Resolution of the causation issue is a factual determination for the ALJ. *Id.*

7. In ascertaining whether a claimant is able to earn any wages, the ALJ 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. *Bymer*, 955 P.2d at 556; *Holly Nursing v. ICAO,* 992 P.2d 701, 703 (Colo. App. 1999). The critical test, which must be conducted on a case-by-case basis, is whether employment exists that is reasonably available to the claimant under her particular circumstances. *Bymer,* 955 P.2d at 557. Ultimately, the determination of whether a Claimant suffers from a permanent and total disability is an issue of fact for resolution by the ALJ. *In Re Selvage,* W.C. No. 4-486-812 (ICAP, Oct. 9, 2007).

8. As found, Claimant has demonstrated by a preponderance of the evidence that she is unable to earn any wages in the same or other employment. Considering a variety of "human factors" Claimant has proven that there is no employment that is reasonably available under her particular circumstances. ATP Dr. Green assigned Claimant significant work restrictions as a result of her industrial injuries. The restrictions included not working in excess of 1-2 hours each day. Dr. Green explained that he based Claimant's permanent work restrictions on her June 2, 2009 FCE and his clinical judgment. He specified that he based Claimant's work restrictions on her functional abilities and not specifically her CRPS diagnosis. On September 1, 2009 Claimant underwent a second FCE as part of a vocational assessment with Ms. Shriver. In conducting an employability assessment Ms. Shriver considered Claimant's education, academic ability, strength, coordination and ability to sustain work postures. Ms. Shriver persuasively concluded that Claimant was unable to perform any work as it is customarily defined. After a third FCE vocational expert Ms. Burns acknowledged that, if she accepted Dr. Green's restriction of Claimant's inability to work in excess of 1-2 hours each day, Claimant would be unable to obtain employment or earn wages.

9. As found, in contrast, Dr. Olsen performed an independent medical examination of Claimant and determined that objective criteria under the Guidelines did not support a diagnosis of CRPS. After a third FCE, Dr. Olsen determined that Claimant could perform light duty work because her only restrictions were 20 pounds maximum lifting and 10 pounds repetitive lifting. In assuming Claimant could work an eight-hour day and could not engage in repetitive lifting with her left arm, Ms. Burns concluded that Claimant was capable of obtaining employment and earning wages. However, because Dr. Green was Claimant's ATP and two out of three of Claimant's FCE's reflected consistent results, Dr. Green's work restrictions are appropriate. Furthermore, regardless of Claimant's diagnosis of CRPS, her functional limitations prevent her from earning wages in any capacity.

Disfigurement

10. Section 8-42-108, C.R.S. provides that a claimant may obtain additional compensation if she is seriously disfigured as the result of an industrial injury. As found, Claimant submitted photographs showing a 2.5 inch scar on her shoulder blade, a 2.5 inch scar on her back where the battery for her stimulator is located, a 3 inch scar on her back where the stimulator is connected, and a 4 inch scar on her left arm from the ulnar nerve surgery. The disfigurement is serious, permanent, and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $1,000.00.

ORDER

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

1. Claimant is unable to earn wages in any capacity because of her industrial injuries. Respondents shall thus pay Claimant PTD benefits.

2. Claimant is entitled to a total disfigurement award of $1,000.00.

3. Any issues not resolved in this Order are reserved for future determination.

DATED: February 10, 2010.

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Peter J. Cannici
Administrative Law Judge

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OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-759-948, 4-767-443 and 4-770-346

W.C. No. 4-759-948 concerns an alleged right knee injury of May 7, 2008. A limited General Admission of Liability for medical benefits only was filed in this case. W.C. No 4-767-443 concerns an alleged low back injury of May 22, 2008. A limited General Admission for medical benefits only was filed in this case. W.C. No. 4-770-346 concerns alleged bilateral knee injuries of July 25, 2008. Respondents filed a General Admission for medical benefits and temporary total disability (TTD) benefits from July 26, 2008 to an undetermined date. Respondents seek to prospectively withdraw all previously filed admissions.

ISSUES

The issues to be determined by this decision concern whether Respondents may prospectively withdraw previously filed admissions of liability on the allegations that none of the admitted incidents amounted to compensable injuries, specifically, did the Claimant sustain injuries or merely non-compensable incidents at work on May 7, 2008, May 22, 2008 or July 25, 2008; whether the need for ongoing medical treatment and disability is proximately caused by the incidents of May 7, 2008, May 22, 2008 or July 25, 2008; and, whether the Claimant is entitled to ongoing TTD benefits as a result of the incidents which occurred on May 7, 2008, May 22, 2008 or July 25, 2008. Alternatively, may Respondents prospectively suspend medical and TTD benefits because of a severance of the proximate causal connection between the incidents and Claimant's present disability and need for medical treatment. Succinctly stated, the issue is whether Claimant sustained long-term

compensable aggravations of her pre-existing degenerative condition in the incidents alleged; or, did the Claimant sustain temporary exacerbations after which she returned to a baseline of the natural progression of her pre-existing degenerative condition.

FINDINGS OF FACT

1. The Claimant was involved in three separate and distinct incidents. These include a May 7, 2008 injury to the right knee, a May 22, 2008 injury to the low back, and a July 25, 2008 injury to the bilateral knees. The Claimant suffers from extensive pre-existing arthritis and degenerative changes affecting all aspects of her body. Specifically, she suffers from osteoarthritis in her bilateral knees and low back. She also underwent prior right knee surgery and right Achilles tendon surgery for which she was on medical leave immediately prior to the first incident on May 7, 2008. As a result of the prior surgery, the Claimant had to wear a CAM boot, an assistive device to help her walk after her surgery.

2. Michelle Walcott, M.D., Claimant's primary care physician, is treating her for her bilateral knee arthritic condition. Dr. Walcott recommended, and the Claimant received, viscol supplementation for her knees. Dr. Walcott also recommended total right knee replacement, which the Claimant received in March 2009. Dr. Walcott does not indicate in any of her records that Claimant's need for treatment is related to any of the work incidents. The medical records suggest that the Claimant's treatment is a result of her underlying arthritic and degenerative condition. Specifically, the Claimant had been diagnosed with tricompartmental degenerative osteoarthritis in the right knee in May, 2006. Claimant had experienced swelling in her right knee 5 ½ months prior to the May 7, 2008 incident.

Right Knee Incident -- May 7, 2008

3. The Claimant alleges a fall onto her right knee on May 7, 2008 after she tried to pick up a cleaning machine which had fallen over. On May 9, 2008, Dr. Walcott aspirated 20 ccs of "straw colored fluid" from Claimant's right knee. Dr. Walcott did not indicate that this was due to the Claimant hitting her knee on May 7, 2008. Initial imaging of Claimant's knee failed to show any evidence of trauma. At most, the falling incident temporarily exacerbated Claimant's underlying degenerative osteoarthritis.

4. Douglas Scott, M.D., performed an Independent Medical Examination (IME) for Respondents. Dr. Scott was of the opinion that given that there was no bloody fluid drained from the Claimant's knee, there was no evidence of trauma to the right knee. Dr. Scott wasd also of the opinion that while subsequent diagnostic studies revealed a sub-chondral fracture to the right knee, this had healed by September 17, 2008 and was not playing a role in Claimant's present right knee pain. Furthermore, the Claimant admitted that her right knee pain was caused by the CAM boot she was wearing and by walking awkwardly

as a result of the boot. The Claimant wore this boot until July 25, 2008. The Claimant had to wear this boot as a result of her pre-existing condition and prior surgery to her right knee and right Achilles tendon.

5. Dr. Scott was of the opinion that the viscol supplementation, which the Claimant underwent for her knees, was treatment that was performed on people with osteoarthritis and degenerative changes. Dr. Scott was further of the opinion that the need for the total right knee replacement was "due to degenerative joint of the right knee." He also expressed the opinion that the fracture did not accelerate the need for the Claimant's total knee replacement. The ALJ finds Dr. Scott's testimony in this regard persuasive, credible and consistent with the totality of the evidence.

6. According to Dr. Scott, with the Claimant's weight of 235 pounds there should have been some bruising of her right knee but there was no evidence of bruising during her exam with Dr. Walcott. Additionally, Dr. Scott credibly and persuasively stated that an individual with osteoarthritis and arthritic conditions has waxing and waning pain and swelling.

7. Samuel Chan, M.D., is an authorized treating physician (ATP) for the Claimant's three incidents. Dr. Chan was also of the opinion that the Claimant's total right knee replacement was to treat the underlying degenerative and arthritic conditions and was not a result of the three work incidents from May to July 2008. Furthermore, Dr. Chan was of the opinion that the comminuted fracture was not "a significant traumatic injury." Dr. Walcott indicated that the Claimant has end-stage degenerative joint disease in her right knee and she did not indicate that this was accelerated or exacerbated by the claimed work injuries.

Low Back Incident – May 22, 2008

8. Claimant states that a stool or chair with wheels on it rolled out from underneath her, causing her to fall and injure her back. This occurred on or about May 22, 2008. Dr. Chan was of the opinion that this incident would not have caused bulging discs in Claimant's spine. Moreover, according to Dr. Chan, the degenerative changes in the Claimant's back were not caused, accelerated or aggravated by claimant's work incident. Specifically, Dr. Chan was of the opinion that the Claimant's CAM boot could cause muscle spasm and pain in her back. Finally, the Claimant's back pain resolved as of January 2009 and Dr. Chan persuasively stated his opinion that "any ongoing symptoms after that or re-exacerbation, most likely is not because of the incidents that occurred May 22, 2008." Dr. Chan also expressed the opinion that the Claimant's back pain was not the result of the May 7, 2008 injury. He states that it is unclear what really is the Claimant's pain generator.

9. With regard to the May 22, 2008 incident, David Kistler, M.D., noted 5 days after the incident that the Claimant had inconsistent physical findings and positive pain

behaviors. He also indicated that "[d]espite her description of so much pain, she does seem to be smiling as she describes her pain." Furthermore, Dr. Kistler noted that he saw "no evidence of serious injury and I view the spondylolisthesis as a pre-existing condition." Dr. Kistler's opinion is in agreement with the opinions of Dr. Chan and Dr. Scott.

10. Elizabeth Steiner, M.D., another ATP, also indicated that the Claimant's CAM boot could cause the muscle spasms the Claimant experienced in her back. Also, an MRI (magnetic resonance imaging) of the low back failed to show any injury. The MRI revealed degenerative changes in the spine.

11. Claimant has a longstanding history of back pain for which she has received ongoing and consistent treatment since 2005.

Bilateral Knee Incident – July 25, 2008

12. Claimant had a slip and fall incident on July 25, 2008 wherein she landed on both knees, but primarily landed on her left knee. An MRI of the left knee revealed no traumatic injury. The MRI revealed degenerative changes.

13. Dr. Walcott diagnosed the Claimant with bilateral knee degenerative joint disease. The ALJ finds that this was not aggravated by the work incidents under consideration herein.

The Three Incidents

15. Ultimately, Dr. Scott expressed the opinion that the Claimant has osteoarthritis of her knees, degenerative spinal disc and joint disease, and these medical conditions "were neither caused by nor aggravated by the three claimed work injuries." Claimant's treatment is to treat these underlying conditions. Furthermore, Dr. Chan concurs with Dr. Scott's opinion that the treatment the Claimant received and continues to receive is due to her underlying degenerative changes and not the claimed work injuries. The testimony of Dr. Chan and Dr. Scott that the treatment the Claimant received was to treat her underlying osteoarthritic conditions and degenerative changes. The MRI studies of the Claimant's knees did not reveal any traumatic injuries. Likewise, the MRI of the Claimant's back only revealed degenerative changes. Dr. Chan and Dr. Scott credibly and persuasively rendered opinions that these pre-existing conditions were not aggravated by any of the three incidents from May through July 2008. Moreover, although the Claimant had a fracture of the right tibial plateau, this was not determined to be a significant injury and did not hasten the need for the Claimant's total knee replacement. In the absence of any bruising on the Claimant's knees after each fall, medical opinions that the three incidents were not significant enough to cause injuries is credible and persuasive. The ALJ finds that Claimant's incidents were not sufficient to constitute injury requiring medical treatment and the need for disability.

16. There is no persuasive medical evidence that the three incidents under consideration aggravated and accelerated the Claimant's underlying degenerative condition. Claimant, in the answer brief, refers to Dr. Wolcott's statement: "On examination, she does have severe lateral tracking of her patella. This has been her original problem on her right knee, which subsequently along with a fracture and degenerative changes led to her right knee replacement." Based on this statement, Claimant implicitly argues that the ALJ should draw an inference that Dr. Wolcott is opining that the fracture arose out of the three incidents and it aggravated and accelerated Claimant's degenerative condition to the point of a need for a right knee replacement. Such an inference cannot fairly be drawn on this statement considered along with the totality of what Dr. Wolcott did **not** state. Insofar as this proposition is inconsistent with the opinions of Drs. Chan, Scott and Steiner, the implication is assigned no evidentiary weight.

17. Dr. Chan expressed the opinion that the Claimant received adequate treatment for any injuries as a result of the three incidents and any additional treatment is not related to the incidents. Based on the totality of Dr. Chan's opinions, the ALJ finds that this statement fails to proximately and causally connect the Claimant's need for medical treatment to the three incidents.

18. The totality of the evidence shows that the Claimant suffered from pre-existing and symptomatic arthritic conditions to her bilateral knees and low back prior to the incidents of May 7, 2008, May 22, 2008 or July 25, 2008. Claimant underwent prior right knee surgery and suffered from degenerative changes in both knees for which she was receiving injection treatment. Additionally, the medical records show that the Claimant suffered from pre-existing degenerative changes in her spine. Claimant experienced swelling in her knee 5 ½ months prior to May 7, 2008. Dr. Scott persuasively and credibly testified that individuals with osteoarthritis and degenerative changes often experience waxing and waning of pain and swelling in the joints. The fact that the Claimant's right knee was aspirated and only straw colored fluid was seen shows that the Claimant did not sustain a significant injury requiring treatment or impairment, according to Dr. Scott. The subsequent incidents were also insufficient and not medically probable to cause injuries requiring treatment, impairment or disability.

Ultimate Findings

19. Respondents have proven, by a preponderance of the evidence, that none of the three incidents herein aggravated and accelerated Claimant's underlying degenerative osteoarthritis and the sequelae thereof. Therefore, Respondents have proven that all previously filed admissions were based on the mistaken belief that the incidents aggravated and accelerated the Claimant's underlying degenerative condition.

CONCLUSIONS OF LAW

Credibility

a. In deciding whether a party has met its 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, the opinions of Dr. Chan, the ATP, and Dr. Scott, the IME, are persuasive, credible and not rebutted by any plausible inferences which could be drawn from Dr. Wolcott's statements. Indeed, as found, the ALJ **cannot** draw a plausible inference that Dr. Wolcott's statements support a finding the fracture was causally related to the three incidents and, therefore, it aggravated and accelerated the Claimant's underling "end-stage" degenerative osteoarthritis. This being the case, the opinions of Drs. Chan, Scott and Steiner are not contradicted by competent medical evidence to the contrary. *See* The medical opinions on reasonable necessity are 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.

Withdrawal of the Admissions

b. Once a carrier admits liability, in the absence of fraud, it may only obtain prospective relief from an admission. *Pacesetter Corp. v. Indus. Claim Appeals Office*, 33 P.3d 1230 (Colo. App. 2001); *Rocky Mountain Cardiology and State Farm Ins. Cos. v. Indus. Claim Appeals Office*, 94 P.3d 1182 (Colo. App. 2004); *HLJ Mgmt Group v. Kim*, 804 P.2d 250 (Colo. App. 1990). As found, Respondents filed the admissions under the mistaken belief that the three incidents in question aggravated and accelerated the effects of Claimant's underlying degenerative arthritis. In fact, this was not so.

Burden of Proof

c. Ordinarily, the injured worker has the burden of proof, by a preponderance of the evidence, of establishing the proximate causal relationship between an incident/injury and the need for medical treatment, plus the entitlement to benefits. §§ 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). In the present case, Respondents are requesting withdrawal of previously filed admissions of liability. Therefore, the burden of proof is on the Respondents, who assert the affirmative of the proposition that they be allowed to prospectively withdraw previously filed admissions of liability. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). 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, Respondents have sustained their burden with respect to lack of causal relationship between the medical treatment, TTD and withdrwal of previously filed admissions of liability.

<u>The Incidents</u>

d. There is a distinction between the terms "accident" and "injury". The term accident refers to an "unexpected, unusual or undersigned occurrence." § 8-40-201(1), C.R. S. (2009). In contrast, an "injury" refers to the physical trauma caused by the accident. In other words, an "accident" is the cause and an "injury" is the result. *City of Boulder v. Payne*, 426 P.2d 194 (Colo. 1967). No benefits flow to the victim of an industrial accident unless an "accident" results in a compensable "injury." Compensable injuries involve an "injury" which requires medical treatment or causes disability. *H & H Warehouse v. Victory*, 805 P.2d 1167, 1169 (Colo. App. 1990). All other "accidents" are not compensable injuries. *Ramirez v. Safeway Steel Prods. Inc.*, W.C. No. 4-538-161 (Sept. 16, 2003). As found, the Claimant did not suffer compensable aggravations and accelerations of her underlying condition, arising out of her employment on May 7, May 22, or July 25, 2008.

e. If an industrial injury aggravates a pre-existing condition, the claim is compensable. *H&H Warehouse v. Victory*, 805 P.2d 1167, 1169 (Colo. App. 1990). A claimant, however, is only entitled to benefits as long as the industrial injury remains the proximate cause of the claimant's need for medical treatment. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949). Additionally, ongoing benefits may be denied if the current and ongoing need for medical treatment or disability is not proximately caused by an injury arising out of and in the course of the employment. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997). As found, Claimant's need for the right knee replacement and her medical treatment after the three incidents was not proximately caused by the work-related incidents under consideration herein.

f. The determination of whether a claimant's pain is the result of a new injury or the natural progression of a pre-existing condition is one of fact for the ALJ. *F.R. Orr*

Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985). Pursuant to *Wherry v. City and County of Denver*, W.C. No. 4-475-818 [Industrial Claim Appeals Office (ICAO), March 7, 2002], if an incident is not a significant event resulting in an injury, a claimant is not entitled to benefits. As found, none of the three incidents in question were medically significant enough to entitle the Claimant to workers' compensation benefits.

g. The incidents subsequent to May 7, 2008 were also insufficient and not medically probable to cause injuries requiring treatment or impairment. See *Wherry v. City and County of Denver*, *supra*. As found, the totality of the evidence established that the Claimant suffered from pre-existing and symptomatic arthritic conditions to her bilateral knees and low back prior to the incidents of May 7, 2008, May 22, 2008 or July 25, 2008.

h. As found, the treatment the Claimant received was to treat the underlying osteoarthritic conditions and degenerative changes. *See Wherry v. City and County of Denver*, *Id.* As found, ongoing medical treatment and disability for the bilateral knees and low back is not proximately caused by the incidents on May 7, May 22 and July 25, 2008. *See Snyder v. City of Aurora*, *supra*.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents are hereby permitted to withdraw all previously filed admissions, prospectively, effective December 14, 2009, the date that the hearing was concluded.

B. Any and all claims for additional workers' compensation benefits after December 14, 2009 are hereby denied and dismissed.

DATED this_____day of February 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-758-569

ISSUES

The issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant was convicted of forgery of checks. Her acts impeach her credibility as a witness. She was incarcerated for the conviction and then for parole violations.

2, On March 21, 2007, while incarcerated, claimant sought treatment due to a few months of pain on the medial and posterior aspects of the right knee. Dr. DeGroote diagnosed osteoarthritis of the right knee.

3. On an unknown date, claimant underwent a mastectomy with abdominal flap.

4. On March 19, 2008, claimant began work as a housekeeper for the employer. She was employed for a 30-day probationary period.

5. Claimant had some problems with attendance and failed to show up or call in on a couple of occasions. She also was warned on multiple occasions about appearing for work with the smell of alcohol on her breath.

6. Claimant alleges that she suffered an accidental injury to her right knee and her abdomen on April 11, 2008. Claimant alleges that she carried boxes of linens (pillows and comforters), which she estimated at 50 pounds or more, down a half-mile hallway, outside, up a wooden ramp and into a storage trailer. Claimant alleged that she was proceeding up the wooden ramp when her right knee went backwards, causing immediate and severe pain in her right leg, as well as a burning sensation in her abdomen. Claimant admitted that she finished her shift on April 11, 2008, and went home at the end of the day without reporting the alleged work injury, even though she acknowledged that company policy required her to do so. Claimant testified at hearing that the next day, April 12, 2008, she contacted her supervisors, informed them of her injury, and told them she could not come into work because of the pain she was suffering. Claimant alleged that she requested assistance with medical treatment from her supervisors, but was told that they did not wish to help her. She states that she was fired over the phone, but was not given any explanation as to why she was terminated. Claimant stated at hearing that she has been in constant pain in her right knee and abdomen since the date of her alleged injury. She further testifies that she is

forced to walk with a limp and cannot perform normally at all.

7. G, the Facilities Manager for the employer, testified that on April 11, 2008, he saw claimant and she again smelled of alcohol. He again warned her that she could not show up for work smelling of alcohol. G testified that he did not speak with claimant on April 12, 2008, as she again failed to show up for her shift or call in to advise that she would be out. Claimant did not call him to report any work injury. He called claimant on April 14, 2008, to advise her that her employment was terminated due to her failure to show up for scheduled shifts and for showing up smelling of alcohol. Claimant's time card/wage records corroborated G's testimony.

8. H, inspector/supervisor for housekeeping, testified that on April 11, 2008, she was working directly with Claimant. H stated that she was loading boxes with linens and placing the boxes on a wheeled cart. Claimant was pushing the cart with boxes to the end of the hall, where a maintenance man would pick up the box and place it in storage. H testified that the boxes weighed 5-10 pounds, and that Claimant was not lifting or carrying the boxes during this activity. H testified that she worked with Claimant throughout the day, and at no time did Claimant indicate that she injured herself in any way. Further, H met with Claimant prior to Claimant clocking out from work. At that time, Claimant reported no injury and demonstrated no pain behaviors. H testified that she did not receive a call from Claimant the following day, and at no time was informed by Claimant that she suffered a work related injury. H further testified that Claimant was terminated on April 14, 2008 for failure to show up for her scheduled shifts and for showing up smelling of alcohol.

9. The employer's first report of injury indicates that claimant reported to the employer on April 19, 2008, that she had suffered the alleged work injury.

10. On May 22, 2008, claimant sought care at Penrose Hospital emergency room, which referred her to Dr. Jepson. On May 23, 2008, Dr. Jepson examined claimant, who reported a history of hyperextending her right knee while walking down stairs on April 11, 2008. Claimant did not report any history of preexisting right knee problems or treatment. Claimant did not report any abdominal pain or injury. Dr. Jepson noted no swelling, significant range of motion deficit, tenderness, or crepitus in the right knee. He recommended a magnetic resonance image ("MRI") of the right knee.

11. The June 3, 2008, MRI showed degenerative changes of the medial and lateral compartments and a possible anterior cruciate ligament strain.

12. On June 16, 2008, Dr. Jepson diagnosed an aggravation of claimant's degenerative arthritis and administered an injection of the right knee.

12. Claimant was again incarcerated for several months.

14. On November 9, 2009, Dr. Hall performed an independent medical examination ("IME") for claimant. Claimant reported that she injured her right knee and abdomen while walking down a wooden ramp while at work. Claimant denied any pre-existing right knee injury or treatment. Dr. Hall specifically noted Claimant's complaints of problems with her abdominal wall and daily knee pain regardless of whether she is weight bearing on her right leg or not. She also complained to Dr. Hall that she feels her leg lacks strength and support. On examination, Dr. Hall stated that he was unable to perform range of motion testing of the right knee because claimant was quite limited in flexion due to pain. Dr. Hall diagnosed right knee ACL or meniscus injury and an abdominal wall defect probably related her previous abdominal surgery.

15. Surveillance video of claimant on the morning of November 9, 2009, before the IME by Dr. Hall, showed claimant able to flex her right knee without problems.

16. On November 22, 2009, Dr. L. Barton Goldman performed an IME for respondents. Claimant specifically denied any pre-existing knee injury when asked by Dr. Goldman. On exam, Dr. Goldman noted that Claimant was wearing a right knee brace and kept her right leg outstretched in front of her, complaining that she could not bend it. He noted that claimant walked with an antalgic gait and when asked to march in place, she stated that she could not do so.

17. Dr. Goldman noted the video surveillance of Claimant on November 9, 10, and 11, 2009. He noted that on November 9, 2009, Claimant is seen sitting, clearly able to flex her knee to 100 degrees with no pain behaviors. He also noted that Claimant rose from a seated position and performed a partial squat without any difficulty. This video was taken the same day that Claimant saw Dr. Hall and complained that she could not flex her right knee. In summarizing the November 10, 2009, video surveillance, Dr. Goldman noted that Claimant easily flexed her right knee with no pain behaviors. He also noted a normal gait throughout the while Claimant was working for Cricket holding up a street corner sign. Dr. Goldman noted that the video showed that Claimant can readily stand and walk in excess of 2 hours, and he was impressed with her balance and stance, contrasting with her complaints of injury and lack of abilities provided at the time of his examination. Finally, Dr. Goldman noted that the video surveillance from November 11, 2009, showed fluid movements without any pain behavior. He noted that claimant was able to transfer in and out of a chair without difficulty and readily went up and down stairs. Dr. Goldman noted that the level of activity and abilities on the video surveillance is significantly inconsistent with how claimant presented to Dr. Hall and how she presented to Dr. Goldman just ten days later.

18. Dr. Goldman opined in his report that it is highly unlikely that Claimant suffered a work related injury on April 11, 2008. He noted insufficient medical evidence, significant symptom magnification, and inconsistencies in Claimant's reported symptoms

compared to the video surveillance. Dr. Goldman also questioned the mechanism of injury in this matter, stating that a hyper-extension of the knee is more likely to occur while walking down a ramp, rather than up a ramp as Claimant describes.

19. Dr. Goldman testified by deposition consistently with the findings and opinions in his report. Dr. Goldman also reviewed the March 21, 2007 report of Dr. DeGroote. That report indicated that Claimant did have a prior right knee injury, which was treated fairly extensively with injections. In his deposition testimony, Dr. Goldman noted that this was inconsistent with the history that Claimant gave to the physicians in this claim.

20. Claimant's testimony was not credible. Claimant's prior bad acts of forgery impeach her veracity as a witness. Claimant's version of the mechanism of injury is inconsistent among the various physicians involved in this matter. Furthermore, claimant's alleged disabilities resulting from the alleged injury are inconsistent with the findings of Dr. Goldman and the activities in the video surveillance.

21. Claimant has failed to prove by a preponderance of the evidence that she suffered an accidental injury to her right knee or abdominal hernias arising out of and in the course of her employment on April 11, 2008. While incarcerated, claimant sought treatment for right knee pain and was diagnosed with osteoarthritis of the right knee. She worked for less than the one-month probationary period for the employer. She was warned about showing up for work with the smell of alcohol on her breath, including a warning on the day in question. G and H are credible and persuasive that claimant was not carrying 50-pound boxes on the day in question; she was pushing a cart with several 5-10 pound boxes down a short hallway for others to carry. There was no ramp. Claimant did not suffer an injury carrying boxes up or down a ramp. She did not report any work injury, even during an informal meeting at the end of the day. She was terminated for failing to show up or call in on April 12 and 13. Six days later she reported her alleged work injury. The November 9, 2009, surveillance video shows claimant sitting for an extended period with her right knee flexed, but later on the same day she was unable to flex the knee in Dr. Hall's examination. She made no report of any abdominal hernia problem until Dr. Hall's examination. Claimant had a previous mastectomy with abdominal flap, which is the likely cause for abdominal hernias. The remainder of the surveillance video on November 10 and 11, 2009, shows claimant flexing her right knee, standing, and walking without problems. Dr. Goldman is persuasive that claimant did not even suffer a temporary work injury.

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). 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 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. As found, claimant has failed to prove by a preponderance of the evidence that she suffered an accidental injury to her right knee or abdominal hernias arising out of and in the course of her employment on April 11, 2008.

ORDER

It is therefore ordered that:

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

DATED: February 16, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-801-539

ISSUES

The sole issue determined herein is safety rule violation.

FINDINGS OF FACT

1. Claimant was employed as a sales specialist for the employer for almost four years. He previously worked in a Denver store and then moved to the Pueblo store, where he worked for about one year, 10 months.

2. Claimant admitted that the employer had a safety rule that prohibited any employee from intentionally detaining a shoplifter in any way or following a shoplifter. Claimant received training about the rule and was taught to "customer service" a suspected shoplifter, but not to detain a shoplifter in any way. The training included instruction that the employee is not to get in front of the shoplifter at the exit door in an attempt to prevent the shoplifter from leaving the store. The employer has previously terminated the employment of employees who attempted to stop shoplifters from leaving the store.

3. Claimant has had no previous altercations with a shoplifter even though he deals with shoplifters a few times per week.

4. A few days before August 15, 2009, claimant had observed a shoplifter taking power tools from the store. Claimant did not try to detain the shoplifter in any way.

5. At 10:00 a.m. on August 15, 2009, claimant began work in the millworks department. J, the operations manager, called claimant and informed him that the same shoplifter was back in the store and that claimant was to keep an eye on him.

6. Claimant approached the shoplifter in the tool section. The shoplifter was ripping into boxes of power tools. Claimant asked the shoplifter not to destroy the boxes. The person replied that he was going to buy those tools. Claimant asked if he could help. The individual stood up, walking a circle around an aisle and returned to the power tools. The shoplifter picked up a box with a drill and started walking to the front of the store.

7. Claimant testified that he did not intend to detain the shoplifter or to have any physical confrontation because he was aware of the employer's safety rule. Claimant stated that he only wanted to hurry to the front of the store to see if there was a get-away driver or if claimant could spot a license plate number. Claimant denied "jumping" or stepping in front of the shoplifter at the store exit. He testified that he merely turned and braced himself as the shoplifter collided with claimant.

8. Claimant walked behind the shoplifter past the self-service checkout stands. As the shoplifter turned to walk to the front exit of the store, claimant was able to walk in front of the shoplifter and to his right. The store surveillance cameras left a gap of about five seconds from the checkout stands to the exit. K, the head cashier standing beside the front exit, asked the shoplifter for a receipt for the drill and then warned claimant that the shoplifter was

behind him. Claimant felt the shoplifter "nudge" him. Claimant denied that he suffered injury from the "nudge."

9. At 10:15.58.01, as they neared the front exit, claimant turned to his left, toward the shoplifter and away from the exit. At 10:15.59.08, the shoplifter, who was carrying the drill box in his left hand, put his right hand on claimant's left shoulder to attempt to push claimant out of from in front of the shoplifter. Claimant felt a pop in his right shoulder as the shoplifter pushed claimant to claimant's right. He did not feel any immediate pain in his right shoulder. He insisted that his effort was to maintain his balance.

10. At 10:16.00.15, the shoplifter is seen moving forward and to his right and claimant's left in an attempt to exit the store. Claimant, despite being shoved to his right, moved to his left and backwards toward the exit, placing himself between the shoplifter and the exit. Claimant and the shoplifter, facing each other, held on to each other. At 10:16.01.21, the shoplifter fell onto the security pedestal to the right of and just inside the exit. Claimant stood, leaning over the shoplifter, who had a hold of claimant's vest.

11. At 10:16.02.02, the shoplifter got up and pushed claimant backwards until claimant struck the side of the sliding exit door, which then pushed outward from the store. At 10:16.03.35, claimant backed up because he did "not want any more contact."

12. The shoplifter then bent over to retrieve the drill box that had dropped to the floor behind the broken pedestal. The shoplifter walked out the exit. Claimant stepped aside and let the shoplifter exit the store.

13. Claimant and K then walked outside the store and observed the shoplifter walk to the garden department entrance. The shoplifter retrieved a skateboard that he had stored there and he proceeded out of the employer's parking lot.

14. Claimant denied that he suffered the right shoulder injury when the suspect fell or when he pushed claimant into the door. Claimant testified that the main contact, and point of injury, was just before 10:15.59.08, when the shoplifter pushed claimant's left shoulder and claimant put his right arm out to maintain his balance and brace himself.

15. On August 15, 2009, claimant prepared a written statement of the incident. Claimant omitted any mention of the first "nudge" by the shoplifter. Claimant reported that K warned him to "watch out" and claimant turned with his arms raised to protect himself when the first contact was made. Claimant noted in his statement that the shoplifter had stolen from the employer over the past one year and nothing had been done to him. Claimant insisted that he would stand idly by while the shoplifter threatened his life, but only if he had no other way out of the situation.

16. On August 19, 2009, claimant prepared a brief written statement of the incident. Claimant again omitted any reference to the initial "nudge" by the shoplifter. He reiterated

that K had warned him that the shoplifter was behind him. He stated that he had turned and unfortunately the shoplifter turned in the same direction, with claimant's right shoulder receiving the brunt of the impact from the resulting collision.

17. On August 19, 2009, the employer prepared the first report of injury, describing the injury as resulting when the shoplifter "slammed into" claimant's right shoulder.

18. On August 21, 2009, the employer terminated claimant's employment because he had "tried to physically apprehend a shoplifter" in violation of the employer's policy.

19. The insurer filed a general admission of liability for temporary total disability benefits commencing August 16, 2009. The admission asserted a 50% offset due to claimant's violation of a safety rule.

20. Respondents have proven by a preponderance of the evidence that claimant willfully violated the employer's safety rule against intentionally detaining a shoplifter in any way. Respondents are correct that the most persuasive evidence is the series of surveillance camera photos. The record evidence demonstrates that claimant intentionally stepped in front of the shoplifter near the front exit in an effort to detain the shoplifter. The preponderance of the evidence demonstrates that claimant attempted to impede the progress of the shoplifter from the store by placing himself between the shoplifter and the exit. He did not grasp the shoplifter, but he attempted to "detain" the shoplifter in violation of the employer's reasonable safety rule. Claimant did not engage in an "unconscious" act and did not act in self-defense in attempting to place himself between the shoplifter and the exit. Claimant admitted that he knew the shoplifter wanted to exit the store. The injury resulted from claimant's attempt to place himself between the shoplifter and the exit in his effort to detain the shoplifter. The injury did not result from the shoplifter simply assaulting claimant. The injury did not result from an unseen contact by the shoplifter's body with claimant's right shoulder between the photographs at 10:15.58.01 and 10:15.59.08. The fact that claimant has crossed across in front of the shoplifter in the photo at 10:15.59.08 rather than remaining on the shoplifter's right side demonstrates that claimant's right shoulder had not been impacted by the shoplifter. The injury occurred either with the push at 10:15.59.08 or during the subsequent approximate four seconds of contact.

21. Claimant probably had good motives to stop a thief, but he willfully violated the employer's safety rule. It is not up to claimant, or this Judge, to determine whether the employer should have this particular safety rule. L, the human resources manager, testified persuasively that the purpose of the rule was mostly for the safety of employees. The employer's decision to terminate claimant's employment is, of course, not pertinent to the specific issue in this hearing. L alluded to claimant committing other rule violations, for example by following the shoplifter. The only rule at issue in this hearing is the rule against intentionally detaining a shoplifter in any way. Claimant admitted that he was aware of the rule. He argues that he did not violate the rule and was merely a victim of assault. The

problem with claimant's version of events is that he cannot explain why he hurried in front of the shoplifter. He did not need to do so in order to spot a getaway vehicle or to get a license plate number. Claimant's testimony shades the truth. This weakness in claimant's version weighs toward a contrary interpretation of the series of security camera photos. Claimant does not appear to be an unwitting victim of an assault. Claimant appears to attempt to maintain his position between the shoplifter and the exit for several seconds until he finally decided to step out of the way and allow the shoplifter to exit. The trier-of-fact infers that claimant intentionally tried to detain a shoplifter, in violation of the safety rule.

CONCLUSIONS OF LAW

1. As found, respondents have proven by a preponderance of the evidence that they are entitled to a reduction in benefits pursuant to section 8-42-112(1), C.R.S. That section provides for a reduction where the injury results from the employee's willful failure to obey a reasonable rule adopted by the employer for the safety of the employee. The "safety rule" penalty is only applicable if the violation is "willful." *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). Violation of a rule is not "willful" unless the claimant intentionally did the forbidden act. *Bennett Properties Co. v. Industrial Commission*, 437 P.2d 548 (Colo. 1968); *Stockdale v. Industrial Commission*, 232 P. 669 (Colo. 1925); *Brown v. Great Peaks, Inc.*, W.C. No. 4-368-112 (Industrial Claim Appeals Office, July 29, 1999). A violation which is the product of mere negligence, forgetfulness or inadvertence is not "willful." *Johnson v. Denver Tramway Corp.*, 171 P.2d 410 (Colo. 1946). As found, claimant willfully violated the reasonable safety rule against intentionally detaining a shoplifter in any way. Consequently, respondents are entitled to the 50% reduction in indemnity benefits as alleged in the admission of liability.

ORDER

It is therefore ordered that:

1. Claimant's request for payment of the additional 50% compensation benefits is denied and dismissed.

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

DATED: February 16, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

STATE OF COLORADO

W.C. No. 4-680-008

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUE

The sole issue to be determined by this decision concerns whether the Employer is entitled to an offset for an occupational disability retirement pension, despite the fact that Claimant did not apply for or receive a disability retirement pension.

FINDINGS OF FACT

1. Claimant was born on April 30, 1948. She worked as a Police Officer until her straight retirement on August 31, 2008.

2. On March 7, 2006, Claimant was injured while subduing a 6'3", 295 lbs, combative suspect. Respondent admitted liability and provided medical treatment for the Claimant.

3. Following the injury, the Claimant received treatment from a variety of clinicians and therapists including physical therapy, osteopathic manipulation, acupuncture, pilates and injections.

4. The Employer referred the Claimant to Dr. George Schakaraschwili, M.D., in May 2006.

5. By August 2006, Claimant's symptoms were primarily focused in the right scapular region, left lumbosacral region, and the neck. Claimant's MRI (magnetic resonance imaging) showed severe L5-S1 degenerative disc disease and mild disc bulging that abutted the L5 nerve roots.

6. Dr. Schakaraschwili ultimately determined that Claimant had a 29% whole person permanent impairment for specific disorders of and loss of range of motion in the cervical and lumbar spine. The ALJ finds Dr. Schakaraschwili's opinions persuasive, credible and undisputed.

7. On March 13, 2007, Dr. Schakaraschwili determined that the Claimant was at maximum medical improvement (MMI). He did not order a formal Functional Capacity Evaluation (FCE) because he felt it would not adequately measure police requirements. Dr. Schakaraschwili's permanent work limitation recommendation was that Claimant should not lift more than 50 lbs occasionally, and 25lbs on a regular basis. He also restricted the

Claimant from frequent twisting or bending for more than 20 minutes an hour or for 1 hour a day. The Claimant cannot do any work as a police officer with these restrictions. Desk or light duty assignments with the police department are of a temporary nature only.

8. On June 1, 2007 Claimant was released to work with permanent restrictions assigned by Dr. Schakaraschwili..

9. William Shaw, M.D., evaluated the Claimant on October 2, 2007. Dr. Shaw concurred with Dr. Schakaraschwili's assessment but found a final combined impairment of 27% of the whole person. The ALJ finds Dr. Shaw's opinions persuasive, credible and undisputed.

10. Based on Dr. Shaw's report, the ALJ finds that Claimant cannot perform the essential functions of a police officer and would, therefore, to a reasonable degree of probability, be entitled to disability retirement benefits.

11. On June 2, 2008, Respondent wrote to the Claimant and requested that she apply for disability retirement benefits from the Fire and Police Pension Association (FPPA).

12. Claimant retired from her employment on August 31, 2008. Claimant entered the Deferred Retirement Option Program (DROP) [straight retirement without regard to disability] in 2003. As a condition of DROP, Claimant had a mandatory retirement date of September 1, 2008. Claimant made a determination that it was in her best financial interests to take a straight retirement rather than a disability retirement.

13. On January 26, 2009, Respondent again wrote to the Claimant to request that she apply for the disability retirement pension. Respondent informed Claimant that she had until February 27, 2009 to do so.

14. Respondent made a final request of the Claimant by letter on February 20, 2009.

15. Claimant applied for a lump sum payment of her remaining permanent partial disability benefits (workers' compensation). Although Respondent objected to the payment because the offset for a disability pension had not been determined, the Director overruled the objection and the lump sum order was issued March 10, 2009.

16. Claimant entered the Deferred Retirement Option Program (DROP) [straight retirement without regard to disability] in 2003. As a condition of DROP, Claimant had a mandatory retirement date of September 1, 2008. Claimant's participation in DROP does not affect her eligibility for the disability retirement pension because she entered DROP before her admitted injury and based on a vested retirement.

17. To be eligible for an Occupational Disability Retirement Pension, a finding that a member is no longer able to perform the duties of the job must be made. The Fire and Police Pension Association makes this finding after the member has been examined by three doctors. This finding has not been made by the FPPA.

18. KLI, General Counsel to the Fire and Police Pension Association (FPPA), stated that to be eligible for an occupational disability retirement pension a finding must be made, based

on the examination of three doctors, that the member is no longer able to perform the duties of his or her job. Claimant never applied for the disability retirement pension, and thus was not examined by a panel of three doctors and no such finding was made. Respondent, however, has proven, through Claimant's medical records and the testimony of Sgt. T, that it is reasonably probable that Claimant would be found to be no longer able to perform the duties of her job as a police officer. The ALJ further finds that, based on the analysis of Dr. Schakaraschwili, Dr. Shaw and the testimony or Sgt. T, the Claimant would have been entitled to a disability retirement had she applied, and thus the disability benefits are "payable" to the employee.

19. If the Claimant had applied for the100% Employer financed FPPA disability pension, she would have received $1, 456.80 per month, or $336.18 per week.

20. Respondent has proven, by a preponderance of the evidence, that Claimant is no longer able to perform the duties of a police officer and, therefore, she would have been entitled to a disability retirement from the FPPA, which was 100% Employer financed.

CONCLUSIONS OF LAW

Credibility

a. 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). The medical opinions concerning the Claimant's permanent work restrictions are 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. As found, the opinions of Dr. Scharakaschwili and Dr. Shaw, concerning the Claimant's permanent work restrictions, are persuasive, credible and un-contradicted. The testimony of Sgt. Theriot is persuasive, credible, and it supports a fairly drawn inference and finding that the Claimant would have been awarded a disability pension had she applied.

Burden of Proof

b. The burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). In this case, Respondent is asserting entitlement to an offset for a disability pension for which Claimant did not apply. 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, Respondent has sustained its burden.

Obligation to Apply for a Disability Pension

c. An employee must apply for periodic disability benefits upon the request of the insurer or employer. §8-42-103(1)(d)(II), C.R.S. (2009). As found, the Employer requested that the Claimant apply for such disability benefits on June 2, 2008, January, 27, 2009, and February 20, 2009. Failure to apply after the Employer's request "shall be cause for suspension of benefits." *Id.* The question is if the Employer does not request that Claimant's benefits be suspended, may the Employer receive the offset as if a claimant had been awarded a disability pension.

d. § 8-42-103 (1)(d)(I), C.R.S. (2009), provides that "in cases where it is determined that periodic disability benefits are payable to an employee under the provisions of a pension or disability plan financed in whole or in part by the employer…the aggregate benefits payable for temporary partial disability, permanent partial disability, and permanent total disability to this section shall be reduced, but not below zero, by an amount equal as nearly as practical to such employer pension or disability plan benefits…" For the Employer to collect an offset, it must be determined that disability benefits are "payable" to the Claimant. The term "payable" does not mean that a claimant has actually applied for or obtained an employer disability pension, but rather the question is "whether he or she is entitled to the benefits." *Culver v. Ace Electric*, 952 P.2d 1200, 1204 (Colo. App. 1997). As found, Claimant would have been entitled to disability retirement had she applied, and thus the disability benefits are "payable" to the Claimant within the meaning of the *Culver* opinion.

e. The intent of the offset provision is to prevent employees from receiving double disability benefits both financed by the employer. *See Scriven v. Indus. Comm'n*, 736 P.2d 414 (Colo. App. 1987); *Sparling v. Colo. Dept. Hwys*, 812 P.2d 686 (Colo. App. 1990). The purpose of the statutory offset is not met in this case because Claimant is not seeking to receive duplicative disability benefits. The Employer, however, is entitled to an offset even thought the Claimant did not realize any economic gain. *Ihnen v. Western Forge*, 936 P.2d

634 (Colo. App. 1997). The Court of Appeals recognized that in certain situations people elect to not apply for disability benefits because it is not in their best financial interests. *Id.* at 636. The court, however, concluded that it was not the proper position of the judiciary to create exemptions to clearly written statutes: "It may well be more equitable for the General Assembly to create an exception to the offset statute in circumstances when, as here, the claimant has a valid reason not to accept [a disability pension] or does not benefit from a determination that [a disability pension] is payable. However, it is not the function of this court to rewrite the legislation, as the power to change the present scheme rests with the General Assembly." *Id.* As found, although it is not in the Claimant's best economic interests to apply for the disability pension, the Employer is nonetheless entitled to an offset.

The Offset Calculation

f. The offset calculation is controlled by §8-42-103 (1)(d)(III), C.R.S. (2009), which provides:

> The provisions of this paragraph (d) shall apply to a disability pension paid pursuant to article 30.5 or 31 of title 31, C.R.S.; except that said reduction shall not reduce the combined weekly disability benefits below a sum equal to one hundred percent of the state average weekly wage as defined in section 8-47-106 and applicable to the year in which the weekly disability benefits are being paid.

As found, If the Claimant had applied for the100% Employer financed FPPA disability pension, she would have received $1, 456.80 per month, or $336.18 per week.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant is entitled to a FPPA disability retirement pension, thus periodic disability benefits are "payable" to Claimant within the meaning of § 8-42-103(1)(d)(II), C.R.S. (2009).

B. The Employer is entitled to claim an offset for a 100% Employer financed occupational disability retirement pension in the amount of $1,456.80 per month, or $336.18 per week.

DATED this_____day of February 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-164-840

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that a wheelchair-accessible van constitutes a reasonable and necessary medical apparatus designed to provide therapeutic relief from the effects of his industrial injury.

2. Whether Claimant has proven that Respondents violated WCRP 16 and a wheelchair-accessible van has been authorized as a matter of law.

FINDINGS OF FACT

1. On February 1, 1993 Claimant suffered a compensable industrial injury during the course and scope of his employment with Employer. The severity of the injury rendered him a T7 paraplegic and permanently confined him to a wheelchair. Respondents initially admitted liability for Claimant's paraplegia through a General Admission of Liability filed on November 7, 1993. Respondents subsequently filed several Final Admissions of Liability (FAL). The most recent FAL was dated July 1, 2009.

2. Indira Lanig. M.D. testified by telephone at the hearing in this matter. She was recognized as an expert in both (1) physical medicine and rehabilitation; and (2) spinal cord injury medicine. Dr. Lanig has been Claimant's primary Authorized Treating Physician (ATP) since his February 1, 1993 industrial injury. She explained that she has treated Claimant for skin-related medical complications since his original injury.

3. Dr. Lanig testified that she initially prescribed a modified, wheelchair-adapted vehicle for Claimant on July 20, 2007. She submitted the request directly to Insurer. On October 3, 2007 nurse case manager Torrey Beil sent a letter to Dr. Lanig asking the following three questions: (1) whether her prescription for independent driving equipment was reasonable for Claimant's treatment; (2) whether it was necessary for the Claimant's treatment, and; (3) if reasonable and necessary, upon what did Dr. Lanig base her conclusions. On October 23, 2007 Dr. Lanig responded to the questions.

4. On March 18, 2008 Dr. Lanig sent a second letter to Ms. Beil. The letter directly addressed Claimant's medical and treatment needs regarding a modified, wheelchair accessible van. Dr. Lanig mentioned Claimant's T7 paraplegia, bilateral rotator cuff pathology, and shoulder girdle musculoskeletal tightness with attendant scoliosis. She noted that occupational and physical therapists, as well as a driving rehabilitation specialist, had evaluated Claimant. Dr. Lanig specified that the original modified vehicle prescription was

written for reasons “considered medically reasonable and necessary for safe transport by the Association for Driver Rehabilitation Specialists.” She described the need for medically necessary methods of preventing “overuse injuries and damage to upper extremities” that could “become critical when considering the potential permanent nature of these injuries and their impact on the patient’s long-term functional outcomes for basic activities of daily living.” Dr. Lanig specifically identified the medical basis for the modified van request including: (1) preservation of Claimant’s upper extremities; (2) reduction of physical strain caused by loading and unloading a wheelchair; and (3) alleviation of vehicle transfer difficulties.

5. On April 30, 2009 Dr. Lanig prepared a third letter outlining the medical necessity of a wheelchair-accessible van for Claimant. She remarked that Claimant’s hospitalization and skin surgery had highlighted the need to again address the necessity of an adaptive vehicle.

6. At the hearing in this matter Dr. Lanig addressed what she referred to as the multi-fold therapeutic necessity of a wheelchair-accessible van. She commented that the first part of therapeutic necessity pertained to Claimant’s neurological deficits. She specifically noted that Claimant lacks the use of his legs and therefore cannot drive a standard vehicle. Dr. Lanig remarked that the second therapeutic need relates to Claimant’s bilateral shoulder deterioration. She emphasized that Claimant’s spinal cord injury has forced him to use his upper extremities as weight-bearing limbs for nearly 17 years. The deterioration in his shoulders is eliminating the possibility of using a manual wheelchair. Dr. Lanig also noted that she had recommended specific ways in which Claimant could interface with a modified van to relieve pressure on shoulders “already trashed as a result of the spinal cord injury.” She commented that the third therapeutically necessary reason for an adapted van is Claimant’s demonstrated vulnerability to skin or tissue damage when he cannot properly interface with a vehicle. Dr. Lanig further testified that her recommendations regarding the van were made to help prevent secondary and tertiary complications that result from spinal cord injuries. She finally noted that the use of private medical transport services rather than a modified vehicle would not only be therapeutically unsound with regard to inevitable shoulder, tissue and neurological problems, but would also act as a deterrent to psychological health.

7. Claimant testified at the hearing in this matter. He specifically recounted an event in January 2009 when he was traveling in an unmodified van. The van became stuck in the snow on a return trip from Utah. Because Claimant was unable to move from his seat, he suffered skin sores and tissue damage to his tailbone area. Claimant explained that during training with wheelchair modified vans he was able to transfer between a driver’s chair, built to swivel, and his wheelchair. The adaptive feature of a modified van would have allowed him to prevent pressure sores. Claimant further testified that the physical toll taken by transfers in non-adapted vehicles would be almost completely eliminated if he had access to either a van that permitted him to remain in his wheelchair as the operator or a van with pilot chair seat maneuverability and swivel capability.

8. A review of the medical records reveals that January 2009 was not the only time that Claimant suffered serious wounds caused by the vehicle transfer process. Considering only the most recent medical records dealing with tissue damage directly related to the transfer process, Claimant had to undergo a wound debridement and ulcer excision surgery performed by Daniel J. MacFarlane, M.D. on February 26, 2009. Claimant also required additional wound treatment and surgery throughout March of 2009.

9. Matthew Brodie, M.D. conducted a records review of Claimant's medical treatment. He considered the necessity of Claimant's request for a wheelchair-accessible van and testified at the hearing in this matter. He explained that a wheelchair-accessible van was not a reasonable and necessary apparatus for Claimant. Dr. Brodie noted that a wheelchair-accessible van could not be uniquely differentiated from currently available modalities of transportation. He remarked that the private medical transport services offered by Respondents would constitute a reasonable alternative to a wheelchair-accessible van. Dr. Brodie emphasized that a wheelchair-accessible van did not constitute a medical apparatus and lacked a medical function.

10. Steven L. Snively testified through an evidentiary deposition in rebuttal to Dr. Brodie's conclusions. He is an expert in plastic and reconstructive surgery. He commented that serious spinal cord injuries cause an almost complete loss of sensation below the injury site. Patients thus develop pressure areas where they cannot feel the affected tissue. As they perform weight shifts, the pressure creates open wounds that may ultimately require plastic surgery.

11. Dr. Snively specifically addressed the January 2009 incident in which Claimant was trapped for several hours in an unmodified van. He commented that Claimant suffered significant tissue damage attributable to "incomplete pressure relief" resulting in the development of "a pressure sore, that being a sacral or sacroccygeal pressure sore." Because of the incident Dr. Snively performed a myocutaneous flap closure in Claimant's tailbone area. Dr. Snively concluded that a modified van would significantly reduce the likelihood that Claimant would develop wounds, sores and tissue damage. He also remarked that Claimant's use of medical transport or public transportation would be "substantially suboptimal."

12. Claimant has demonstrated that it is more probably true than not that a wheelchair-accessible van constitutes a reasonable and necessary medical apparatus designed to provide therapeutic relief from the effects of his industrial injury. Similar to *In Re Harrison* Claimant is a paraplegic who has suffered from repeated skin and tissue damage because of transfers involving unmodified vehicles. His shoulder deterioration will also be mitigated by the use of a wheelchair-accessible van. Claimant's tissue and shoulder conditions have required repeated medical and surgical intervention. He thus received a prescription for a modified, wheelchair-accessible van as a medical aid to relieve the effects of his paraplegia.

13. ATP Dr. Lanig persuasively detailed the therapeutic value of a modified, wheelchair-accessible van. She emphasized that Claimant's spinal cord injury has forced him to use his upper extremities as weight-bearing limbs for nearly 17 years. The deterioration in his shoulders is eliminating the possibility of using a manual wheelchair. Dr. Lanig noted that she had recommended specific ways in which Claimant could interface with a modified van to relieve pressure on his deteriorating shoulders. She commented that another therapeutically necessary reason for an adapted van is Claimant's demonstrated vulnerability to skin or tissue damage when he cannot properly interface with a vehicle. Dr. Lanig concluded that her recommendations regarding the van were made to help prevent secondary and tertiary complications that result from spinal cord injuries. Moreover, Dr. Snively persuasively concluded that a modified van would significantly reduce the likelihood that Claimant would develop wounds, sores and tissue damage. He also remarked that Claimant's use of medical transport or public transportation would be "substantially suboptimal." In contrast, Dr. Brodie testified that a wheelchair-accessible van was not a reasonable and necessary apparatus for Claimant. He noted that a wheelchair-accessible van could not be uniquely differentiated from currently available modalities of transportation. However, Dr. Brodie's opinion is not persuasive because he merely conducted a records review of Claimant's condition and neither managed nor regularly treated Claimant for the injuries he sustained while using an unmodified van.

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. §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. §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. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, 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. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). Employers have thus been required to provide services that are either medically necessary for the treatment of a claimant's injuries or incidental to obtaining treatment. *In Re Robertson,* W.C. No. 4-389-907 (ICAP, Jan. 10, 2007).

5. For a particular apparatus to constitute a medical necessity, it must provide therapeutic relief from the effects of the injury. *In Re Robertson,* W.C. No. 4-389-907 (ICAP, Jan. 10, 2007). The terms "medical" and "therapeutic relief" have been narrowly construed and apparati prescribed for the purpose of "easing some aspect of the claimant's life or to afford greater personal independence and productivity are not 'medical' in nature." *In Re Atkinson,* W.C. No. 4-206-051 (ICAP, Aug. 9, 1999); *see In Re Robertson,* W.C. No. 4-389-907 (ICAP, Jan. 10, 2007). Similarly, an apparatus does not constitute a medical benefit simply because it may assist a claimant in avoiding a future aggravation of his condition. *In Re Atkinson,* W.C. No. 4-206-051 (ICAP, Aug. 9, 1999). The determination of whether a particular apparatus provides a therapeutic benefit to a claimant is a question of fact for resolution by the ALJ. *In Re Robertson,* W.C. No. 4-389-907 (ICAP, Jan. 10, 2007).

6. In *In Re Harrison,* W.C. No. 4-192-027 (ICAP, Nov. 3, 2006), ICAP affirmed an ALJ's determination that the claimant's request for a modified van was not based simply upon a desire to be more independent or to maintain an active lifestyle. The ALJ found that the claimant "was prescribed a van as a medical aid to relieve the effects of his paraplegia." The ALJ identified several medical effects the wheelchair accessible van would have on the claimant's paraplegia. The effects included the following: (1) prevention of further shoulder deterioration caused by transfers from the claimant's manual wheelchair to an unmodified Ford Explorer; (2) the inaccessibility of the claimant's power wheelchair to the unmodified Ford Explorer; and (3) the claimant's skin breakdowns resulting from transfers between his manual wheelchair and the unmodified vehicle. The ALJ concluded that the modified van relieved the claimant's paraplegia symptoms and was therefore a medically necessary apparatus. ICAP concluded that there was no basis on which to interfere with the ALJ's determination.

7. As found, Claimant has demonstrated by a preponderance of the evidence that a wheelchair-accessible van constitutes a reasonable and necessary medical apparatus designed to provide therapeutic relief from the effects of his industrial injury. Similar to *In Re Harrison* Claimant is a paraplegic who has suffered from repeated skin and tissue damage because of transfers involving unmodified vehicles. His shoulder deterioration will also be mitigated by the use of a wheelchair-accessible van. Claimant's tissue and shoulder

conditions have required repeated medical and surgical intervention. He thus received a prescription for a modified, wheelchair-accessible van as a medical aid to relieve the effects of his paraplegia.

8. As found, ATP Dr. Lanig persuasively detailed the therapeutic value of a modified, wheelchair-accessible van. She emphasized that Claimant's spinal cord injury has forced him to use his upper extremities as weight-bearing limbs for nearly 17 years. The deterioration in his shoulders is eliminating the possibility of using a manual wheelchair. Dr. Lanig noted that she had recommended specific ways in which Claimant could interface with a modified van to relieve pressure on his deteriorating shoulders. She commented that another therapeutically necessary reason for an adapted van is Claimant's demonstrated vulnerability to skin or tissue damage when he cannot properly interface with a vehicle. Dr. Lanig concluded that her recommendations regarding the van were made to help prevent secondary and tertiary complications that result from spinal cord injuries. Moreover, Dr. Snively persuasively concluded that a modified van would significantly reduce the likelihood that Claimant would develop wounds, sores and tissue damage. He also remarked that Claimant's use of medical transport or public transportation would be "substantially suboptimal." In contrast, Dr. Brodie testified that a wheelchair-accessible van was not a reasonable and necessary apparatus for Claimant. He noted that a wheelchair-accessible van could not be uniquely differentiated from currently available modalities of transportation. However, Dr. Brodie's opinion is not persuasive because he merely conducted a records review of Claimant's condition and neither managed nor regularly treated Claimant for the injuries he sustained while using an unmodified van.

ORDER

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

1. Respondents shall furnish Claimant with a modified, wheelchair-accessible van.

2. Because Claimant has established that a wheelchair-accessible van constitutes a reasonable and necessary medical apparatus designed to provide therapeutic relief from the effects of his industrial injury, it is unnecessary to address whether Respondents violated WCRP 16.

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

DATED: February 16, 2010.

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Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-719-401

ISSUES

Ø Did the claimant prove by clear and convincing evidence that the DIME physician erred in placing him at MMI? Specifically did the DIME physician err in determining that the claimant's bladder condition is not causally related to the industrial injury?

Ø Did the respondents prove by clear and convincing evidence that the DIME physician erred in assigning an impairment rating for CRPS II?

FINDINGS OF FACT

1. In 2000, the claimant experienced an incident where he sought medical treatment because he was retaining urine.

2. On March 31, 2007, the claimant fell from a piece of heavy equipment. The claimant fell at least 8 feet and broke his left wrist. Much of the controversy in this case results from the question of whether the claimant sustained any additional injuries in this fall.

3. Dr. Susan Geiger, D.O., was the primary treating physician for the claimant's industrial injury. Dr. Geiger first examined the claimant on April 2, 2007. The claimant gave a history of falling off of a loader and landing on his left arm. Dr. Geiger diagnosed a fracture of the distal radius. The claimant underwent a surgical reduction of the fracture.

4. On July 25, 2007, the claimant advised PA-C Jennifer Maestas that he was experiencing numbness, tingling and discoloration of the skin of the left forearm and hand after physical therapy. PA Maestas examined the left upper extremity and noted the "left hand is cooler than he his right hand." She assessed "possible reflex sympathetic dystrophy."

5. Dr. Geiger placed the claimant at MMI on September 12, 2007. At that time the claimant reported that his he was not experiencing pain in the wrist. Dr. Geiger noted that range of motion (ROM) was good and no edema was noted. Dr. Geiger determined the claimant was at MMI and assessed a 4 percent upper extremity impairment rating based on reduced ROM. Dr. Geiger testified that during the course of her treatment the claimant never complained to her of back pain or urinary retention. This testimony is corroborated by pain diagrams, completed by the claimant, which show that his complaints to Dr. Geiger were limited to the left upper extremity. Dr. Geiger testified that December 11, 2007, was the first

time that the claimant complained of “stomach pain.” The claimant reported he had vomited two weeks previously.

6. On September 28, 2007, the claimant presented to Dr. Geiger complaining that his left hand was cold and uncomfortable while working. Dr. Geiger noted that the left hand was cold and slightly blue in color. The claimant was referred to Dr. Rice. On November 5, 2007, Dr. Rice performed nerve conduction studies on the left upper extremity. These studies were reported as normal.

7. On December 11, 2007, Dr. Geiger noted that Dr. Rice had prescribed Ultram and Lyrica. The claimant reported an incident of vomiting two weeks earlier. The claimant also reported that his hands were still getting cold and blue, although Dr. Geiger noted that they were equal in warmth on this examination.

8. On January 31, 2008, Dr. Geiger referred the claimant to a vascular specialist to evaluate his complaints involving the left wrist and hand. The claimant expressed concern that Lyrica was causing bloating and flatulence.

9. On March 12, 2008, Dr. Gregory Carlson, M.D., a specialist in vascular surgery, evaluated the claimant’s hand. Dr. Carlson reported that noninvasive studies showed no evidence of arterial insufficiency of the left upper extremity. Dr. Carlson stated that he suspected the claimant was “getting some vasospasm consistent with Raynaud’s phenomenon when he gets finger discoloration.” However, Dr. Carlson opined that he did not think the claimant’s pain and numbness could be blamed on vascular flow.

10. In February 2008 the claimant sought emergency room treatment for abdominal pain. The claimant then came under the care of PA-C Kulp. PA Kulp referred the claimant for a CT scan that revealed a markedly distended bladder. PA Kulp referred the claimant to Dr. Richard Brownrigg, M.D., urologist. On February 18, 2008, PA Kulp noted the claimant gave a history of experiencing symptoms beginning 2-1/2 to 3 months ago when he was started on Lyrica for left upper extremity neuropathy. PA Kulp noted from the Lyrica package insert that clinical studies showed that urinary retention is a possible side effect of Lyrica. In his February 26, 2008, referral letter to Dr. Brownrigg, PA Kulp noted that the claimant had undergone an MRI of the lumbar spine that revealed some bulging discs at L1-2 and L5-S1 with impingement on the thecal sac.

11. Dr. Brownrigg examined the claimant on referral from PA Kulp. On February 27, 2008, Dr. Brownrigg issued a report is which he noted that PA Kulp advised him that the claimant had “injured his left upper extremity and chest and had been started on Lyrica for management of his pain.” Dr. Brownrigg stated that the claimant had not had “any problems voiding prior to the injury,” and opined that the “injury would appear to be the precipitating cause.”

12. On May 5, 2008, Dr. J. Allen Beck M.D. noted the claimant had “symptoms that would

be consistent with diabetes insipidus." On May 6, 2008, PA Kulp diagnosed the claimant with probable diabetes insipidus.

13. On May 15, 2008, Dr. Matthew Brodie, M.D., performed an IME at the respondents' request. Dr. Brodie noted that on July 25, 2007, PA Maestas reported the claimant's left hand was cooler to the touch than the right, and Maestas assessed "possible reflex sympathetic dystrophy." On examination of the left upper extremity Dr. Brodie noted a "hint of left hand skin modeling [sic] compared to the right." On palpation the left hand was substantially cooler than the right. There was no defined skin atrophic changes or asymmetries. Dr. Brodie stated that CRPS "may be present," but observed that "all diagnostic studies to date have been negative regarding determination of the underlying etiology" of the claimant's hand and wrist symptoms. Dr. Brodie recommended provocative thermography and a triple phase bone scan to rule out CRPS.

14. Dr. Brodie further opined that it is "substantially less than 50% probable" that the claimant's neurogenic bladder is causally related to the industrial injury. Dr. Brodie noted a lack of temporality of the onset of low back symptoms relative to the work injury. Specifically, Dr. Brodie noted that complaints of back pain were absent from the medical records of until approximately 11 months after the injury, and that the MRI results did not document a likely central nervous system cause of the neurogenic bladder. Dr. Brodie further noted that the medical literature documents a relationship between diabetes insipidus and neurogenic bladder, and opined that diabetes insipidus is the "more probable underlying cause" of the bladder problem.

15. On July 10, 2008, the claimant underwent a Division Independent Medical Examination (DIME) performed by Dr. Terry Struck, M.D. The claimant gave a history of injuring his left wrist when he fell onto the bucket of a loader, and then fell another 8 feet landing on the left wrist. The claimant also gave a history of low back pain and buttock pain radiating into the abdomen, pelvic girdle and lower extremities. The claimant further reported difficulties with voiding his bladder. Dr. Struck noted that the back, abdominal and lower extremity complaints were not documented in the medical records pertaining to the industrial injury, and that only wrist and forearm problems were recorded on pain diagrams through August 29, 2007.

16. Dr. Struck examined the claimant's left upper extremity and reviewed numerous medical records pertaining to treatment of that body part. Dr. Struck diagnosed a "pain syndrome-closed distal radius displaced interarticular fracture which has healed with good alignment," but with the claimant describing "deep" periodic discomfort with activities. Dr. Struck noted no vascular dysfunction on examination of the wrist. However she noted that, "other examiners over time have documented such to be evident." Dr. Struck opined the claimant's diagnosis is most likely "CRPS Type II felt to be due to his workers' compensation injury." Dr. Struck recommended a three phase bone scan to "assist with the diagnosis." However, Dr. Struck also recommended that a rheumatologist evaluate the claimant to rule

out vasculopathy associated with rheumatologic diseases. Dr. Struck opined the claimant was at MMI for his wrist injury and related diagnoses. Dr Struck assessed an impairment rating of 14 percent of the left upper extremity, consisting of 5 percent for reduced range of motion and 9 percent for vascular system impairment. Dr. Struck converted the 14 percent upper extremity impairment to 8 percent whole person impairment.

17. Dr. Struck also evaluated various other body parts and symptoms. These included the claimant's back, neck, torso, urologic and gastrointestinal disorders. Dr. Struck stated that these conditions and symptoms "are not able to be connected to [the claimant's] 3/31/07 workers' compensation injury." Dr. Struck specifically stated the "etiology of his neurogenic bladder is unknown." Dr. Struck stated that there is no documentation of the claimant having any back, neck or torso injury in regard to his 3/31/07 workers' compensation injury. Dr. Struck recommended claimant see an endocrinologist and an urologist for a second opinion.

18. Dr. Geiger testified that she reviewed the DIME report. Dr. Geiger disagreed with Dr. Struck's diagnosis of CRPS II. Dr. Geiger, relying on the Medical Treatment Guidelines (MTG) WCRP 17, Exhibit 7, opined that the claimant did not satisfy the criteria for the diagnosis of CRPS II found at page 19. Specifically, Dr. Geiger opined that the claimant did not exhibit vasomotor signs, there was only one instance of sudomotor signs on September 28, 2007 (coolness in hand), the claimant exhibited no trophic changes, and the he did not demonstrate positive results on at least two diagnostic tests. Specifically, Dr. Geiger noted the three phase bone scan performed after the DIME was negative.

19. On January 22, 2009 claimant underwent an IME with Dr. Richard Heppe, M.D., a urologic specialist. The claimant gave a history of an 8-foot fall onto his left side. The claimant also stated that three weeks after surgery for repair of his wrist injury he was complaining of pain radiating pain from the left groin up to the left flank and into the left stomach. Following review of medical records and examination, Dr. Heppe indicated that claimant's complaints and findings were certainly unusual given the mechanism of injury and the time course of events. Dr. Heppe opined that if the claimant had reported an accurate history he could think of only one physiological explanation to tie together the unusual constellation of findings. Dr. Heppe stated that some patients have an underlying atonic bladder, but function normally without symptoms. Dr. Heppe opined that if the claimant had such an underlying problem low back pain and the resulting pelvic floor muscle spasms could lead to increasing bladder outlet obstruction and increasing urinary retention. Dr. Heppe indicated this was a very unusual spectrum of complaints and findings making an easy explanation elusive.

20. Dr. Brownrigg testified by deposition on February 9, 2009. Dr. Brownrigg noted the claimant gave him a history of severe abdominal pain ever since the date of injury. Dr. Brownrigg stated that he performed a cystoscopy that did not reveal any obstruction causing the urinary retention in the bladder. Consequently, Dr. Brownrigg opined that there was a chronological association between the onset of symptoms and the injury. Dr. Brownrigg

opined that to the extent the claimant experienced urinary retention in 2000 it creates the probability that he had a preexisting condition that may have been aggravated by the industrial injury. Dr. Brownrigg also stated that it was speculative to state whether the bladder condition was caused or aggravated by the direct effects of the industrial injury or was secondary to medications given to treat the injury. Dr. Brownrigg stated he was unaware of any diagnosis of diabetes insipidus, but stated that diagnosis would not interfere with the function of the bladder. However, Dr. Brownrigg later stated that diabetes could cause increased fluid in the bladder and act as a “co-factor” in aggravating the claimant’s bladder.

21. The claimant failed to prove it is highly probable and free from serious doubt that Dr. Struck incorrectly determined that the claimant’s bladder condition is unrelated to the industrial injury. Dr. Struck’s finding is corroborated by the credible opinions of Dr. Geiger and Dr. Brodie. Both Dr. Geiger and Dr. Brodie credibly note that the medical records do not document any reports of injury to the claimant’s torso and back at the time of the industrial injury. Therefore, the ALJ credits the opinion of Dr. Brodie that it is unlikely there is any causal relationship between trauma at the time of injury and the development of bladder problems. Further, Dr. Brodie credibly opined that the diabetes insipidus diagnosed by PA Kulp (and noted by Dr. Beck) is a likely cause of the bladder condition. Dr. Brodie credibly observed that medical literature documents this relationship. Considering the totality of the evidence, Dr. Struck’s opinion that the etiology of the claimant’s bladder problems is unknown and cannot be causally connected to the industrial injury is found to be persuasive.

22. Dr. Brownrigg’s contrary opinions concerning the cause of the bladder condition are not sufficiently credible and persuasive to overcome Dr. Struck’s opinion. As found, the medical records do not support Dr. Brownrigg’s opinions to the extent he believes the injury resulted in trauma that directly caused or aggravated the bladder condition. Neither is the ALJ persuaded that it is highly probable and free from serious doubt that the use of medications was the cause of the bladder condition. Dr. Brodie has indicated that the medical literature does not support this assertion and posed an equally plausible theory that the bladder condition was caused by diabetes insipidus. Even Dr. Brownrigg concedes that diabetes could be a “co-factor” in causing the bladder condition.

23. To the extent Dr. Heppe’s opinions could support a finding of causal relationship between the injury and the bladder problems they are also unpersuasive. The ALJ is not persuaded that Dr. Heppe received an accurate history of the injury. Therefore, his opinion that it might have been the cause of the bladder problem is not credible. Indeed, Dr. Heppe expresses substantial reservations about the cause of the bladder condition.

24. Exhibit 7 of the MTG provides the following criteria must be met for a diagnosis of CRPS II: (1) pain complaints; (2) documentation of peripheral nerve injury with pain initially in the distribution of the nerve; (3) physical examination findings of vasomotor and/or sudomotor signs, while allodynia and/or trophic changes add strength to the diagnosis; (4) at least two diagnostic testing procedures are positive. With respect to the fourth criterion the MTG state

that "even the most sensitive tests can have false negatives" and the patient "can still have CRPS-II, if clinical signs are strongly present." Further, the MTG state that in "patients with continued signs and symptoms of CRPS-II, further diagnostic testing may be appropriate."

25. The respondents failed to prove it is highly probable and free from serious doubt that Dr. Struck correctly diagnosed injury-related CRPS II and assigned and impairment rating for that condition. First, the ALJ finds that, contrary to the respondents' position, there is not clear and convincing evidence to establish the claimant lacks the vasomotor and/or sudomotor changes required by diagnostic criterion 3 of the MTG. Although Dr. Struck did not observe vasomotor changes on her examination, she recognized that such findings were present in the medical records. Dr. Struck's finding is corroborated by the fact that the claimant was referred to Dr. Carlson, who documented vasospasm which he diagnosed as "consistent with Raynaud's syndrome." On September 28, 2007, Dr. Geiger noted the claimant was exhibiting "coldness and color change in his left hand." Dr. Geiger admitted in her deposition that this observation amounted to the observation of a sudomotor sign. Despite Dr. Geiger's assertion that there was "one episode" of coldness in the hand, the record establishes that symptom was noted during other medical examinations. PA Maestas documented coolness of the left hand on July 25, 2007, and made a provisional assessment of RSD. Dr. Brodie noted the left hand was substantially cooler than the right, and opined the claimant should receive further diagnostic workup for CRPS. On February 6, 2008, Dr. Geiger again noted the claimant's hand was "slightly cool to touch."

26. The respondents failed to prove it is highly probable and free from serious doubt that that Dr. Struck erred in diagnosing CRPS II because the claimant has not demonstrated positive results on two diagnostic tests. The ALJ notes that prior to the DIME the claimant had not undergone any of the tests listed in the MTG as specific for CRPS II. Instead, the claimant had undergone a negative EMG study. The MTG state that and EMG is not used to establish CRPS but "may provide other useful information." WCRP 17 Exhibit 7 (F)(5)(a). After the DIME the claimant underwent a triple phase bone scan, which was reportedly negative. However, the claimant has not yet undergone *two* tests specific to CRPS II. As noted in Finding of Fact 24, the MTG provide that even the most sensitive tests may give a false negative, and a patient may still have CRPS II in the face of negative testing if clinical findings are "strongly present." Moreover, the MTG, WCRP 17 Exhibit 7 (F), states the "Division recommends" that diagnostic procedures for CRPS "be considered, at least initially, the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established."

27. Dr. Struck diagnosed CRPS II without two positive test results, but based the diagnosis on medical records documenting the presence of other diagnostic criteria. The ALJ finds that at the time Dr. Struck conducted the DIME she could not meet requirement of two positive test results because no tests specific to CRPS had been conducted during the course of the claimant's treatment. The ALJ considers the failure to complete the tests prior to the DIME to be significant since the MTG indicate that it is the insurer's responsibility to

conduct such tests where the diagnosis is entertained. The ALJ further finds that the lack of two positive test results was not attributable to some error by Dr. Struck in applying the MTG, but instead to the failure of the respondents and the treating physicians to conduct such tests. In these circumstances the ALJ places no great weight on the fact that there was a deviation from the diagnostic criteria that the MTG lists for CRPS II. The ALJ finds that Dr. Struck's diagnosis was made on the basis of the best diagnostic and clinical information available to her. Moreover, the ALJ finds that the one negative post-DIME test (three phase bone scan) is not sufficient to overcome Dr. Struck's diagnosis of CRPS II. As found, the MTG themselves require two specific tests, and suggest that such tests may need to be repeated when they are negative in the presence of strong clinical signs.

CONCLUSIONS OF LAW

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

CLAIMANT'S ATTEMPT TO OVERCOME DIME ON THE ISSUE OF MMI AS RELATED TO THE CAUSE OF BLADDER PROBLEMS

The claimant argues that he has proven that he is not at MMI for the bladder condition. The claimant asserts the evidence establishes that Dr. Struck, the DIME physician, erred in finding the bladder condition is unrelated to the injury or the treatment for

the injury. The ALJ disagrees with the claimant's argument.

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). 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). 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). 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. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, supra.*

As determined in Findings of Fact 21 through 23, the claimant failed to present clear and convincing evidence to establish that Dr. Struck erred in finding the claimant is at MMI because there is no established causal relationship between the bladder problems and the industrial injury, or treatment for that injury. The ALJ is persuaded that Dr. Struck accurately stated that the cause of the claimant's bladder problems is unknown and cannot be causally related to the industrial injury. The ALJ has found that this opinion is corroborated by the credible opinions of Dr. Brodie and Dr. Geiger. Further, for the reasons described in Findings of Fact 22 and 23, the ALJ is not persuaded by the contrary opinions of Dr. Brownrigg and Dr. Heppe.

RESPONDENTS' ATTEMPT TO OVERCOME IMAPIRMENT RATING FOR CRPS II

The respondents contend that the evidence establishes that Dr. Struck erred in finding that the injury caused CRPS II (causalgia) and assigning a whole person impairment rating based on that diagnosis. Relying principally on the testimony of Dr. Geiger the respondents assert that the claimant does not meet the diagnostic criteria for CRPS II found in the MTG WCRP 17, Exhibit 7, because he has not exhibited vasomotor or sudomotor signs, and because two diagnostic testing procedures have not yielded positive results. Therefore the respondents contend the claimant should be restricted to an upper extremity impairment rating rather than the whole person rating assigned by Dr. Struck.

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.; §8-42-107(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. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician's rating 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 MTG generally establish the standards for treatment of workers' compensation injuries. *Rook v. Industrial Claim Appeals Office,* 111 P.3d 549 (Colo. App. 2005). Consequently, "health care practitioners" must use the MTG to treat workers' compensation injuries. Section 8-43-101(3)(b), C.R.S. However, the MTG themselves recognize that they are only guidelines and that deviations may be appropriate in certain circumstances. *See Hall v. Industrial Claim Appeals Office,* 74 P.3d 459 (Colo. App. 2003).

As determined in Findings of Fact 25 through 27, the respondents failed to prove it is highly probable and free from serious doubt that Dr. Struck erred in diagnosing injury-related CRPS II and assigning a whole person impairment rating for that condition. As determined in Finding of Fact 25, there is not clear and convincing evidence that the claimant lacked the vasomotor and/or sudomotor changes required by diagnostic criterion 3 of the MTG. For the reasons stated in Findings of Fact 26 and 27, the ALJ finds that Dr. Struck's deviation from the MTG criterion concerning diagnostic testing is not sufficient to establish that she erred in diagnosing CRPS II and assigning an impairment rating for that condition.

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 shall pay permanent partial disability benefits in accordance with the

statutory formula and Dr. Struck's whole person impairment rating.

3. Any issues not resolved by this order are reserved for future determination.

DATED: February 16, 2010

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-718-292

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUE

The sole issue to be determined by this decision concerns whether the decompression and fusion at L4-5 recommended by authorized treating physician (ATP) Brian E. H. Reiss, M.D., is reasonably necessary treatment for the Claimant's admitted industrial injury of March 16, 2007.

FINDINGS OF FACT

1. The Claimant sustained an admitted back injury on March 16, 2007. A General Admission of Liability, dated December 9, 2008, admitting for medical benefits and temporary total disability (TTD) benefits from March 1, 2008 to "undetermined," is still in effect.

2. On May 4, 2007, the Claimant underwent right L4-5 micro laminectomy with removal of a large fragment, nerve root decompression, and discectomy by Gene Bolles, M.D., to address the symptoms of the admitted injury.

3. Following this surgery, the Claimant initially experienced some improvement in low back pain and right back pain, however, his condition deteriorated.

4. On October 1, 2007, the Claimant underwent a L4 discectomy on the right side with Brian E.H. Reiss, M.D., to again address the symptoms of the admitted injury.

5. On October 9, 2007, following the October 1, 2007, surgery, the Claimant stated, "[d]oing extremely well."

6. On October 30, 2007, the Claimant reported, "[o]verall much improved."

7. On November 27, 2007, the Claimant reported, “[o]verall improvement.” Thereafter, the Claimant’s condition generally and progressively worsened.

8. On December 23, 2008, Dr. Reiss recommended far lateral decompression and L4 facetectomy, decompression of L4-L5 nerve roots, interbody fusion at L4-L5, screws, rods, and recovery.

9. On July 29, 2009, authorized treating physician, Rachel Basse, M.D., put together a detailed treatment summary, detailing the course of Claimant’s care from date of injury up and through May 6, 2009.

10. Since that time Dr. Basse has again returned the Claimant to Dr. Reiss who on August 25, 2009,again expressed the opinion:

We will get some new x-rays when he returns to see us and we are gong to request some decompression and fusion at L4-L5, basically transforaminal lumbar interbody fusion L4-L5 off to the right with decompression, posterior fusion, screws, ad rods.

11. On September 16, 2009, in response to correspondence from the Claimant’s counsel addressing Dr. Reiss’ August 25, 2009, surgical recommendation, Dr. Reiss stated the opinion:

As you know I am quite familiar with [the Claimant]. I have been following him for quite some time. His original surgery was done elsewhere. I did a repeat decompression in his lumbar spine. He did very well with that but only for a short period of time. Various conservative measures were tried to get his symptoms under control but they have failed.

As I have mentioned in my notes there was some apparent abnormality on his x-ray present at the L45 level on the right-hand side in the area of his previous surgery. Further imaging studies seem to confirm that. It is my opinion based upon review of all the studies, that he still has some nerve irritation in the sub articular area on the right-hand side. I feel that the best way to solve this problem is to further decompress that area removing more of that abnormal and fusing the L45 level.

I believe he has a legitimate abnormality [which] is quite likely to respond to further surgery. His presentation in my office has always been appropriate. In light of the report from the psychiatrist as opposed to the previous report from the psychologist I believe it would be appropriate to proceed.

All of his symptomatology stems back quite clearly to his original injury and subsequent surgical procedures.

The ALJ places considerable weight on Dr. Reiss’ testimony in that he has identified the pain generator, his treatment addressed the pain generator, and his opinion is that the need for surgery stems from the original injury of March 16, 2007.

12. Respondents conducted video surveillance on the Claimant on numerous occasions and had the Claimant evaluated by their appointed physicians including, but not limited to, Andrew Castro, M.D., Jeffrey A. Wunder, M.D., and Steven Moe, M.D., a psychiatrist. The ALJ observed portions of these videos (admitted into evidence) and finds them unpersuasive on Respondents' proposition that Claimant is a malingerer or symptom magnifier. Indeed, the videos show the Claimant engaged in light activity for a few minutes. It makes no sense for the Claimant to assume the risks of back surgery if he is a malingerer or symptom magnifier.

13. At hearing, Dr. Reiss, Rebecca Hawkins, Ph..D., clinical psychologist, Dr. Moe, and Dr. Wunder testified. The ALJ has considered all of the opinions, whether written or in person at hearing, of the treating doctors and retained experts. The ALJ, however, is particularly persuaded by the written reports and testimony of Dr. Reiss, who has specific expertise and testimony was clear in identifying the pain generator, the proposed fix for that pain generator, and assigning a percentage for improvement of Claimant's condition if the proposed surgery is successfully completed.

14. Essentially, Psychologist Dr. Hawkins and Dr. Moe expressed the opinions that Claimant was not a good psychological candidate for the recommended surgery because Claimant's expectations concerning the outcome of the proposed surgery were too high. This is contradicted by Dr. Ogsbury's opinion that Claimant fully understands the risks and still wants the surgery. More importantly, the psychological/psychiatric opinions are contraindicated by Dr. Reiss' specific surgery proposal to "fix the problem." Indeed, the opinions of Dr. Hawkins and Dr. Moe go beyond normal psychology/psychiatry insofar as they are laden with a flavor of *parens patriae* by substituting their judgment concerning Claimant's best interests for Claimant's judgment.

15. The ALJ also gave due consideration and weight to the written opinion of James S. Ogsbury, III, M.D., who on March 10, 2009, set forth:

Therefore, it remains my opinion that, if the patient fully understands the very small chance that he will improve with surgery and the significant risks of the surgery and that the not small chance he will require another surgery based on the first surgery, it is unreasonable to prevent him from considering that surgery. And if Dr. Reiss continues to believe that it is a reasonable option to perform the surgery even after assessing the evaluation by Dr. Moe and the report by Dr. Wong's group and given that the performance of this surgery in t his circumstance falls within the Colorado State Workers Compensation Medical Guidelines, then it would be my opinion that it is unreasonable to prevent Dr. Reiss from performing that surgery if he is requested to do so by [the Claimant].

Credibility

16. The ALJ finds that the opinions of Dr. Reiss and Dr. Ogsbury are more persuasive and outweigh the opinions of all of the medical and psychological experts in this matter.

Ultimate Finding

17. Claimant has proven, by a preponderance of the evidence that the surgery recommended by Dr. Reiss is reasonably necessary to cure and relieve the effects of Claimant's admitted injury of March 16, 2007.

CONCLUSIONS OF LAW

Credibility

a. 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, the opinions of Dr. Reiss and Dr. Ogsbury are more persuasive and outweigh the opinions of all of the medical and psychological experts in this matter.

Burden of Proof

b. 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. §§ 8-43-201 and 8-43-210, C.R.S. (2008). *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 that the surgery recommended by Dr. Reiss is reasonably necessary to cure and relieve the effects of his admitted injury of March 16, 2007.

Reasonably Necessary Surgery

c. The Respondents are liable for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury. § 8-42-101 (1)(a), C.R.S. (2009); *Snyder v. Industrial Claim Appeals Office*, 942 P .2d 1337 (Colo. App. 1997); *Country Squire Kennels v. Tarshis*, 899 P. 2d 362 (Colo. App. 1995). Where a claimant's entitlement to benefits is disputed, the claimant has the burden to prove a casual relationship between the work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P .2d 1337 (Colo. App. 1997). Whether the Claimant sustained his burden of proof is generally a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P .2d 496 (Colo. App. 1997). The ALJ's factual determination must be supported by substantial evidence and plausible interferences drawn from the record. *Id.: Delta Drywall v. Industrial Claim Appeals Office*, 868 P .2d 1155 (Colo. App. 1993). As found, the ALJ places considerable weight on Dr. Reiss' testimony in that he has identified the pain generator, his treatment addressed the pain generator, and his opinion is that the need for surgery stems from the original injury of March 16, 2007.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Respondents shall pay all of the costs for Dr. Reiss' proposed L4-5 decompression and fusion surgery on the Claimant.

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

DATED this_____day of February 2010.

_____
EDWIN L. FELTER, JR.

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-795-999

PROCEDURAL HISTORY

Claimant filed an Application for Hearing requesting an order finding that she had suffered an injury arising out of and in the course of her employment with employer on June 16, 2009. At the close of the claimant's evidence in her case in chief, respondents moved for a directed verdict denying and dismissing claimant's claim for compensation and benefits. The Judge granted respondents's motion for directed verdict.

ISSUES

Ø Did claimant prove by a preponderance of the evidence that she sustained an injury arising out of the course and scope of her employment?

FINDINGS OF FACT

1. Employer operates a skilled nursing and assisted living facility for patients and residents. Claimant worked for employer as a certified nursing assistant (CNA). Claimant's date of birth is _; her age at the time of hearing was 22 years.

2. On June 16, 2009, claimant experienced an episode of light-headedness while assisting a resident with a transfer from bed to wheelchair in preparation for dinner. After assisting the resident, claimant walked up to M, a nurse, working at the nursing cart. Crediting the testimony of Nurse M, the Judge finds: Claimant appeared pale and reported feeling queasy and light-headed. Nurse M asked claimant if she had eaten, and claimant replied that she had. Nurse M told claimant to sit down. Claimant walked forward, became more pale, passed out, and fell forward into Nurse M. Both claimant and Nurse M fell to the floor, where claimant landed atop Nurse M. Nurse M was lying on her back on the floor with claimant on top of her. Other employees helped Nurse M out from beneath claimant. When claimant awoke, they helped her into a wheelchair. Nurse M took claimant's blood pressure, checked her blood sugar level, and sent her to the emergency room of a local hospital (ER).

3. Crediting the testimony of Nurse M, the Judge finds: When claimant awoke, she was aware of herself and her surroundings. After returning to work from the ER, claimant complained of back pain.

4. Crediting her testimony, claimant recalls only that she was standing one moment and passed out. Claimant has no memory of what happened when she passed out. Claimant recalls nothing further until she awoke and was receiving first aid. When claimant awoke, she noticed that her back was hurting.

5. Claimant later sought medical attention from Orthopedic Surgeon Gerald Rupp, M.D., who examined her on September 14, 2009. Claimant reported the following history to Dr. Rupp:

a. [O]n 6/16/2009 [claimant] passed out at work (cause unknown) as she was falling one of the nurses tried to catch her and [claimant] landed on the nurse's knees.

6. The Judge credits the report of Dr. Rupp, as consistent with claimant's testimony, in finding that claimant passed out on June 16, 2009, from unknown causes. Claimant's loss of consciousness, and fall onto Nurse M, is unexplained. The Judge credits the testimony of Nurse M, who was an eyewitness, over claimant's hearsay-based understanding that she landed on the nurse's knees.

7. Claimant failed to show it more probably true than not that she sustained an injury arising out of her employment as a CNA for employer on June 16, 2009. Here, claimant's injury from her fall at employer on June 16, 2009, occurred within the course of her employment, *i.e*., within the time and place constraints of her employment. Claimant however failed to establish a *prima facie* case showing that her fall leading to her injury "arose out of" her employment. The Judge finds it more probably true that the cause of claimant's fall is unknown or idiopathic. As such, claimant's fall is not compensable absent a showing that claimant's injury was the result of some special hazard of her employment. Claimant failed to show it more probably true that her injury resulted from a special hazard of her employment.

CONCLUSIONS OF LAW

Claimant argues she has proven by a preponderance of the evidence that she sustained an injury arising out of the course and scope of her employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Workers' Compensation Act), §§8-40-101, *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 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*.

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).

Rule 41(b)(1), C.R.C.P., provides that a directed verdict may be entered after a claimant has completed her presentation of the evidence and where she has failed to present a *prima facie* case for relief. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988); (CRCP applied insofar as not inconsistent with procedural or statutory provisions of the

Workers' Compensation Act). The judge is not required to view evidence in light most favorable to the non-moving party in ruling on a motion for directed verdict. *Rowe v.* Bowers, 168 Colo. 379, 417 P.2d 503 (1966); *Blea v. Deluxe/Current, Inc*., W.C. No. 3-940-062 (June 18, 1997), (applying these principals to worker's compensation proceedings). Neither is this court required to indulge in every inference that can be drawn from evidence which would favor the claimant. Rather, because this matter is tried without a jury the resulting test is whether a finding for the respondents is justified on the claimant's evidence. *American National Bank v. First National Bank,* 28 Colo. App. 486, 476 P.2d 304 (1970); *Bruce v. Moffitt County Youth Care Center*, W.C. No. 4-311-203 (March 23, 1998).

Section 8-41-301, *supra*, provides that an injury is compensable under the Workers' Compensation Act:

> (b) Where, at the time of the injury, the employee is performing service arising out of and in the course of the employee's employment;
>
> (c) Where the injury or death is proximately caused by an injury or occupational disease **arising out of** and in the course of **the employee's employment** and is not intentionally self-inflected.
>
> (Emphasis added).

Here, the Judge found claimant failed to show it more probably true than not that she sustained an injury arising out of her employment as a CNA for employer on June 16, 2009. Claimant thus failed to prove by a preponderance of the evidence that she sustained a compensable injury.

As found, claimant's injury from her fall at employer on June 16, 2009, occurred within the course of her employment, *i.e*., within the time and place constraints of her employment. Claimant however failed to establish a *prima facie* case showing that her fall leading to her injury "arose out of" her employment. The Judge found it more probably true that the cause of claimant's fall is unknown or idiopathic. As such, claimant's fall is not compensable absent a showing that claimant's injury was the result of some special hazard of her employment. Claimant failed to show it more probably true that her injury resulted from a "special hazard: of her employment. *See Gates Rubber Company v. Industrial Commission*, 705 P.2d 6 (Colo. App. 1985); *Ramsdell v. Horne*, 781 P.2d 150 (Colo. App. 1989).

The Judge concludes that claimant's claim for compensation and 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:

1. Claimant's claim for compensation and benefits under the Workers' Compensation Act is denied and dismissed.

DATED: _February 18, 2010__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-804-460

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she suffered compensable injuries on August 17, 2009 during the course and scope of her employment with Employer.

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

3. Whether Claimant has proven by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits for the period August 18, 2009 until terminated by statute.

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

5. Whether Employer is subject to penalties pursuant to §8-43-408(1), C.R.S. for failing to carry Worker's Compensation insurance on August 17, 2009.

FINDINGS OF FACT

1. Claimant worked for Employer as a dishwasher and prep cook. She also performed mopping and sweeping duties.

2. On August 17, 2009 Claimant was mopping floors in Employer's kitchen. She explained that she slipped on the wet floor and landed in a sitting position. Claimant testified that she injured her hip and back as a result of the incident.

3. Claimant earned $7.00 per hour while working for Employer. She worked from approximately 4:00 p.m. until 10:00 p.m. for five days each week. Claimant therefore worked a total of 30 hours each week. She thus earned an Average Weekly Wage (AWW) of $210.00.

4. Employer did not possess Colorado Worker's Compensation insurance on August 17, 2009.

5. Immediately after the incident Claimant called for help and N entered the kitchen. N testified that he saw Claimant grabbing a table to pull herself up from the floor.

6. Although Claimant informed N of her injuries, Employer did not direct her to medical care. Employer instead told Claimant to go home. Claimant subsequently went home and did not return to work for Employer. Nevertheless, Employer remained in contact with Claimant and she informed him of her continuing medical concerns.

7. On August 27, 2009 Employer transported Claimant from her home to North Colorado Medical Center for treatment. Claimant underwent an examination, received medications and was referred for an additional evaluation. She was directed to refrain from working until she was feeling better.

8. Employer subsequently referred Claimant to Next Care for medical treatment. Medical providers noted that Claimant was suffering from back pain. Claimant received medications and underwent an MRI. She was referred to an orthopedic surgeon for an evaluation. A September 24, 2009 office note reveals that Claimant was unable to return to work. On October 5, 2009 Claimant's medical care ceased because Employer refused to pay for additional treatment.

9. Employer has paid Claimant a total of $900.00 in lost wages as a result of the August 17, 2009 industrial incident.

10. Claimant has incurred outstanding medical bills as a result of the August 17, 2009 incident. The bills pertained to medical visits on August 27, 2009 and September 30, 2009. The outstanding medical bills total $3,568.10.

11. Claimant has demonstrated that it is more probably true than not that she suffered compensable injuries on August 17, 2009 during the course and scope of her employment with Employer. Claimant testified that she worked for Employer as a dishwasher and prep cook. She credibly explained that she was mopping floors in Employer's kitchen. Claimant remarked that she slipped on the wet floor and landed in a sitting position. She commented that she injured her hip and back as a result of the incident. Employer N acknowledged that he saw Claimant grab a table to pull herself up from the floor after the incident.

12. Claimant has established that it is more probably true than not that she received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of her industrial injuries. Although Claimant reported her injuries on August 17, 2009 Employer did not immediately direct her to medical treatment. However, on August 27, 2009 Employer transported Claimant from her home to North Colorado Medical Center for

treatment. Claimant underwent an examination, received medications and was referred for an additional evaluation. Employer subsequently referred Claimant to Next Care for medical treatment. Claimant received medications and underwent an MRI for her back condition. She was referred to an orthopedic surgeon for an evaluation, but Employer refused to pay for additional medical treatment. Claimant incurred medical bills from providers that total $3,568.10. All of Claimant's medical treatment was reasonable and necessary to cure or relieve the effects of her August 17, 2009 industrial injuries. Furthermore, Employer is also responsible for Claimant's referral to an orthopedic surgeon and any additional medical treatment that is reasonable and necessary to cure or relieve the effects of her August 17, 2009 industrial injuries.

13. Claimant has proven that it is more probably true than not that she is entitled to TTD benefits for the period August 18, 2009 until terminated by statute. Because of her industrial injuries Claimant was unable to perform her job duties for Employer. Medical providers noted that Claimant was unable to return to work and she has not subsequently been released to work. Claimant has thus demonstrated that her August 17, 2009 industrial injuries caused a disability that contributed to a subsequent wage loss.

14. Claimant has established that Employer was not insured on August 17, 2009. Her disability benefits shall be increased by 50% because of Employer's failure to comply with the insurance provisions of the Act.

15. Claimant has incurred medical bills totaling $3,568.10. She is entitled to receive TTD benefits at an AWW of $210.00 from August 18, 2009 until terminated by statute. However, Employer has paid Claimant $900.00 in lost wages as a result of the August 17, 2009 industrial incident. Thus the total present dollar amount that Employer owes to Claimant through February 18, 2010 is $8,300.

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. §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. §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. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, 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).

Compensability

4. For an injury to be compensable under the Act, it must "arise out of" and "occur within the course and scope" of employment. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. § 8-41-301(1)(c) C.R.S.; *Faulkner v. Industrial Claim Appeals Office,*12 P.3d 844, 846 (Colo. App. 2000). The question of causation is generally one of fact for determination by the ALJ. *Faulkner,* 12 P.3d at 846.

5. As found, Claimant has demonstrated by a preponderance of the evidence that she suffered compensable injuries on August 17, 2009 during the course and scope of her employment with Employer. Claimant testified that she worked for Employer as a dishwasher and prep cook. She credibly explained that she was mopping floors in Employer's kitchen. Claimant remarked that she slipped on the wet floor and landed in a sitting position. She commented that she injured her hip and back as a result of the incident. Employer N acknowledged that he saw Claimant grab a table to pull herself up from the floor after the incident.

Medical Benefits

6. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met her burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

7. If an employer is notified of an industrial injury and fails to designate an Authorized Treating Physician (ATP) the right of selection passes to the employee. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565, 567 (Colo. App. 1987). An employer is deemed notified of an injury when it has "some knowledge of the accompanying facts connecting the injury or illness with the employment, and indicating to

a reasonably conscientious manager that the case might involve a potential compensation claim." *Bunch v. industrial Claim Appeals Office,* 148 P.3d 381, 383 (Colo. App. 2006).

8. As found, Claimant has established by a preponderance of the evidence that she received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of her industrial injuries. Although Claimant reported her injuries on August 17, 2009 Employer did not immediately direct her to medical treatment. However, on August 27, 2009 Employer transported Claimant from her home to North Colorado Medical Center for treatment. Claimant underwent an examination, received medications and was referred for an additional evaluation. Employer subsequently referred Claimant to Next Care for medical treatment. Claimant received medications and underwent an MRI for her back condition. She was referred to an orthopedic surgeon for an evaluation, but Employer refused to pay for additional medical treatment. Claimant incurred medical bills from providers that total $3,568.10. All of Claimant's medical treatment was reasonable and necessary to cure or relieve the effects of her August 17, 2009 industrial injuries. Furthermore, Employer is also responsible for Claimant's referral to an orthopedic surgeon and any additional medical treatment that is reasonable and necessary to cure or relieve the effects of her August 17, 2009 industrial injuries.

TTD Benefits

9. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). To demonstrate entitlement to TTD benefits a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that she 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). 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 her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999).

10. As found, Claimant has proven by a preponderance of the evidence that she is entitled to TTD benefits for the period August 18, 2009 until terminated by statute. Because of her industrial injuries Claimant was unable to perform her job duties for Employer. Medical providers noted that Claimant was unable to return to work and she has not subsequently been released to work. Claimant has thus demonstrated that her August 17, 2009 industrial injuries caused a disability that contributed to a subsequent wage loss.

AWW

11. 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, §8-42-102(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). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant's wages based on the particular circumstances of the case. *In Re Broomfield,* W.C. No. 4-651-471 (ICAP, Mar. 5, 2007). As found, Claimant earned an AWW of $210.00.

Penalties for Employer's Failure to Carry Worker's Compensation Insurance

12. Claimant seeks penalties against Employer for failing to carry worker's compensation insurance pursuant to §8-43-408, C.R.S. Section 8-43-408(1), C.R.S. provides that an injured employee's benefits shall be increased by 50% for an employer's failure to comply with the insurance provisions of the Act. If compensation is awarded the Judge shall compute and require the employer to pay a trustee an amount equal to the present value of all unpaid compensation or require the employer to file a bond within 10 days of the order. §8-43-408(2), C.R.S. The term "compensation" refers to disability benefits. *In Re of Shier,* W.C. No. 4-573-910 (ICAP, Dec. 15, 2005).

13. As found, Claimant has established that Employer was not insured on August 17, 2009. Her disability benefits shall be increased by 50% because of Employer's failure to comply with the insurance provisions of the Act.

14. As found, Claimant has incurred medical bills totaling $3,568.10. She is entitled to receive TTD benefits at an AWW of $210.00 from August 18, 2009 until terminated by statute. However, Employer has paid Claimant $900.00 in lost wages as a result of the August 17, 2009 industrial incident. Thus the total present dollar amount that Employer owes to Claimant through February 18, 2010 is $8,300.

ORDER

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

1. Claimant suffered compensable injuries during the course and scope of her employment with Employer on August 17, 2009.

2. Claimant is entitled to reasonable and necessary medical treatment that is designed to cure or relieve the effects of her August 17, 2009 industrial injuries.

3. Claimant is entitled to TTD benefits for the period August 18, 2009 until terminated by statute.

4. Claimant earned an AWW of $210.00.

5. Claimant's benefits shall be increased by 50% because of Employer's failure to comply with the insurance provisions of the Act.

6. The total present dollar amount that Employer owes to Claimant through February 18, 2010 is $8,300.

7. Any issues not resolved in this order are reserved for future determination.

DATED: February 18, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-779-285

ISSUE

The following issue was raised for consideration at hearing: Whether the Prehearing Administrative Law Judge (PALJ) Order finding that Respondent did not timely file a Notice and Proposal to Select the Division Independent Medical Examiner (DIME) is correct.

FINDINGS OF FACT

1. Claimant suffered an admitted injury on April 25, 2008. Claimant suffered injury her low back and into the left leg while moving a chair in the course and scope of her employment. Respondent did not pay temporary total disability benefits after November 9, 2008.

2. Claimant was unrepresented at the time that she reached maximum medical improvement (MMI). She was placed at MMI and was rated at 12% whole person by Dr. Nicholas K. Olsen on December 9, 2008. Dr. Gregg Trigg's reiterated MMI on December 15, 2008, and relied on Dr. Olsen for the impairment rating.

3. Respondent received a M-164 medical record by Dr. Triggs in December of 2008 indicating that Claimant was at MMI and indicating that Dr. Olsen would perform an impairment rating.

4. The parties stipulated that Respondent received Dr. Olsen's impairment report, dated December 9, 2008, on January 5, 2009. The parties further stipulated that Respondent received the impairment report on January 5, 2009, but this report did not contain the range of motion worksheets.

5. It is found that although the range of motion worksheets were not attached to that December 9, 2008, report received by Respondent on January 5, 2009, in the report Dr. Olsen described range of motion deficits in forward flexion and left lateral bending equating to 4% and 1%, respectively. Specifically, Dr. Olsen stated in that report, in pertinent part, as follows:

> [Claimant's] MRI demonstrates disc protrusion at L5-S1 and annular tear. She is rated in table 53, II-C on page 80 of the Guides for a 7% impairment. Range of motion deficits are noted in forward flexion and left lateral bending equating to 4% and 1%, respectively. The total range of motion deficit is 5%. Neurologic examination is intact. The 7% is combined with 5% for a final impairment of 12% whole person.

6. Despite the above quoted discussion of Claimant's range of motion, the narrative medical report by Dr. Olsen dated December 9, 2008, stated: "Please referred to [range of motion] worksheet for values." However, on January 5, 2009, Respondent did not receive the referenced range of motion worksheets.

7. The parties stipulate that Respondent did not receive the range of motion worksheets on January 5, 2009, even though they existed based on the narrative report.

8. On February 6, 2009, Respondent received multiple medical records, including the December 9, 2008, narrative medical report by Dr. Olsen. On this date, February 6, 2009, the range of motion worksheets were attached to Dr. Olsen's December 9, 2008, report.

9. The parties stipulate that Respondent received the range of motion worksheets on February 6, 2009.

10. Respondent filed a Notice and Proposal to Select a DIME on March 6, 2009. The Notice and Proposal to Select a DIME was filed 28 days after Respondent received the range of motion worksheets. Respondent's Notice and Proposal to Select a DIME was filed 58 days after Respondent received Dr. Olsen's December 9, 2008, report on January 5, 2009.

11. Dr. Olsen's December 9, 2008, received by Respondent on January 5, 2009, is found to be the disputed finding or determination within the meaning of Section 8-42-107.2(2)(a)(I)

(B), C.R.S. from which Respondent had 30 days to file a Notice and Proposal to Select a DIME. Respondent did not timely file the Notice and Proposal to Select a DIME when it filed the Notice and Proposal to Select a DIME 58 days after receipt of the disputed finding or determination contained in Dr. Olsen's December 9, 2008, report.

12. PALJ McBride entered an order on November 16, 2009, striking the Notice and Proposal to Select a DIME on the grounds that it was not timely filed under Section 8-42-107.2(2)(a)(I)(B), C.R.S.

13. The parties stipulated and the PALJ ordered that any obligation on the part of the Respondent to take further action in connection with its desire for a DIME was stayed on the date of the prehearing conference, November 16, 2009, until a merits ALJ reviewed the PALJ's ruling.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to insure 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.

2. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The requirements of proof for civil non-jury cases in the district courts apply in workers' compensation hearings. Section 8-43-210, 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 may lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering Inc. v. Industrial Claims Appeals Office*, 5 p. 3d 385 (Colo. App 2000).

3. In this case, it is concluded that the plain language of the statute applies. Section 8-42-107.2(2)(a)(I)(B) provides as follows: For the insurer or self-insured employer, the time for selection of an IME commences with the date on which the *disputed finding or determination is mailed or physically delivered* to the insurer or self-insured employer. (Emphasis added). Similarly, the pertinent portion of Section 8-42-107.2(2)(b) states: Unless such notice and proposal are given within thirty days after…the date of mailing or delivery of the disputed finding or determination, as applicable pursuant to paragraph (a) of this subsection (2), the authorized treating physician's findings and determinations shall be binding on all parties and on the division.

4. The primary objective when interpreting a statute is to follow the legislative intent. To this end, the words and phrases in a statute should be given their plain and ordinary meanings, because the General Assembly is presumed to have meant what it clearly said. *Weld County School District RE-12 v. Bymer,* 955 P.2d 550 (Colo. 1998); *Lobato v. Industrial*

Claim Appeals Office, P.3d (Colo. App. No. 02CA1145, June 5, 2003). The General Assembly has expressly stated that when interpreting statutes the entire statute is intended to be effective and that just and reasonable results are intended. When the word "or" is used in a statute it is presumed the General Assembly intended the disjunctive sense of the term. *Burns v. Robinson Dairy, Inc.,* 911 P.2d 661 (Colo. App. 1995). The statute refers to a "finding or determination."

5. Respondent had all of the information concerning the "finding or determination" of Dr. Olsen on January 5, 2009, when it received the rating report dated December 9, 2008. There is no authority for Respondent's contention that a procedure that was designed to protect Claimants is applicable here to allow Respondent to ignore its obligation to respond to a rating.

6. Under 8-42-107.2(2)(a)(I)(B) and Rule 5-5(E), Respondent had 30 days from January 5, 2009, to file a notice and proposal. Dr. Olsen's December 9, 2008, report constitutes the disputed finding or determination, which was mailed or physically delivered to Respondent on January 5, 2009. Respondent's notice and proposal was not file until March 6, 2009. Respondent filed the notice and proposal in excess of 30 days from the date Respondent received the disputed determination. Under the plain language of the statute and rule, Respondent's notice and proposal was untimely and is stricken.

7. Respondent's counsel relies on a series of cases under a different statutory section to argue that the time period for filing a notice and proposal did not begin until the range of motion worksheets were received. *McCotter* v. *U.S. West Communications, Inc.,* W.C. No. 4-430-792 (ICAP, March 25, 2002); and *Siegmund v. Fore Property Company,* W.C. No. 4-649-193 (ICAP, Jan. 30, 2007). Yet those cases construe 8-43-203(2)(b)(1) and Rule 5-5(A) and have no application to Respondent's obligation to request a DIME in a timely fashion. Those cases stand for the proposition that a final admission that does not include the entire impairment report, including the worksheets required by Rule 5-5(A), is legally insufficient.

8. Two recent decisions have further limited the reach of the *McCotter* line of cases. *Harrison v. DunMier Property*, W.C. 4-676-410 ICAP, (Dec. 4, 2009)(ROM worksheets do not need to be attached to Final Admission of Liability (FA) if they are not used in rendering an impairment rating) and *Aguilar v. Colorado Flatwork*, W.C. 4-741-897, ICAP, (Aug. 3, 2009) (ROM worksheets do not need to be attached to FA if they were not prepared).

9. Respondent argues that it should not be obligated to do anything in response to an impairment report without the worksheets. Respondent's counsel also argues that a contrary ruling would require a respondent to file an unnecessary notice and proposal when, if it had the worksheets, a respondent may admit for the rating.

10. Respondent presented no evidence of steps taken to obtain Dr. Olsen's range of motion worksheets after his report was received on January 5, 2009, in which the worksheets

were clearly referenced. If Respondent had questions about the range of motion deficits and wanted to file a FA in response with Dr. Olsen's report, then it could have obtain the range of motion worksheets within the thirty-day time period.

11. As a consequence, PALJ McBride's order is correct and is upheld here. The notice and proposal filed by the Respondent on March 6, 2009, is stricken. Respondent is bound by Dr. Olsen's December 9, 2008, the impairment rating and must respond to that rating as required by the Act.

ORDER

It is therefore ordered that:

PALJ McBride's November 16, 2009, order is correct and is upheld. The notice and proposal filed by the Respondent on March 6, 2009, is stricken. Respondent is bound by Dr. Olsen's December 9, 2008, the impairment rating and must respond to that rating as required by the Act.

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: February 18, 2010

_____
Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-786-122

ISSUES

1. Whether claimant has proven that the Division IME Physician's causation opinion (that the left shoulder condition is not work-related) was wrong by clear and convincing evidence.

2. Whether claimant overcame the Division IME Physician's opinion that claimant reached maximum medical improvement by clear and convincing evidence.

3. Whether claimant has proven he is entitled to maintenance medical treatment (or entitled to reasonable and necessary medical benefits for his shoulder condition).

4. If the left shoulder injury is found to be work related, whether claimant is entitled to disfigurement benefits.

5. Whether Respondents proved an overpayment in the amount of $514.63.

STIPULATIONS

The parties reached the following stipulations:

1. October 4, 2008 is the correct date of injury.

2. Claimant has a 4% impairment rating of the hand for his thumb injury per Dr. Richman's DIME.

These stipulations were approved and accepted by the ALJ.

FINDINGS OF FACT

1. Claimant is a forty eight year old man who was employed by employer when he sustained a left thumb fracture after he caught his left hand in a pallet jack on October 4, 2008.

2. Paramedics were called to the employer's location on October 4, 2008. The claimant reported that he smashed his left finger between the power jack and another machine. Examination of the thumb revealed a swelling with a two-inch laceration on the lateral interior thumb.

3. Claimant was transported to Longmont United Hospital where he was examined by Dr. Johanos. Dr. Johanos had an X-ray taken of his left thumb, which revealed an open fracture of the distal phalanx with probable injury to the distal digital nerves. Claimant or his coworker reported that claimant got his thumb crushed between two pieces of metal equipment at work. Claimant's wound was cleaned and he was provided a splint. He was then referred to Dr. Pater for follow up care. Examinations of all other areas, including upper extremities and back were reported to be normal.

4. Employer referred Claimant to Dr. Caton for medical treatment.

5. Claimant reported to Dr. Caton on October 6, 2008 with complaints of pain and swelling in the left thumb after his left thumb was crushed between a rack and a power jack. Dr. Caton prescribed Percocet for claimant's pain and referred claimant to Dr. Pater for a surgical evaluation for the left thumb. Claimant did not complain of left shoulder pain at the time of this examination.

6. On October 7, 2009, Dr. Pater completed a formal I & D and fixation of the left thumb fracture with appropriate soft tissue repair.

7. Dr. Caton treated claimant for his left thumb injury on seven different occasions from October 6, 2008 until December 19, 2008. Claimant did not complain of left shoulder pain at any of these appointments.

8. Claimant did not complain to Dr. Caton about left shoulder pain until December 30, 2008. At that time, Dr. Caton noted general complaints of muscle pain in his left upper extremity. Dr. Caton opined this muscle pain may be due to deconditioning while claimant was in the sling. (Depo Tr. of Dr. Caton, p 14 l. 16 to p 15 l.13; Resp. Ex. A, Bates Stamp 16).

9. Claimant reported for the first time on January 27, 2009 that he hit his left shoulder in the October 4, 2008 accident. Due to this new report of the mechanism of injury and the continued pain complaints, Dr. Caton ordered an MRI scan of the left shoulder.

10. An MRI of the left shoulder taken on February 6, 2009 revealed a moderately large full thickness rotator cuff tear involving the distal supraspinatus tendon with a 3.3 cm retraction of the tendon of that same area with moderate to severe tendonitis in the supraspinatus tendon fibers that were still attached and associated muscle atrophy. It also revealed chronic mild tendinosis involving the distal infraspinatus and a possible very small SLAP tear involving the midposterior labrum. There was also moderate proliferative degenerative changes involving the acromioclavicular joint with moderate spurring over the inferior and lateral aspect of the acromion. (Resp. Ex. H, Bates Stamp 124).

11. On February 10, 2009, Dr. Caton reviewed the MRI scan findings and made the following comment regarding the findings:

> [The MRI findings] do not suggest an acute mechanism when he crushed his left thumb. It is doubtful that he has never had some form of soreness or pain in this shoulder prior to the work comp injury. He may be noting the soreness more as he did not use this arm for a prolonged period due to injury and during rehabilitation of the thumb, he has been progressively utilizing the shoulder again.

Dr. Canton advised claimant to seek private care for his shoulder injury. (Resp. Ex. A, Bates Stamp 8)

12. On February 26, 2008, Dr. Caton placed claimant at maximum medical improvement for his thumb injury and assigned a 6% rating of the hand with no permanent restrictions. Dr. Caton opined that there was no maintenance care after MMI required and the left shoulder complaints were not work related. This opinion is credible and persuasive.

13. Respondents filed a Final Admission of Liability on March 12, 2008 admitting for permanent partial disability benefits in the amount of $1,543.90 for a 6% rating for the hand based on Dr. Caton's February 26, 2009 report. (Resp. Ex. K).

14. Claimant sought treatment for his shoulder with Dr. Schneider on February 20, 2009. Dr. Schneider performed a left shoulder arthroscopic surgery on March 16, 2009. During the surgery, Dr. Schneider performed a rotator cuff repair, a subacrominal decompression with acromioplasty and biceps tenodesis.

15. Dr. Richman performed a Division IME. In his report dated July 22, 2009, Dr. Richman opined that claimant was at maximum medical improvement as of February 26, 2009. Dr. Richman also opined that claimant had a 4% rating of the hand for claimant's thumb injury. Dr. Richman agreed with Dr. Caton that claimant did not require any additional maintenance treatment.

16. Dr. Richman opined that claimant's shoulder condition was not related to the October 4, 2008 work-related injury. (Resp. Ex. C, Bates Stamp 52). Specifically, Dr. Richman provided the following opinion: "[i]f in fact [claimant] had a rotator cuff tear that was traumatically induced at the time of his work injury, he would have been expected to have felt discomfort of the shoulder and have reported this." (Resp. Ex. C, Bates Stamp 52). He further noted that the medical treatment records do not reflect any complaints until December 30, 2009. Id. Dr. Richman's opinions are credible and persuasive and not overcome by clear and convincing evidence.

17. Respondents filed a Final Admission of Liability based on Dr. Richman's Division IME report on August 6, 2009 admitting to an impairment rating of 4% of the hand for the thumb, denying liability for maintenance treatment, and asserting an overpayment in the amount of $514.63 for the decreased impairment rating from 6% to 4%.

18. Claimant began treating with Dr. Yamamoto on April 15, 2009. Dr. Yamamoto opined that claimant's rotator cuff tear was a result of the October 4, 2008 injury. Dr. Yamamoto also opined that it cannot be determined whether the tear was acute or degenerative from the MRI. Dr. Yamamoto opined that due to the timing of the complaints and the fact that claimant did not have any previous shoulder pain, it was more probable than

not that the rotator cuff tear was a result of the October 4, 2008 injury. Dr. Yamamoto's opinions are a difference of opinions and do not rise to the level of clear and convincing evidence to overcome Dr. Richman's opinions.

19. Dr. Caton stated that claimant did not report any pain or injury to his shoulder prior to December 30, 2009. At that time, claimant began to complain of general muscle soreness in his left upper extremity. She stated that as a result she wanted to investigate whether the cause of this injury was work related, particularly whether the shoulder pain was the result of deconditioning while his arm was in a cast. (Depo. Tr. of Dr. Caton, p. 20 l. 6 to p 22, l. 11). However, when claimant changed his description of how the incident occurred to include being struck on the shoulder on January 27, 2009, Dr. Caton recommended an MRI to further investigate whether the shoulder pain was caused by the work injury, either in the form of a possible contusion or labral partial RTC tear injury. (Depo. Tr. of Dr. Caton, p. 20 l. 6 to p 22, l. 11; p. 52 ll. 1-13).

20. Dr. Caton opined that the changes shown on the MRI were degenerative, chronic and took a long time to occur. The degenerative changes could not occur in the three month convalescent period when claimant wasn't using his shoulder but would have been occurring over an accumulation of years. (Depo. Tr. of Dr. Caton, p. 24 l. 22 to p. 24 l. 22). Because of these degenerative changes, particularly the atrophy surrounding the rotator cuff tear, claimant's shoulder injury could not have been caused by an acute mechanism or deconditioning after the October 4, 2008 injury. (Depo Tr. of Dr. Caton, p. 32 l. 19 to p. 34, l. 20; p. 49 ll. 8-19). This opinion is credible and persuasive.

21. Even assuming the claimant's shoulder injury was acute and not degenerative, Dr. Caton further opined that an accident to his shoulder to cause something even remotely close to the rotator cuff tears of three of the four rotator cuff muscles as seen on the MRI would have to be a very high velocity mechanism, like falling from height or a major motor vehicle accident without restraint. (Depo Tr. of Dr. Caton, p. 25, l.12-14; p. 34 ll. 6-20). According to Dr. Caton, it is very unlikely that the claimant would have been distracted from reporting that shoulder pain for three months especially considering the amount of force it would have taken to cause the tears found on claimant's MRI. (Depo Tr. of Dr. Caton, p. 21 ll.2 to 9; p. 25 ll. 18-22; p. 30 l. 25 to p. 31 l.25).

22. Claimant has permanent disfigurement of his left thumb that consists of a one-inch scar on the inside of the thumb and a one-inch scar on the outside of the thumb. Additionally, Claimant's thumbnail is deformed and the side of the thumbnail is deformed. This scar is permanent, serious, and exposed to public view.

CONCLUSIONS OF LAW

Claimant Failed to Overcome the Division IME's Causation and MMI Opinions By Clear

and Convincing Evidence

1. A Division IME physician's finding concerning whether the claimant has reached MMI and regarding permanent medical impairment shall be binding unless overcome by clear and convincing evidence pursuant to C.R.S. 8-42-107(8)(b)(III) and C.R.S. 8-42-107(8)(c), respectively. A Division IME physician's determination that the industrial injury has caused a particular medical condition must also be overcome by clear and convincing evidence. Cordova v. Industrial Claim Appeals Office, 55 P.3d 186 (Colo.App. 2002); Leprino Foods Co. v. I.C.A.P., 134 P.3d 475, 483 (Colo. App. 2005) (distinguishing the facts of that case from situations where the existence of a compensable injury in the first place is in question).

2. Clear and convincing refers to evidence that is stronger than a preponderance, is unmistakable and is free from serious or substantial doubt. DiLeo v. Koltnow, 200 Colo. 119, 613 P.2d 318 (1980); Page v. Clark, 197 Colo. 306. 592 P.2d 792 (1979). Under the standard of "clear and convincing evidence," it must be established that it is highly probable the Division IME physician's determination is incorrect. Metro Moving & Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995); Qual-Med, Inc. v. Industrial Claim Appeals Office, 961 P.2d 590 (Colo.App. 1998).

3. The party contesting the Division IME's findings bears the burden of proof. Cowin v. Medina, 860 P.2d 535 (Colo. App. 1992).

4. The Division IME in this case determined that claimant's left shoulder injury was unrelated to the work injury on October 4, 2008. Specifically, Dr. Richman opined that claimant's left shoulder injury was not work related, claimant was at maximum medical improvement by February 26, 2008 and claimant had a 4% impairment rating of the hand for his thumb injury. These opinions are credible and persuasive and supported by the evidence.

5. Claimant has failed to meet his burden to overcome the Division IME's opinions by clear and convincing evidence. Specifically, Dr. Richman's opinions are supported by the evidence in the hearing record and are not highly probable to be incorrect. As a result, claimant remains at maximum medical improvement for his work injury as of February 26, 2009 with a 4% impairment rating for the left hand.

Claimant failed to prove entitlement to post-MMI maintenance medical treatment.

6. Claimant must prove by a preponderance of evidence that he is entitled to maintenance medical treatment. Grover v. Industrial Commission, 759 P.2d 705 (Colo.1988). Both Dr. Caton (the ATP) and Dr. Richman (the Division IME) opined that claimant does not require any maintenance medical treatment for his thumb injury. Those opinions were found credible and persuasive. Therefore, claimant failed to prove that he is entitled to any additional maintenance medical care for his work-related injury.

Disfigurement

7. Claimant has permanent disfigurement of his left thumb that consists of a one-inch scar on the inside of the thumb and a one-inch scar on the outside of the thumb. Additionally, Claimant's thumbnail is deformed and the side of the thumbnail is deformed. Claimant has sustained a serious permanent disfigurement to areas of his body normally exposed to public view, which entitles Claimant to additional compensation. Section 8-42-108 (1), C.R.S. Insurer shall pay Claimant $1000.00 for that disfigurement. Insurer shall be given credit for any amount previously paid for disfigurement in connection with this claim.

Respondents are entitled to an offset for an overpayment of $514.63

8. Respondents paid a total of $1,543.90 in disability benefits based on a 6% rating of the hand per Dr. Caton's February 26, 2009 report. After the Division IME, Respondents filed another Final Admission admitting to a lower impairment rating of 4% of the hand and permanent partial disability benefits in the amount of $1,029.27.

9. Claimant did not challenge Dr. Richman's impairment rating for the thumb at the hearing. Thus, the overpayment is $514.63. As a result, respondents are entitled to an offset against those benefits due in the amount of $514.63.

ORDER

It is therefore ordered that:

1. Claimant's left shoulder condition is not causally related to the October 4, 2008 work-related injury.

2. Claimant has a 4% permanent impairment rating for the left hand as a result of the October 4, 2008 injury. Claimant is not entitled to any additional permanent impairment benefits.

3. Claimant's claim for past due and ongoing medical benefits for treatment for his left shoulder are denied and dismissed. Respondents are not liable for medical benefits related to the left shoulder or for maintenance medical treatment for the admitted left thumb injury.

4. Respondents shall pay Claimant disfigurement benefits in the amount of $1000.00.

5. Respondents are entitled to an offset of $514.63 against any additional indemnity benefits due to an overpayment.

DATED: February 18, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-721-835

ISSUES

The issues to be determined by this decision are as follows:

1. Did respondents overcome the DIME with clear and convincing evidence?

2. If Respondents did overcome the DIME with clear and convincing evidence, what is the correct impairment rating?

FINDINGS OF FACT

1. Claimant is a 46-year-old laborer for Employer. On April 13, 2007, Claimant was involved in an automobile accident while within the course and scope of his employment. The vehicle that Claimant was traveling in was struck from behind by a semi tractor-trailer as Claimant was attempting to pull his vehicle off the highway. At the time that Claimant presented to the emergency room he was assessed with minor abrasions to the right elbow and elbow pain. Claimant did not report any lumbar spine pain at the time he presented in the emergency room.

2. Four days following the accident, on April 17, 2007, Claimant reported to Concentra Medical Centers where he was evaluated by Dr. George Kohake. Claimant indicated that he was now suffering from neck and mid-back pain that became progressively worse over the twenty-four hours following the accident. Claimant's condition had progressed to the point that he could hardly move his neck. Claimant had pain over the back of the neck and into the mid-back area, but denied any radiation of pain, numbness, pain or weakness into his arms or legs. Claimant specifically denied any low back pain, hip pain, or leg pain.

3. Claimant was diagnosed with a neck and mid-back strain/sprain type injury. He began a course of physical therapy and by April 19, 2007, indicated that his neck was feeling slightly better with an increased range of motion. However, by April 24, 2007, Claimant was complaining of tingling down the right arm, both in the front and back, to about the wrist area with numbness and tingling in the front of both legs, into the back of the calves of both legs, but not in the back or the side of both legs. Although Claimant had lower leg symptoms, straight leg raising was negative bilaterally for any lower back pain. Claimant again specifically denied any lower back pain. The medical evidence credibly shows that these lower extremity symptoms without lower back pain would more likely than not be related to Claimant's injury in the cervical spine, and do not represent a lower back condition.

4. On May 7, 2007, Claimant underwent an MRI that revealed degenerative changes of the cervical spine with an acute-on-chronic injury at the C6-7 level. This imaging suggested a disc protrusion with narrowing of the right foramen at the same level. At all other levels degenerative changes with osteophyte formations were identified without specific indication of traumatic injury.

5. On May 10, 2007, Claimant's right arm symptoms were markedly improved and he was no longer having any numbness involving his arm. Claimant's neck was still sore and stiff with limitations in range of motion. Claimant noted for the first time that he was now having lower back pain that he said occurred the previous Saturday while walking four blocks. At that time Claimant revealed that he had previously suffered two slipped discs in his lumbar spine in 1987, but denied any prior history of neck or thoracic spine injuries.

6. On August 7, 2007, Dr. Matthew Brodie assumed the care of Claimant. At the time of his first evaluation Dr. Brodie identified specific problems Claimant had following up with scheduled referrals to Dr. Lesnak. Although Claimant continued to indicate that no follow-up appointments had ever been set, this information was specifically refuted by Dr. Lesnak. Dr. Brodie determined that it was more likely than not that Claimant was changing his story regarding follow-up visits. During his discussions with Dr. Brodie, Dr. Lesnak noted that there were non-organic factors involved in Claimant's presentation and that his neck dysfunction was non-physiologic. Dr. Brodie tended to agree and found that it was certainly not clinically feasible to have no range of motion after four months despite all of the therapy. Both physicians agreed that a psychological review should be conducted to identify non-organic pain generators such as factitious disorder. Dr. Brodie specifically noted that he would have to start considering other possible issues including secondary gain or malingering for drug seeking and/or other work-related factors.

7. As of August 7, 2007, Claimant continued to have neck pain and low back pain. In regards to Claimant's low back pain, Dr. Brodie noted that an MRI had indicated a disc bulge at L5-S1. Dr. Brodie commented that it was unclear whether or not this condition was related

to Claimant's symptom complex. Dr. Brodie again noted concerns with Claimant's statement regarding appointments with Dr. Lesnak. He also noted that Claimant's failure to progress was quite concerning and that there were some red flags in the case regarding his presentation and lack of improvement. Psychological referral was considered to rule out factitious disorder.

8. Claimant followed up with Dr. Brodie on August 21, 2007. Claimant indicated that neither his neck pain nor back pain had improved. Dr. Brodie found that there was an unclear relationship between the bulging disc findings on MRI and Claimant's cervical pain and low back pain. Dr. Brodie also noted that Claimant's lack of extension of the cervical and lumbar spine was physiologically inconsistent with the nature of his injury and its duration following the injury date. Dr. Brodie stated, "It is substantially possible that he has a component of non-organic pain, although the relative contribution between organic and non-organic has not yet been fully analyzed."

9. Based upon the referral of Dr. Brodie, Claimant underwent a psychological evaluation with Dr. Ron Carbaugh on September 4, 2007. Dr. Carbaugh noted that anger, frustration and irritability were evident in Claimant's presentation. He found that Claimant's pain behavior was moderate to high and variable over time. He concluded that Claimant's pain report appeared to be somewhat distorted, at least from a psychometric standpoint. Dr. Carbaugh stated:

i. Based upon his presentation on this date, there does appear to be a contribution of non-organic factors to [Claimant's] pain report and/or behavior. He appears to be mislabeling some non-pain symptoms as being somatic pain, i.e. he is confusing pain and suffering to some degree. His anger and depressive symptoms are likely to be leading to distortions in his pain perception. Most notably, there was very poor agreement between his pain behavior and report of present pain. Note that the above findings do not rule out an underlying physiologic basis for [Claimant's] discomfort. However, his symptom report to care providers does appear to be influenced by psychological and potentially compensatory factors.

ii. [Claimant] is reporting elevated depressive symptoms when his responses are compared to an appropriate normative group of chronic pain patients. [Claimant] appears to be having a difficult time accommodating and adjusting to his ongoing pain and restrictions. It is likely that his personality and coping style, with some tendency toward anger and aggressiveness, are impacting his overall coping.

10. Dr. Carbaugh concluded that Claimant's prognosis for improvement in terms of his attitude and overall coping was guarded and that there remained a concern that Claimant's anger and resentment at the circumstances of his injury and potentially compensatory and retribution factors would continue to impact Claimant's recovery.

11. As of September 11, 2007, Claimant was still non-compliant with following up with Dr. Lesnak. According to Dr. Brodie Claimant continued to describe a similar story to what he had stated before and indicated that Dr. Lesnak's office had told him that a repeat referral was necessary. Dr. Brodie indicated that this was not consistent with the information he obtained from Dr. Lesnak's office and discussion with Dr. Lesnak directly. Dr. Brodie had a strong suspicion that there was some type of passive-aggressive behavior for Claimant in terms of not rescheduling a follow-up with Dr. Lesnak.

12. On January 8, 2008, Dr. Brodie indicated that, after conducting multiple examinations, he felt that it was still plausible that Claimant had a non-organic component to his pain, a potential for which had been suggested by the psychological evaluation.

13. However, even in light of these ongoing suspicions, Claimant was cleared to proceed with a rhizotomy with Dr. Ring on March 24, 2008. Following that procedure, Claimant indicated that his left-sided neck pain was down to a 3/10 and he was happy with the results. In regards to his low back, Claimant felt as if he had no long or short term improvement in symptoms and a surgical evaluation was recommended.

14. Dr. Reiss performed a surgical evaluation on April 29, 2008, and recommend a discogram for further diagnostics. On October 23, 2008, Claimant was referred to Dr. James Ogsbury, for review of a request for discography and possibly surgical intervention. Although Dr. Ogsbury identified a disagreement between spine surgeons as to whether or not discography was useful, that procedure was ultimately approved by Respondents. The results from that test showed that Claimant had subjective indications of low back pain at the L4-L5 level (although the disc appeared normal) discordant pain at the L3-L4 level, and no pain elicited with injection at the L5-S1 level (which appeared completely collapsed). Based upon the findings, Dr. Reiss did not believe that surgery would be helpful and recommended a core stabilization, conditioning, and stretching program.

15. On February 12, 2009, Dr. Brodie placed Claimant at maximum medical improvement. At that time he noted that Claimant had not substantially improved with conservative treatment including physical therapy, home exercises, injections and medicines. Claimant had also been using a TENS machine daily at home and had been provided chronic pain medications through Dr. Sacha. At that time, Claimant complained of substantial cervical and lumbar pain. On March 3, 2009, Claimant was evaluated for a permanent impairment rating and was provided a 27% impairment for his cervical spine and a 25% impairment for his lumbar spine. 20% of the cervical spine impairment rating and 18% of Claimant's lumbar impairment were related to range of motion limitations.

16. Respondents timely challenged the impairment rating and sought a DIME. Dr. Brian Shea performed the DIME on June 5, 2009, which affirmed the 45% whole person

impairment provided by Dr. Brodie. In regards to specific disorders, Dr. Shea identified three levels of cervical spine impairment for 9%, and two levels of lumbar impairment for 9%. This was combined with lumbar range motion impairment of 18% and cervical range of motion impairment of 20%.

17. Dr. Shea testified in regards to his DIME impairment rating. After reviewing video surveillance he stated that his lumbar impairment rating was incorrect and should be lower. He noted that, based upon what he saw with Claimant pivoting when getting into a car, his measurements do not match with the video from March 2009. He agreed that the epidural and facet injections would not have been a factor in March 2009. There was a possibility that if Claimant's Kadian medications were peaking out at the time of the video he would be able to move a bit better. However, it was expected that Claimant would have been on his pain medications at the time of the DIME evaluation. In regards to his measurements, Dr. Shea indicated that he would tend to lower his impairment for the lumbar back 4-6% for range of motion. The DIME physician ultimately agreed that the impairment ratings contained in his impairment sheets were not accurate. The DIME opinion has been overcome by the clear and convincing evidence of Dr. Shea's own testimony.

18. Dr. Shea was also asked to explain how he arrived at additional levels for specific disorders of the cervical and lumbar spine. In regards to the cervical spine, Dr. Shea indicated that additional levels were appropriate because facet injections had been done at these levels and he was concerned that a lawyer in court would ask him about that. Dr. Shea stated that injections in this area could be for diagnostic purposes and that Claimant did not have much resolution from those procedures. Dr. Shea testified that he rated these areas in a more broad fashion because sometimes it is unable to be determined. In regards to the identification of Claimant's pain generators, the level injured, and the cause of the identified conditions, there is no specific indication that Dr. Shea performed a sufficient causation analysis.

19. Likewise, for Claimant's low back condition, Dr. Shea agreed that the only reason he found the low back related was because symptoms came on within 4-6 weeks after the accident. However, this finding ignores the fact that Claimant stated that the back pain had come on while walking four blocks. After reviewing the discogram findings, Dr. Shea noted that he could easily see why other experts would not include the additional lumbar levels. He felt that this was a judgment call and the fact that other physicians had paid enough attention to inject these levels contributed to his decision to rate those levels. However, this finding ignores the fact that the L5-S1 level, was found to not be a pain generator, the L4-5 was found to be a pain generator with out identification of abnormality, and the L3-4 level was found to have pain symptoms which were not what would be expected. Dr. Shea's explanation for the reasons he identified multiple levels in both the lumbar spine and cervical spine is not logical and his rational does not support a conclusion that all the identified levels in Claimant's neck and lumbar spine are related to the accident, to a reasonable degree of

medial probability.

20. Claimant's treating physician, Dr. Brodie was also presented with surveillance video for review and asked to opine on how it affected his medical opinion. On August 5, 2009, Dr. Brodie opined:

i. The video surveillance in March of 2009, which immediately followed [Claimant's] release at maximum medical improvement shows that [Claimant] demonstrated no obvious disability in terms of ambulation, standing, or transfers to a sitting position. During the video, [Claimant] did not show obvious pain mannerisms or difficulty with functional motion of his cervical or lumbar spine during ambulation or during positional changes from standing to sitting. This video does not show that [Claimant] had reduced pace, reduced velocity, reduced motion, reduced coordination, increased effort during motion, pain mannerisms during motion, or other obvious functional deficit or disability. . . .

ii. As stated above, the functional movements demonstrated in the March 2009 video surveillance are not consistent with [Claimant's] clinical presentation when he was placed at maximum medical improvement and when impairment rating was rendered. The clinical presentation that [Claimant] presented with when released at maximum medical improvement appears to be highly similar to the clinical presentation documented by Dr. Brian Shea [at] the time of his DIME. Therefore, although the functional movements observed in the video surveillance from March of 2009 reasonably correlate with my clinical observations in January 2009, just prior to when he was placed at maximum medical improvement, the functional movements in the March 2009 video do not correlate to [Claimant's] functional movements or clinical presentation when he was placed at maximum medical improvement in February of 2009, nor when impairment rating was rendered in March of 2009. Also, based upon my review of the DIME report, there is a mismatch between the March 2009 video surveillance functional abilities and his clinical presentation when the DIME examiner evaluated him. . . .

iii. The discrepancies between these functional observations may not be explained by [Claimant's] physiological disease alone. Given that each of [Claimant's] evaluations occurred while he was under the influence of chronic narcotic pain preparations, the utilization of narcotic pain preparations may not account for the differences in functional movement patterns. In my opinion, it is likely that the differences observed are due to non-physiological parameters, which may include factitious disorder.

21. Dr. John Hughes evaluated Claimant on April 11, 2008, and again on August 20, 2009. Dr. Hughes statedthat he disagreed with the impairment rating provided by the DIME physician, both in regards to the specific disorder impairments and the range of motion evaluation. Dr. Hughes noted that he had twice asked Claimant about his past medical history and Claimant denied a history of two slipped discs in the lumbar spine in 1987. Dr.

Hughes noted that the information provided by Claimant was inaccurate according to medical records that he had reviewed. Dr. Hughes noted that identification of organic pathology responsible for Claimant's severe and incapacitating symptoms had been elusive. This history, in conjunction with the relative lack of pathology responsible for Claimant's pain, suggested the possibility of malingering behaviors that included work cessation and care seeking. During his evaluation Claimant had highly reduced ranges of motion in both the cervical and lumbar spine regions. At the time of the April 20, 2009, evaluation, Dr. Hughes had not yet reviewed surveillance videotapes and noted that the subjective limitations appeared discrepant with informally observed motion. After reviewing the video surveillance, Dr. Hughes concluded that there was a remarkable degree of inconsistency between what he had observed in the surveillance videotapes compared to what he directly observed in clinic three weeks earlier. These findings led Dr. Hughes to conclude that there was a strong suspicion that Claimant was manifesting malingering behaviors.

22. Dr. Hughes testified credibly at the hearing regarding the proper impairment rating. Dr. Hughes was qualified at hearing as an expert in occupational medicine and a Level II accredited physician. He also indicated that he has been an instructor for the State of Colorado on impairments of the spine. In regards to Dr. Shea's specific disorder impairment for the cervical spine, Dr. Hughes disagreed noting that Dr. Shea had failed to follow impairment rating procedures promulgated by the Division of Workers' Compensation in the impairment rating tips of November 2008. According to Dr. Hughes, spinal conditions that required multiple rhizotomies at different levels are divided by a factor of two. The correct impairment rating would be the same six percent for Table 53 II(C) specific disorder and only one percent for the additional level. According to Dr. Hughes, this calculation is not discretionary and the proper procedure was resolved by the Division in 2008.

23. Dr. Hughes also testified that the lumber spine specific disorder impairment provided by Dr. Hughes is also incorrect for similar reasons. The correct impairment rating would be seven percent from Table 53 II(C) and one additional level for a total of eight percent impairment. Again, Dr. Hughes noted that this calculation is not one that was open to the discretion of the physician and was resolved by the Division in 2008.

24. Dr. Hughes further indicated that Claimant specifically attempted to withhold information from him in regards to his prior conditions. Dr. Hughes stated that Claimant was specifically concealing information for the purpose of secondary gain. Dr. Hughes also found that Claimant's emergence of lumbar spine symptoms a month after the collision, especially in light of the prior low back injury, suggested that the condition was not related. Dr. Hughes noted that an apportionment analysis should have been conducted and that Dr. Shea failed to even fill in the apportionment section required by the Division. Because he did not find that Claimant's low back condition is related, providing any impairment for the low back would be inappropriate.

25. Dr. Hughes testified that Claimant's measured range of motion for his cervical spine taken by Dr. Shea is inaccurate. During Dr. Hughes' own physical examination. Claimant was highly limited in both the cervical and lumbar regions. Even before viewing surveillance, Dr. Hughes observed discrepancies in Claimant's motion during his first examination, including, much more motion in the cervical region. Upon informal observation Dr. Hughes noted up to 30% cervical range of motion (compared to 7% and 9% during measurements). Dr. Hughes testified that Claimant's subjective limitations were "way more" than what would be expected based upon Claimant's condition. Dr. Hughes specifically identified section 3.3 of the AMA Guides, which warns that high degree of limitations may lead to inflated impairment ratings. When such extreme limitations exist, measurement should be taken for comparison purposes only and Claimant should return for re-measurement. These guidelines have been specifically adopted by the Division of Workers' Compensation. There is no evidence that Dr. Shea or Dr. Brodie performed more than one set of impairment measurements.

26. Dr. Hughes reviewed surveillance and testified that there was a remarkable discrepancy between what he saw on the video and what he measured during examination. Nothing on any of the videos suggests that Claimant ever appeared to be in a high degree of pain. The surveillance, in the opinion of Dr. Hughes, showed much more motion than what was formally measured by Dr. Shea during the DIME. Dr. Hughes disagreed with the conclusions of Dr. Shea in regards to the differences seen in cervical range of motion during formal measurements and what was apparent on the video.

27. Dr. Hughes was asked specifically what a physician should do in regards to impairment when it appears that a Claimant is presenting fictitiously in regards to range of motion limitations. Dr. Hughes opined that a physician is required to fall back on what is medically probable, and in this case it is not possible to provide impairment for range of motion based upon measurements. Dr. Hughes believes that the AMA Guides implies that a 0% impairment for range of motion is appropriate in theses sorts of circumstances and he has done so in his practice.

28. In comparison to the opinion of Dr. Shea, Dr. Hughes' impairment analysis is more persuasive and acceptable. Dr. Hughes applied the proper calculations for Claimant's specific disorder ratings, and clearly explained the problems he had with range of motion limitations as measured. Dr. Shea's opinion was overcome by his own admission that his measurements were incorrect and that he could understand the argument that it may not be appropriate to include additional levels of specific disorder impairment. In addition to Dr. Hughes, Dr. Brodie believed that Claimant's impairment measurements were inaccurate. When one considers the expertise of Dr. Hughes in this area, as well as his clear explanation of proper impairment calculation, his impairment rating is persuasive. Dr. Hughes has opined that Claimant should be provided a 7% Table 53 II(C) impairment for his cervical spine. The lumbar spine is not related; however if it were, Claimant would be entitled only to an 8%

Table 53 II(C) impairment for his lumbar spine. Claimant's inaccurate presentation for range of motion measurements makes this rating unreliable and inaccurate. Claimant does not have a valid range of motion impairment.

CONCLUSIONS OF LAW

1. When a party seeks to overcome a Division IME physician's opinions and conclusions regarding causation and permanent medical impairment, the burden of proof is increased to "clear and convincing evidence." *See Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590, 592 (Colo.App. 1998); *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186, 189-190 (Colo.App. 2002); *Sholund v. John Elway Dodge Arapahoe,* W. C. No. 4-522-173 (ICAO, October 22, 2004); *Kreps v. United Airlines,* W.C. Nos. 4-565-545 and 4-618-577 (ICAO, January 13, 2005).

2. "Clear and convincing evidence is evidence which demonstrates that it is *'highly probable'* the DIME physician's rating is incorrect. In order to overcome the DIME physician's opinion, there must be evidence establishing that the DIME physician's determination is incorrect and this evidence must be unmistakable and free from serious or substantial doubt." *See Adams v. Sealy, Inc.,* W.C. No. 4-476-254 (ICAO, October 4, 2001).

3. A DIME physician must rate impairment in accordance with the provisions of the *AMA Guides.* Section 8-42-101(3.7), C.R.S.; Section 8-42-107(8)(c), C.R.S.; *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo.App. 2003). The DIME physician's finding of impairment is binding unless overcome by clear and convincing evidence. Section 8-42-107 (8)(c), C.R.S. Whether the DIME physician properly applied the AMA Guides, and ultimately whether the rating has been overcome by clear and convincing evidence are issues of fact for determination by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 2002 (Colo.App. 2000).

4. In this matter, the DIME physician admitted that his impairment was incorrect and reduced the impairment rating. Moreover, Dr. Hughes testified as to the proper way to calculate specific disorder impairment of the spine, citing to the AMA Guides and Impairment Tips provided by the Division of Workers' Compensation. The proper method of impairment was not followed by the DIME physician. Either of these findings is sufficient to show that the DIME physician's opinion was incorrect. Respondents therefore met their burden of showing it was "highly probable" that the DIME physician's opinion was incorrect. However, the evidence also supports a finding that the DIME physician failed to complete the impairment evaluation by considering apportionment and did not provide a credible rationale for inclusion of Claimant's lumbar spine as part of the work-related injury.

5. Where the ALJ determines that the DIME physician's rating has been overcome, the question of Claimant's correct medical impairment rating then becomes a question of fact for

the ALJ. The only limitation is that the ALJ's findings must be supported by the record and consistent with the AMA Guides and other rating protocols. Thus, once the ALJ determines that the DIME's rating has been overcome in any respect, the ALJ is free to calculate the claimant's impairment rating based upon the preponderance of the evidence. *Garlets v. Memorial Hospital,* W.C. No. 4-336-566 (ICAO, September 5, 2001). In *Deleon v. Whole Foods Market, Inc.,* W.C. No. 4-600-477 (ICAO November 16, 2006), the ICAO held that when applying the preponderance of the evidence standard the ALJ is "not required to dissect the overall impairment rating into its numerous component parts and determine whether each part or sub-part has been overcome by clear and convincing evidence." *See also Ortiz v. Service Experts, Inc.,* W.C. No. 4-657-974 (ICAO January 22, 2009) (favorably citing *Deleon).*

6. An ALJ may consider the fact that a claimant is symptom magnifying or inconsistent in presentation and invalidate any range of motion measurements. In *Garcia v. Merry Maids*, W.C. No. 4-493-324 (ICAO, August 12, 2002), ICAO upheld an ALJ's finding which excluded range of motion impairment and stated:

> Claimant's argument notwithstanding, the ALJ was not compelled to find the DIME physician deviated from the AMA Guides by declining to include impairment for the valid range of motion measurements. In *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 202 (Colo. App. 2000), the court stated that under the AMA Guides a clinical evaluation includes information obtained by history and by clinical findings from examination, tests and functional measurements. The *Wackenhut* court further noted that the AMA Guides state that an " *[e] valuation or rating of impairment* is an assessment of data collected during a clinical evaluation and the comparison of those data to the criteria contained in the *Guides*." (Emphasis in original) 17 P.3d at 204.
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> Here, the DIME testified that his rating was issued in accordance with the AMA Guides. Further, he explained that the valid range of motion measurements obtained by the physical therapist were inconsistent with the much more limited range of motion which Claimant exhibited on clinical examination. Moreover, the DIME physician noted Claimant exhibited non-physiologic complaints suggestive of symptom magnification.
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> Under these circumstances, the ALJ logically inferred that the DIME physician acted in accordance with the AMA Guides in disregarding the range of motion measurements when assessing the impairment rating. It is true the treating physician gave testimony which might have supported a contrary result, but the treating physician also conceded that clinical observations may justify disregard of otherwise valid range

of motion measurements. The mere existence of conflicting evidence affords no basis for concluding the ALJ erred in finding Claimant failed to overcome the DIME physician's rating. *May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo.App. 1988).

7. To the extent Claimant's condition and symptoms are magnified or without objective basis for the ongoing pain symptoms, a finding of no permanent impairment under AMA Guides is appropriate. Moreover, absent a finding of specific related disorder under Table 53, it would be improper to assign a range of motion impairment. *Lopez v. Oasis Outsourcing*, Inc., W.C. No. 4-416-822 (January 8, 2001) (ALJ's opinion upheld by ICAO).

8. This ALJ has considered all of the evidence presented to determine what is an appropriate impairment rating for Claimant's related conditions. Both Dr. Brodie and the DIME physician, Dr. Shea, were shown surveillance video that showed significantly greater ranges of motion than what Claimant displayed during his rating examinations. After seeing the video, the DIME physician stated that he would lower the rating for Claimant's lumbar range of motion and provided a total impairment of 41%. Dr. Brodie stated that there were mismatches between Claimant's clinical presentations and functional movement pattern shown on the video. He stated that the discrepancies cannot be explained by Claimant's physiological disease alone. Dr. Hughes also agreed that the significant differences between what was seen on the surveillance video and how Claimant presented at the time of his impairment measurements could not be described on a physiological basis. Claimant's presentation and limitations at the time of his impairment rating are more probably than not illegitimate and not representative of Claimant's true physical restrictions. Therefore, range of motion measurements are not valid and cannot support a finding of impairment which would truly represent Claimant's limitations. Dr. Hughes, after examining Claimant on multiple occasions and reviewing the surveillance videos, agreed that it would not be proper to provide an impairment rating for range of motion. In addition, Dr. Hughes credibly testified about the proper way to evaluate impairment for multiple levels of the spine. Dr. Hughes' opinion was persuasive, credible, and based upon a clear understanding of the AMA Guides.

9. To the extent causation is at issue, the burden of proof remains with Claimant. According to Section 8-43-201, C.R.S., "(a) Claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence; the facts in a workers' compensation case shall not be interpreted liberally in favor of either the rights of the injured worker or the rights of the Employer, and a workers' compensation case shall be decided on its merits." *Also see Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590, 592 (Colo.App. 1998) ("The 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).

10. In establishing causation, Claimant "must show that the industrial injury bears a 'direct causal relationship between the precipitating event and the resulting disability.'" *See Garcia v. CF&I Steel,* W.C. No. 4-454-548 (ICAO, May 14, 2004).

11. Claimant failed to show that his lumbar spine condition was more probably related to his work-related injury. Dr. Hughes credibly testified that he did not believe Claimant's lumbar spine condition could be attributed to Claimant's automobile accident. Dr. Hughes testimony was persuasive and supports a finding that Claimant's lumbar spine condition was pre-existing to some extent, and aggravated by other events other than the automobile accident. Including impairment ratings for the lumbar spine was therefore not appropriate. In deciding whether Claimant has met his burden of proof on causation, 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." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo.App. 2002).

12. Credibility of information relied upon by Claimant's physicians, and the DIME physician may be considered by the ALJ. 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). Claimant was not credible in regards to the information provided to his physicians and to Dr. Hughes. Claimant's subjective range of motion limitations at the time of his impairment do not represent his true limitations. The evidence supports a finding that Claimant did not credibly present to his physicians during the impairment rating process. In addition, Claimant was not forthcoming with Dr. Hughes about his pre-existing lumbar condition, and denied any such condition when specifically asked about it. Claimant's explanation at hearing as to why he denied his prior condition to Dr. Hughes is also not credible.

ORDER

IT IS, THEREFORE, ORDERED that Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 7% whole person. Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

DATED: *February 18, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-672-214

ISSUES

- Did the respondents prove by clear and convincing evidence that the DIME physician erred in finding that the claimant sustained injury-related depression?

- Did the respondents establish that the DIME physician gave an erroneously high rating for CRPS?

- What is the claimant's average weekly wage?

- Did the claimant prove entitlement to an award of post-MMI medical benefits?

FINDINGS OF FACT

1. On July 20, 2005, the claimant sustained a compensable foot injury. She was diagnosed with a fracture of the fifth metatarsal. She was also diagnosed with Complex Regional Pain Syndrome (CRPS).

2. The medical records document that prior to July 20, 2005, the claimant had a significant history of depression and treatment for that condition. This history is well documented in the respondents' exhibits and the report of the respondents' independent medical examination (IME) physician, Dr. Stephen Moe, M.D., psychiatrist. The claimant was prescribed and took medications for treatment of the pre-injury depression. The medical records further document that after July 20, 2005, the claimant continued to seek treatment for depression from personal physicians. These visits reflect stress attributed to difficulties with post-injury employment and other non-injury related factors. This history is also well documented in the respondents' exhibits and the report of Dr. Moe.

3. On December 28, 2005, the claimant advised Dr. James Boland, M.D., one of the treating physicians for the industrial injury, that she was experiencing anhedonia, frustration and weight gain. Dr. Boland prescribed the drug Cymbalta and referred the claimant for counseling with Craig Rose, Ph.D., licensed psychologist.

4. Dr. Rose examined the claimant on January 10, 2006. Dr. Rose noted that the claimant was experiencing symptoms of frustration, pain, and decreased activity and crying. The claimant gave a psychiatric history that she experienced depression in 1989 when her father died, and again in 2001 when her mother died. The claimant reported that she took medications including Cylert, Prozac, Wellbutrin, Celexa and other drugs that she did find to

be helpful. The claimant denied any other depressive episodes. Dr. Rose opined that the claimant had an "undisputable injury which is having difficulty healing," and that her pain complaints appeared to be "normal and a direct result of this injury." Dr. Rose diagnosed "major depression – moderate, in partial remission," and "Adjustment Disorder –mixed." Dr. Rose opined within a reasonable degree of medical probability that the claimant's "current emotional symptoms appear related to her accident." In expressing this opinion Dr. Rose noted that, except for the episodes surrounding the death of her parents the claimant reported "no other previous history of significant depression or anxiety which would be contributing or have caused her current emotional state." Dr. Rose recommended the claimant continue with Cymbalta because it appeared to provide better results that "past antidepressants." Dr. Rose also recommended counseling sessions to assist the claimant in dealing with her pain, and he provided such treatments through February 2006.

5. In February 2007 Dr. Boland referred the claimant to Dr. Barton Goldman, M.D., for a physiatric consultation and second opinion. Dr. Goldman noted the claimant reported problems with several activities including walking, housecleaning, and sexual activities, and that she admitted to feelings of depression and anxiety. The claimant also reported experiencing memory problems. Dr. Goldman assessed "Depressive disorder NOS".

6. In January 2008, Dr. Linda Mitchell, M.D., assumed duties as the primary treating physician for the claimant's injury. Dr. Mitchell placed the claimant at MMI on March 23, 2009. On March 23 Dr. Mitchell noted that the Dr. Rose treated the claimant for depression and an adjustment disorder. Dr. Mitchell assessed a fifth metatarsal fracture and CRPS I. Dr. Mitchell stated the claimant would need maintenance treatment to include medications with follow-up adjustments, a narcotics agreement and a psychological evaluation for chronic opiod use. Using Table 1 p. 109 of the AMA Guides, Dr. Mitchell assigned 15% whole person impairment for the claimant's CRPS. Dr. Mitchell did not assign any rating for psychological impairment. Dr. Mitchell stated there "are no restrictions on [the claimant's] activities, which she may pursue as tolerated."

7. On April 8, 2009, Dr. Glenn Kaplan, Ph.D., clinical psychologist, performed the evaluation recommended by Dr. Mitchell to assess the claimant's suitability for use of opiod medications. Dr. Kaplan noted that the claimant gave no history of psychiatric hospitalization, but had received counseling after the injury. Dr. Kaplan noted "episodic/ reactive depression secondary to chronic pain." Dr. Kaplan did not recommend further counseling but stated that biofeedback relaxation training might be helpful for the CRPS. Dr. Kaplan approved the use of opiod medications subject to a narcotics contract.

8. Dr. Katherine J. Leppard, M.D., performed a DIME on August 20, 2009. The claimant stated she was experiencing symptoms of "constant left foot pain" as well as numbness and tingling on the top of the foot. The claimant further reported right-sided back pain, but was "not certain if this [was] from an altered gait." Finally the claimant reported "significant depression as a result of this injury" as reflected in reduced sexual function, difficulties with personal relationships and reduced recreational activity. Dr. Leppard noted the claimant was using numerous medications including OxyContin, Dilaudid, Effexor and Celexa. Dr. Leppard

reviewed medical records including the reports of Dr. Kaplan, Dr. Rose, and Dr. Mitchell. Dr. Leppard assessed CRPS, a healed fifth metatarsal fracture and "depression as a result of her chronic pain" that is "clearly related to the work injury."

9. Dr. Leppard assigned 20% whole person impairment for CRPS. Dr. Leppard determined that this rating was appropriate under the Spinal Cord Injury Table on page 109 of the AMA Guides, because the claimant "can stand but walks with difficulty." Initially, Dr. Leppard assessed a psychological impairment rating of 7% whole person for depression. The rating was primarily based on disrupted social functioning, memory, and the use of antidepressant medications. Dr. Leppard later modified the psychological impairment rating to 5% whole person. Dr. Leppard recommended permanent restrictions of "no prolonged standing or walking." She further stated that the claimant needs ongoing medical care in the form of medications and physician visits three times per year.

10. At the behest of the respondents Dr. Moe performed a psychiatric examination of the claimant, reviewed pertinent medical records and authored a report dated October 29, 2009. Dr. Moe also testified at hearing. Dr. Moe opined that the effects of the injury were probably not a "significant cause" of the claimant's depression. In support of this opinion Dr. Moe pointed out that the claimant had a long-standing history of depression that pre-dated the industrial injury. He further opined that to the extent the claimant's symptoms persisted after the industrial injury they were most probably caused by stressors associated with her post-injury employment. Dr. Moe also stated in his report, and at hearing, that the claimant was not honest in reporting her pre-injury psychiatric history to him and other providers. Dr. Moe suspected the claimant's desire to connect her depression to the effects of the industrial injury is motivated by anger at her treating physicians and employers, and a concomitant desire to inflict revenge on them. Dr. Moe further opined that the claimant's behavior during the examination was not consistent with the reported level of pain. However, Dr. Moe acknowledged that chronic pain resulting from CRPS is a "well-accepted model for the development of depression."

11. The claimant's husband, Timothy Roberts, testified at the hearing. Mr. Roberts married the claimant in November 2006, but has known her since June 2002. Mr. Roberts testified that, based on his observations of the claimant she was more out-going before the injury and is now more reclusive than she was before. He also noted that they socialized more before the injury, and the claimant was less forgetful.

12. The respondents failed to prove that it is highly probable and free from serious doubt that Dr. Leppard erred in finding the claimant's rating for depression is causally related to chronic pain resulting from the industrial injury. In this regard, the ALJ acknowledges that Dr. Leppard did not have access to all of the claimant's medical records documenting pre-injury and post-injury treatment for depression, and that the claimant has not always been forthcoming in relating her history to her doctors and Dr. Moe. However, it is also true that prior to issuing the DIME report Dr. Leppard reviewed the report of Dr. Rose, which contains documentation of some of the claimant's pre-injury psychological treatment, including the use of psychoactive medications. Thus, Dr. Leppard was not completely unaware of pre-existing

psychiatric issues. Further, Dr. Leppard's opinion that the claimant's depression is causally related to the industrial injury is corroborated by the credible opinions of Dr. Rose and Dr. Kaplan. Even Dr. Moe concedes that chronic pain resulting from CRPS can cause depression. The ALJ is persuaded that the claimant suffers serious pain as a result of the medically documented CRPS, and that the pain has caused at least some of the claimant's ongoing depression and resulting impairment. In this regard the ALJ finds there is a temporal relationship between the injury and the worsening of some of the claimant's psychiatric symptoms. Specifically, in December 2005 the claimant mentioned her psychiatric problems to Dr. Boland. In 2006 Dr. Rose treated the claimant for depression and an "adjustment disorder" that he considered to be the "normal" effects of her injury and the fact that it was not healing. The chronological correlation between the injury and the decline of the claimant's mental health is corroborated by the credible testimony of the claimant's husband.

13. In 2005, while the claimant was working for the employer, she earned approximately $711 per week. Mr. Roberts credibly testified that during her subsequent employment in a similar business she earned $840 per week.

CONCLUSIONS OF LAW

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

RESPONDENTS' ATTEMPT TO OVERCOME IMPAIRMENT RATING BASED OF CAUSE OF DEPRESSION

The respondents contend clear and convincing evidence establishes that Dr. Leppard was mistaken in assigning an impairment rating for the claimant's depression. They argue the evidence establishes that the depression was not caused by the industrial injury, but is attributable to the claimant's pre-existing condition or to post-injury stressors unrelated to the injury. The ALJ disagrees with the respondents' argument.

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.; §8-42-107(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).

As determined in Finding of Fact 12, and for the reasons stated therein, the ALJ concludes the respondents failed to prove it is highly probable and free from serious doubt that Dr. Leppard, the DIME physician, was incorrect in finding the claimant suffers from depression and impairment causally related to the industrial injury. The ALJ is persuaded that the claimant suffers from serious pain problems attributable to injury-related CRPS. The ALJ is further persuaded that this pain has caused the claimant to experience depression resulting in impairment. The claimant's symptoms are documented in the medical records, and Dr. Leppard was aware of at least some of the claimant's preexisting psychological problems. Dr. Rose and Dr. Kaplan corroborate Dr. Leppard's opinion concerning the depressive effects of the claimant's pain. Even the respondents' expert, Dr. Moe, concedes that chronic pain can cause depression, though he does not believe it is the cause of the claimant's depression.

The respondents further argue that if they have overcome Dr. Leppard's rating for depression, a preponderance of the evidence establishes that Dr. Mitchell's 15% rating for

CRPS is more correct than Dr. Leppard's 20% rating. However, as found, the respondents failed to overcome Dr. Leppard's rating for depression by clear and convincing evidence. Therefore, the preponderance standard does not apply to determination of the rating for CRPS. Further, the ALJ finds that Dr. Mitchell's rating does not rise to the level of clear and convincing evidence to overcome Dr. Leppard's 20% rating for CRPS. At most, two highly qualified physicians have expressed differing opinions concerning the proper rating based on their respective observations of the claimant's limp. In this case Dr. Mitchell's opinion does not rise to the level of clear and convincing evidence.

AVERAGE WEEKLY WAGE

The claimant contends that her average weekly wage (AWW) should be based on the greater earnings she received after she left work with the employer. The respondents did not address this issue in their position statement. The ALJ agrees with the claimant's argument.

Section 8-42-102(2), C.R.S., requires the ALJ to base the claimant's AWW on her 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, § 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 § 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*. Further, the "time of the injury" does not necessarily occur until the claimant becomes disabled by the injury. *Avalanche Industries, Inc. v. Clark, supra.*

The ALJ exercises his discretion to base the claimant's AWW on the $840 per week she was earning on the date of MMI. The evidence establishes the claimant continued working after the injury, albeit largely for different employers. By the time she was placed at MMI in March 2009 almost four years after the original date of injury she was earning substantially more per hour that she was on the date of the accident. Considering this substantial increase, the ALJ concludes it would be fundamentally unfair to base the claimant's PPD award on wages she was earning four years before. That approach would substantially understate her loss of earning capacity as reflected by the increased earnings in 2009. The claimant's AWW is found to be $840.

ONGOING MEDICAL BENEFITS AFTER MMI

The claimant seeks an award of ongoing medical benefits after MMI. The ALJ concludes the claimant is entitled to an award of benefits.

Medical treatment may extend beyond the point of MMI where claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to 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). 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). The claimant must prove entitlement to *Grover* medical benefits by a preponderance of the evidence. *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915 (Colo. App. 1993). An award of *Grover* medical benefits should be general in nature. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003).

The ALJ concludes the claimant has presented substantial evidence that there is an ongoing need for medical treatment after MMI to relieve the ongoing effects of the industrial injury. The ALJ credits the opinions of Dr. Mitchell and Dr. Leppard, particularly with regard to the need for ongoing medications and doctor visits to monitor the use of medications. The claimant is entitled to a general award of *Grover* medical benefits.

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 shall pay permanent partial disability benefits based on the impairment rating of the DIME physician, Dr. Leppard.

3. The claimant's average weekly wage is found to be $840.

4. The respondents shall pay for reasonable and necessary medical treatment needed to relieve the ongoing effects of the industrial injury and prevent deterioration of the claimant's condition.

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: February 19, 2010

_____

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-794-217

ISSUES

1. Initially the issues for hearing were compensability and temporary total disability (TTD) benefits. Subsequent to the date set for hearing and the submission of position statements the Respondent-Insurer filed a general admission of liability, agreeing that the claim was compensable for medical care only.

2. This decision addresses the remaining issue of TTD.

STIPULATIONS

1. Claimant earned $700.00 per week at the time of his now admitted compensable injury.

2. Claimant did do the work as complained with a jackhammer for the Respondents.

3. Claimant's injury was reported timely.

4. Claimant worked for Respondent until November 12, 2008 when he was laid off and that Claimant, if called to testify, would testify consistent with these stipulations.

FINDINGS OF FACT

1. Claimant is a 57-year old male who injured his bilateral upper extremities on July 8, 2008 while using a jackhammer in the course of and arising out of his employment with the Respondent-Employer.

2. On July 8, 2008, Claimant notified the Respondent-Employer of the injury and complained of numbness in his first, second and third fingers, numbness in his right hand and pain and numbness in his right elbow. Claimant was initially examined by Jennifer Wilson, R. N., the onsite nurse at the Respondent-Employer's place of business, and was diagnosed

with an arm strain. Ms. Wilson recommended a change in Claimant's job duty task assignments and recommended Claimant follow-up if the pain continued. Ms. Wilson did not assign Claimant any work restrictions on July 8, 2008.

3. On November 12, 2008, Claimant was terminated from his employment with the Respondent-Employer due to a reduction in force layoff.

4. Claimant did not follow-up for his July 8, 2008 injury until Dr. Bradley examined him on January 17, 2009 at EmergiCare. At that initial evaluation, Claimant complained of pain in his hands and fronts of his wrists and right shoulder. Dr. Bradley reported that upon objective evaluation, Claimant had good grip and strength and full range of motion of all fingers, thumbs, wrists, elbows and shoulders and that Claimant had tenderness over the lower wrists with no swelling or discoloration. Dr. Bradley also reported that Claimant had positive Phalen's signs, negative Tinel's signs and negative Finklestein signs. Dr. Bradley diagnosed Claimant with chronic strain to both wrists and elbows and reported that Claimant could perform his full duty work. Claimant did not follow-up with any other treatment with Dr. Bradley following the initial evaluation on January 17, 2009.

5. On December 7, 2009, the parties took the deposition of Dr. Bradley. In his deposition, Dr. Bradley noted that he would have likely assigned Claimant restrictions as of the date that Claimant was terminated on November 12, 2008. However, Dr. Bradley did state that would have been preventative in nature and did admit that Claimant's symptoms improved following his termination. Dr. Bradley also stated that he believed that based on the physical therapy note dated October 21, 2008 Claimant would not have needed the restrictions as to the July 8, 2008 work-related injury. Dr. Bradley also noted that he believed as of January 17, 2009, when he examined the Claimant, Claimant was not in need of work restrictions as related to the July 8, 2008 injury.

6. Dr. Bradley also believed at the time of his deposition that in retrospect he would have restricted the Claimant from using jackhammers and indicated he may have restricted the Claimant from using hammers in general.

7. The evidence is insufficient to establish that it is more likely than not that the Claimant is entitled to TTD. There is insufficient evidence establishing that the Claimant was disabled as a result of his work-related injury. There is insufficient evidence to establish that the Claimant lost wages as a result of his work-related injury.

CONCLUSIONS OF LAW

1. 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), C.R.S.,

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).

2. Claimant is not entitled to TTD benefits as he was never given work restrictions and never lost time as a result of the July 8, 2008 injury. Upon his initial evaluation with Jennifer Wilson, the onsite nurse, on July 8, 2008, Claimant was never assigned work restrictions and did not lose time from work as a result of his right upper extremity injury. In fact, Claimant was never off of work and never followed up with any physician regarding complaints to his wrist or right upper extremity until two months after he was laid off from the Respondent-Employer.

3. Dr. Bradley supports Respondents position that no work restrictions were or should have been assigned to the Claimant as of his termination. Dr. Bradley agreed that there was no objective findings supporting the need for restrictions upon in his initial evaluation dated January 17, 2009. On that date, Dr. Bradley released Claimant to full duty work even though Claimant continued to complain of pain in his volar wrist. This was so even though Claimant had a positive Phalen's sign. In addition, Dr. Bradley agreed in his deposition that no restrictions were placed on the Claimant at the time of his termination because of Claimant's own self report that he was performing full duty work including jackhammering in the October 21, 2008 physical therapy note.

4. Dr. Bradley testified that he would have assigned Claimant restrictions at the time of Claimant's termination because jackhammering could cause similar complaints in other workers. He believed, however, that the restrictions would have been preventative in nature and not necessarily due to Claimant's complaints.

5. As noted above, Dr. Bradley agreed that in this particular case based, on the objective findings and Claimant's own self-report, no restrictions should have been assigned to the Claimant as he was not having problems with his right upper extremity as of October 21, 2008 or on the date of his termination. Lastly, Dr. Bradley agreed that there was no objective findings supporting the need for restrictions upon in his initial evaluation dated January 17, 2009 which was more than two months after Claimant's termination.

6. The evidence is insufficient to establish that it is more likely than not that the Claimant is entitled to TTD. There is insufficient evidence establishing that the Claimant was disabled as a result of his work-related injury. There is insufficient evidence to establish that the Claimant lost wages as a result of his work-related injury.

ORDER

It is therefore ordered that: Claimant's claim for temporary total disability benefits is denied and dismissed. All matters not determined herein are reserved for future determination.

DATE: February 19, 2010 /s/ original signed by:
Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-299

ISSUES

The following issues were raised for consideration at hearing: Compensability and Medical Benefits.

FINDINGS OF FACT

1. On August 8, 2008, Claimant filed a claim for Workers' Compensation alleging a work injury to his lungs on July 22, 2008. Claimant contends that the air he breathed at worked caused him to suffer from a lung injury.

2. Claimant admits that he suffers from a non work-related medical condition known as "papillomatosis of the larynx."

3. Papillomatosis of the larynx and vocal cords is caused by infection from the Human Papilloma Virus ("HPV"). Claimant tested positive for HPV. The most common cause/spread of papilloma is during childbirth when an infant goes through the birth canal becoming infected when HPV is on the cervix of the woman. In adults, the most common cause is a venereal spread.

4. Papillomas grow in the narrow opening of the glottic area of the larynx and lead to upper airway obstruction, which is fixed. This caused wheezing is not due to asthma, but rather related to the airflow obstruction inlet to the thoracic part of the chest. The natural progression of a papilloma is to grow without any regard to outside forces. A papilloma will grow at the same speed regardless of exposures or job duties.

5. Claimant is a 42-year-old male who worked for Respondent-Employer as a grinder for 8 months, beginning in October 2007, and prior to the alleged injury. Claimant worked on cement molds, performed acid etching and ground cement. Claimant testified that his job involved grinding, which exposed Claimant to large quantities of concrete dust. Claimant contends that exposure to dust beginning in March 2008, sensitized him and caused him to wheeze and that he subsequently developed bronchial spasms or aggravated underlying asthma.

6. On July 22, 2008, approximately 1 ½ hours after leaving work for the day, Claimant testified that he was getting ready to take a shower at home when he could not breathe in and developed severe respiratory distress. Claimant presented to the emergency room of St. Mary Corwin Hospital and was intubated with great difficulty. Claimant was placed on mechanical ventilation and was treated by Harvey W. McClung, M.D.

7. Claimant's initial diagnosis was that he had signs of negative pressure pulmonary edema. The intubating physician noted significant obstruction in the laryngeal area and was able to suction some tissue fragments following the intubation.

8. Dr. McClung diagnosed acute respiratory failure, and central vascular bihilar haze consistent with adult respiratory distress syndrome. It was noted that Claimant had a polyp removed from his throat in the past. Dr. McClung also noted that Claimant had bihilar infiltrates consistent with either volume overload or negative pressure pulmonary edema.

9. Dr. McClung testified at deposition that when he first saw Claimant, Claimant had come up from the ER, intubated and on a ventilator. Claimant had been recently paralyzed and had an abnormal chest X-ray. It was found that Claimant had increased lung water, known as "noncardiogenic pulmonary edema".

10. Claimant was able to be exubated and on August 28, 2008, Claimant underwent surgery by Charlene J. Hickson, M.D. The surgery consisted of "direct microlaryngoscopy with debridement of papilloma and bronchoscopy." Dr. Hickson documented that Claimant's laryngeal papilloma involved the entire right and left vocal cord. Dr. Hickson assessed laryngeal papilloma causing upper airway obstruction, which led to the development of negative pressure pulmonary edema. No record or opinion was made by Dr. Hickson of asthma or aggravation of asthma or a work-related cause or aggravated medical condition of any kind from exposures at work or job duties. The ALJ finds Claimant had surgery solely for the purpose of treating a non work-related "laryngeal papilloma."

11. Dr. McClung testified that Claimant had an "acute lung injury" or an "acute vascular injury with leaky fluid." According to Dr. McClung: "The lung is a membrane that separates blood from the air, and some of the fluid leaked into [Claimant's] air spaces."

12. Dr. McClung also testified that when he read Dr. Hickson's description of Claimant having a 6 to 7 millimeter opening in his throat he found that "exceedingly remarkable"

because that represents “a near critical obstruction of [Claimant’s] airway.” According to Dr. McClung, this obstruction in Claimant’s throat caused the cascade of events that led to Claimant’s hospitalization on July 22, 2008.

13. Significantly, no treating physician in this case, including Dr. McClung and Dr. Hickson, opined that Claimant’s medical condition was in any way caused or aggravated by exposures at work or job duties. No physician, including Dr. McClung and Dr. Hickson, opined that Claimant was hospitalized and needed medical treatment of any kind, including surgery, due to a work-related aggravation of asthma. Indeed, no physician has given Claimant a definitive asthma diagnosis. The ALJ finds there is no credible medical evidence to support a work-related injury in this case.

14. Dennis P. Clifford, M.D., a pulmonary and internal medical expert, conducted an IME on February 11, 2009. Dr. Clifford took a medical history from Claimant and Claimant reported that he had a history of seasonal allergies and active smoking of cigarettes, which Claimant had done since his youth. According to Claimant’s history, he began smoking at age 16 and smoked cigarettes for more than 18 years. Claimant denied having any prior history regarding throat problems or previous papillomas.

15. Dr. Clifford explained that the HPV caused the papilloma and that there was no relationship to exposures at work or job duties.

16. Dr. Clifford credibly explained that the nature of the condition is such that as the wart blocking Claimant’s throat continued to grow thereby decreasing the room for Claimant to breath, Claimant would have eventually self suffocated and died even if he was completely sedentary. Claimant’s requirement for additional air on July 22, 2008, had nothing to with work. The sole reason Claimant required additional air is because the hole in Claimant’s throat was getting smaller and smaller and the wart growing in his throat grew. The ALJ finds Dr. Clifford’s testimony credible.

17. No medical evidence was presented to contradict the opinions of Dr. Clifford and the ALJ accepts those opinions.

CONCLUSIONS OF LAW

1. The purpose of the Workers’ Compensation Act of Colorado (Act), Sections 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. 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. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of a witness' 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 of employment. Section 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. A compensable injury is one that "arises out of" and "in the course of" employment. *See* § 8-41-301(1)(b), C.R.S. (2005); *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999); *Price v. Indus. Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). An injury "arises out of" employment when the origins of the injury are sufficiently related to the conditions and circumstances under which the employee usually performs his or her job functions as part of the employee's services to the employer. *See General Cable Co. v. Indus. Claim Appeals Office*, 878 P.2d 118, 122 (Colo. App. 1994); *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). "In the course" of employment "refers to the time, place, and circumstances under which the injury occurred." *Popovich*, 811 P.2d at 383; *Triad Painting Co. v. Blair*, 812 P.2d 638, 641 (Colo. 1991).

6. This claim is denied and dismissed. The precipitating cause of Claimant's injury is a pre-existing non work-related wart that was lodged in Claimant's throat and growing on its own with no regard to external factors. The wart continued to grow on a daily basis simply because that is the nature of a papilloma. Claimant failed to establish that a "special hazard" of employment combined with the pre-existing condition to cause the work injury. Claimant contends that exposure to dust was a special hazard that contributed to the injury but there is

no medical record, no medical opinion, and consequently, no medical evidence indicating that dust exposure caused the non work-related wart to grow faster than it would have if Claimant was not exposed to dust. There is no medical record, no medical opinion, and consequently, no medical evidence to support the claim that "but for" exposure to dust, the wart would have stopped growing. Indeed, the medical evidence establishes the exact opposite: Claimant would have ended up in the emergency room on July 22, 2008, at the exact same moment regardless of what he was doing at the time. It is worth reiterating that Claimant was not at work when the wart grew to the point where it blocked the small hole in Claimant's throat to the point where Claimant could not breathe. The evidence establishes that even if Claimant never worked for Respondent-Employer, he would have likely had the same medical problem arise because the problem is wholly independent from work.

7. Claimant's alterative theory that the physical exertion at work caused him to need more air than he would have needed if he was not at work lead to breathing failure. The ALJ rejects this contention. As Dr. Clifford credibly testified, the physical exertion necessary to cause Claimant to need additional air was something as simple as walking up stairs or walking to the bathroom. The physical activity used by Claimant at his job as a cement worker was not required to trigger the medical condition which would have occurred regardless of where Claimant worked or if Claimant did not work, and which has apparently happened to Claimant before, according to his testimony, and, according to Dr. Clifford, will happen to Claimant again.

8. Claimant failed to meet his burden of proof in establishing a compensable work-related injury.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: February 19, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-794-805

ISSUES

The issues presented for determination are:
1. Compensability;
2. Medical benefits;
3. Average weekly wage; and,
4. Temporary total disability benefits.

FINDINGS OF FACT

1. Claimant began employment with Respondent-Employer on June 7, 2007.

2. Claimant worked Saturdays and Sundays, and each shift was 14 hours with a 2-hour break, at an average weekly wage of $293.88 and temporary total disability (TTD) rate of $196.01.

3. Claimant's duties were that of a cashier, along with assisting in sweeping, mopping, and stocking items.

4. On May 23, 2009 Claimant arrived at the parking lot of Respondent-Employer's place of business shortly before her shift was to begin it 5:30 a.m.

5. Upon arrival, Claimant stepped out of her car to begin walking towards the entrance of Respondent-Employer's building.

6. In the parking lot of Respondent-Employer's place of business, there are concrete dividers that contain rocks varying in size from an inch in diameter to approximately a grapefruit size.

7. As Claimant was walking towards the building, she stepped over a concrete divider, and upon placing her foot down, Claimant stepped on a rock, which caused her left foot and ankle to either twist or bend to the point where Claimant heard a distinct snapping sound.

8. The Claimant fell immediately to the ground in pain, whereafter she was able to pick herself up and make her way to her supervisor's office.

9. Claimant's supervisor is JP.

10. Although there were no witnesses to the fall, Claimant immediately reported the injury to her supervisor, JP, who then filled out an employer investigation form with the Claimant and the secretary SH.

11. JP and Claimant observed the injured foot and ankle and noted it was swollen and

black and blue.

12. Claimant worked throughout her shift that day. After working her shift, Claimant sought treatment on her own at Memorial Health Systems, where she was diagnosed with an acute, obliquely oriented fracture through the mid and distal shaft of the fifth metatarsal.

13. The ALJ finds Claimant's recitation of the events to be more credible than contrary evidence.

14. Claimant has established that it is more likely than not that she suffered a work related injury.

15. Claimant was not able to work due to her injury from May 30, 2009 through July 24, 2009. Claimant is entitled to temporary total disability benefits for this period.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), §§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. 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, *supra*.

2. In accordance with Section 8-43-215, C.R.S., this decision contains specific Findings of Fact, Conclusions of Law, and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office,* 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *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'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. Claimant has established by a preponderance of the evidence, through credible evidence, including her own testimony as corroborated by other evidence, that she sustained a work-related injury on May 23, 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. Based upon the finding of compensability, the ALJ concludes that the Respondents are responsible for all reasonable and necessary medical care related to Claimant's injury.

7. To obtain an award of temporary total disability (TTD) benefits or temporary partial disability (TPD) benefits, a claimant must prove a causal connection between the employee's work injury and her temporary loss of wages. To establish such a connection, a claimant must prove that the industrial injury has caused a "disability," that she left work as a result of the injury, and she sustained an actual loss of wages. Section 8-42-103(1), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546 (Colo. 1995). For purposes of temporary disability benefits, a "disability" exists when the claimant is unable to fully perform the duties of her pre-injury employment. *See e.g. McKinley v. Bronco Billy's*, 903 P.2d 1239 (Colo.App. 1995). Cf. In re Smith, W.C. No. 4-504-184 (ICAO, 6/17/04).

8. The ALJ concludes that the Claimant has proven by a preponderance of the evidence that she is entitled to total temporary disability benefits beginning May 30, 2009 through and including July 24, 2009.

ORDER

It is therefore ordered that:

1. Claimant's claim is compensable.
2. Respondent-Insurer shall pay for all reasonable and necessary medical care related to Claimant's injury.
3. Claimant's average weekly wage is $ 196.01.
4. Respondent-Insurer shall pay Claimant TTD benefits from May 30, 2009 through and including July 24, 2009.
5. The Respondent-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: February 19, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-759-274

ISSUES

1. Whether the division independent medical evaluation (DIME) report issued by Dr. Timothy Sandell, on July 21, 2009, is ambiguous with regard to whether the left shoulder condition is related to the compensable right shoulder injury occurring on December 16, 2007.

2. Whether Claimant has established by clear and convincing evidence that her left shoulder condition is related to the compensable right shoulder injury occurring on December 16, 2007.

3. Whether Claimant is entitled to a general award of any and all reasonably necessary medical benefits for the left shoulder condition.

4. Whether Claimant's scheduled impairment rating should be converted to a whole person impairment rating because Claimant has suffered a functional impairment that is not listed on the schedule of disabilities.

5. Whether Claimant is entitled to an award for any and all reasonably necessary maintenance medical benefits.

6. Whether Claimant's average weekly wage should include both her wages from the Holly Nursing Care Center and her wages from Eads Home Health.

FINDINGS OF FACT

1. On December 16, 2007, Claimant sustained injury to her right shoulder in the course and scope of her employment with Respondent/Employer. A workers' compensation claim was filed and liability was admitted. Claimant began to treat with Dr. Sonia Seufer.

2. Claimant's first visit with Dr. Seufer occurred on January 8, 2009. At that time, Dr. Seufer diagnosed a right shoulder strain and recommended conservative therapy and diagnostics. Dr. Seufer returned Claimant to work with the temporary physical restriction of no lifting the right arm away from the body and no lifting the right arm above shoulder height. At that time, Claimant was experiencing no left shoulder problems and no treatment was provided for the left shoulder.

3. Claimant returned to work with Respondent/Employer and Eads Home Health. She

was essentially performing both of her jobs using only her left arm.

4. When Claimant failed conservative therapy for her right shoulder, an MRI was ordered. The MRI took place on April 10, 2008. The MRI ultimately revealed a significant amount of internal derangement in the right shoulder.

5. Claimant was referred by Dr. Seufer to Dr. Sanchez for a surgical consultation. Dr. Sanchez opined that surgery was necessary and he performed arthroscopic surgery on the right shoulder on June 4, 2008.

6. Claimant was off work for exactly 11 days for her right shoulder surgery. Subsequent to her surgery, Claimant was restricted from any use of her right arm. As such, Claimant continued to perform her job duties using only her left arm.

7. Around the time Claimant had surgery for her right shoulder condition, Claimant began to experience pain and discomfort in her left shoulder. Claimant noted that she would experience pain in her left shoulder subsequent to working her job all day and using her left arm exclusively. At that time, Claimant was under physical restrictions prohibiting any use of the right arm.

8. On October 28, 2008, Claimant was examined by Dr. Seufer. At that time, Dr. Seufer notes Claimant's left shoulder complaints. Dr. Seufer ordered a left shoulder x-ray and MRI.

9. The left shoulder MRI occurred on November 9, 2008. The MRI showed internal derangement.

10. Claimant was put at MMI by Dr. Seufer on December 16, 2008. Respondents filed a Final Admission of Liability consistent with Dr. Seufer's opinions. Claimant objected and requested a DIME.

11. The DIME was performed by Dr. Sandell and a report was generated July 21, 2009. Dr. Sandell's report is unambiguous in its determination that Claimant's left shoulder complaints are not related to the work-related injury of December 16, 2007. Dr. Sandell clearly and repeatedly states he found and concluded claimant's left shoulder condition is not causally related to this claim. On page 4 of his report, Respondents' Hearing Exhibit A, page 5, Dr. Sandell writes, "Left shoulder pain, unrelated to this work injury." On page five of his report, page 6 of Respondents' Hearing Exhibit A, in his section titled, "Can a cause and effect relationship be established?" he only states the right shoulder condition is causally related to the claim. In the "Final Comments" section of his report, page 7 or Respondents' Hearing Exhibit A, he writes, "she is now complaining of left shoulder [symptoms]. This has been determined to not be related to the original injury; therefore, I am addressing the right shoulder injury only today." On page 3 of his report, he writes, "She complains of ongoing left

shoulder pain. Based on review, the left shoulder is not related to this current injury and IME; therefore, it was not evaluated further." These statements are not ambiguous, and clearly show Dr. Sandell determined claimant's left shoulder condition is not related to this claim.

12. On September 14, 2009, Dr. Seufer drafted a letter in which she opined that Claimant's left shoulder complaints are related to her right shoulder condition.

13. The ALJ finds that the letter by Dr. Seufer merely expresses an opinion without foundation for that opinion. The letter falls far short of establishing by clear and convincing evidence that the DIME opinion is wrong.

14. The ALJ finds Claimant's left shoulder complaints are unrelated to the work-related injury of December 16, 2007.

15. Based upon the finding in the previous paragraph it is not necessary to address medical benefits for the left shoulder.

16. Claimant's testimony is insufficient to establish that she suffers from a functional impairment above her right arm. Additionally, the ALJ credits the testimony of the physical therapists that treated the Claimant that, in essence, no functional impairment exists. Claimant has failed to establish by a preponderance of the evidence that the scheduled impairment rating of 10% should be changed to a whole person impairment.

17. Dr. Sandell recommended no additional follow-up treatment was necessary other than a home exercise program previously provided to the Claimant.

18. Dr. Seufer in her notes of December 16, 2008, in which she determined the Claimant to be at MMI, did not recommend any maintenance care following MMI.

19. Claimant's testimony is insufficient to establish that she is in need of post-MMI medical maintenance for her right shoulder injury.

20. Claimant has failed to establish by a preponderance of the evidence that she is in need of post-MMI medical maintenance care.

21. As of the date of injury, Claimant had concurrent employment with Eads Home Health. Claimant was earning $8.50 per hour and was working an average of 15.61 hours a week. As such, Claimant was earning an average of $132.69 a week for her work at Eads Home Health.

22. Claimant's average weekly wage from her employment with the Respondent-Employer is $326.26. Combined with Claimant's second job her average weekly wage

becomes $458.95.

CONCLUSIONS OF LAW

1. Claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence; the facts in a workers' compensation case shall not be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer, and a workers' compensation case shall be decided on its merits." *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590, 592 (Colo. App. 1998).

2. 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.

3. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *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)

4. 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). 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).

5. Under the Colorado Workers' Compensation Act, 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 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. Therefore, the DIME physician's opinions on these issues are binding unless overcome by clear and convincing evidence. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002).

6. Here, the evidence is insufficient to find that the DIME physician's opinion is clearly erroneous. The DIME physician was clear in stating that the Claimant was at MMI on December 16, 2008 and that the left shoulder complaints were not work related. The finding that the Claimant was at MMI on December 16, 2008 precludes the possibility that the left shoulder was caused by her work-related injury, absent clear and convincing evidence to the contrary.

7. Since the left shoulder injury is not related there is no need to address the issue of medical benefits for the left shoulder condition.

8. Section 8-42-107 (1), C.R.S., provides that claimant is limited to a scheduled disability award if the claimant suffers an "injury or injuries" described in § 8-42-107(2), C.R.S. *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). In the context of § 8-42-107(1), the term "injury" has been defined to refer to the manifestation in a part or parts of the body which have been functionally impaired or disabled as a result of the industrial accident. *Strauch v. PSL Swedish Healthcare System,* supra. Where the claimant suffers an injury not enumerated in § 8-42-107(2), claimant is entitled to whole person impairment benefits under § 8-42-107(8), C.R.S.

9. It is well established that the question of whether the claimant sustained a scheduled injury within the meaning of § 8-42-107 (2) (a), C.R.S., or a whole person medical impairment compensable under § 8-42-107 (8) (c), is one of fact for determination by the ALJ. *Walker v. Jim Fuoco Motor Co.*, 942 P.2d 1390 (Colo. App. 1997); Kolar v. Industrial Claim Appeals Office, 122 P.3d 1075 (Colo. App. 2005). In resolving this question the ALJ must determine the situs of the claimant's functional impairment, and the site of the functional impairment is not necessarily the site of the injury itself. Langton v. Rocky Mountain Health Care Corp., 937 P.2d 883 (Colo. App. 1996); Strauch v. PSL Swedish Healthcare System, 917 P.2d 366 (Colo. App. 1996). A physician's rating is not alone dispositive of this question, although it is certainly relevant. Id.

10. The presence of pain above the arm at the shoulder does not compel the finding of a whole person impairment. See *Langton v. Rocky Mountain Health Care*, 937 P.2d 883, 885 (Colo. App. 1996) (Claimant with pain and peripheral nervous system impairment related to shoulder injury found to have sustained scheduled injury).

11. Evidence presented by Claimant did not establish that it is more likely than not that she suffers from a functional impairment above the shoulder.

12. Respondents 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). The burden of proof is on claimant to establish entitlement to *Grover* medical benefits. *Grover v. Industrial Commission*, supra; *Cordova v. Foundation Builders Inc.*, W. C. No. 4-296-404 (April 20, 2001).

13. In order to receive *Grover* medical benefits, claimant must present, at the time permanent disability benefits are determined, substantial evidence that future medical treatment is or will be reasonably necessary to relieve the claimant from the effects of the injury or to prevent deterioration of the claimant's condition. See *Hanna v. Print Expediters Inc.*, 77 P.3d 863 (Colo. App. 2003); *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995). The question of whether the claimant met the burden of proof to establish an entitlement to ongoing medical benefits is one of fact for determination by the ALJ. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999); *Renzelman v. Falcon School District*, W. C. No. 4-508-925 (August 4, 2003).

14. As found, there is insufficient evidence in the record to establish by a preponderance of the evidence that Claimant is in need of post-MMI, *Grover*-type treatment.

15. Claimant’s average weekly wage is $458.95.

ORDER

It is therefore ordered that:

1. Claimant’s request to overcome the DIME and determine that the left shoulder is related to the work-related injury is denied and dismissed.

2. As such, Claimant’s claim for medical benefits for her left shoulder condition is denied and dismissed.

3. Claimant’s request to have the scheduled impairment rating of the DIME physician converted to a whole person rating is denied and dismissed.

4. Claimant’s request for post-MMI *Grover*-type treatment for her work-related right shoulder condition is denied and dismissed.

5. Claimant’s average weekly wage is $458.95.

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.

DATE: February 19, 2010 /s/ original signed by:
Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-754-962

ISSUES

- Whether Claimant sustained an injury while in the course and scope of her employment;
- Whether Claimant is entitled to medical benefits associated with the injury;
- Whether the treatment providers Claimant has treated with are authorized;
- Whether the treatment rendered and recommended is reasonable and necessary;
- Whether Claimant is entitled to temporary total disability (TTD) benefits commencing on January 22, 2008, through December 16, 2008;
- Whether Employer should be penalized for failing to maintain workers' compensation insurance; and
- Whether Claimant was responsible for the termination of her employment.
- The Employer's owner, Craig Sanders, also raised the issue of whether he should be held personally liable if his business is organized as a corporation.

FINDINGS OF FACT

1. Claimant began working for Employer in November 2007. She performed general office duties, such as answering telephones, filing, creating files and other paperwork. Claimant and Employer arranged for Claimant to work approximately 25 hours per week at the pay rate of $9.00 per hour.

2. Craig Sanders solely owns and manages the Employer which is organized as a corporation rather than a sole proprietorship.

3. On January 21, 2008, Claimant was making a file for a new client. She went to the closet where the file folders were stored. The closet had a sloped ceiling so she needed

to bend down to go inside the closet. Once Claimant found the right box, she attempted to lift it, but dropped it due to its weight. She felt a pulling sensation in her back. She then inched out of the closet backwards, still stooped, and walked over to her desk and sat down. Claimant then called Employer who gave her permission to close the office and go home.

4. The next day, Claimant called Employer and reported that her pain had not improved. At the suggestion of a friend, Claimant went to see a chiropractor, Dr. Gulau. Claimant saw Dr. Gulau twice, but his treatment did not help her.

5. On Friday, January 25, 2008, Claimant returned to work. She worked for five hours although her pain had not improved. Sanders suggested that Claimant see his chiropractor, Dr. Matt Kriewall.

6. Claimant worked on January 28, 2008, for six and one-half hours. Claimant also worked on January 29, 2008, for three hours and fifteen minutes.

7. Claimant worked on January 30, 2008, for four hours. Employer ultimately sent Claimant home because she was in obvious pain. Claimant never returned to working for Employer.

8. On January 30, 2008, Claimant saw Dr. Kriewell. Following an x-ray and physical examination, Dr. Kriewall diagnosed Claimant with a bulged or herniated disc at L4-5 and L5-S1. He also noted advanced Phase I degeneration and an anterior superior body at L4, which was present prior to the incident of January 21, 2008. Dr. Kriewall explained that the body was an incidental finding. He explained that Phase I degeneration means malalignment, misalignment, malfunction, soft tissue damage, and nerve irritation. Dr. Kriewall recommended that Claimant return for treatment four times per week for two weeks, then three times per week for four weeks, then once per week for five weeks.

9. Dr. Kriewall testified that when Claimant presented to him on January 30, 2008, she was in acute distress and could not have worked with that level of pain. There is no persuasive evidence that Dr. Kriewall released Claimant to return to full duty or modified duty work at any time until he placed her at maximum medical improvement on December 16, 2008.

10. On February 24, 2008, Claimant and Sanders had a meeting during which Claimant asked him about workers' compensation. Claimant had no previous knowledge of the workers' compensation system and she was upset because Sanders never told her about workers' compensation after her injury. Sanders ultimately told her that Employer did not have workers' compensation insurance. Claimant believed she still worked for the Employer at that time.

11. On April 15, 2008, Claimant went to the Employer's office to return a mailbox

key. When she arrived, Sanders was on the phone with a client. Claimant waited for some time for Sanders to finish his phone call. Once it became apparent to Claimant that Sanders was not going to end the call, Claimant went to her desk to retrieve a personal photograph. She gave Sanders the key then left the office. At the time, it was not her intent to quit, but simply to return the key.

12. In May 2008, Claimant and Sanders met again to discuss the workers' compensation claim. Claimant still believed that she worked for Employer. Claimant credibly testified that she felt bad that she was missing so much work and that Sanders kept telling her not to worry about it.

13. Claimant never resigned her employment and Employer never terminated her employment.

14. On March 10, 2008, Claimant saw Dr. Kenneth Pettine for a second opinion. Employer agreed with pursuing the second opinion. Dr. Pettine recommended a MRI scan to rule out a herniated disc.

15. Claimant underwent the MRI on June 24, 2008, which revealed, *inter alia*, some facet arthropathy at the L4-5 and L5-S1 levels, no significant-sized disc herniation or stenosis, and no significant loss of disc height below the L-1 level.

16. After reviewing the MRI, Dr. Pettine recommended a disc replacement surgery. Claimant declined to pursue surgery at that time.

17. Dr. Kriewell referred Clamant to Dr. Michael Curiel, a neurologist. Claimant saw Dr. Curiel on September 4, 2008. Dr. Curiel concluded that Claimant had symptoms suggestive of radiculopathy and some spinal abnormalities at the T12-L1 and L5-S1 levels. He opined that since Claimant's symptoms were steadily improving and with the mild abnormalities, surgery was not indicated. Dr. Curiel advised Claimant to avoid heavy lifting especially in the immediate future.

18. Claimant continued to treat with Dr. Kriewell through December 16, 2008, when he placed her at maximum medical improvement. Dr. Kriewall felt that Claimant's progress was slower than first expected, but she had followed his treatment recommendations faithfully and had now reached a plateau. Dr. Kriewall referred Claimant to Dr. Curiel for an impairment rating.

19. Dr. Kriewall testified that he understood that Claimant is probably still experiencing some pain and discomfort. He recommended that she seek steroid injections and then possibly surgery. He also suggested that Claimant have regular chiropractic care benefit to maintain her current physical condition.

20. Claimant sustained an injury to her low back while in the course and scope of her employment. No credible or persuasive evidence contradicts Claimant's account of the events of January 21, 2008. Further, Claimant's reports of the mechanism of injury to her doctors, the Employer and her friends have been consistent.

21. Employer referred Claimant to Dr. Kriewall, thus he is an authorized provider. Dr. Kriewall indicated that he referred Claimant to Dr. Curiel, and acupuncturist Scott Blunk. All referrals made by Dr. Kriewall are authorized. Although Claimant testified that she sought a second opinion from Dr. Pettine on her own, Dr. Kriewall also mentions the referral in his report dated December 16, 2008. In addition, Employer agreed to the appointment with Dr. Pettine.

22. Any referrals for diagnostic testing by Drs. Kriewall, Pettine and Curiel are also authorized.

23. All treatment described herein that Claimant received through December 7, 2009, is reasonable, necessary and related to her work injury.

24. No evidence was offered as to the dollar amounts of any outstanding medical bills.

25. The wage records reflect Claimant's net earnings rather than her gross earnings making such records unreliable for the purposes of determining Claimant's average weekly wage. According to Claimant's hourly wage and the average number of hours worked each week, Claimant's average weekly wage is $225.

26. Employer procured workers' compensation insurance effective February 26, 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 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.

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).

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).

Compensability

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).

As found, Claimant has established, by a preponderance of the evidence, that she sustained an injury to her low back on January 21, 2008, while in the course and scope of her employment. On January 21, Claimant bent over and attempted to lift a box while performing her work duties for Employer. As she stood up, she felt pain in her lower back. Claimant had immediate difficulty standing up straight and walking. She reported the injury to Employer on the same day and needed to leave work due to the pain. Thereafter, Claimant underwent medical treatment to relieve her of the effects of the injury. There is no credible or persuasive evidence that Claimant had a pre-existing low back condition or that she injured herself in anyway other than how she described.

Authorized provider

The employer or insurer has the right to select a physician in the first instance to attend an injured employee. Upon proper showing to the division, the employee may procure its permission at any time to have a physician of the employee's selection attend said employee. Section 8-43-404(5)(a), C.R.S.

Employer referred Claimant to Dr. Kriewall rendering him an authorized provider. Thus all referrals made by Dr. Kriewall including, but is not limited to, Dr. Curiel, and acupuncturist Scott Blunkm, are authorized. Claimant testified that she sought a second opinion from Dr. Pettine on her own; however, Dr. Kriewall also mentions the referral in his report dated December 16, 2008. In addition, Claimant testified that Employer agreed to the appointment with Dr. Pettine. Therefore, Dr. Pettine is an authorized provider and any referrals by Dr. Pettine are also authorized.

Medical Benefits

Respondents 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).

Claimant has established that she is entitled to medical treatment that is authorized, reasonable, necessary and related to the work injury, including treatment Claimant has previously received. Therefore, Employer is responsible for medical treatment that includes, but is not limited to, the visits to the treatment providers and their referrals described in paragraph 8 above.

Average Weekly Wage

The ALJ 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, which must include any advantage or fringe benefit provided to the employee in lieu of wages. *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995). As found, Claimant earned $9.00 per hour and was scheduled to work about 25 hours per week making her average weekly wage $225.00. There was no credible evidence presented to the contrary.

Temporary Total Disability

To prove entitlement to 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), C.R.S., requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. The work-related injury, however, need not be the sole cause of the wage loss, but must contribute to some degree. *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 her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 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 to perform her regular employment effectively and properly. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

Claimant has established that she is entitled to TTD commencing on January 31, 2008. Because Claimant continued to work after January 21, 2008, and did not endorse temporary partial disability benefits as an issue, she has not established that TTD should commence on

January 22, 2008. Dr. Kriewall testified that when Claimant presented to him on January 30, 2008, she was in acute distress and could not have worked with that level of pain. Thereafter, Claimant did not return to work for Employer although she did work for a few days between January 22 and 30. Claimant testified that on January 30, her pain was so evident that Employer sent her home. There is no persuasive evidence that Dr. Kriewall released Claimant to return to full duty or modified duty work at any time until he placed her at maximum medical improvement on December 16, 2008. Further, the medical records reflect that Claimant continued to have pain complaints throughout her treatment and Claimant testified that she had significant pain following the injury. Accordingly, Employer shall pay TTD commencing on January 31, 2008. TTD shall continue until Dr. Kriewall placed Claimant at maximum medical improvement on December 16, 2008.

Responsibility for Termination

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. Respondent shoulders the burden of proving by a preponderance of the evidence that Claimant was responsible for her termination. *See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P.3d 1209 (Colo. App. 2000).

An employee is "responsible" if the employee precipitated the employment termination by a volitional act which 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 (September 27, 2001). Thus, the fault determination depends upon whether a 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.* Employer has not established that Claimant was responsible for termination of her employment. While it is true that Claimant returned a key to the Employer and simultaneously picked up some personal items from the office, the evidence is insufficient to establish that Claimant was at fault for the termination of her employment, or that her employment was even terminated. Claimant believed she was still employed. Based upon the totality of the circumstances, Claimant did not commit a volitional act that led to the termination of her employment. Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., do not bar Claimant from receiving temporary disability benefits.

Penalties

Pursuant to §8-43-408(1), C.R.S., if an employer fails to comply with the insurance provisions contained within the Workers' Compensation Act, the amount of compensation paid to an injured employee shall be increased by fifty percent. At the close of Claimant's case-in-chief,

Employer moved for summary judgment on the issue of failure to maintain workers' compensation insurance. Employer contended that Claimant failed to present any evidence that Employer was not insured on the date of the injury. The motion for summary judgment is hereby denied. Claimant testified that Employer told her that he did not carry workers' compensation insurance. This constitutes a statement against interest, which the Judge finds credible and persuasive. Thus, Claimant's TTD rate shall be increased by fifty percent. The Judge acknowledges that Employer procured workers' compensation insurance since Claimant was injured; however that does not affect the imposition of penalties pursuant to §8-43-408(1), C.R.S.

Piercing the corporate veil

Claimant worked for Employer as evidenced by the payroll information and by Sanders' uncontested testimony. Claimant presented no evidence that the corporate veil should be pierced resulting in Sanders being held personally liable. Accordingly, liability extends only to the Employer.

ORDER

It is therefore ordered that:

1. Claimant sustained a compensable injury to her low back on January 21, 2008.

2. Claimant is entitled to medical treatment to cure and relieve her of the effects of the work-related injury.

3. Employer is liable for payment of Claimant's medical expenses pursuant to the fee schedule and payable directly to Claimant's medical treatment providers, which shall include, but is not limited to Dr. Kriewall, Dr. Pettine, Dr. Curiel and diagnostic studies recommended by these physicians. Because Employer is liable for payment of Claimant's medical costs associated with her work injury, no medical provider shall seek to recover such costs from Employee. Section 8-42-101(4), C.R.S.

4. Employer is also liable for TTD payments in the amount of $10,317.86 (AWW of $225.00 per week multiplied by 66 2/3 percent ($150.00) plus 50 percent penalty resulting in a TTD rate of $225.00 per week from January 31, 2008 through December 16, 2008).

5. Employer shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due. As of the date of the December 7, 2009, hearing, Employer is liable for $1,219.40 in interest on the unpaid TTD with daily interest continuing to accrue at the rate of $2.53.

6. In lieu of payment of the above compensation and benefits to the Claimant, the

Employer shall:

a. Deposit the sum of $20,000.00 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to and sent to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Sue Sobolik, Subsequent Injury Fund; or

b. File a bond in the sum of $20,000 with the Division of Workers' Compensation within ten (10) days of the date of this order:

(1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or

(2) 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 the Employer 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 the Employer of the obligation to pay the designated sum to the trustee or to file the bond. Section 8-43-408(2), C.R.S.

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

DATED: February 19, 2010

_____
Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-093

ISSUES

Ø Whether claimant has proven by a preponderance of the evidence that surgery

and treatment to cure and relieve her cervical spine condition at the C5-C6-C7 levels was reasonably necessary to the cure and relieve the effects of her admitted injury?

Ø Whether claimant has proven by a preponderance of the evidence that treatment for her mid-back or thoracic spine condition, including massage therapy and hot stone therapy, is authorized, reasonably necessary, and causally related to her admitted injury?

Ø Whether claimant has proven by a preponderance of the evidence that she is entitled to temporary total disability (TTD) benefits from February 1, 2008, through May 24, 2008, and from June 22, 2008, through March 24, 2009?

Ø Whether claimant has proven by a preponderance of the evidence that she is entitled to temporary partial disability (TPD) benefits from May 25, 2008, through June 21, 2008, and from March 24, 2009, ongoing?

Ø Whether claimant has proven by a preponderance of the evidence that an average weekly wage of $298.00 more accurately reflects her wage loss as a result of her injury?

STIPULATION

The Judge adopts the stipulation of the parties in finding that medical care and surgery required to evaluate and treat claimant's thyroid cancer/condition is causally unrelated to her workers' compensation claim. Respondents shall not be liable to pay for any medical benefits related to claimant's thyroid treatment.

FINDINGS OF FACT

1. Employer operates a regional medical center (hospital). Claimant's date of birth is March 17, 1961; her age at the time of hearing was 48 years. Claimant worked in the kitchen of the hospital, preparing meals, washing dishes, stocking, cleaning and lifting. Claimant worked for employer for some 15 months from October of 2007 through January 31, 2008. On January 31, 2008, claimant sustained an admitted injury when a ceiling tile, weighing some 5 pounds, fell from 8 to 10 feet from the ceiling and struck claimant on the top of her head.

2. Claimant's supervisor took her to the hospital's emergency department (ER), where she reported to the physician that she was hit on the top of the head by a wooden tile that weighed 10 to 20 pounds and that broke from the impact. Contrary to claimant's representation to the ER physician, the tile is a standard office-ceiling tile, which is 5/8 of an inch thick, measuring 24 inches by 28 inches, and weighing 5 pounds. The ceiling tile is a composite cardboard-type material, painted white on the underside. The tile did not break as a result of the impact with claimant's head.

3. The ER physician referred claimant for CT scan study of her head and cervical spine, which was taken on January 31, 2008. The CT scan of claimant's cervical spine failed to show any acute cervical injury, such as fractures, compressions, or luxation deformities. The CT scan instead revealed the following evidence of age-related, preexisting degenerative disk disease (DDD): Posterior projecting osteophytes at the 5th cervical interspace, more

prominent on the left, with moderate to marked encroachment of the bony neural foramina at that level. Minimal degenerative spurring elsewhere with mild narrowing of the 6th cervical interspace. Facet arthropathy (arthritis) with spurring at the 2nd cervical interspace on the left. Sclerosis on the 3rd cervical segment on the right. The CT scan also revealed incidental findings of complex thyroid masses. The ER physician gave claimant pain medications, diagnosed a contusion of her scalp and neck strain, and discharged her to home.

4. Employer referred claimant to Thomas E. White, M.D., who initially examined her on February 1, 2008. Dr. White agreed that the CT scan of claimant's head was normal and that the CT scan of her neck showed preexisting, long-standing arthritic changes. Dr. White's examination findings suggested a soft tissue injury. Dr. White diagnosed a contusion to the top of the head and cervical muscle strain. Dr. White restricted claimant from work at employer and from her concurrent work at Cottonwood Hot Springs, where she gave facials and performed some massage duties.

5. Dr. White referred claimant for physical therapy treatment. Dr. White referred claimant for a magnetic resonance imaging (MRI) scan of her cervical spine on February 12, 2008, and an MRI of her thoracic spine on June 19, 2008. The cervical MRI scan revealed left-sided, lateralizing disk herniations at the C5-C6 and C6-C7 levels of her cervical spine. Dr. White referred claimant to Orthopedic Surgeon Todd W. Peters, M.D., for a surgical consultation. Dr. Peters recommended epidural steroid injection (ESI) therapy administered at both levels. Dr. Peters referred claimant to Scott Raub, D.O., for ESI therapy. Dr. Peters later referred claimant for an electro-diagnostic nerve conduction study (NCS) of her upper extremities, which was negative for radiculopathy. Dr. Peters eventually recommended surgical fusion of the C5-C6 and C6-C7 levels of claimant's cervical spine, which he performed in January of 2009.

6. At respondents' request, Henry J. Roth, M.D., performed an independent medical examination (IME) of claimant on May 5, 2008. At claimant's request, John S. Hughes, M.D., performed an IME of claimant on September 4, 2008. Both Dr. Roth and Dr. Hughes testified as experts in the area of occupational medicine.

7. Both Dr. Roth and Dr. Hughes agree that the findings on the January 31, 2008, CT scan study of claimant's cervical spine represent long-standing degenerative changes that preexisted the falling-tile incident at employer.

8. Respondents obtained videotape surveillance of claimant after her IME appointment with Dr. Roth on May 5, 2008. Dr. Roth initially believed the surgery recommended by Dr. Peters was reasonably necessary to treat claimant's cervical injury at employer. After reviewing the video surveillance of claimant, Dr. Roth changed his opinion. Dr. Roth noted that claimant's appearance on the video surveillance was markedly inconsistent with her presentation at the time of the IME; he wrote:

Throughout the length of the video, there is normal body motion and posture including cervical in all directions.

Based on video review, I do not find it medically necessary to assign any restrictions. The video … does not demonstrate loss of capacity. **The video … is contrary to [claimant's] claims, both subjective and functionally.** (Emphasis added).

9. Dr. Roth testified that claimant's injury at employer caused a strain to her neck that had no effect upon her underlying age-related, preexisting DDD. According to Dr. Roth, claimant's injury failed to cause any change to her cervical spine anatomy or pathology. Dr. Roth stated:

[Claimant's] anatomy, as you can see on the CT scan, doesn't show anything acute, just how she looked ahead of time. That's just degenerative change.

[Claimant's injury] doesn't change [her cervical anatomy] acutely and it won't change its future either. So the notion that … the strain or sprain has aggravated [the underlying anatomy] … such that it's going to be different than it would not have otherwise, there's no truth to that. The progression of degenerative change is not the response to physical phenomenon, but rather a genetically-prescribed biologic process.

10. In his testimony, Dr. Hughes agrees that the bony, osteophytic changes and narrowing of the foramina shown on the CT scan are preexisting changes, unrelated to the ceiling-tile incident.

11. The Judge credits the medical opinion of Dr. Roth in finding that claimant, at most, sustained a sprain or strain type injury that did not change the underlying pathology or result in her need for surgery in January of 2009. Dr. Roth's opinion is supported by Dr. White's initial diagnosis of a sprain injury. In so finding, the Judge further relies upon the testimony of Dr. Hughes showing that claimant's condition had improved by the time he examined her, such that her arm weakness had resolved weeks before. Dr. Hughes testified:

[This] would be consistent with a nerve being bruised, swelling, a cascade of progressive nerve worsening and then rest, and the swelling goes down and some healing takes place, and maybe this completely resolves without surgery.

12. Dr. Hughes testimony here supports Dr. Roth's opinion that claimant returned to baseline and that surgery to address pathology that preexisted the tile incident was elective surgery. Dr. Roth's opinion was supported by Dr. Peters' opinion that the surgery was elective surgery.

13. Dr. Roth's opinion is further supported by the opinion Dr. White expressed on July 8, 2008, after reviewing Dr. Roth's report. In response to a question asking him whether he continued to believe claimant warranted work restrictions, Dr. White wrote:

I [believed work restrictions were reasonable] at the time, now I have my doubts.

I have my doubts now. Although I have not seen the video, I am starting to wonder if [claimant] is really in so much pain that a surgery is indicated. Today she did not look at all like she was in pain. If my neck was so bad that I needed surgery, I wouldn't be planning a vacation as she is.

Although I initially believed [claimant's] story, now I have doubts. Why isn't she improving?

14. Dr. White's opinion here supports a release to regular work as of July 8, 2008. Claimant's testimony concerning her symptoms and ability to work lack credibility when weighed against the medical opinion of Dr. Roth and against Dr. White's above-quoted opinion.

15. Claimant failed to show it more probably true than not that surgery performed by Dr. Peters was reasonable and necessary to cure and relieve the effects of her injury. Here, claimant failed to show it more probably true than not that the ceiling-tile injury aggravated, accelerated, or combined with her preexisting cervical DDD to produce the need for surgery performed by Dr. Peters on January 8, 2009.

16. Claimant failed to show it more probably true than not that massage therapy or hot stone therapy treatment was reasonably necessary to treat her thoracic spine complaints. Dr. White wrote on June 3, 2008, that he never referred claimant for such treatment. Claimant's request for an award of medical benefits for massage therapy or hot stone therapy treatment is denied and dismissed.

17. Claimant showed it more probably true that an average weekly wage (AWW) of $298.00 fairly approximates her wage loss as a result of the injury at employer. As found, claimant at the time of her injury held concurrent employment at Cottonwood Hot Springs. Claimant, from October 21, 2007, through January 26, 2008 (97 days), earned $2,638.15 in gross wages from employer for an AWW of $190.38. In 2007, claimant earned a total of $5,596.00 with Cottonwood for an AWW of $107.62. When combining the AWW from both jobs, claimant's AWW in this claim is $298.00.

18. Claimant showed it more probably true than not that her injury prevented her from performing her regular work from February 1, 2008, through July 8, 2008, when Dr. White expressed doubt that claimant warranted work restrictions. Claimant proved by a preponderance of the evidence that she is entitled to an award of temporary total disability (TTD) benefits from February 1 through May 24, 2008 (she returned to work at Cottonwood on May 25, 2008). Claimant also proved by a preponderance of the evidence that she is entitled to an award of temporary partial disability (TPD) benefits from May 25 through June 21, 2008, and an award of TTD benefits from June 22 through July 8, 2008.

CONCLUSIONS OF LAW

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *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*.

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. Medical Benefits:

Claimant argues she has proven by a preponderance of the evidence that surgery and treatment to cure and relieve her cervical spine condition at the C5-C6-C7 levels and that that treatment for her mid-back or thoracic spine condition, including massage therapy and hot stone therapy, were authorized, causally related to her admitted injury, and reasonably necessary to the cure and relieve the effects of her admitted injury. The Judge disagrees.

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). 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); *Martinez v. Monfort, Inc*., W.C. No. 4-284-273 (ICAO August 6, 1997).

An industrial aggravation of a preexisting medical condition can result in a compensable injury as long as the aggravation is the proximate cause of the need for treatment. *H & H Warehouse v. Vicory*, 805 P.2d 1167, 1169 (Colo. App. 1990). Claimant is entitled to medical benefits only for so long as the continuing pain in proximately caused by the industrial injury and not the underlying preexisting condition. *Conry v. City of Aurora*, W.C. No. 4-195-130, April 24, 1996; *Youderian v. Echosphere*, W.C. No. 4-538-294 (March 31, 2003); *Parra v. Ideal Concrete*, W.C. No. 4-179-455 (April 8, 1998); *Witt v. James J. Kell, Jr.,* W.C. No. 4-225-334 (April 7, 1998). 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 employer must take an employee as it finds her and is responsible for any increased disability resulting from the employee's preexisting weakened condition. *Cowin & Co. v. Medina*, 860 P.2d 535, 538 (Colo. App. 1992). Thus, when an 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. *Duncan v. Indus. Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004).

Here, the Judge found claimant failed to show it more probably true than not that the ceiling-tile injury aggravated, accelerated, or combined with her preexisting cervical DDD to produce the need for surgery performed by Dr. Peters on January 8, 2009.

The Judge concludes that claimant's request for an award of medical benefits to cover the

surgery performed by Dr. Peters in January of 2009, and for an award of medical benefits for ongoing treatment of her cervical spine and cervical disc condition, should be denied and dismissed, with prejudice. The Judge further concludes that claimant's request for an award of medical benefits to cover the medical care associated with her recovery from the surgery performed by Dr. Peters on January 8, 2009, and mileage reimbursement requests, should be denied and dismissed, with prejudice.

B. Temporary Disability Benefits:

Claimant argues she has proven by a preponderance of the evidence that she is entitled to TTD benefits from February 1, 2008, through May 24, 2008, and from June 22, 2008, through March 24, 2009, and to TPD benefits from May 25, 2008, through June 21, 2008, and from March 24, 2009, ongoing. The Judge agrees that claimant proved by a preponderance of the evidence that her injury prevented her from performing her regular work from February 1, 2008, through July 8, 2008.

Section 8-42-102 (2), *supra*, requires the judge to base the claimant's average weekly wage (AWW) on her earnings at the time of injury. Section 8-42-102 (3), *supra*, grants the ALJ discretionary authority to alter the formula used to calculate a claimant's 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); *Campbell v. IBM Corp*., *supra*.

Claimant carries the burden of proving entitlement to temporary total disability benefits. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). Temporary disability benefits are payable if the claimant proves a causal connection between the industrial injury and the temporary loss of wages. To establish an entitlement, the claimant must first prove that the industrial injury caused a "disability." Section 8-42-103(1)(a), *supra*; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995).

The Judge found that claimant showed it more probably true than not that her injury prevented her from performing her regular work from February 1, 2008, through July 8, 2008. Claimant thus proved by a preponderance of the evidence that she is entitled to an award of TTD benefits from February 1 through May 24, 2008, when she returned to work at Cottonwood. Claimant also proved by a preponderance of the evidence that she is entitled to an award of TPD benefits from May 25 through June 21, 2008, and an award of TTD benefits from June 22 through July 8, 2008. As found, claimant's AWW is $298.00.

The Judge concludes insurer should pay claimant TTD benefits based upon an AWW of $298.00 from February 1, 2008, through May 24, 2008, and from June 22, 2008, through July 8, 2008. The Judge further concludes insurer should pay claimant TPD benefits from May 25, 2008, through June 21, 2008.

ORDER

1. Claimant's request for an award of medical benefits to cover the surgery performed by Dr. Peters in January of 2009, and for an award of medical benefits for ongoing treatment of her cervical spine and cervical disc condition, is denied and dismissed, with prejudice.

2. Claimant's request for an award of medical benefits to cover medical care associated with her recovery from the surgery performed by Dr. Peters on January 8, 2009, and associated mileage reimbursement requests, is denied and dismissed, with prejudice.

3. Insurer shall pay claimant TTD benefits based upon an AWW of $298.00 from February 1, 2008, through May 24, 2008, and from June 22, 2008, through July 8, 2008.

4. Insurer shall pay claimant TPD benefits from May 25, 2008, through June 21, 2008.

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

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

7.

DATED: _February 16, 2010_

_____
Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-791-494

ISSUES

1. Whether Claimant has proven by a preponderance of evidence that he suffered a compensable injury on April 21, 2009.

2. Whether Claimant has proven he is temporarily disabled after Dr. Larson released him to regular employment on June 2, 2009.

3. Whether Claimant has proven by a preponderance of evidence he has an ongoing medical condition after June 2, 2009 that is causally related to a compensable work injury on April 21, 2009.

4. Whether Claimant's medical treatment after June 2, 2009 was causally related to or reasonable and necessary to cure the effects of the work injury on April 21, 2009.

FINDINGS OF FACT

1. Claimant was working for the Respondent-Employer as a mechanic on April 21, 2009, the date of the alleged work injury. Claimant's job duties required him to fix vehicles referred to as PCs and other broken vehicles and equipment for the Respondent-Employer.

2. Claimant has experienced chronic back pain and radiculopathy with leg pain in the past dating to an injury he suffered in the Navy in approximately 1988. Claimant continued to report problems with back pain and leg symptoms into approximately the 2007 to 2008 time frame.

3. There also was a history of some limited knee complaints documented in Claimant's medical records. For example, Claimant reported increasing difficulty in his hips and knees into approximately October of 2006. Claimant also provided the following history to a physician at the VA in approximately January of 2008: knees pop when getting up.

Claimant hurt his left knee as a result of an incident at work on April 21, 2009. Specifically, Claimant was working on a PC that had broken down. Claimant was working in front of the vehicle at the time of the incident.

4. The injury occurred when a co-employee (O) accidentally drove another PC into the vehicle the Claimant was working on. The impact caused the vehicle Claimant was working on to lurch. The evidence demonstrated that although the impact appeared to be slight, there was contact with Claimant's knee.

5. The finding that the impact appeared to be slight was corroborated by the testimony of O. He testified that there was not a significant impact and the PC did not move very much. He stated that the impact between the PC vehicles was not significant.

6. It did not appear that the Claimant was significantly injured after the incident so the Respondent-Employer did not provide medical treatment.

7. Claimant was examined on or about April 21, 2009 (the date of the alleged injury) at ExpressCare Plus with the following physical findings noted: "no edema, erythema, or ecchymosis. No abrasions or lacerations of the skin."

8. Dr. Fraley at ExpressCare Plus referred Claimant to Dr. Wallace Larson for an orthopedic evaluation. Dr. Larson examined Claimant on May 5, 2009 and confirmed that

Claimant did not have any outward evidence of an injury. Specifically, Dr. Larson noted that Claimant… "has no external deformities. I do not specifically detect any external deformity or joint effusion on the left side."

9. Dr. Larson testified at the hearing that Claimant did not have any outward physical symptoms consistent with the occurrence of a work injury on April 21, 2009.

10. The results of Claimant's testing revealed de minimus objective data to indicate Claimant suffered any significant damage as a result of the accident.

11. An x-ray was taken of Claimant's left knee on or about April 23, 2009. The reviewing radiologist provided the following interpretation: Soft tissue evaluation shows no evidence of effusion, soft tissue calcification, or soft tissue gas. The bones are well mineralized. There is no evidence of fracture or subluxation.

12. Dr. Larson also noted on the examination on May 5, 2009 that Claimant's symptoms were diffuse: "He has quite diffuse tenderness." Dr. Larson testified at the hearing that Claimant's left knee complaints were diffuse and inconsistent with any significant anatomic injury to the knee.

13. An MRI scan was taken of Claimant's left knee on or about May 8, 2009. The radiologist noted that Claimant had no evidence of any meniscal or cruciate ligament tear or any other type of injury or deformity. The only significant finding was mild joint effusion.

14. Dr. Larson testified at the hearing that he had actually reviewed the MRI scan personally and noted that it was normal. He indicated that the statement in the medical record regarding mild joint effusion did not signify any abnormality. Specifically, Dr. Larson indicated that the reported mild joint effusion in the knee was actually just normal fluid based upon his personal review of the MRI film.

15. Dr. Larson wanted to ensure that he was not missing anything when reviewing the MRI scan films so he sent the films to Dr. Lowery. Dr. Larson subsequently confirmed that Dr. Lowery had reviewed the MRI scans and found that Claimant's left knee condition was normal: "I have received verbal report on voice mail from Dr. Lowery that he was not able to identify any significant abnormalities on his MRI scan."

16. Dr. Mark Walton provided the following assessment of the MRI scan: "An MRI scan of the knee is absolutely normal."

17. The Respondent-Employer on this case did not designate an authorized treating physician because the claim was denied. As a result, Claimant went to see his own family physician at ExpressCare Plus. His personal physician ultimately referred Claimant to Dr.

Wallace Larson to perform an orthopedic evaluation.

18. Dr. Larson provided the following history in a report dated approximately May 12, 2009: “He has quite a bit of tenderness in multiple locations but no specific isolated tenderness suggestive of specific ligamentous disruption.”

19. Dr. Larson also provided the following history in a report dated approximately May 26, 2009: “On physical examination he has no joint effusion. He has relatively global tenderness to the left knee. There is no detectable instability on my examination… I have reviewed his MRI films again and I do not see anything that could explain the type of gross instability or pain that he describes… At this time I am not able to explain his symptoms of pain or instability or the symptoms of knee popping out of place.”

20. On or about June 2, 2009, Dr. Larson confirmed that Claimant could return to full-time employment, stating:

> On physical examination he has no external deformities. He has full range of motion. There is no joint effusion. Collateral and cruciate ligaments are stable. He reports several medical and lateral joint line tenderness. He is very hyperreactive to examination and reports several global tenderness… I had a long talk with Mr. Brown and his wife. Absent any abnormalities objectively on physical examination and absent any abnormalities on MRI scan, I cannot justify keeping him out of work any longer or placing him on specific limitations. His subjective symptoms do not suggest specific anatomic injury. He is quite angry about this but I have explained to him that there is no reasonable choice at this time and no additional diagnostic studies that need to be contemplated.

21. Dr. Larson testified at the hearing that Claimant had no evidence of any significant injury to the left knee. Dr. Larson explained that Claimant’s symptoms were diffuse and inconsistent with any significant injury. He stated that the subjective symptoms appeared exaggerated and global even though he had full range of motion. Dr. Larson testified that Claimant presented with no evidence of any significant work injury related to the incident on April 21, 2009.

22. Dr. Larson clarified that Claimant did not need any additional medical care or restrictions for the work injury to his left knee after approximately June 2, 2009.

23. Dr. Watson performed an IME for respondents in July of 2009. Dr. Watson noted in his initial report that by history Claimant reported a left knee injury. Dr. Watson noted that if such a history was correct, the condition should have resolved within a couple weeks. Specifically, Dr. Watson stated as follows: “These usually resolve in a few weeks without difficulty.. . . It is concerning that he remains on crutches and continues to wear a knee brace

given the lack of objective pathology in his knee…" Dr. Watson confirmed that if Claimant actually suffered an injury to the left knee, the condition should have resolved within several weeks, as there is not objective pathology.

24. The evidence demonstrates that Claimant suffered a mild injury to his knee as a result of the incident on April 21, 2009.

25. Dr. Larson is an authorized treating physician. His opinion that Claimant was capable of returning to regular employment without medical restrictions on June 3, 2009 is persuasive and adopted by the ALJ. The evidence demonstrates that Claimant could perform his regular employment starting on June 3, 2009.

26. Dr. Larson's testimony that Claimant did not require any additional medical care after approximately June 2, 2009 is persuasive and adopted by the ALJ. The court also finds persuasive Dr. Larson's testimony that Claimant's work-related knee condition had resolved by approximately June 2, 2009. These findings are also supported by Dr. Watson's conclusions that the knee condition should have resolved within several weeks.

27. Claimant was paid gross payments totaling $5,040.00 in short-term disability from April 22, 2009 through June 30, 2009. This disability was fully funded by the Respondent-Employer. Claimant is responsible for arranging for any repayments to the short-term disability insurer that would result in overpayments to the Claimant.

CONCLUSIONS OF LAW

1. C.R.S. 8-41-301 requires an injury to arise out of and in the course of employment for it to be considered compensable. *See* C.R.S. 8-41-301.

2. Claimant has proven by a preponderance of evidence that he suffered a compensable injury. The evidence demonstrates that the vehicle Claimant was working on did lurch forward and contact his knee. Claimant did initially require minimal medical care for the knee after this incident and, as a result, there was a compensable work injury.

3. Based on the above, Claimant has proven that he suffered a compensable injury on April 21, 2009.

4. Claimant must prove that he is disabled from the work injury to receive temporary disability benefits.

5. C.R.S. 8-42-105(3)(c) indicates that Claimant is not entitled to TTD benefits after the authorized treating physician releases Claimant to regular employment. *See* C.R.S. 8-42-105 (3)(c).

6. Claimant did prove that he initially was entitled to TTD benefits following the work injury. However, Claimant failed to prove by a preponderance of evidence that he was disabled from performing his regular employment after June 2, 2009. Dr. Larson, an authorized provider, credibly testified that there was no reason to keep Claimant off from work after June 2, 2009. Specifically, there was no objective evidence of any significant injury on the diagnostic studies or examinations: Dr. Larson opined:

> Absent any abnormalities objectively on physical examination and absent any abnormalities on MRI scan, I cannot justify keeping him out of work any longer or placing him on specific limitations. His subjective symptoms do not suggest specific anatomic injury. He is quite angry about this…

7. Dr. Larson released Claimant to regular employment on June 2, 2009. Claimant failed to prove that as a result of his work-related injury of April 21. 2009, he was disabled from performing his regular employment after June 2, 2009. As a result, respondents are only responsible for paying TTD benefits to Claimant from April 21, 2009 through June 2, 2009.

8. Even though a Claimant suffers a compensable injury in the first instance, an ALJ may still deny a claim for workers' compensation benefits if the Claimant fails to establish, by a preponderance of the evidence, that the current and ongoing need for medical treatment or disability is proximately caused by the injury arising out of and in the course of the employment. *See Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. Ct. App. 1997). In other words, a party has a viable defense to a claim for future benefits even if the claim was originally compensable as long as the medical condition at issue is no longer related to or caused by the compensable work injury. *Id*. *See, also,* *Cooper v. Industrial Claim Appeals Office*, 1999 WL 976657 (Colo. Ct. App. 1999); *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. Ct. App. 1986) (a Claimant is entitled to compensation only for the disability caused by the industrial injury).

9. The Court of Appeals specifically provided the following holding in the *Snyder* case:

> We decline to so limit the ability to dispute a Claimant's entitlement to continued medical benefits where, as here, medical information obtained subsequent to an admission of liability brings into question the compensability of the Claimant's injury. The right to workers' compensation benefits, including medical payments, arises only when an injured employee initially establishes, by a preponderance of evidence, that the need for medical treatment was proximately caused by an injury arising out of and in the course of the employment… Therefore, in a dispute over medical benefits that arises after the filing of a general admission of liability, an employer generally can assert, based on subsequent medical reports, that the Claimant did not establish the threshold requirement of a direct causal relationship between the on-the-job injury and the need for medical treatment.

Snyder v. City of Aurora, 942 P.2d 1337 (Colo. Ct. App. 1997).

10. Of note here is the fact that the Respondent-Insurer denied the entire claim and there was no admission of liability filed. Considering the appellate court has determined that a Respondent-Insurer is not liable for unrelated treatment or temporary benefits in a case where there is an admission, the argument would appear to be even more significant hereunder.

11. The ICAO has confirmed that a *Snyder* argument is still viable and applies to both medical benefits and compensation. *F v. G&K Services*, W.C. No. 4-660-213 (April 27, 2007). As a result, respondents can successfully terminate both medical benefits and temporary disability benefits even if the claim was originally compensable if Claimant fails to prove that his ongoing condition is work-related.

12. Even though Claimant did initially suffer a work injury on April 21, 2009, he failed to prove that his ongoing medical condition after June 2, 2009 is work-related based in part on the following evidence:

- Claimant's x-ray and MRI scans were reported to be normal by treating physicians. Dr. Walton noted that the MRI scan was "absolutely normal" and Dr. Larson indicated that he personally reviewed the scan and it was normal. Dr. Larson also had another physician confirm that the MRI scan failed to demonstrate any significant abnormalities.

- Claimant's symptoms were reported to be diffuse. Claimant also had no evidence of any significant outward injury to his left knee following the injury on April 21, 2009.

- Dr. Watson opined that even if Claimant had suffered a left knee "injury" that the condition should have resolved within several weeks. Dr. Watson testified that Claimant had no objective evidence of an ongoing injury to the left knee.

- Dr. Larson also testified that there was no evidence of any disability or need for medical treatment after June 2, 2009. Specifically, Dr. Larson opined that there was no evidence of any ongoing medical condition after June 2, 2009.

13. Claimant failed to prove that his ongoing medical condition after June 2, 2009 is work-related. As a result, respondents have no obligation to pay Claimant any additional medical benefits or temporary disability benefits after June 2, 2009. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. Ct. App. 1997).

14. In addition, C.R.S. 8-42-101(1)(a) indicates that medical treatment must cure and relieve Claimant from the effects of the injury to be considered compensable. In other words,

respondents are not required to pay for medical treatment, which is unrelated to the work injury. *See* C.R.S. 8-42-101(1)(a).

15. Claimant failed to prove that his medical care after June 2, 2009 is work-related or reasonable and necessary to address the work injury. As a result, respondents have no obligation to pay for medical care after that date.

16. Respondents are not required to pay for unauthorized medical services. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. Ct. App. 1999). Claimant is, however, entitled to the payment of medical treatment from ExpressCare Plus and Dr. Larson between April 21, 2009 and June 2, 2009, as this treatment was authorized and reasonable and necessary to address the work injury.

17. Any offsets for short-term disability payments shall be determined after Claimant attempts resolution through the short-term carrier.

ORDER

It is therefore ordered that:

1. Claimant suffered a compensable work-related injury on April 21, 2009.

2. Claimant is entitled to, and the Respondent-Insurer shall pay, temporary disability benefits from April 21, 2009 through June 2, 2009.

3. Claimant is entitled to, and the Respondent-Insurer shall pay for all reasonable and necessary medical treatment between April 21, 2009 and June 2, 2009.

4. Claimant's request for temporary disability benefits between June 2, 2009 and November 23, 2009, the date of last hearing hereunder, 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.

6. This decision does not address the issue of maximum medical improvement (MMI) for this work-related injury, as no authorized treating physician has placed Claimant at MMI.

7. This decision does not close this claim and the Respondent-Insurer is ordered to file a general admission of liability consistent with this decision. The Respondent-Insurer shall proceed to handle this claim as it is required to do while a general admission controls the obligations of the Respondent-Insurer.

Any offsets for short-term disability payments shall be determined after Claimant attempts

resolution through the short-term carrier.

DATE: February 19, 2010 /s/ original signed by:
Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-722-585

ISSUES

The following issue was raised for consideration at hearing: Respondents challenge (request to overcome) the Division Independent Medical Examiner's ("DIME") opinions regarding maximum medical improvement ("MMI"), causality, (relatedness) of Claimant's low back condition and permanent partial disability ("PPD").

FINDINGS OF FACT

1. Claimant works as a Social Worker involved in Case Management for Respondent-Employer. Claimant's primary duties involve providing resource information to families, attending court appearances, making home visits, providing crisis intervention and investigating allegations of abuse, dependency and delinquency.

2. On November 28, 2006, Claimant was making a home visit to a client's home when she caught her left toe on a step and fell forward landing directly on her hands and knees and jarring her low back in the process. At the time the Clamant was performing duties arising out of and in the course of her employment with Respondent-Employer.

3. Claimant reported her injury and was referred to Respondent-Employer's designated medical provider for treatment. Claimant came under the care of J. Douglas Bradley, M.D. at Emergicare who diagnosed Claimant as having suffered bilateral knee contusions and low back strain among other conditions. Dr. Bradley initiated physical therapy and Claimant made slow progress under close supervision.

4. By February 2007, Claimant's pain was primarily centered in her low back, right knee and left ankle. An MRI of the right knee performed February 28, 2007 demonstrated severe progressive degenerative changes with moderate joint effusion. Claimant was referred to an orthopedist, John Xenos, M.D. who recommended a right total knee replacement.

5. Claimant has a history of prior injury to her low back resulting in surgical intervention

as performed by Dr. Michael Janssen, M.D.

6. Following her November 28, 2006 injury, Claimant was referred to Dr. Janssen on April 13, 2007 for further evaluation of her low back condition. Dr. Janssen recommended a repeat MRI of the low back.

7. On May 3, 2007, an MRI of the Claimant's lumbar spine was completed as previously recommended by Dr. Janssen. The MRI of the lumbar spine demonstrated "mild central canal stenosis at L2/3, but no definite neuroforaminal stenosis". A lumbar myelogram was performed on July 27, 2007 which demonstrated "no significant intra or extra dural defects".

8. On May 7, 2007 Dr. John Xenos replaced Claimant’s right knee.

9. Following her total knee replacement, physical therapy to Claimant’s back and knee was reinstated and Claimant made sufficient progress to resume full duty work on August 1, 2007 per the release to return to work completed by Dr. Bradley.

10. Dr. Bradley placed claimant at maximum medical improvement on August 21, 2007 with a 25% lower extremity impairment rating by report of September 10, 2007. On October 5, 2007, Respondents filed a Final Admission of Liability consistent with Dr. Bradley's opinions regarding maximum medical improvement and impairment of the right knee.

11. Dr. Bradley did not provide an impairment rating for Claimant's low back condition. Rather, Dr. Bradley's report of September 10, 2007 simply indicates that he did not "see worsening of her lumbar condition". The report is devoid of information regarding Claimant’s range of motion and/or other objective findings from physical examination.

12. Claimant objected to Respondents' October 5, 2007 Final Admission of Liability and requested a Division Sponsored Independent Medical Examination which, after proceeding through the recognized selection process was completed by Dr. Timothy Hall on February 22, 2008.

13. In his February 22, 2008 Division Independent Medical Examination report, Dr. Hall opined that the Claimant had reached maximum medical improvement with respect to her right knee condition on August 8, 2007 but was not at MMI for her lumbar spine condition which he related by way of aggravation of a pre-existing condition to Claimant’s November 28, 2006 industrial injury. In his narrative report of February 22, 2008, Dr. Hall notes as follows:

> At this time, the patient's back pain is daily. She has a lot of muscle spasm with

radiated pain into the buttock, more on the left side than on the right. The pain in her low back limits bending, stooping and predominately the muscle spasm is a problem when she tries to involve herself in those kinds of activities. It is important to mention before the fall that she did not have any significant leg symptoms at all, primarily low back pain.

14. Dr. Hall noted on physical examination that the Claimant had "markedly impaired range of motion, essentially no extension, minimal flexion, and reasonable side bending that brings on spasm. Dr. Hall concluded that the Claimant had a fall at work that had resulted in "permanent aggravation of lumbar pathology/symptomology (work-related and not at MMI) in addition to the documented and accepted right knee injury.

15. Following Dr. Hall's February 22, 2008 Division Sponsored Independent Medical Examination, Respondents retained the services of Dr. Scott Primack, who performed an Independent Medical Examination at Respondents' request on May 21, 2008. Dr. Primack concluded that Claimant suffered a temporary aggravation of a pre-existing underlying condition of the lumbar spine, which would not, in his opinion, entitle Claimant to an impairment rating. Dr. Primack failed to perform any range of motion measurements.

16. Following her original DIME with Dr. Hall, Claimant relocated to Missouri and found it hard to access care. Thus, Claimant elected not to pursue further treatment with respect to her low back and was returned to Dr. Hall for a follow-up Division Independent Medical Examination.

17. On March 16, 2009, Dr. Hall performed a follow-up Division Sponsored Independent Medical Examination at which Dr. Hall noted that the only change with respect to Claimant's condition was a continued worsening of her low back condition, which had not "gotten better or gone away". According to Dr. Hall's March 16, 2009 report, Claimant's back pain continued to be a "significant problem for her, which it was not before this work injury". Due to Claimant's decision not to pursue further treatment for her low back, Dr. Hall declared that Claimant was at maximum medical improvement for her low back condition and apportioned his impairment with respect to Claimant's low back condition based upon Claimant’s prior lumbar spine fusion. Dr. Hall concluded that Claimant had suffered a 5% whole person impairment rating to the low back as part of her November 28, 2006 industrial injury.

18. On May 29, 2009, the parties deposed Dr. Hall who appeared confused concerning the content of his February 22, 2008 Division Independent Medical Examination report. Based upon his confusion regarding both MMI and impairment of Claimant's lower extremity and lumbar spine, Dr. Hall requested that he be allowed to review the entire record and submit supplemental records and reconvene in a follow up deposition, if necessary, to clarify his opinion. Respondents had no objection to the suggestion/request of Dr. Hall.

19. Despite his confusion with regard to the date of MMI and permanent impairment caused by Claimant's low back and lower extremity conditions, Dr. Hall was clear with regard to his opinions concerning causality of Claimant's low back condition and her general entitlement to an impairment rating for her low back.

20. In his deposition of May 29, 2009, Dr. Hall, opined as follows:

> What I heard from the patient was different from this idea that it was a temporary aggravation. She was adamant that her back situation is considerably different since this event, as documented or discussed in that paragraph on page 2 of my report. So I guess I take exception with the qualification or the characterization of her problem being a temporary aggravation. So that's how she presented to me, and it's purely based on her history given to me that there had been a permanent aggravation of her back problem, at least from a functional perspective.

21. In furtherance of his opinion regarding causation, Dr. Hall responded to an inquiry from Respondents' counsel regarding whether his opinion would change if imaging studies demonstrated no acute changes following the work-related injury of November 28, 2006. In response, Dr. Hall noted as follows:

> No. That's what I was eluding to when we started on this question because that - that implies a direct connection between imaging results and clinical presentation or functional levels and there just isn't that direct connection.

23. As noted, at his May 29, 2009 deposition, Dr. Hall requested a chance to review his entire file and prepare a supplemental report. Despite issuing a new Examiner Summary Sheet, questions regarding Claimant's MMI date and impairment persisted. Thus, the parties elected to depose Dr. Hall a second time on July 6, 2009. At his July 6, 2009 deposition, Dr. Hall clarified his opinion regarding maximum medical improvement and impairment. Following that deposition, the parties reached a stipulation concerning the testimony given by Dr. Hall at his July 6, 2009 deposition.

24. The parties stipulated that Claimant reached maximum medical improvement for her knee condition on August 8, 2007. Additionally, the parties stipulated that Claimant suffered a 34% lower extremity impairment before apportionment and a 20% right lower extremity impairment attributable to the November 28, 2006 industrial injury. Regarding Claimant’s low back, the parties' stipulation provides that Claimant reached maximum medical improvement on February 27, 2008 and that Claimant suffered a 14% whole person impairment rating before any apportionment and a 5% whole person impairment attributable to the November 28, 2006 industrial injury.

25. Respondents have failed to prove by clear and convincing evidence that the

determination of the DIME regarding MMI, causality and impairment are incorrect. The opinions of Dr. Hall, which are supported by the medical records and his deposition testimony, are credible and persuasive. The contrary opinions of Dr. Bradley and Dr. Primack do not demonstrate that it is highly probable and free from serious or substantial doubt that the DIME is incorrect.

CONCLUSIONS OF LAW

1. 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 v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

2. The opinions of the Division IME physician concerning causality and impairment are binding unless overcome by clear and convincing evidence. All written reports, subsequent opinions including the DIME physician's testimony, are to be considered in determining the DIME physician's true opinion as a matter of fact. *Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005); *Lambert and Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d, 656 (Colo. App. 1998); *Dazzio v. Rice and Rice, Inc*., W.C. Number 4-660-140 (Industrial Claim Appeals Office, June 30, 2008). Once the ALJ determines a DIME physician's opinions, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. *Dazzio v. Rice and Rice, Inc., Supra; Clark v. Hudick Excavating, Inc*., W.C. Number 4-524-162 (Industrial Claim Appeals Office, November 5, 2004); *Lambert and Sons, Inc. v. Industrial Claim Appeals Office*, supra.

3. In the instant case, Respondents have a clear and convincing burden of proof to overcome the determination of Dr. Hall that Claimant's low back condition is not related to her industrial injury. Clear and convincing evidence is highly probable and free from serious or substantial doubt and the party challenging the DIME physician's findings must produce evidence that it highly probable that the DIME physician is incorrect. *Metro Moving and Storage v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact of proposition has been proven by clear and convincing evidence if, considering all of the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving and Storage Company v. Gussert*, Supra. A mere difference of opinion between physicians fails to constitute error. *Gonzales v. Browning Ferris Indus. of Colorado,* W.C. Number 4-350-356 (Industrial Claim Appeals Office, March 22, 2000). After a review of the totality of evidence including the testimony of Dr. Hall, the ALJ concludes that although there is conflicting medical opinions, the opinions of Dr. Bradley and Dr. Primack are insufficient in establishing by clear and convincing evidence that the opinions of Dr. Hall regarding the causality of Claimant's low back condition as being related to her November 28, 2006 industrial injury and constituting a permanent aggravation of a pre-existing condition are incorrect. Respondents request to set aside Dr. Hall's opinion that Claimant's low back condition is causally related to

her November 28, 2006 industrial injury and constitutes a permanent aggravation of a pre-existing condition which entitles her to a 5% apportioned impairment rating is denied and dismissed.

4. The MMI determination of the DIME physician is binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S.; *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cudo v. Blue Mountain Energy, Inc*., W.C. Number 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). After review of the entire record, it cannot be said that Dr. Hall's determination of MMI is incorrect. Although, Respondents assert that Dr. Hal's date of MMI for the low back condition is arbitrary, Respondents presented insufficient evidence to establish that Claimant was in fact, at MMI prior to February 27, 2008, the date and time which Dr. Hall had initially concluded that Claimant was not at MMI as she had not received adequate treatment for the aggravation of her low back condition. The conflicting medical opinions of Dr. Bradley and Dr. Primack are insufficient to establish by clear and convincing evidence that Dr. Hall was clearly wrong in his findings, conclusion and opinions in this regard.

5. Maximum Medical Improvement is defined as:

> [A] point in time when any medically or physical 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 significantly improve the condition or the possibility of improvement or deterioration resulting of 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.

C.R.S. § 8-40-201(11.5).

6. The Division Independent Medical Examination of Dr. Hall performed February 22, 2008 demonstrates that Dr. Hall felt that there was additional medical treatment that could reasonably be expected to improve Claimant’s low back condition. Respondents have failed to carry their burden of proof to establish that Dr. Hall's opinion concerning MMI for Claimant's related low back condition is incorrect.

ORDER

It is therefore ordered that:

1. Respondents request to set aside Dr. Hall's opinion that Claimant's low back condition constitutes a permanent aggravation of a pre-existing condition which entitles her to

a 5% apportioned impairment rating is denied and dismissed.

2. Respondents' request to set aside the opinion of Dr. Hall that Claimant reached maximum medical improvement for her low back condition on February 22, 2008 after Claimant elected not to pursue additional low back treatment is denied and dismissed.

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

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

DATE: February 23, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-729-639

ISSUES

The issue determined herein is claimant's motion to strike the Final Admission of Liability ("FAL") as "invalid" and the corresponding claim for reinstated temporary total disability ("TTD") benefits. The parties stipulated that claimant was entitled to a "general order" for medical benefits after maximum medical improvement ("MMI")

FINDINGS OF FACT

1. On July 10, 2007, claimant suffered an admitted injury to his right hand. He underwent surgical repair of the right hand. Dr. Castrejon, an authorized treating physician ("ATP") provided follow-up medical care.

2. Claimant demonstrated emotional problems and Dr. Castrejon referred claimant to Dr. Shockney, a psychologist. Dr. Shockney examined claimant on January 30, 2008, and diagnosed depressive disorder, moderate to severe. Dr. Shockney recommended behavioral psychotherapy and medication. Dr. Castrejon then prescribed the recommended Lexapro.

3. Dr. Shockney continued to provide regular treatment for claimant's psychological condition. On March 20, 2008, Dr. Shockney noted that claimant had increased depressive symptoms, probably because he had mistakenly concluded taking the Lexapro without obtaining a refill. Dr. Shockney recommended cognitive behavioral therapy. On April 15,

2008, Dr. Shockney noted that claimant's emotional condition had eroded.

4. On May 5, 2008, Dr. Shockney reexamined claimant and noted improved affect. Dr. Shockney concluded that claimant demonstrated more anxiety than depression. He recommended that claimant return as scheduled.

5. On May 28, 2008, Dr. Castrejon reexamined claimant and determined that he was at MMI. Dr. Castrejon issued a report of the principal treatments for claimant, including the psychotherapy by Dr. Shockney and the Lexapro. Dr. Castrejon recommended post-MMI continuation of claimant's home exercises, medications, and possible removal of the surgical pin. Dr. Castrejon determined impairment of 16% of the right upper extremity due to loss of range of motion of the digits of the right hand.

6. On July 9, 2008, the insurer filed a FAL that terminated TTD benefits after May 27, 2008, admitted for permanent partial disability ("PPD") benefits based upon 16% of the right arm at the shoulder, admitted for post-MMI medical benefits, asserted an overpayment of TTD benefits, and denied any benefits not otherwise admitted in the FAL. The FAL attached the entire May 28, 2008, report by Dr. Castrejon. The FAL contained the required notice to claimant that the claim would be closed unless claimant objected in writing, requested a Division Independent Medical Examination ("DIME"), and applied for hearing within 30 days.

7. Claimant did not file an objection to the FAL and did not file a Notice and Proposal for a DIME.

8. On July 24, 2008, claimant applied for hearing on the issues of medical benefits and penalties. Claimant did not set a hearing pursuant to the application. By letter dated August 22, 2008, respondents' attorney memorialized the agreement that claimant was not setting a hearing and was not re-filing the application for hearing because the issues had been resolved.

9. Claimant moved to strike the FAL as invalid and he requested a DIME. Respondents moved to strike claimant's request for a DIME. By order dated December 4, 2008, Judge Krumreich granted the motion to strike the DIME request and denied claimant's motion to strike the FAL. Claimant appealed only the order denying the motion to strike the FAL.

10. On March 16, 2009, ICAO affirmed the order denying the motion to strike the FAL, noting that claimant's argument was, in essence, that Dr. Castrejon's MMI determination was not clear and unequivocal. ICAO noted that argument supported Judge Krumreich's denial of claimant's motion for summary judgment on the issue of striking the FAL. Rather, the parties could apply for hearing to determine evidentiary facts about Dr. Castrejon's determination.

11. Dr. Castrejon's May 28, 2008, determination was that claimant was at MMI for the work injury. Neither party obtained any additional report or testimony by Dr. Castrejon. Dr. Castrejon's May 28 report clearly acknowledges that Dr. Shockney has been providing

psychological care, while Dr. Castrejon was prescribing the psychotropic medications. Dr. Castrejon was certainly in the best position to determine if claimant was at MMI for all aspects of the admitted work injury. His report does not equivocate and unmistakably determines MMI. He did not attempt to “divide” MMI for the work injury.

12. Similarly, Dr. Castrejon determined the permanent impairment rating for the work injury. Based upon the record evidence, the Judge finds that Dr. Castrejon implicitly determined that claimant did not have permanent mental impairment from the work injury. The record evidence does not demonstrate that Dr. Castrejon created any additional worksheets other than the entire report that was attached to the FAL. Claimant certainly was free to disagree with the MMI and impairment rating determination by Dr. Castrejon and his remedy was to file an objection to the FAL and a timely request for a DIME. He failed to do so.

CONCLUSIONS OF LAW

1. Claimant argues that the FAL is invalid because it relies on Dr. Castrejon’s MMI and impairment rating report. Claimant argues that MMI is not divisible and Dr. Castrejon did not determine MMI for claimant’s psychological condition. Claimant also argues that Dr. Castrejon did not address claimant’s mental impairment rating and respondents are not permitted to terminate TTD benefits without “addressing” permanent impairment. Respondents argue that they have complied with all statutory and rule requirements. The Judge agrees with respondents.

2. Section 8-42-107(8)(b)(I), C.R.S., provides that an ATP shall make a determination as to when the injured employee reached MMI. Section 8-42-107.2(2)(b), C.R.S., provides that if any party disputes a finding or determination of the ATP, that party shall request a DIME. WCRP 5-5(E) provides that within 30 days after delivery of a determination of medical impairment by the ATP, the insurer shall either file an admission of liability consistent with the physician's opinion or request a DIME. WCRP 5-5(H) provides a similar 30-day period for scheduled impairment injuries in which the insurer must file an FAL or apply for hearing at OAC.

3. Section 8-42-107.2(2)(a)(I)(A), C.R.S., provides that the time period for claimant to request a DIME commences with the date of mailing of a FAL that includes an impairment rating issued in accordance with section 8-42-107, C.R.S. Section 8-43-203(2)(b)(II), C.R.S. 2009, sets forth the necessary components of an FAL and specifically mandates that when an FAL "is predicated upon medical reports, such reports shall accompany" it. WCRP 5-5(A) requires attachment of not only the supporting medical reports, but also any worksheets and other evaluation information associated with the impairment rating.

4. No DIME is required for the Judge to resolve an internal conflict in MMI determinations by the ATP. *Blue Mesa Forest v. Lopez*, 928 P.2d 831 (Colo. App. 1996). A

Judge may not resolve a dispute regarding MMI determinations by conflicting authorized treating physicians without a DIME. *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002). In essence, the Judge may only make a finding about what the ATP determined, not whether the determination is correct.

5. Claimant is certainly correct that MMI is not "divisible and cannot be parceled out among the various components of a multi-faceted industrial injury." *Paint Connection Plus v. Industrial Claim Appeals Office,* ___ P.3d ___ (Colo. App. No. 09CA0598, January 7, 2010); *Parra v. Haake Farms*, W.C. No. 4-396-744 (ICAO Mar. 8, 2001); *see also Bernard v. Current, Inc.*, W.C. No. 4-213-664 (ICAO Oct. 6, 1997); *Carrillo v. Farmington PM Group*, W. C. No. 3-111-178 (ICAO Aug. 26, 1997); *Powell v. L & D Electric*, W.C. No. 4-150-716 (ICAO Mar. 21, 1997). As found, Dr. Castrejon did not purport to divide MMI, but found claimant to be at MMI for the work injury. Respondents are correct that this claim is factually distinguishable from *Paint Connection Plus, supra.* In that case, an ATP performed an impairment-rating examination and assigned an impairment of the claimant's right upper extremity. The ATP, however, determined that the claimant was not at MMI for the work-related neck injury. The respondents filed an FAL admitting permanent partial disability based only upon the right upper extremity impairment and asserting that the claimant was at MMI. The ALJ determined that the FAL was invalid because, although the medical report attached to the FAL stated that the claimant was not at MMI, the respondents asserted in the FAL that the claimant had reached MMI. The ALJ concluded that the FAL was not predicated on the medical report that accompanied it, in violation of §8-43-203(2)(b)(II) and Rule 5-5(A). By contrast, in the instant case, respondents relied on the MMI determination by Dr. Castrejon. Dr. Castrejon's MMI determination does not contain any internal inconsistencies. Claimant might disagree with Dr. Castrejon's determination, but his option was to object to the FAL and request a DIME to challenge MMI. He failed to do either on a timely basis.

6. Claimant's reliance on *Dillard v. Industrial Claim Appeals Office*, 134 P.3d 407 (Colo. 2006) is misplaced. That case held that physical and psychological impairment ratings could not be combined for purposes of determining a claimant's overall impairment award and the applicable cap on indemnity benefits. *Dillard*, *supra*, did not address the form that the ATP permanent impairment rating must take. *Town of Ignacio, supra,* applies to the Judge's ability to resolve an internal inconsistency in the impairment rating determination of the ATP. The Judge can determine what the ATP determined. Without a DIME, the Judge is not able to determine if the ATP rating is correct. As found, Dr. Castrejon's impairment rating determination is that claimant suffered only the scheduled impairment of the right arm.

7. Section 8-43-203(2)(b)(II), C.R.S., provides:

> An admission of liability for final payment of compensation shall include a statement that this is the final admission by the workers' compensation insurance carrier in the case, that the claimant may contest this admission if the claimant

> feels entitled to more compensation, to whom the claimant should provide written objection, and notice to the claimant that the case will be automatically closed as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that ripe for hearing, including the selection of an independent medical examiner pursuant to section 8-42-107.2 if an independent medical examination has not already been conducted. When the final admission is predicated upon medical reports, such reports shall accompany the final admission.

As found, the FAL contained this required notice to claimant. Respondents complied with all statutory and regulatory requirements for the FAL. Claimant failed to follow the correct procedure to contest the FAL.

ORDER

It is therefore ordered that:

1. Claimant's motion to strike the FAL is denied and dismissed. Claimant's request for reinstated TTD benefits is denied and dismissed.

2. The insurer shall pay for all of claimant's reasonably necessary medical treatment after MMI by authorized providers for the admitted work injury.

DATED: February 24, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-741-187

ISSUES

The issue to be determined by this Order is whether the left knee tubercle revision procedure recommended by Claimant's authorized treating provider, Dr. Michael Sisk, is related to Claimant's original injury with Employer, and is reasonably necessary to cure and relieve the effects of Claimant's work related injury with Employer.

FINDINGS OF FACT

1. Claimant suffered an admitted work-related injury to her left knee on February 25, 2007. Claimant caught her right foot in some electrical cords while she was performing her duties. She fell forward, landing on both her knees, both wrists, and both elbows.

2. Claimant presented to the emergency room at Craig Memorial Hospital on February 25, 2007, where she was treated with an ACE bandage and Tylenol. Over the course of the next two days, Claimant's knee continued to be painful and swollen. Claimant was referred to Dr. Catherine Crow for treatment. Dr. Crow on February 27, 2007, stated, "No previous knee injuries…. Present disability due entirely to this injury: yes." Dr. Crow initially treated Claimant with Ibuprofen and a knee brace. Claimant's knee pain did not improve. Dr. Crow ordered an MRI, on April 6, 2007. Dr. Crow on April 24, 2007, stated, "MRI with chondromalacia in patellar area and small bakers cyst." Dr. Crow referred Claimant to Dr. Michael Sisk, who is an orthopedic surgeon.

3. Claimant presented for evaluation with Dr. Sisk on May 2, 2007. Dr. Sisk noted, "she is uncomfortable with squatting, lunges or stairs. She states that the knee swells with activity especially toward the end of the day…. I believe [Claimant] may benefit from a steroid injection…. I would like to continue with non-operative measures."

4. On June 13, 2007, Dr. Sisk examined Claimant and noted, "Unfortunately the knee continues to give her pain and a grinding sensation…. [Claimant] and I discussed options at this point. I think she is a candidate for hyaluronic acid series…. Hopefully this will keep her out of the operating room which will be the next option if this fails."

5. Claimant received Supartz injections to her left knee with Dr. Sisk on June 20, 2007, June 27, 2007, July 2, 2007, July 11, 2007, and July 23, 2007. Dr. Sisk's July 23, 2007, narrative stated, "The plan is to let the medicine continue to do its work and [see] me back in a month if she is dissatisfied with the performance. If she is[,] then we need to start thinking about scoping the knee.".

6. The Supartz injections did not relieve Claimant's symptoms. On November 5, 2007, Claimant underwent a left knee arthroscopy with chondroplasty of the femoral condyle and the patella, as well as a medial plica excision with Dr. Sisk.

7. Dr. Sisk explained that this initial arthroscopic surgery was intended to be a diagnostic arthroscopy and that he performed a debridement of the cartilage and removed debris during the surgery. During the arthroscopy, he encountered a very significant chondral injury underneath Claimant's kneecap on the weight-bearing portion of the knee. Dr. Sisk testified that it was clear to him that Claimant's knee injury was not going to be resolved with a simple arthroscopic procedure.

8. On February 13, 2008, Claimant presented to Dr. Sisk for a follow-up visit. Dr. Sisk noted, "She still complains of an aching pain medially and pain going up and down stairs. She is definitely unsatisfied with her knee and unfortunately she has developed plantar fasciitis. She is still working ten-hour shifts on concrete [for Employer]. It is getting to the point where she can hardly stand." Dr. Sisk assessed, "grade III chondral disease of the weight-bearing portion of the medial femoral condyle of the medial facet." Dr. Sisk opined, "[Claimant] is unfortunately in a very tough situation…. She may be a candidate for HTO or maybe a chondral transplantation. I would like to repeat the MRI… and then perhaps get Dr. Gersoff involved for a second opinion."

9. Claimant obtained an MRI at the Grand River Hospital District on March 5, 2008. Upon review of the MRI on March 24, 2008, Dr. Sisk noted, "The MRI does not show any deep cartilaginous lesions within the knee…. We…would like to avoid anything aggressive and suggested a repeat steroid injection…. We will recheck in two weeks to see if she has responded."

10. On April 7, 2008, Claimant returned to Dr. Sisk with returned symptoms. Dr. Sisk stated, "I am unable to offer [Claimant] anything further. I think at this point getting a second opinion for Dr. Wayne Gersoff is probably in her best interest."

11. Dr. Sisk explained at hearing that he referred Claimant to Dr. Gersoff for consideration of a cartilage restoration procedure. Dr. Sisk did not have the expertise to perform such a procedure, so he referred claimant to Dr. Gersoff, who is the leading physician in the state of Colorado specializing in such a procedure.

12. Claimant was examined by Dr. Gersoff on May 5, 2008. Dr. Gersoff stated, "She has had a course of injections, as well as arthroscopy without significant improvement of her symptoms. Her pain is mostly over the medial aspect of her leg…. There is mild joint effusion…. There is medial joint line tenderness noted…. At this point, I think we need to consider her as a possible candidate for a cartilage restoration surgery. We are going to go ahead and proceed with arthroscopy of her knee joint for evaluation and see if she is . . . a candidate or not. At that point, we will go ahead and proceed with cartilage biopsy."

13. Claimant underwent left knee arthroscopy and cartilage biopsy with Dr. Gersoff on May 28, 2008. The biopsy results indicated Claimant was a candidate for cartilage replacement surgery.

14. On August 26, 2008, Claimant underwent a left knee arthroscopy in which Dr. Gersoff implanted carticel. Dr. Gersoff also performed a tibial tubercle elevation and arthrotomy of the patella.

15. Dr. Sisk explained at hearing that Dr. Gersoff performed a carticel implantation because Claimant's cartilage was injured. The purpose of the procedure was to try to get new cartilage to grow in Claimant's knee. Dr. Sisk explained that this was necessary

because once natural occurring cartilage is gone it is gone forever. Dr. Sisk testified that the only other alternative to the carticel implant was a total knee replacement and that Claimant is too young to undergo that procedure.

16. Dr. Sisk testified that Dr. Gersoff also performed a tibial tubercle elevation procedure during the August 26, 2008, arthroscopy. The purpose of the tibial tubercle elevation was to lessen the pressure on Claimant's patella, relieving the pressure underneath her kneecap where Claimant's chondral defect was present. Dr. Gersoff cut the tibial tubercle bone where it attaches to the leg and moved it up and forward.

17. Shortly after the August 26, 2008, surgery, Claimant relocated out of Colorado and was authorized to obtain follow-up treatment for her work injury with Dr. Scott Luallin. Claimant presented for evaluation with Dr. Luallin on September 8, 2008. Dr. Luallin's narrative of that date reads, "She had a chondral defect which was eventually treated by Dr. Gersoff. She had an ACI procedure done. Her harvest was done in May, the implantation done 2 weeks ago."

18. On September 22, 2008, Dr. Luallin indicated that he "would like to start [Claimant] on rehab." Dr. Luallin ordered an x-ray "to check for the tubercle healing." Dr. Luallin referred Claimant for physical therapy with Blue Ridge Physical Therapy. Claimant began physical therapy on September 30, 2008.

19. On October 6, 2008, Dr. Luallin stated, "X-rays demonstrate the tibial tubercle is in good position. It does appear as though it is consolidating. At this time, I think we should continue her physical therapy. This was prescribed."

20. On October 13, 2008, Dr. Luallin made note that, "Last Wednesday she noted a pop anteriorly. She did not think much about it; but then when she started doing therapy on Friday, her pain increased. She describes the pain as diffuse, some posteriorly, some anteriorly…. We will keep her back at full extension in a brace and have her continue therapy, but she will just need to be cautious and do what she can do comfortably."

21. On November 28, 2008, Claimant's physical therapist, John Soukup, PT, noted, "The patient states that her knee still feels like it's going to give out…. The patient continues to wear the brace full time….. There has been minimal functional improvement as the patient feels she needs to wear the brace to be able to walk."

22. Claimant continued her physical therapy program and saw Dr. Luallin in follow-up through the fall and early winter of 2008. On December 1, 2008, Dr. Luallin noted, "She is still having quite a bit of discomfort anteriorly and in reviewing her rehab notes, she is quite a bit behind the protocol."

23. Claimant returned to Dr. Luallin on January 5, 2009. Dr. Luallin stated, "[Claimant] is still having a great deal of discomfort in this knee, particularly in the area of her tibial tubercle

but also in the peripatellar area…. X-rays of the left knee reveal no change in position of the tubercle but it is difficult to ascertain on this 2-dimensional x-ray whether this is truly healed or not. I am concerned about her ongoing pain. I think we should do a CT scan to assess whether this tibial tubercle has indeed healed or not."

24. A CT scan was obtained and reviewed by Dr. Luallin on February 2, 2009. Dr. Luallin stated, "[The CT scan] does demonstrate that the tubercle is incompletely healed…. I think we should go ahead and hook her up with an E-stim device to accelerate the healing of this tubercle. We will need to modify her activities, have her use the brace when she is ambulating."

25. Dr. Luallin, in his note of February 23, 2009, stated, "[Claimant] returns early today secondary to a recent fall that she sustained. She is not certain of the mechanism by which she fell but she had some increased anterior knee pain since then…. We obtained x-rays today and the bone plug is in good position, no change, no failure of the implants."

26. Claimant testified that she does not recall telling Dr. Luallin that she was "not certain of the mechanism by which she fell." Claimant stated she recalls the fall that occurred immediately prior to February 23, 2009. Claimant was dressing. She stood to pull her pants up, her injured knee gave out on her, and she fell.

27. Dr. Sisk testified that a tubercle nonunion would cause Claimant's knee to feel unstable. Claimant had reported a feeling of instability in the knee at a November 28, 2008, appointment. It is likely that Claimant's tubercle nonunion was what caused Claimant's knee to give out and caused her to fall, as described in Dr. Luallin's February 23, 2009, narrative.

28. Dr. Sisk testified that when Claimant returned to him for evaluation after moving back to Colorado in April of 2009, he compared her January 13, 2009, CT scan—taken by Dr. Lualli, with the CT scan he (Dr. Sisk) subsequently took on June 5, 2009. Dr. Sisk testified that there was no change or significant difference between the two CT scans, and they merely demonstrated Claimant was experiencing a persistent non-union. Claimant did not sustain an intervening injury when she fell immediately prior to her February 23, 2009, appointment with Dr. Luallin.

29. On March 30, 2009, Claimant presented to Dr. Luallin for follow-up. Dr. Luallin noted that, "I think at this point I will have her continue to use the e-stim device. She is actually going to be transferred to Colorado so she will follow up with her surgeon out there who originally did the surgery, Dr. Gersoff." Claimant testified at hearing that Dr. Gersoff's office in Lone Tree, Colorado, is too far from her home, and that she preferred to continue her follow-up care with Dr. Sisk, who has an office in Craig, Colorado, closer to her home.

30. Upon returned to Colorado, Claimant scheduled an appointment with Dr. Sisk for April 29, 2009. At that time Dr. Sisk made note that, "[Claimant] has been unable to get her records from Dr. [Luallin]. She reports to me that to her recollection she has a non-united

tuberosity…. She is in her brace, uses the leg limitedly…. Recently, she was smoking up to two packs a day and now down to one pack." At hearing, Claimant testified credibly that she has never smoked two packs per day and that Dr. Sisk's note is mistaken. Claimant testified that the most she has ever smoked is a little over one pack per day. Claimant testified that after Dr. Sisk advised her to quit smoking, she did so within days of the recommendation. Claimant did not smoke from around May of 2009 through October of 2009.

31. On May 2, 2009, May 4, 2009, and May 9, 2009, Dr. Sisk noted that Claimant "must refrain from all work duties."

32. On May 13, 2009, Dr. Sisk noted, "[Claimant] continues to just suffer. She again tried to go to work and after about four hours she cannot bear weight on the leg." Dr. Sisk assessed "tuberosity osteotomy non-union" and noted, "I believe the work situation is just irritating the knee and possibly disallowing the tuberosity to heal. I recommended that she take three weeks off and stay in the immobilizer…. It should be getting close to the point where we are going to re-CAT to evaluate any more healing in the non-union."

33. Claimant returned to Dr. Sisk on June 3, 2009, at which time he noted, "She continues to struggle. She…is using the brace almost full time…. She states that even though [her job] is a seated job she constantly has to get up to grab cigarettes or do other chores around the shop…. She will get the CAT scan."

34. On June 10, 2009, Dr. Sisk noted, "She still continues to be very tender and uncomfortable and is relying completely on her straight leg immobilizer…. I have obtained a CAT scan of her tibia to assess any evidence of healing from her tubercle transfer. Unfortunately, she has what appears to be a non-union and from what I can see it hasn't changed at all despite immobilization and the bone-stimulator. At this point, I think it is clear that this is not going to heal. I have attempted to contact Dr. Gersoff…. We certainly need to come up with a plan for [Claimant] to solve this problem. She cannot move forward with her rehab until we get this tubercle healed. Getting the tubercle to heal shouldn't be all that difficult but I want to confer with Dr. Gersoff and see if he wants to look inside the knee and do a second look at the chondral site transplant in addition to looking at the tubercle."

35. Claimant underwent a left knee arthroscopy, chondroplasty of patella, debridement of fat pad and scar within the knee, and revision of the prior tibial tubercleplasty for nonunion procedure with Dr. Sisk on July 7, 2009.

36. Dr. Sisk testified that he contacted Claimant's prior surgeon, Dr. Gersoff, as a professional courtesy on June 10, 2009, prior to performing the July 7, 2009 arthroscopy. Dr. Sisk and Dr. Gersoff agreed that the next step was a tubercle revision. Dr. Gersoff did not feel it necessary that he be involved in the tubercle revision. Dr. Sisk explained that the purpose of Claimant's July 7, 2009, surgery was to try to develop an environment conducive to healing. Dr. Sisk testified that the surgery involved debriding the bone until it bled and

then punching holes where the bone grows to increase blood supply to the bone. Dr. Sisk applied bone grafts, which he explained provided rigid fixation, and he inserted three screws into Claimant's knee for stability. After the July 7, 2009, surgery, Dr. Sisk testified that he put Claimant in a locked knee brace.

37. Dr. Sisk testified that, during the tubercle revision surgery he performed on July 7, 2009, he observed that the screws Dr. Gersoff had placed in Claimant's knee had backed out. He testified they likely backed out because Claimant's bone was moving due to the non-union of the tibial tubercle. Dr. Sisk testified that this can occur just with contraction of the quadriceps muscle, which he stated is the strongest muscle in the body.

38. Respondents' counsel questioned Dr. Sisk as to why he performed Claimant's fourth surgery (a tubercle revision) on July 7, 2009, when he referred Claimant out to Dr. Gersoff to perform that surgery originally. Dr. Sisk explained that a tubercle revision (aka tubercoplasty) is a procedure that he performs on a regular basis and that the reason that he referred Claimant to Dr. Gersoff for the August 26, 2008, surgery was not because he felt that he could not perform the tubercoplasty effectively, but was because the main reason for that surgery was not the tubercoplasty, but rather carticel implants. Dr. Gersoff is an expert regarding carticel implants.

39. Dr. Sisk testified that he and Claimant made the decision that he would perform the fourth surgery in July 2009, because Dr. Gersoff practices out of Denver and that is too far for Claimant to travel. Dr. Sisk testified that he is very comfortable performing tubercle surgeries and that if he did not feel qualified to perform a surgery, he would have referred Claimant to another physician for the procedure no matter how far she had to travel to have it done.

40. Claimant returned to Dr. Sisk for post-surgery follow-up on August 12, 2009, at which time it was noted, "We saw her last in mid July. She has been doing well since then. She has been keeping her leg immobilized and bending it once a day to 90 degrees. She has been using her bone stimulator."

41. On September 4, 2009, upon evaluation, Dr. Sisk noted that, "She states that she has been in the brace and has not fallen…. The tubercle has some swelling and is tender to palpation. She is unable to do a straight leg raise. I took an x-ray today and unfortunately, she has split the tubercle and the tubercle has displaced superiorly approximately an inch. It has very sclerotic edges." Dr. Sisk assessed, "failed revision of a tubercleplasty" and stated, "This is certainly a terrible complication for [Claimant]…. This is uncharted waters as far as this complication and this problem is an extremely serious one and will need to obtain several opinions on how to proceed before making any decision. This unfortunately will need to be revised or she is going to lose the entire extensor mechanism on that leg which will obviously be a tremendous disability for long term. I told her that I would again review this with several other surgeons to get their opinions before calling her to make some kind of a game plan."

42. Claimant returned to Dr. Sisk on September 23, 2009, at which time he noted, "[Claimant] is here with tibial tubercle nonunion. We have her scheduled for revision surgery for Friday with Dr. [Weidel]. We have reviewed the surgery. We will use some wire to cerclage this tubercle together and try to increase the blood supply to the dying bone. She seems to understand the most important part of the surgery is to get better blood supply and revascularize the bone to get this to heal."

43. Dr. Sisk submitted the tubercle revision surgery to Insurer for preauthorization on September 22, 2009. On September 23, 2009, Respondents' counsel authored a letter to Dr. Sisk that stated, "This letter will confirm that your request for authorization of surgery on [Claimant] dated September 22, 2009, is denied at this time as respondents have not been provided with supporting documentation regarding your request for surgery as required by WCRP 16-9(E)."

44. On September 28, 2009, Dr. Sisk authored a letter to Insurer that stated, "[Claimant's] surgery has been denied. This is very unfortunate as I have spoken with her original operative surgeon, Dr. Gersoff as well as several of my colleagues here in Steamboat in addition to Dr. Weidel at the University of Colorado. All were in agreement that a wire tension band type arrangement was the only way to solve her problem. If nothing is done, [Claimant] will not have an extensor mechanism and will be crippled for life unable to ambulate without a brace. Apparently, there has been some confusion about [Claimant] being non-compliant or somehow contributing to her problem. I believe this is not true and I may have been misrepresented in my last note. If the tubercle fragment is avascular it was not going to heal and it wouldn't take much of a pull certainly within activities necessary to daily living even with the brace that could pull that and break it. I don't think [Claimant] should be specifically blamed for her current problem. At the end of the day, it is going to be fixed. There is no debate about that and there is no way around it. We must get her into the operating room as quickly as possible to get her on the road to recovery."

45. Insurer continued to deny authorization for the surgery proposed by Dr. Sisk.

46. Dr. Sisk testified that he wishes Dr. Weidel to act as a co-surgeon on the procedure he has recommended for Claimant. Dr. Weidel is the Chairman of the Department of Orthopedic Surgery at the University of Colorado Health Sciences Center. Dr. Sisk testified that Dr. Weidel recently retired and is residing in Steamboat Springs, CO. As such, Dr. Weidel is available to co-perform Claimant's surgery with Dr. Sisk. Dr. Sisk stated that Claimant is experiencing a rare and unusual complication that has been seen by very few surgeons and that Dr. Weidel is the best person to assist in resolving Claimant's problem because he has had experience with the complication in the past.

47. Dr. Sisk testified that Dr. Weidel reviewed Claimant's chart as well as her September 4, 2009, x-ray before he offered his professional opinion as to what the course of action should be in regard to Claimant's condition. Dr. Sisk testified that Dr. Weidel agrees with Dr.

Sisk's plan of action. Dr. Sisk stated that there are not any notes from Dr. Weidel in Claimant's chart because Dr. Weidel would not have made any unless Dr. Weidel formally examined the claimant.

48. Dr. Sisk testified that the tubercle controls the quadriceps muscle and that the quadriceps muscle is the muscle that allows movement in the leg. Dr. Sisk stated that the tubercle in Claimant's knee is the bone that the leg is dependent upon to hold oneself up. The blood supply is cut off and the bone is dying because that bone is not attached to the leg any more. Dr. Sisk testified that the normal healing time for a tubercoplasty procedure is two months. It has now been over nineteen months since Claimant's original August 2008 tubercoplasty with Dr. Gersoff.

49. Dr. Sisk testified that this is a terrible complication and that Claimant's condition will not improve until she undergoes revision surgery.

50. Dr. Sisk testified that when he stated in his September 4, 2009, narrative that Claimant's "tubercle has obviously been tugged on and this complication has ensued," that he was not insinuating that Claimant did something outside of her restrictions that re-injured her knee. Dr. Sisk testified that a tugging can occur while performing any activity of normal daily living, such as showering, walking, or getting up and sitting down. Dr. Sisk testified that the only way to ensure that stress is not applied to the tibial tubercle is to never activate the quadriceps muscle. Dr. Sisk stated that it is impossible to not put weight on the tubercle. Dr. Sisk testified that he would expect a tugging to occur even if Claimant was walking with her brace on because there is no way to control muscular contractions within the body. Dr. Sisk testified that Claimant did not advise him of any catastrophic event that could have led to the complication she is experiencing, and that he absolutely believes her.

51. Dr. Sisk requested pre-authorization from Insurer to perform a left knee tubercle revision for Claimant on September 22, 2009. Dr. Sisk testified that the delay in trying to solve Claimant's problem is causing Claimant's injury to get worse. Dr. Sisk testified that every day Claimant's muscle in her leg is wasting away and that when a muscle is left dormant, the body will cannibalize the muscle and turn it into fat. Dr. Sisk testified that Claimant's problem will not be solved without the recommended surgery and that without the surgery claimant may never walk again without a brace.

52. Dr. Sisk testified that it is his opinion that claimant has been 100% compliant with her restrictions.

53. On November 11, 2009, Claimant returned to Dr. Sisk. Dr. Sisk stated, "Her brace has been basically destroyed. She is obviously relying on it to ambulate and she has torn apart yet another brace. She also relates that her surgery has been denied and she is getting nothing but a run around and delays as far as getting the situation resolved. In my opinion, this is quite an unethical breach on the insurance carrier's part. There is no doubt that

[Claimant] needs to have the knee repaired and the delay that is being incurred is definitely going to make the surgery more difficult, her recovery more challenging and perhaps influence the overall outcome. I would like to strongly recommend that work comp get her surgery approved as quickly as possible."

54. Dr. Sisk was questioned as to his comment in his November 11, 2009, narrative that, "her brace has been basically destroyed." Dr. Sisk stated that Claimant cannot do anything without the brace on and that if Claimant's brace looked brand new, he would know that she had failed to wear it has directed. Dr. Sisk explained that Claimant's brace holds up claimant's entire weight. Dr. Sisk testified that the wear and tear he observed on Claimant's brace is what is expected when Claimant is reliant upon the brace to get around. Dr. Sisk opined that Claimant should expect to need a replacement brace every six months and that he is surprised that Claimant made it as long as she did with her original brace.

55. Claimant testified at hearing that Dr. Gersoff's office in Denver is too far away from her home in Craig, CO. Claimant testified that it would be too difficult, and too dangerous in winter weather, for her to travel to Denver for the surgery and then back again for follow-up visits with Dr. Gersoff. Claimant testified that she is satisfied with the care that has been provided her by Dr. Sisk thus far. Claimant testified that she trusts Dr. Sisk and that it does not concern her that she is not fully recovered because it is her understanding that she is experiencing a complication that is very rare and that many surgeons have never encountered.

56. Claimant testified that since her injury she has undergone four surgeries. Dr. Sisk performed two of the four surgeries. The surgery in which her tubercle was cut and elevated was performed by Dr. Gersoff.

57. Claimant testified that it is her understanding that the surgery currently being recommended to revise her tubercle would be performed by Dr. Sisk, with Dr. Weidel acting as co-surgeon. Claimant testified that she wants to undergo the recommended surgery so that she can get back to a halfway decent lifestyle. Claimant stated that she currently cannot drive long distances because she needs to keep her knee elevated. Claimant cannot walk long distances and she cannot kneel or crawl.

58. After her August 2008 surgery, Claimant was restricted from walking unless she had her brace on. This restriction has never been lifted. Claimant testified that she abided by her restrictions and that she did not sustain any intervening injury that caused the need for the recommended surgery. The only falls that Claimant has sustained have been the result of the weakness in her knee due to her work injury. Claimant testified that she did not do anything outside of her restrictions to tug her tubercle.

59. Claimant testified that she cannot walk more than a distance of approximately 150 – 200 feet at a time without severe pain and weakness in her knee. For example, Claimant can

walk from her car in the parking lot of a grocery store into the store where they keep the riding carts. Claimant testified that that is the farthest distance she can tolerate without severe pain.

60. Claimant testified that, prior to when Dr. Sisk advised her to stop smoking in April 2009, none of her physicians advised her to quit or informed her that smoking can inhibit healing. Claimant testified that Dr. Gersoff, the surgeon who performed her second surgery, never mentioned smoking to her at all. Consistent with Claimant's testimony, none of Claimant's medical records indicate Claimant was advised to quit smoking before either her first or second surgery.

61. Claimant testified that she is not currently smoking. She quit smoking between approximately May 2009 and October 2009, began smoking again due to the stress caused by learning her tubercle had split and the revision surgery had been denied, and she quit smoking again in the middle of December 2009.

62. Dr. Michael Sisk testified at hearing via telephone. Dr. Sisk is an orthopedic surgeon. He graduated from the University of Colorado and subsequently did a five-year residency with the University of Colorado. Dr. Sisk has been licensed to practice medicine in Colorado for eleven years and is board certified. Dr. Sisk is a fellow with the Academy of Orthopedic Surgery.

63. Dr. Sisk testified that he is very familiar with the Claimant's case. He stated that he has been directly and indirectly involved with Claimant's care for her knee since the date of her injury.

64. Dr. Sisk testified that Claimant has repeatedly attempted or has quit smoking. Dr. Sisk opined that smoking did not cause the tubercle split to occur and that it would be impossible to prove that it had. Dr. Sisk conceded that smoking could retard healing of claimant's tubercle, but he stated to a reasonable degree of medical probability that it did not cause the nonunion of the tubercle and it did not cause the tubercle to split.

65. Dr. Gersoff is the physician that cut Claimant's tibial tubercle. Dr. Gersoff cut the tubercle in an effort to heal Claimant's work injury. Had Claimant not sustained her February 25, 2007, work injury, the complications she is facing now with her non-united split tubercle, would never have occurred. It is the work injury, and not Claimant's smoking, that is the cause of Claimant's current physical condition and need for surgery.

66. Dr. Sisk testified that it is not probable that the non-union of the tibial tubercle that Claimant has experienced occurred because Claimant was a smoker. Dr. Sisk reiterated that such an opinion could not be proven and even went so far as to opine that it is ridiculous. Dr. Sisk testified that there is not any literature that would support that the condition Claimant has experienced could, within a reasonable degree of medical probability, be attributed solely to Claimant's smoking.

67. The radiology report from Craig Memorial Hospital dated September 4, 2009, states, "Probable union." Dr. Sisk was asked why his interpretation of the September 4, 2009, x-ray was different from the radiologist's interpretation. Dr. Sisk testified that he reviewed the x-ray himself the same day that it was taken and that the radiologist's opinion that the graft site is well healed is impossible. Dr. Weidel also personally reviewed Claimant's x-rays, and he made no changes to the treatment recommendations formulated by Dr. Sisk.

CONCLUSIONS OF LAW

1. Insurer is liable for medical care that is reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Section 8-42-101(1), C.R.S.

2. Claimant did not sustain an intervening injury in February 2009 when she fell while dressing. Claimant did not sustain an intervening injury as a result of smoking cigarettes. Claimant did not sustain an intervening injury that resulted in her tubercle splitting.

3. Claimant has established by a preponderance of the evidence that the surgery being recommended by Dr. Sisk is needed to cure and relieve the pain and symptoms Claimant continues to suffer from her February 25, 2007, work-related injury. Dr. Sisk opines that the pain and symptoms Claimant is currently experiencing relate to her work-related injury. Dr. Sisk's surgery is likely to aid in relieving Claimant's current pain and symptoms. The surgery is reasonably necessary and related to Claimant's February 25, 2007, work-related injury. Therefore, Insurer will be liable for the medical treatment recommended by Dr. Sisk. Insurer shall pay for the tubercle revision procedure recommended by Dr. Sisk pursuant to the Workers' Compensation fee schedule. Section 8-42-101(3), C.R.S.

4. It is reasonable and necessary for both Dr. Sisk and Dr. Wiedel to participate in the surgery recommended by Dr. Sisk, as the complication Claimant has sustained is a rare one.

5. All issues not expressly decided herein are reserved for future determination.

ORDER

It is therefore ordered that Insurer is liable for the medical treatment recommended by Dr. Sisk.

All matters not determined herein are reserved for future determination.

DATED: *February 23, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-802-807

ISSUES

The sole issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant worked for about four months for the employer as a laborer/caulker. On several occasions, claimant failed to show up for work due to use of alcohol.

2. On approximately June 9, 2009, claimant informed "P", the owner, that he had concerns about his heart and had restrictions from his cardiologist. P told claimant to "take it easy." Eventually, on August 18, 2009, claimant did undergo double coronary bypass surgery

3. On August 26, 2009, claimant filed a workers' claim for compensation for an alleged injury on June 12, 2009, to his "back, right foot, left foot, left leg, left hip, right leg, right hip." Claimant also completed a first report of injury to his employer, listing injury to his low back and stating that his injury occurred "Lifting Heavy Items, Herniated Disc, Back, Right Foot, Right Foot [sic], Right Leg, Right Hip, Left Foot, Left Leg, Left Hip."

4. At hearing, counsel for claimant stated for the first time that the claim was actually for a hernia injury with date of onset June 11, 2009.

5. "Q" and P credibly testified regarding the work duties of claimant and regarding the circumstances of June 11, 2009. The employer is a caulking specialist, filling in joints on the concrete floors and perimeter walls of new building construction. Claimant was a laborer for the employer. He was responsible for preparing surfaces for caulking.

6. Co-employee Q testified that he worked with claimant on June 11, 2009, and that claimant did not engage in heavy lifting on that day. The work assigned on that day did not require a ladder and no materials needed to be lifted beyond reach of a person standing on the floor. Claimant was assigned to clean out expansion joints on the floor that day. Claimant appeared to be under the influence of alcohol on that day and was arguing with other employees. It was not uncommon for claimant to appear either hung-over or smelling of alcohol on the job. As a result of his argument with the other employee on June 11, 2009, claimant went outside to sit in the company van with P. Claimant stayed in the van for quite a while during the day. P smelled alcohol on claimant as he sat in the van with claimant that day. Claimant said nothing to either Q or P about being injured on the job on June 11, 2009.

7. On Saturday June 12, 2009, Q credibly testified that he went to claimant's home to pick him up to bring him to work. Claimant did not drive and Q usually provided him a ride to the worksites. Q knocked on the door that morning about 7:30 a.m., and claimant was

unconscious on the couch. Based upon the circumstances and his experience with claimant, Q concluded that claimant had drunk a lot of alcohol the night before and was passed out due to the alcohol. Although Q made several efforts to wake him, claimant did not wake up for some time. Finally, claimant awoke and said that he was not going to work that day. Claimant did not report any injury on June 11, 2009.

8. On the evening of June 12, 2009, the employer terminated claimant's employment because of his refusal to go to work that day, his pattern of similar behavior, and because he threatened physical violence during his argument with another employee on June 11, 2009.

9. Claimant did not report a work injury to the employer from June 11, 2009 forward, although he had several opportunities to do so. P credibly testified that claimant spoke several times to him after his termination, both on the telephone and in person, and did not state that he had injured himself at work. He never reported any work injury even though he requested his job back. The employer was not aware of a claim for a work injury until receipt of the claim for compensation.

10. After his termination and before the claim for compensation was filed, claimant contacted P and requested permission to attend the funeral of P's father. P told claimant he was not invited to the funeral. Claimant was upset and responded by cursing at P. Claimant did not mention any work injury at the time. During the ensuing discussion, claimant threatened to sue the employer, apparently in retaliation for the funeral snub. Claimant then filed his workers' compensation claim after this personal argument in August 2009.

11. On September 29, 2009, claimant sought medical treatment at Peak Vista Community Health Center. Dr. Gary Brown examined claimant, who reported a history of his coronary bypass surgery in August, requested a flu shot, and complained of a right inguinal hernia diagnosed in July 2009. The medical report does not address causation for the right inguinal hernia.

12. Claimant's claim for compensation was retaliatory in nature. No claim was made until after a heated personal argument occurred between P and claimant. No medical evidence supports the claims that have been made. It was not until the date of the hearing that claimant asserted any claim to an inguinal hernia. Claimant's sole evidence, a medical note from Dr. Brown, provides no support for a work injury to the back, right foot, left foot, left leg, left hip, right leg, or right hip. It also does not establish any causation between inguinal hernia identified by Dr. Brown and claimant's work duties on June 11, 2009. The Judge cannot find claimant's testimony incredible; claimant did not appear for the hearing and testify. The testimony of the employer witnesses was credible. It is hard even to imagine how claimant thinks that the record evidence supports finding a compensable hernia injury on June 11, 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). 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). As found, claimant failed to prove by a preponderance of the evidence that he suffered an injury on June 11, 2009, arising out of and in the course of his employment.

ORDER

It is therefore ordered that:

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

DATED: February 24, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-745-732

ISSUES

1. Whether the Respondents overcame the opinion of the Division Independent Medical Examination (DIME) of Edwin Healey, M.D. concluding Claimant's right shoulder condition is related to the November 30, 2007 date of injury?

2. Whether the Respondents overcame the opinion of the Division Independent Medical Examination (DIME) of Edwin Healey, M.D. Claimant's alleged cognitive complaints, including headaches and dizziness, are related to the November 30, 2007 date of injury?

3. Whether Claimant is entitled to medical benefits for either or both conditions if they are found causally related?

4. Whether the Claimant is entitled to indemnity benefits for either or both conditions if they are found causally related?

5. Whether the Claimant remains at maximum medical improvement (MMI) with a 5% whole person impairment for the admitted work related injuries as opined by Daniel Olsen, M. D.?

FINDINGS OF FACT

1. On November 30, 2007 Claimant was leaving her place of employment and while exiting a doorway, slipped, lost her balance and fell backwards off a stoop onto her back.

2. Claimant's injuries were reported and she was referred to the Respondent-Employer's designated treatment provider, Centura Centers for Occupational Medicine ("CCOM"), where an initial evaluation appointment was set for December 7, 2007, approximately one week after Claimant's fall.

3. The claim was admitted and Claimant began treatment in earnest with CCOM primarily under the care of Drs. Peter T. Walsh and Daniel Olson. Claimant has an extensive prior medical history involving her low back, knees and shoulders.

4. According to the initial evaluation report of Dr. Peter T. Walsh, on December 7, 2007 Claimant reported falling backwards off a stoop and onto her back with resultant "intermittent, mild, daily headaches which are new in nature". Claimant also complained of "lower cervical, upper thoracic, mid and low thoracic pain" and "low back pain typical of her previous back pain for which she had received substantial treatment". Dr. Walsh provided an assessment of closed head injury with some post-concussive symptoms, cervical strain, thoracic strain and lumbar strain. Dr. Walsh recommended x-rays of the Claimant's c-spine, thoracic spine, lumbar spine and clavicles. Claimant was instructed to follow up with Dr. Walsh in one week as well as in three weeks with Dr. Daniel Olson, as he was to assume Claimant's care.

5. On December 14, 2007, Claimant was re-evaluated by Dr. Walsh who documented Claimant's ongoing complaints consistent with her closed head injury, cervical strain, thoracic and lumbar strain, including headaches and dizziness. In addition to her persistent complaints regarding headaches and spine, Claimant reported "right wrist pain and a new prominence on her dorsal wrist over the ulna, pain in the anatomic snuffbox in the right wrist, lateral elbow pain and right shoulder pain anterior in nature with decreased range of motion, particularly raising her arm above the horizontal". There is no medical record or other evidence suggesting that Claimant suffered an injury between November 30, 2007 and December 14, 2007.

6. Dr. Walsh opined that Claimant suffered a right shoulder strain and although the mechanism was unclear as the Claimant had fallen on her back, it was "plausible she

reached backwards in the process and is (sic) unaware of this injury to her right shoulder**"**. According to Dr. Walsh's December 14, 2007 note, the "patient's injury pattern with the exception of her bilateral knee pain is likely occupational in etiology". It was recommended that Claimant undergo x-ray studies of the right elbow, wrist and shoulder as well as repeat studies (MRI) of the lumbar spine and thoracic spine. Additionally, Claimant was advised to withhold taking Tylenol No. 4 if it is making her feel groggy. Claimant testified she did not complete a pain diagram on her first medical visit of December 7, 2007 but recalls informing the doctor of pain in her shoulder.

7. Claimant testified to having taken Tylenol No. 4 for years prior to her industrial injury for arthritis pain and low back pain which predates her fall of November 30, 2007.

8. On December 20, 2007 Claimant was re-evaluated by Dr. Peter T. Walsh who documented Claimant's persistent "frequent headaches" and memory difficulties. Claimant's right lateral elbow, right wrist and shoulder strain were not evaluated on this visit as the insurance carrier had denied care for those issues. Dr. Walsh specifically documented that the Claimant "reports that she stopped taking her medication for approximately a five-day period to elucidate whether her memory issues were secondary to either Tylenol No. 4 that she was taking under the direction of her private physician or the Tramadol" that had been prescribed during the Claimant's last visit. According to the report of the Claimant on this date of visit, the memory problems did not appear to be medication related. At hearing, Claimant testified extensively with respect to the fact that her memory difficulties were not medication related.

9. Claimant occasionally expressed concern that she could not perform her job with her memory difficulties; however, Claimant was encouraged to return to work and given restrictions for modified duty.

10. Claimant has undergone numerous imaging studies including a CT scan of the brain given Claimant's increasing headaches.

11. On January 2, 2008 Claimant was evaluated by Dr. Daniel A. Olson who documented that because Claimant had failed to complete a pain diagram with respect to her right shoulder on her first office visit on December 7, 2007, that the insurance company would not cover any treatment for her right side. Dr. Olson provided an assessment of "status post fall with cervical thoracic sprain and closed head injury". Claimant's shoulder complaints were not addressed due to the insurance carrier's unwillingness to authorize the recommended care previously.

12. On January 4, 2008 Claimant was seen by her primary care physician, Dr. Larry Jensen. Dr. Jensen documented that Claimant was having worsening mid to low back pain with some right sciatic radiating down the lateral thigh following her fall. According to Dr. Jensen's note, the Claimant was taking more Tylenol No. 4 than usual, averaging six pills

daily recently. Dr. Jensen suggested a trial of a longer acting medication such as oxycontin. Claimant had previously tried Duragesic for pain control, but she did not care for it, thus it was discontinued. Dr. Jensen provided a trial of oxycontin, 10 mg, to be taken on a regular basis.

13. On January 8, 2008 Claimant returned to Dr. Olson after she requested to be released from work due to a severe headache. On this date, the employer wished to have the Claimant evaluated and Dr. Olson obliged. Dr. Olson listed Claimant's medications as including oxycodone rather than oxycontin. On January 8, 2008 Claimant was provided with an injection of Toradol and provided with Phenergan for nausea due to her headache, which she described as "stabbing pain in her eye".

14. On January 10, 1008, Claimant presented to the emergency room complaining of neck and right arm pain. On Page 7 of the Parkview Emergency Department medical records, Claimant was diagnosed as having "radiculopathy right arm". A c-spine CT scan was done to rule out any fracture, dislocation or other abnormality that might be causing Claimant's pain in the arm and neck. The CT scan was read as demonstrating narrowing with degenerative joint disease. Claimant was provided with an injection of Dilaudid, a script for Dilaudid as well as a Medrol Dosepak to help with the inflammation and pain.

15. Claimant continued to receive prescriptions for Dilaudid, which was reportedly helpful for her headaches. However, by January 21, 2008 Claimant reported that she was having "difficulty balancing her use of narcotic medication for improved function and pain relief with the side effects of this medication". Reportedly the medication assisted in reducing Claimant's pain in her shoulders, arm and low back but it made her sleepy, apparently resulting in her falling asleep at work and being reprimanded by her supervisor. On January 21, 2008 Claimant had called off work because of being "very stiff and in a good deal of pain upon wakening". Physician Assistant Thomas Shepard documented the difficulty in balancing the pain relief effects of Claimant's medication with their side effects, specifically sleepiness.

16. On February 13, 2008 Claimant was re-evaluated by Dr. Olson who once again documented the disagreement between Claimant and the Insurer regarding the condition of her right shoulder. Dr. Olson summarized the disagreement as follows:

17. "She states that when she fell, she tried to brace herself with the right arm. However, that has not been officially accepted by the insurance company. Therefore, she has seen Dr. Taylor on her own for it. She does have a rotator cuff tear by MRI scan report and he has scheduled surgery for February 19, 2008."

18. Despite the apparent disagreement, Dr. Olson did not comment regarding the causality of Claimant's shoulder symptoms.

17. Claimant underwent right shoulder surgery on February 26, 2008 outside of the

worker's compensation system. Following her rotator cuff repair, Claimant was initiated in post-surgical rehabilitation at Parkview Medical Center.

18. On July 18, 2008 Claimant tripped and fell striking her chin. Claimant underwent examination at Parkview Emergency Room and was noted to have a normal neurologic examination. Claimant's wound to her chin was irrigated and repaired. There is no indication that Claimant re-injured her shoulder or suffered additional head injury as a result of this fall.

19. On July 28, 2008 Claimant was re-evaluated by Dr. Olson who had recommended evaluation by David Hopkins, Ph.D. for a neuropsychological assessment given Claimant's ongoing complaints of cognitive dysfunction. At the time of her initial evaluation, Claimant was reportedly taking hypertensive medications, Trazodone, potassium, Protonix, and Zoloft, which she felt calmed her. According to Claimant, she was off of pain medications as of the time of this initial assessment. During the interview, Claimant demonstrated "some word-finding problems", was "somewhat disorganized in her historical report of the accident and its sequelae", was "disorganized in relaying her history, jumping from time to time in her life and making it hard to follow", and had "some difficulty with time sequences from the past". Claimant "described a variety of memory problems", which she felt were worsening since her fall. According to Dr. Hopkins' note, Claimant was having difficulty remembering what she had to do and "becomes distracted and finding herself on tangents". Reportedly Claimant was "writing notes to herself in order to remember to do important things", was having difficulty "remembering phone calls and conversations", "having decreased retention in reading not helped by retrieval cues" and was losing "money around the house". Dr. Hopkins recommended eight to ten hours of neuropsychological testing in order to help "tease out any true residual that may be related to a concussive injury, which she experienced as a result of a fall on November 30, 2007".

20. On October 29, 2008 Claimant was re-evaluated by Dr. Olson who documented that neuropsychological testing had not been performed and that Claimant would require revision surgery to her right rotator cuff.

21. Authorization to proceed with neuropsychological testing proved elusive and as documented by Dr. Olson on December 2, 2008, Claimant had yet to undergo such testing.

22. Neuropsychological testing was completed by Dr. Hopkins on January 15, 2009, January 21, 2009 and January 27, 2009. Claimant's history of cognitive impairment, including deficits with memory and losing train of thought were documented and an MMPI-II validity scores suggested a consistent, valid testing response without exaggeration or symptom magnification.

23. In his report outlining Claimant's neuropsychological testing, Dr. Hopkins documented that it was not "unlikely that Claimant had suffered a mild concussive event, given her age

and the snapping back of her neck". According to Claimant's testing results, there was no "indication in the data to suggest malingering, conscious deception or symptom magnification"; although testing results demonstrated a "very difficult" neuropsychological profile to separate out given Claimant's prior history of a previous car accident as well as a non-penetrating gunshot wound to the head. Dr. Hopkins concluded that there was "at least a mild neurobehavioral deficit that more likely than not was related to Claimant's fall". Dr. Hopkins recommended Claimant to participate in two to three neuropsychological counseling sessions to help Claimant to better understand and develop a more realistic understanding of her level of neurobehavioral dysfunction. Dr. Hopkins also recommended repeat neuropsychological testing in eight to twelve months given Claimant's hypertensive disorder, which would be helpful to determine whether there was a continuing downward course in Claimant's cognitive function. Claimant has not been afforded these treatments.

24. On February 25, 2009 Dr. Olson re-evaluated Claimant and noted that the results of Claimant's neuropsychological testing would put her into the "mild to moderately impaired" category of function. By the time of her February 25, 2009 re-evaluation by Dr. Olson, Claimant had undergone a second and third revision surgery on her rotator cuff. Additionally, according to Dr. Olson's treatment, Claimant was not working. Claimant testified she was terminated from her job as she was unable to perform sufficiently. Respondents presented no evidence to the contrary. Dr. Olson felt Claimant was at maximum medical improvement as of February 25, 2009 and dictated an impairment rating on a separate report.

25. On March 19, 2009 Dr. Olson completed his impairment rating report. The impairment rating report documented the Claimant's complex pre-existing medical history as well as the fact that Claimant had undergone right rotator cuff repair on three separate occasions following her November 30, 2007 fall.

26. In his March 19, 2009 treatment note, Dr. Olson documented that because it was not clear what the exact mechanism of her right shoulder pain was and because she did not complain of right shoulder pain until her second visit, the insurance company had not accepted her right shoulder case. Although Dr. Walsh noted that it was plausible that Claimant injured her right shoulder in her fall, Dr. Olson's treatment records are silent with regard to causality of Claimant's shoulder condition. Dr. Olson provided a 5% whole person impairment for cognitive dysfunction under complex integrated cerebral functions according to the AMA Guidelines to the Evaluation of Permanent Impairment, 3rd Edition Revised. Dr. Olson did not provide an impairment rating for Claimant's low back as, in his opinion, Claimant's low back condition was a pre-existing problem.

27. On April 29, 2009, Claimant underwent a Respondent-requested independent medical examination with Dr. Eric O. Ridings. It is Dr. Ridings' opinion that Claimant's right shoulder complaints are not related to her November 30, 2007 work injury. Dr. Ridings based his opinion on the fact that Claimant fell backwards landing on her back. Thus she could not have injured her shoulder. Additionally, Dr. Ridings opined that if Claimant had suffered a

direct blow to her shoulder on landing on the ground, he would have expected Claimant to have complaints with the shoulder initially rather than developing them subsequently. As support for his opinion, Dr. Ridings cites a September 14, 2007 note from Dr. Jensen, Claimant's primary care physician, which documented that Claimant had complained of a tender lump on her upper right deltoid area for approximately one week leading Dr. Jensen to the belief that Claimant might have suffered a partial biceps tear. Dr. Jensen noted at the time that the Claimant had full range of motion in her right shoulder. MRI scan of the right shoulder following the fall of November 30, 2007 fails to demonstrate a tear to the biceps. Rather, the MRI is consistent with rotator cuff tears and bicepital tendonitis. Dr. Ridings has concluded that the Claimant's right shoulder condition was pre-existing and that in his opinion Claimant did not have any diagnosis for her right shoulder, which was related to her work injury.

28. On August 19, 2009 Claimant underwent a Division sponsored independent medical evaluation with Dr. Edwin M. Healey. Dr. Healey performed an exhaustive medical records review, completed a physical examination and concluded that Claimant's current diagnoses include:

> 1. History of mild traumatic brain injury with post-concussive syndrome manifested by chronic post-traumatic headaches, cognitive dysfunction and disequilibrium with vertigo.
> 2. History of cervical strain with residual cervical myofacial pain; rule out facet arthropathy, which may be amenable to therapy and may improve headaches.
> 3. Permanent aggravation of pre-existing right shoulder pain and rotator cuff tendonopathy; surgery post-op attempts to repair right rotator cuff tear, with residual chronic right shoulder pain, loss of range of motion and weakness.
> 4. Post-traumatic positional vertigo.
> 5. Temporary aggravation of chronic mechanical low back pain, but: currently, it is my opinion that even if she had not had the injury of November 30, 2007, she would still have chronic back pain requiring ongoing treatment, possible surgery and pain medications.
> 6. Complaints of bilateral knee pain; surgery post-op bilateral knee arthroscopy. I am not able to relate this problem to her November 30, 2007 injury."

29. Dr. Healey concurred with Dr. Ridings that it was "somewhat problematic determining the mechanism and extent of injury because Ms. Collins-Smith was acutely confused at the time of her injury". Despite the difficulty in determining the exact mechanism and extent of Claimant's injuries to her right shoulder, Dr. Healey opined that the Claimant's current right shoulder pain was related to her November 30, 2007 fall. In his report of August 19, 2009 Dr. Healey documents his conclusion as follows:

> It is my opinion that her current right shoulder pain is related to her November 30, 2007, fall. She was complaining of some right shoulder pain in September of 2008, but she had full range of motion of the shoulder at that time. However, after her fall, with her complaints to Dr. Walsh on December 14, 2007, he noted she had decreased range of motion and was only able to flex and abduct 80 degrees. She was weak on supraspinatous testing and had a positive impingement sign on her right shoulder. Dr.

> Jensen found full range of motion of her shoulder in September of 2008, and Ms. Collin-Smith adamantly complains that she has had markedly increased right shoulder pain post fall. Therefore, it is my opinion her need for evaluation and treatment of the right shoulder, even though she had a pre-existing of bilateral shoulder degenerative rotator cuff disease, was permanent aggravated as a result of her November 30, 2007, injury.

30. Dr. Healey assigned a 21% scheduled impairment for Claimant's right shoulder injury.

31. In addition to her shoulder and cognitive dysfunction, Dr. Healey provided an opinion with regard to Claimant's episodic neurological disorder consisting of a post-traumatic positional vertigo which had not been evaluated or treated by her physicians, yet according to Dr. Healey remained very symptomatic and required further treatment. For her positional vertigo, Dr. Healey opined that Claimant would require vestibular rehabilitation and although he provided an impairment rating of 10% of the whole person based upon the AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition Revised, pursuant to page 170 under Class 2.

32. Dr. Healey concluded that the Claimant is not at maximum medical improvement for all conditions caused by her industrial injury, as she required vestibular evaluation, trigger point injections in Claimant's suboccipital and cervical region as well as consideration of a cervical facet median branch block to determine if Claimant's fall and complaints of neck pain since her injury are causing secondary headaches.

33. Dr. Healey's impairment ratings of 21% upper extremity, 10% whole person for nervous system dysfunction and 10% whole person impairment for vestibular dysfunction are advisory only as Dr. Healey has concluded that Claimant is not at maximum medical improvement.

34. Dr. Ridings testified at deposition on two separate occasions. Dr. Ridings testified consistently with his report; however, at his deposition on November 23, 2009, Dr. Ridings admitted that Dr. Healey's opinions simply differed from his, that Dr. Healey's report and the opinions reached therein were not contrary to any requirement set forth by the AMA Guidelines to the Evaluation of Permanent Impairment, 3rd Edition Revised, or the Level II Training and Accreditation Manual. Rather, the difference in opinions was based upon interpretation of the medical records.

35. Dr. Ridings also conceded that Claimant may have reflexively extended her arm when she fell.

36. In a follow-up report dated September 30, 2009, Dr. Ridings puts great weight on the purported fact that Dr. Jensen saw the Claimant in September 2008, and at that time had full range of motion in her shoulder. Dr. Ridings appears to rely upon the statement in the DIME report on page seventeen of the report that's states, "Dr. Jensen found full range of motion of her shoulder in September 2008, and [Claimant] adamantly complains that she has had markedly increased right shoulder pain post fall." Dr. Healey goes on to use this statement in

support of his opinion that the Claimant's shoulder condition was permanently aggravated by the fall.

37. It would not seem to make sense that the Claimant's full range of motion in September 2008 would support a determination of causality for an injury in November 2007. In fact a review of the medical records reveals that the visit to Dr. Jensen occurred on September 14, **2007**. (Emphasis added.) It was obviously a typographical error in stating the incorrect year.

38. Claimant is in need of additional medical treatment as recommended by Dr. Healey in his Division Independent Medical Examination and Claimant has expressed a desire to proceed forward with those recommendations.

39. Claimant testified that she was terminated from her employment due to the residual sequelae of her industrially caused medical conditions, primarily her vertigo and/or cognitive impairment. The medical records document Claimant's need for medications which may have impacted Claimant's ability to work; however, those medications were required to effectively treat Claimant's pain caused by her industrial injury to the neck, shoulder, and back. Claimant has not worked as documented in medical records since February 26, 2009. Claimant's testimony is unrebutted and considered persuasive. The ALJ finds Claimant to be credible.

40. Respondents have failed to prove by clear and convincing evidence that the determination by the DIME is incorrect. The opinions of Dr. Healey, supported by the medical records of the various medical providers and the record as a whole are credible and persuasive. The contrary opinions of Dr. Ridings do not demonstrate that it is highly probable and free from serious or substantial doubt that the DIME is incorrect. Consequently, Claimant is not at maximum medical improvement and requires further medical evaluation and subsequent treatment as a natural consequence of the Claimant's admitted work injury.

CONCLUSIONS OF LAW

1. 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 v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

2. 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. The opinions concerning causality of the Claimant's impairment or need for medical treatment are also binding unless overcome by clear and convincing evidence. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cudo v. Blue Mountain Energy Inc.*, W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999).

3. All written reports and subsequent opinions, including the DIME physician's

testimony, are to be considered in determining the DIME physician's true opinion as a matter of fact. *Andrade v. Industrial Claim Appeals Office,* 121 P.3d 328 (Colo. App. 2005); *Lambert & Sons, Inc. v. Industrial Claim Appeals Office,* 984 P.2d 656 (Colo. App. 1998); *Dazzio v. Rice & Rice, Inc.,* W.C. No. 4-660-140 (Industrial Claim Appeals Office, June 30, 2008). Once the ALJ determines the DIME physicians' opinions, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. *Dazzio v. Rice & Rice, Inc.,* supra; *Clark v. Hudick Excavating, Inc.,* W.C. No. 4-524-162 (Industrial Claim Appeals Office, November 5, 2004); *Lambert & Sons, Inc. v. Industrial Claim Appeals Office,* supra. Respondents have a clear and convincing burden of proof to overcome the determination of Dr. Healey that Claimant's right shoulder and vestibular conditions are related to her industrial injury. Additionally, Respondents have a clear and convincing burden to overcome the opinion that Claimant's cognitive dysfunction is related to her industrial injury. A fact or proposition has been proved by "clear and convincing evidence" if, after considering all of 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. Healey, determined that the Claimant was not at maximum medical improvement. Consequently, Respondents must prove by clear and convincing evidence that his determination is incorrect. It is specifically concluded that Respondents have failed to carry their burden for the reasons set out more fully below.

4. "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.

5. Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent upon 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). In the instant case, it appears that there is a difference of opinion between Dr. Healey and Dr. Ridings as it relates to causality for Claimant's medical conditions and, thus, MMI. A difference of opinion between physicians fails to constitute error sufficient to overcome, by clear and convincing evidence, the opinions of the DIME physician. *Gonzalez v. Browning Ferris Indus. of Colorado,* W.C. No. 4-350-356 (Industrial Claim Appeals Office, March 22, 2000). After review of the totality of the evidence, including the testimony of Dr. Ridings and the medical records of Dr. Olson, Dr. Jensen and the DIME report of Dr. Healey, it cannot be concluded that Dr. Healey's conclusions regarding causality and MMI are incorrect. Completion of further examination is necessary before Claimant can reasonably be said to be at MMI. Once further examination and

treatment has been completed, including vestibular evaluation and rehabilitation as well as injection therapy, Claimant should be returned to Dr. Healey for further comment regarding MMI and impairment.

6. As found, Claimant was unable to perform her usual job due to the effects of the work injury and/or the medications required to treat her work injury. Consequently, Claimant is "disabled" within the meaning of §8-42-105, C.R.S. and is entitled to TTD benefits. *Culver v. Ace Electric,* 971 P.2d 641 (Colo. 1999); *Hendericks v. Keebler Company,* W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). In this case, Claimant is entitled to TTD benefits because her injuries caused a disability, the disability caused her to leave work, and Claimant missed more than three regular working days. Claimant testified that she was having difficulty performing the essential duties of her work, either due to cognitive sequelae or the impairing effects of medications necessary to treat her increased pain following her fall. The Claimant's testimony is unrebutted and supported by the voluminous medical records. TTD benefits continue until the occurrence of one of the four terminating events specified in §8-42-105(3), C.R.S., *PDM Molding, Inc. v. Stanberg,* 898 P.2d 542 (Colo. 1995). Because Claimant has been determined not to be at maximum medical improvement and Respondents have failed to overcome that opinion and have not presented evidence of one of the four terminating events specified in §8-42-105(3), C.R.S., Claimant is entitled to TTD benefits commencing February 25, 2009 and continuing until one of the four terminating events specified in §8-42-105(3) is satisfied.

ORDER

It is therefore ordered that:

1. Respondents' request to overcome and set aside Dr. Healey's opinion that the Claimant is not at maximum medical improvement is denied and dismissed. Respondents have failed to carry their burden of proof by clear and convincing evidence that Dr. Healey's opinions are incorrect. Claimant's right shoulder condition is compensable and the treatment for that condition is related to Claimant's industrial injury of November 30, 2007.

2. Respondents' request to overcome and set aside Dr. Healey's opinion that the Claimant is not at maximum medical improvement is denied and dismissed. Respondents have failed to carry their burden of proof by clear and convincing evidence that Dr. Healey's opinions are incorrect. Claimant's cognitive complaints, including headaches and dizziness, are related to the November 30, 2007 date of injury.

3. The Insurer shall pay for the reasonable and necessary medical costs associated with Claimant's work-related conditions, giving special emphasis to the recommendations of the DIME.

4. Claimant is entitled to temporary total disability benefits commencing on February 25, 2009 and continuing until the occurrence of one of the four terminating events specified in §8-42-105(3), C.R.S. is established.

5. The issue of permanent partial disability benefits is not yet ripe for determination as Claimant is not currently at maximum medical improvement.

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.

DATE: February 24, 2010 /s/ original signed by:
Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-253

ISSUES

The issues determined herein are maximum medical improvement ("MMI"), post-MMI medical benefits, and change of authorized treating physician ("ATP").

FINDINGS OF FACT

1. In February 1991, claimant suffered a right knee injury and underwent multiple surgeries. In 2006, claimant suffered additional right knee injury in a motor vehicle accident. He again underwent arthroscopic surgery on the knee.

2. On June 2, 2008, claimant suffered an admitted work injury to his right knee when he tripped over clamps on the floor and fell. Claimant felt pain and swelling in the right knee.

3. On June 3, 2008, Dr. Walker, the ATP, examined claimant and diagnosed right knee strain. She prescribed a brace, medications, and physical therapy.

4. A June 23, 2008, magnetic resonance image ("MRI") showed a medial meniscus tear as well as findings of the prior partial meniscectomy, advanced focal changes of chondromalacia in the periphery of the medial compartment, moderate joint effusion, and moderate focal chondromalacia in the trochlear groove of the patellofemoral joint.

5. On July 30, 2008, Dr. Walden performed arthroscopic surgery for a partial medial meniscectomy. He diagnosed a meniscal tear and osteoarthritis.

6. Claimant then underwent another course of physical therapy. Claimant also demonstrated psychological problems and was referred to Dr. Reilly, a psychologist, who diagnosed adjustment disorder and provided biofeedback and counseling.

8. On October 20, 2008, Dr. Walker reexamined claimant, who reported that he was about the same. He reported that his knee buckled if he twisted it wrong, but it did not actually give out or lock. Dr. Walker found a little puffiness in the inferolateral area, but claimant was nontender to palpation. Dr. Walker determined that claimant was at MMI and did not need any maintenance medical care, but instructed him to return to the clinic as needed. Dr. Walker released claimant to work without restrictions. She determined 22% impairment of the right leg due to loss of knee flexion and for the partial meniscectomy.

8. On November 13, 2008, Dr. Walden reexamined claimant and recommended that he obtain treatment for his arthritis outside of the workers' compensation providers.

9. On January 15, 2009, Dr. Hall performed an independent medical examination ("IME") for claimant. Dr. Hall concluded that claimant was not at MMI for the work injury and needed an MRI or arthrogram.

10. On February 11, 2009, Dr. Walker reviewed preexisting medical records and apportioned claimant's impairment rating for the right knee injury. Dr. Walker noted that claimant was still at MMI.

11. On June 29, 2009, Dr. Fernandez performed the Division IME ("DIME"). Dr. Fernandez agreed that claimant was at MMI on October 20, 2008. She determined 24% permanent impairment of the right leg, but apportioned 7% of the impairment due to similar loss of range of motion in the contralateral left leg. Dr. Fernandez recommended post-MMI treatment to include a repeat MRI of the right knee. She noted, "It is possible there is pathology which could be treated. However, if the MRI does not reveal additional surgical lesions I do not think he is likely to benefit from further physical therapy." She recommended only the MRI and then further determinations by the ATP.

12. On September 3, 2009, the insurer filed a final admission of liability for permanent partial disability benefits based upon the rating by Dr. Fernandez. The insurer denied liability for post-MMI medical benefits.

13. On November 23, 2009, Dr. Walker reexamined claimant, who reported that his right knee started popping in about February 2009. Dr. Walker concluded that claimant's symptoms were due to his arthritis rather than from his meniscal injury. She referred claimant for the repeat MRI.

14. The December 9, 2009, MRI showed fraying of the inferior articular surface and a free edge of the posterior horn of the medial meniscus, 50% loss of cartilage thickness, and a medial cruciate ligament sprain.

15. On January 15, 2010, Dr. Walker reviewed the MRI results with claimant by

telephone. She noted that the MRI did not show any changes and that claimant was still at MMI. She concluded that the arthritis of the medial compartment caused the majority of claimant's pain symptoms and this was not due to the work injury. She noted that there was no treatment, although synvisc injections could decrease symptoms from arthritis. She noted that injuries do sometimes increase symptoms from arthritis.

16. Claimant lives 10 miles south of Ramah, Colorado, which is 100 miles away from Dr. Walker's offices. The parties stipulated that claimant would need at ATP in Colorado Springs if he needed additional treatment for the work injury.

17. Claimant has failed to prove by clear and convincing evidence that the DIME erred in determining that claimant was at MMI on October 20, 2008. Dr. Fernandez agreed with the ATP, Dr. Walker, that claimant was at MMI on that date. Dr. Hall's contrary opinion does not demonstrate that it is highly probable that Dr. Fernandez was wrong. Dr. Fernandez's determination is not inconsistent. She determined that claimant's condition from the work injury was stable. She did not recommend post-MMI treatment other than a repeat MRI just to see if claimant had any surgical lesion. On January 15, 2010, after receiving the MRI report, Dr. Walker reiterated that claimant was still at MMI for the work injury.

18. Claimant has failed to make a substantial showing that he needs post-MMI medical treatment for the work injury. Dr. Walker concluded that claimant's ongoing symptoms were the result of his medial compartment arthritis rather than the work injury. She noted that synvisc injections could decrease symptoms from the arthritis. She noted that injuries do sometimes increase symptoms from arthritis, but she concluded that claimant's symptoms were not the result of the work injury. Consequently, claimant does not need additional post-MMI medical treatment for the work injury.

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. Fernandez, determined that claimant was at MMI. Consequently, claimant 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, claimant has failed to prove by clear and convincing evidence that Dr. Fernandez erred in determining that claimant was at MMI on October 20, 2008.

3. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury, including treatment after MMI. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). In *Milco Construction v. Cowan,* 860 P.2d 539 (Colo. App. 1992), the Court of Appeals established a two-step procedure for awarding ongoing medical benefits under *Grover*. The court stated that an ALJ must first determine whether there is substantial evidence in the record to show the reasonable necessity for future medical treatment for the work injury. If the claimant reaches this threshold, the court stated that the ALJ should enter "a general order, similar to that described in *Grover*." Nevertheless, *Grover* provided, “[B]efore an order for future medical benefits may be entered there must be substantial evidence in the record to support a determination that future medical treatment will be reasonably necessary to relieve the injured worker from the effects of the work-related injury or occupational disease.” While claimant does not have to prove the need for a specific medical benefit at this time, and respondents remain free to contest the reasonable necessity of any future treatment, claimant must prove the probable need for some treatment after MMI due to the work injury. *Milco Construction, supra.* As found, claimant has failed to make such a showing in this case.

4. Respondents stipulated that, if claimant were entitled to post-MMI medical treatment, he was entitled to a change to an ATP in Colorado Springs. Because claimant failed to prove entitlement to post-MMI medical treatment, no change of ATP is necessary.

ORDER

It is therefore ordered that:

1. Claimant’s request for additional medical treatment to attain MMI is denied and dismissed.

2. Claimant’s request for post-MMI medical benefits and a change of ATP is denied and dismissed.

DATED: February 24, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

W.C. No. 4-805-179

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern Claimant's entitlement to temporary total disability (TTD) benefits beginning on May 22, 2009 and ongoing. Respondents do not dispute that the Claimant has been temporarily totally disabled during this time; however, they allege the affirmative defense that the Claimant was responsible for her termination and thus is not entitled to TTD benefits pursuant to §8-42-105(4) C.R.S. (2009). The issue of average weekly wage (AWW) was reserved for future determination.

FINDINGS OF FACT

1. The Claimant was an employee of the Employer and worked at one of its stores.

2. Respondents filed a General Admission of Liability, dated October 21, 2009, admitting for medical benefits and an average weekly wage (AWW) of $360. It is still in effect.

3. At the commencement of the hearing, the parties stipulated that the Claimant has been receiving $227.00 per week in unemployment (UI) benefits from August 15, 2009 and continuing. The parties further stipulated that the Respondents are entitled to an offset of the full amount of unemployment benefits received by the Claimant, and the ALJ so finds.

4. On May 18, 2009, the Claimant was working with one other employee, Brenda Yoshima.

5. When the store closed, the Claimant locked the front door of the store, went to the cash register area, opened the safe, removed the contents and placed the money on the counter.

6. The company's procedure for closing the store was that after the door was locked, the door remained locked until the money was counted and placed back in the safe and the employees were ready to leave the store.

7. After the Claimant put the money on the counter, she saw that R had opened the front door and was standing in the doorway talking to unknown persons outside.

8. The Claimant twice told R to come inside and lock the front door. R refused.

9. The Claimant then went to the door and pushed R out the door and locked it. In the process of doing this, the Claimant injured her right hand. A video presented by the Respondents shows the Claimant doing this. The Claimant's testimony was consistent with

the video.

10. According to the Claimant, in the year before she began working at the store, it had been robbed on three occasions. Claimant also stated, and it is un-rebutted, that she was robbed at gunpoint while working at the store. During the May 18, 2009 incident, the Claimant thought that she was about to be robbed and wanted to secure the store and the money. She did not know who the people were outside the store and thought that she could be in the process of being set up for another robbery. She also stated that there was $3,000 on the counter and that she was panicked, afraid and wanted to get the door secured as quickly as possible. She pushed R out the door so that she could lock the door and protect herself and the money. Also, she pushed R out of the door because if she had pulled R into the store, R could have simply unlocked the door again. In a sense, the Claimant had a "choice of evils:" push R or not push R and risk a robbery.

11. S, the Area Operations Manager for the Employer, stated that the Claimant was terminated for violence in the workplace and creating a hostile work environment. The basis of the termination was because the Claimant pushed R out the door. She also stated that R was terminated for violating store procedures by unlocking the door after the store had been closed and before the money had been counted and put back in the safe. The ALJ observes that the Employer attempts to portray R as the innocent victim of workplace "violence" and a "hostile work environment," yet the Employer terminated R for the incident on the ground of "violating procedures." The ALJ infers and finds that the inconsistency of the Employer's rationale, after the incident, does not compute well on the calculator of reasonableness. The Claimant's explanations were reasonable and credible. The Employer's grounds for firing the Claimant are not credible and may characterized in the nature of "cutting off one's nose to spite her face." The Claimant was trying to protect her Employer from a potential robbery.

12. The Claimant has proven, by a preponderance of the evidence that she has not earned wages, not been released to return to full duty and not been declared to be at maximum medical improvement since May 22, 2009. Therefore, the Claimant has proven that she has been temporarily and totally disabled since that date.

13. Respondents have failed to prove the affirmative proposition of "responsibility for Termination" by preponderant evidence.

CONCLUSIONS OF LAW

Credibility

a. 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 Employer's apparent outrage over the "workplace violence" and "hostile work environment" is inconsistent with its actions vis a vis Brenda R. Indeed, its grounds for firing the Claimant are not credible and may characterized in the nature of "cutting off one's nose to spite her face." The Claimant was trying to protect her Employer from a potential robbery.

Burden of Proof

b. Ordinarily, the injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. §§ 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). The burden of proof, however, is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). 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 proven entitlement to TTD benefits from May 22, 2009 and continuing. Respondents have failed to sustain their burden on the affirmative proposition of Claimant's "responsibility for termination."

Responsibility for Termination

c. In 1999, § 8-42-105(4) was added to the Workers Compensation Act and it provides that when an employee is responsible for termination, the resulting wage loss shall not be attributable to the on-the-job injury. This amendment introduced the concept of fault into the Workers Compensation Act as it applied to a claimant's eligibility for temporary total disability (TTD) benefits. *See Colorado Springs Disposal v. Indus. Claim Appeals Office,* 58 P3d 1061 (Colo. App. 2002). The concept of fault presupposes that worker has done something wrong. It is similar to the concept that one should not be allowed to benefit from her wrongdoing. In this case, the Claimant was found to have acted reasonably. Within a short period of time, she had to make a choice as to how to secure the premises against a potential robbery. She

reasonably believed that a fellow employee was setting her up for a robbery. When R refused to close and lock the door, the Claimant acted reasonably in securing the store by pushing R out of the doorway and locking the door behind her. The reasonableness of her actions is buttressed by the fact that the store had been robbed several times and that the Claimant herself had been robbed at gunpoint at this same store. Had the Claimant allowed the door to remain unlocked, it would have been a violation of store policy, and it would have endangered her personally and exposed the store to a potential store robbery. Under the circumstances, instead of firing the Claimant, the Employer should have given the Claimant an "employee-of-the-month" citation.

d. The doctrine of choice of evils as codified in §18-1-702, C.R.S. (2009), is recognized in criminal law and has a corollary in this case. The statute holds that there can be a justifiable use of physical force when it is necessary as an emergency measure to avoid an imminent public or private injury which is about to occur by reason of a situation occasioned or developed through no conduct of the actor. As found, the Claimant in this case was not at fault for the door being opened. Her actions were the result of an emergency situation not of her making. It is not known with a certainty if a robbery was about to occur, however, the Claimant reasonably believed, based on past experience, that this was going to occur and she acted reasonably based upon this belief.

e. Although the Claimant was not at fault for her termination, even if she was, she would still be entitled to TTD benefits. In *Colorado Springs Disposal, supra*, the employee was terminated for a trucking accident that also caused his injuries. The Court ruled that the word "responsible" does not refer to an employee's injury-producing activity. The court stated," Hence, the termination statutes are inapplicable where an employer terminates an employee because of the employee's injury or injury-producing conduct." *at 1064.* In this case, the Claimant was injured for the same action that precipitated her termination, albeit not for fault.

UI Offset

f. § 8-42-103 (1) (f), C.R.S. (2009), permits a 100% offset for UI benefits. As stipulated and found, Claimant has been receiving $227.00 per week in unemployment (UI) benefits from August 15, 2009 and continuing. Therefore, Respondents are entitled to an offset in this amount.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay the Claimant temporary total disability benefits at 2/3rds of her AWW from May 22, 2010 and ongoing until terminated by operation of law.

B. Respondents are entitled to an offset $227 per week for unemployment benefits received by the Claimant beginning August 15, 2009 and continuing.

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 February 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-740-062

ISSUES

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

2 Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period February 16, 2007 until terminated by statute.

3. Whether Respondents are entitled to recover an overpayment of TTD benefits.

STIPULATION

Claimant receives Social Security Disability Insurance (SSDI) benefits in the amount of $1,361.50 per month. He has received in excess of $30,000 in SSDI benefits but could not locate his initial entitlement documents. Because the exact date of Claimant's initial entitlement to SSDI benefits is currently unknown, the parties agreed that Respondents are permitted to an SSDI offset beginning on the date he was first entitled to SSDI benefits.

FINDINGS OF FACT

1. In 2002 Claimant earned a Master's Degree in Real Estate Construction Management from the University of Denver. While earning his Masters Degree, Claimant interned as an assistant construction superintendent for T on a restaurant construction project. After Claimant completed his Masters Degree in 2002, he continued to work for T as a Project Manager.

2. Between late 2002 and late 2005, Claimant built a 6,500 square foot mansion, known as the U project. Claimant acted as the developer and builder. He oversaw the three-year construction of the project from start to finish. Claimant lived on the U property in his camper during the construction period. In December 2006, he sold the house for $1.575 million.

3. After completing the U project Claimant began working as a subcontracted construction superintendent for V. Claimant's duties involved supervising the construction of a restaurant in Aurora, Colorado. During his work for V, Claimant was responsible for all phases of the construction of the restaurant, including quality control, scheduling, safety, record keeping and acting as a liaison with the city.

4. On May 10, 2006 Claimant injured his right knee while working for V when he slipped while exiting his construction trailer. Claimant reported the injury to Insurer on May 31, 2006.

5. On June 2, 2006 Claimant visited Castle Rock Family Medicine for an evaluation. He was diagnosed with a sprain/strain of his right knee. Claimant was instructed to apply ice and heat and to remain off of work until his next appointment on June 6, 2006. Claimant did not miss any days of work and failed to follow-up with Castle Rock Family Medicine on June 6, 2006. Claimant continued to work full duty without restrictions f until July or August 2006.

6. Claimant's initial contract with V was for 30 weeks at $1,676.00 per week. However, V terminated the contract after 21 weeks for reasons unrelated to Claimant's knee injury. V records reflect that during the 21 weeks Claimant worked for the company he earned $1,676.00 per week minus expenses.

7. Claimant subsequently obtained a construction superintendent position with B Construction. His duties involved overseeing the construction of a L's Restaurant. Claimant's responsibilities required him to manage all phases of the construction project including quality control, scheduling, safety, record-keeping and acting as a liaison between the owner and the city. Although Claimant explained that he left the position because he was unable to climb stairs and a ladder to perform inspections, he was under no medical restrictions during his employment with B Construction. Claimant received his last paycheck from B Construction on September 15, 2006.

8. During 2006 Claimant was also affiliated with W Holding, LTD, LLC (W). W consisted of Claimant and two other partners who purchased a golf course and surrounding

property. The partners intended to build a golf course community consisting of residential homes and a convenience center. Claimant moved from Colorado in 2006 and lived in an RV park next to the W property for five months. He attempted to obtain funding for the project. Claimant was paid on a project-by-project basis. Between August 31, 2006 and January 17, 2007 Claimant received $48,000 from W. Furthermore, Claimant's K-1 document for the 2006 tax year revealed that he was a shareholder in W. He claimed $15,550 in earnings and $62,006 in ordinary income loss from W for 2006.

9. Claimant did not obtain medical treatment between June 2, 2006 and April 19, 2007. However, on April 19, 2007 Claimant visited St. Joseph-Caldwell Family Medicine Clinic in Texas. Claimant initially received treatment from John Scott Chennault, D.O. for tremors and right knee pain. A May 2, 2007 MRI of Claimant's right knee revealed an ACL tear and degenerative changes.

10. Based on a referral, Claimant visited surgeon Barry L. Veazey, M.D. for an evaluation on May 4, 2007. Claimant reported right knee pain but no instability. Because of a serious prior leg injury, Dr. Veazey concluded that Claimant would ultimately need an arthroplasty. However, Dr. Veazey noted that surgery could be delayed as long as possible. He recommended exercises and therapy but did not impose any work restrictions.

11. Claimant's 2007 bank records reflect that he began the year with over $200,000 in his bank accounts. He was financially active in 2007 by writing large checks out of his accounts, depositing large amounts of money, and making numerous money transfers throughout the year. Claimant's Amended 2007 Federal Tax Return reveals that he was active and working in 2007. He reported business expenses of $17,906.00 and expenses for the business use of his home in the amount of $968.00. Claimant's business expenses included car and truck usage, contract labor, depreciation, legal and professional services, office expenses, repairs and maintenance, taxes and licenses, travel, meals and entertainment. He also claimed a deduction for business/investment use of his vehicle based on driving 15,096 miles.

12. In early 2007 Claimant began the development of a duplex community called "X." Claimant located suitable property, analyzed the market and confirmed that he could construct a duplex community on the land. He purchased the property in February 2007.

13. Shortly after acquiring the land, Claimant bought a new $54,799 fifth wheel camper and resided on the property during the development of the duplex community. Claimant sketched the building plans and hired a draftsman to prepare the blueprints. In approximately March 2008 Claimant hired RF Construction Company as the builder of the first two buildings. Owner of RF Construction Company Y confirmed that Claimant had plans to build 30 more duplexes. Initially, Claimant agreed to terms with Mr. Y to build the first two duplexes. However, construction was delayed because Claimant sought construction financing. On September 23, 2008 Claimant obtained a $164,400 construction loan from

State Bank. He thus materially participated in the pre-construction phase of the X project.

14. Although he was not the builder, Claimant oversaw the construction of the first two duplexes. Construction lasted from approximately September 2008 until January 2009. Claimant lived on the land in his fifth wheel on a hill overlooking the project and was on-site during the entire building phase. Claimant sat in his truck to watch the contractors and inspected the work to the best of his ability. He met with the builder in the mornings for 15 to 20 minutes to discuss the project. Claimant also managed the construction loan account. Upon completion of the project, Claimant ultimately withheld money from Mr. Y because of concerns with the texture work and punch-out list. Notably, Claimant developed a website to market the duplexes and purchased signage that he placed in front of the properties. He sought to sell the duplexes for prices in the mid $150,000s.

15. On January 9, 2008 Claimant returned to Dr. Veazey because he was experiencing right knee pain. Dr. Veazey recommended a right knee arthroplasty but again did not impose any work restrictions.

16. Claimant's Amended 2008 Federal Tax Return is similar to his 2007 tax return. Claimant identified his profession as "non residential business construction." He claimed $32,020 in business expenses for the year and $1,243 as an expense for the business use of his home. Claimant's business expenses included car and truck usage, commissions and fees, insurance, legal and professional services, office expenses, supplies, taxes and licenses, travel, meals, entertainment, postage, a business telephone, waste management, credit card fees, tolls and parking, pest control, internet, software, tools, copies and Turbotax. Claimant also claimed depreciation for his RV, Nissan Murano, laptop computer, project camera, notebook, and duplex construction. He claimed ownership of a Section 179 residential rental property in the amount of $800,000 and depreciation for the residential rental property in the amount of $141,407. Claimant asserted that he drove 14,245 miles for the business use of his vehicle. He claimed a net operating business loss in the amount of $157,517.

17. When Claimant could not immediately sell the two finished X duplexes he decided to rent the units. Claimant's first tenant entered a lease agreement on February 1, 2009. A second tenant moved into a different unit on June 1, 2009 and another tenant moved into a third unit on August 1, 2009. All three tenants executed leases requiring them to pay $665 per month. Claimant also continued to market and advertise the duplexes for prices in the mid $150,000s. Claimant's website reveals that the company selling the duplexes is "Z."

18. On September 16, 2009 Claimant underwent right knee ACL reconstruction. He has received physical therapy following the surgery.

19. On December 2, 2009 Insurer filed a General Admission of Liability

acknowledging an AWW of $2,770.49 and TTD benefits from September 16, 2009 until terminated by statute. Insurer relied on V records as a reflection of Claimant's earnings although the records included expense reimbursements. In addition, Respondents did not take credit for an SSDI offset because Claimant had not notified Insurer of his receipt of the benefits.

20. Claimant testified at the hearing in this matter. He explained that his responsibilities as a construction project manager required him to manage all phases of construction projects including quality control, scheduling, safety, record-keeping and acting as a liaison between the owner and the city. He remarked that he was unable to perform his regular job duties after his industrial injury on May 10, 2006. Claimant noted that he left his position with B Construction because he was unable to climb stairs and a ladder to perform inspections. He commented that his condition continued to deteriorate and he was unable to work after ending his relationship with W on February 15, 2007. Nevertheless, he acknowledged that his job duties were essentially sedentary in nature. Claimant also recognized that he has been receiving SSDI benefits of $1,361.50 each month since approximately October 1, 2007.

21. An AWW of $1,155.94 constitutes a fair approximation of Claimant's wage loss and diminished earning capacity as a result of his May 10, 2006 industrial injury. On May 10, 2006 Claimant was injured while working as a self-employed construction contractor for V Construction. Claimant's initial contract with V was for 30 weeks at $1,676.00 per week. V records also reflect that during the 21 weeks Claimant worked for the company he earned $1,676.00 per week minus expenses. For the 2006 tax year Claimant claimed $27,043.52 or $520.06 per week in business expenses. Claimant's Form 1040 Schedule C reflects that the expenses included repairs and maintenance, travel, mortgage payments, car and truck expenses and depreciation. Based on Claimant's work as a self-employed construction contractor, the deductions bear some logical relationship to his actual diminution in earnings. Accordingly, Claimant's AWW of $1,676.00 should be reduced by $520.06 per week for a total AWW of $1,155.94.

22. Claimant has failed to prove that it is more probably true than not that he is entitled to receive TTD benefits from February 16, 2007 until terminated by statute. Nevertheless, based on Respondents' General Admission of Liability, Claimant is entitled to receive TTD benefits for the period September 16, 2009 until the date of the hearing in this matter. He has not established that his May 10, 2006 industrial injury caused a disability or that he suffered an actual wage loss. Following his right knee injury, Claimant continued to work full duty without restrictions for V and B Construction. He then moved to Texas and worked for W on a project-by-project basis. Claimant earned $48,000 from W after his right knee injury. In early 2007 Claimant began the development of the X duplex community. He materially participated in the pre-construction phase of the project and oversaw the construction of the first two duplexes. After construction, Claimant developed a website and marketed the first two duplexes. Because he could not immediately sell the two duplexes,

Claimant rented the units for $665.00 per month.

23. Claimant's financial activities and business expense reports suggest that he was performing work activities related to the preceding construction projects. Claimant's Amended 2007 Federal Tax Return reveals that he reported business expenses of $17,906 and expenses for the business use of his home in the amount of $968. Claimant claimed business expenses for car and truck usage, contract labor, depreciation, legal and professional services, office expenses, repairs and maintenance, taxes and licenses, travel, meals and entertainment. He also deducted driving expenses of 15,096 miles because of the business/investment use of his vehicle. Claimant's Amended 2008 Federal Tax Return is similar to his 2007 tax return. He identified his profession as "non residential business construction." Claimant claimed $32,020 in business expenses and $1,243 as an expense for the business use of his home. Claimant's business expenses included car and truck usage, commissions and fees, insurance, legal and professional services, office expenses, supplies, taxes and licenses, travel, meals, entertainment, postage, a business telephone, waste management, credit card fees, tolls and parking, pest control, internet, software, tools, copies and Turbotax. Claimant also claimed depreciation for his RV, Nissan Murano, laptop computer, project camera, notebook, and duplex construction. Claimant's business records thus reveal that he did not suffer a disability or actual wage loss as a result of his industrial injury.

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. §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. §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. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, 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).

Average Weekly Wage

4. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on his 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, §8-42-102(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). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant's wages based on the particular circumstances of the case. *In Re Broomfield,* W.C. No. 4-651-471 (ICAP, Mar. 5, 2007).

5. In *Elliott v. El Paso County,* 860 P.2d 1363 (Colo. 1993) the Colorado Supreme Court concluded that depreciation claimed by a self-employed worker must generally be deducted from gross receipts when determining an AWW. The Court reasoned that depreciation represents a method of recovering the expenses of capital equipment over time. *Id.* at 1365-66. Consequently, "reasonable depreciation deductions are necessary to accurately determine the appropriate amount of income of those who are self-employed." *Id.* However, the Court cautioned that it was not establishing a "per se rule of depreciation deduction for the simple reason that it would be manifestly unjust" to consider the deduction in calculating an AWW. *See In Re Anderson,* W.C. No. 4-176-931 (ICAP, Dec. 23, 1998). Instead, the deduction must bear "some logical relationship to a self-employed claimant's actual diminution in earnings as a result of capital expenditures." *Elliott,* 860 P.2d at 1366; *In Re Anderson,* W.C. No. 4-176-931 (ICAP, Dec. 23, 1998). Relying on *Elliott,* an ALJ correctly calculated a claimant's AWW based on gross receipts as a self-employed truck driver minus "service and repair" expenses. *In Re Anderson*, W.C. No. 4-176-931 (ICAP, Dec. 23, 1998). Expenses may thus be deducted from gross receipts in calculating an AWW if a claimant is self-employed. *See In Re Hunterson,* W.C. No. 4-552-585 (ICAP, Sept. 29, 2004).

6. As found, an AWW of $1,155.94 constitutes a fair approximation of Claimant's wage loss and diminished earning capacity as a result of his May 10, 2006 industrial injury. On May 10, 2006 Claimant was injured while working as a self-employed construction contractor for Day-Lin Construction. Claimant's initial contract with V was for 30 weeks at $1,676.00 per week. V records also reflect that during the 21 weeks Claimant worked for the company he earned $1,676.00 per week minus expenses. For the 2006 tax year Claimant claimed

$27,043.52 or $520.06 per week in business expenses. Claimant's Form 1040 Schedule C reflects that the expenses included repairs and maintenance, travel, mortgage payments, car and truck expenses and depreciation. Based on Claimant's work as a self-employed construction contractor, the deductions bear some logical relationship to his actual diminution in earnings. Accordingly, Claimant's AWW of $1,676.00 should be reduced by $520.06 per week for a total AWW of $1,155.94.

Temporary Total Disability Benefits

7. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). To demonstrate entitlement to TTD benefits a 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). 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 a claimant must present medical evidence from an attending physician to establish a physical disability. *See Lymbum v. Symbois Logic,* 952 P.2d 831 (Colo. App. 1997). Instead, a claimant's testimony is sufficient to demonstrate a temporary "disability." *Id.* Section 8-42-105(3), C.R.S. provides that TTD benefits shall continue until respondents demonstrate that claimant has reached MMI, returned to work, was released to regular employment, or was released to modified employment and failed to accept a written offer of modified employment. §8-42-105(3), C.R.S.

8. As found, Claimant has failed to prove by a preponderance of the evidence that he is entitled to receive TTD benefits from February 16, 2007 until terminated by statute. Nevertheless, based on Respondents' General Admission of Liability, Claimant is entitled to receive TTD benefits for the period September 16, 2009 until the date of the hearing in this matter. He has not established that his May 10, 2006 industrial injury caused a disability or that he suffered an actual wage loss. Following his right knee injury, Claimant continued to work full duty without restrictions for V and Buffalo Construction. He then moved to Texas and worked for W on a project-by-project basis. Claimant earned $48,000 from W after his right knee injury. In early 2007 Claimant began the development of the X duplex community. He materially participated in the pre-construction phase of the project and oversaw the construction of the first two duplexes. After construction, Claimant developed a website and marketed the first two duplexes. Because he could not immediately sell the two duplexes, Claimant rented the units for $665.00 per month.

9. As found, Claimant's financial activities and business expense reports suggest that he was performing work activities related to the preceding construction projects.

Claimant's Amended 2007 Federal Tax Return reveals that he reported business expenses of $17,906 and expenses for the business use of his home in the amount of $968. Claimant claimed business expenses for car and truck usage, contract labor, depreciation, legal and professional services, office expenses, repairs and maintenance, taxes and licenses, travel, meals and entertainment. He also deducted driving expenses of 15,096 miles because of the business/investment use of his vehicle. Claimant's Amended 2008 Federal Tax Return is similar to his 2007 tax return. He identified his profession as "non residential business construction." Claimant claimed $32,020 in business expenses and $1,243 as an expense for the business use of his home. Claimant's business expenses included car and truck usage, commissions and fees, insurance, legal and professional services, office expenses, supplies, taxes and licenses, travel, meals, entertainment, postage, a business telephone, waste management, credit card fees, tolls and parking, pest control, internet, software, tools, copies and Turbotax. Claimant also claimed depreciation for his RV, Nissan Murano, laptop computer, project camera, notebook, and duplex construction. Claimant's business records thus reveal that he did not suffer a disability or actual wage loss as a result of his industrial injury.

ORDER

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

1. Claimant earned an AWW of $1,155.94.

2. Claimant's request for TTD benefits for the period February 16, 2007 through September 15, 2009 is denied and dismissed.

3. Respondents are responsible for TTD benefits from September 16, 2009 until the date of the hearing in this matter.

4. Respondents are entitled to an SSDI offset of $1,361.50 per month beginning on the date Claimant was first entitled to SSDI benefits.

5. Any issues not resolved in this Order are reserved for future determination.

DATED: February 26, 2010.

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Peter J. Cannici
Administrative Law Judge

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[1] The ALJ notes that there is some dispute by Dr. Waksman over whether Claimant was exposed to fumes or simply odors. The ALJ makes no finding as to whether Claimant was exposed to fumes in this case and finds that it is immaterial at this time in determining whether Claimant suffered a compensable injury while employed with employer. The undisputed evidence establishes that Claimant's place of work had an odor caused by the remodel work being performed on a separate part of the building and the odors caused physical symptoms to develop in Claimant and other employees that included headaches, dizziness, light headedness and nausea.