O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-764-364

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable industrial injury to his left knee during the course and scope of his employment with Employer on March 20, 2008.

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

3. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits.

4. Whether Respondents have established by a preponderance of the evidence that Claimant is precluded from receiving 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. Employer is a company that installs commercial swimming pools and aquatic features. On February 27, 2008 Claimant began working for Employer as a construction laborer.
2. On March 20, 2008 Claimant was performing plumbing work in a collection tank. The collection tank was approximately 18 feet deep. Claimant descended into the tank on rungs that were attached to a concrete wall. He lost his balance, missed the last rung, twisted his left knee and fell several feet. Claimant landed on the concrete floor at the bottom of the tank. He experienced pain in his left knee and remained on the concrete floor for a short period of time. Claimant then completed his tasks in the collection tank, climbed up the rungs of the tank and finished his work shift.
3. Claimant's supervisor RP also testified about the March 20, 2008 incident. Mr. P explained that he witnessed Claimant fall several feet off the rungs of the collection tank onto the concrete floor at the bottom of the tank. Claimant remained on the floor for a short period of time but stood up without assistance. Mr. P then inquired about how Claimant was feeling and Claimant responded that he was sore. However, Claimant did not request medical treatment. Claimant then climbed up the rungs to the top of the collection tank and completed his work shift.
4. On March 21, 2008 Claimant completed his eight and one-half hour work shift for Employer. He spent most of the day crawling on his knees over rebar while searching for a leak. Mr. P explained that, although Claimant complained of knee pain, he did not relate the pain to the March 20, 2008 incident. Instead, Claimant attributed his knee pain to working on his knees over the course of many years.

5. After the March 20, 2008 incident Claimant completed his job duties for Employer over the next two and one-half months. However, Claimant explained that his work activities aggravated his knee pain and caused swelling on a daily basis.

6. On June 17, 2008 Employer terminated Claimant from employment. Employer's owner RR testified that he had expected Claimant to learn the trade and become a foreman for Employer but Claimant failed to demonstrate any initiative. He specifically noted that he worked with Claimant on a project during May of 2008. Claimant worked slowly, inefficiently and required more time than other employees to complete his job tasks. Mr. R terminated Claimant on June 17, 2008 because Claimant was the wrong person for the job, worked slowly and did not desire to learn the technical aspects of the business.

7. On June 25, 2008 Claimant visited Edward H. Parks, M.D. to obtain medical treatment for left elbow pain and left knee pain. Claimant reported that, while working on March 20, 2008, he was climbing down a ladder into a cistern. He missed the last three steps of the ladder and fell approximately six feet. Claimant explained that he did not immediately seek medical treatment but continued to experience swelling and discomfort in his left knee.

8. X-rays of Claimant's left knee did not reveal any fractures or lesions. Dr. Parks thus diagnosed a "possible meniscus tear" and "lateral epicondylitis." He then administered cortisone injections into Claimant's left elbow and left knee.

9. On July 3, 2008 Claimant filed a Worker's Claim for Compensation. He reported that he was climbing down a ladder in a concrete vA on March 20, 2008 while performing his job duties for Employer. He fell off the ladder, twisted and landed on his left knee at the bottom of the vA. Claimant noted that, because his left knee condition continued to worsen, he visited Dr. Parks on June 25, 2008.

10. On August 6, 2008 Claimant engaged in a telephone discussion with Dr. Parks. Dr. Parks recommended an MRI of Claimant's left knee.

11. Claimant has proven that it is more probably true than not that he sustained a left knee injury on March 20, 2008 during the course and scope of his employment with Employer. Claimant credibly testified that he descended into a collection tank on rungs that were attached to a concrete wall. He lost his balance, missed the last rung, twisted his left knee, and fell several feet to the bottom of the tank. Claimant immediately experienced left knee pain but completed his work shift. Claimant's supervisor Mr. P corroborated Claimant's account of the incident in the collection tank. Furthermore, the medical records of Dr. Parks regarding the March 20, 2008 incident are consistent with Claimant's account. The March 20, 2008 incident thus aggravated, accelerated, or combined with Claimant's pre-existing left knee condition to produce a need for medical treatment.

12. Claimant has demonstrated that it is more probably true than not that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left knee injury. Claimant credibly explained that, although he performed his job duties for approximately two and one-half months after the incident, he continued to experience swelling and discomfort in his left knee. Because x-rays of Claimant's left knee did not reveal any fractures or lesions, Dr. Parks diagnosed a "possible meniscus tear" and "lateral epicondylitis." Dr. Parks subsequently recommended an MRI of Claimant's left

knee. Claimant's medical treatment with Dr. Parks and an MRI of his left knee are designed to evaluate his left knee condition and relieve the effects of the March 20, 2008 incident.

13. Claimant has failed to establish that it is more probably true that not that he is entitled to TTD benefits. He has not proven that his March 20, 2008 industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. Claimant continued to perform his job duties for approximately two and one-half months after he injured his left knee. Although he experienced pain and swelling in his left knee as a result of his job activities, he did not suffer a wage loss. Claimant did not cease working for Employer until June 17, 2008 when he was terminated from employment based on an unsatisfactory job performance.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §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 determination by the Judge. *Faulkner, 12 P.3d at 846.*

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has proven by a preponderance of the evidence that he sustained a left knee injury on March 20, 2008 during the course and scope of his employment with Employer. Claimant credibly testified that he descended into a collection tank on rungs that were attached to a concrete wall. He lost his balance, missed the last rung, twisted his left knee, and fell several feet to the bottom of the tank. Claimant immediately experienced left knee pain but completed his work shift. Claimant's supervisor Mr. P corroborated Claimant's account of the incident in the collection tank. Furthermore, the medical records of Dr. Parks regarding the March 20, 2008 incident are consistent with Claimant's account. The March 20, 2008 incident thus aggravated, accelerated, or combined with Claimant's pre-existing left knee condition to produce a need for medical treatment.

Medical Benefits

7. 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 his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

8. As found, Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left knee injury. Claimant credibly explained that, although he performed his job duties for approximately two and one-half months after the incident, he continued to experience swelling and discomfort in his left knee. Because x-rays of Claimant's left knee did not

reveal any fractures or lesions, Dr. Parks diagnosed a "possible meniscus tear" and "lateral epicondylitis." Dr. Parks subsequently recommended an MRI of Claimant's left knee. Claimant's medical treatment with Dr. Parks and an MRI of his left knee are designed to evaluate his left knee condition and relieve the effects of the March 20, 2008 incident.

Temporary Total Disability Benefits

9. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S. 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 a claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). A claimant suffers from an impairment of earning capacity when he has a complete inability to work or there are restrictions that impair his ability to effectively and properly perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

10. As found, Claimant has failed to establish by a preponderance of the evidence that he is entitled to TTD benefits. He has not proven that his March 20, 2008 industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. Claimant continued to perform his job duties for approximately two and one-half months after he injured his left knee. Although he experienced pain and swelling in his left knee as a result of his job activities, he did not suffer a wage loss. Claimant did not cease working for Employer until June 17, 2008 when he was terminated from employment based on an unsatisfactory job performance.

ORDER

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

1. Claimant suffered a compensable left knee injury on March 20, 2008.

2. Respondents shall pay for all of Claimant's authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his work-related left knee injury.

3. Claimant's request for TTD benefits is denied and dismissed. It is therefore unnecessary to address Respondents' contention that Claimant is precluded from receiving TTD benefits because he was responsible for his termination from employment under the termination statutes.

4. Any issues not resolved by this Order are reserved for future determination.

DATED: Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-710-481

ISSUES

¬ Did respondents overcome by clear and convincing evidence the determination of Dr. Machanic that claimant's injury includes a cervical spine component and that claimant has not reached maximum medical improvement?
¬ Did respondents overcome by clear and convincing evidence the determination of Dr. Machanic that claimant's cognitive impairment warrants a rating of 20% of the whole person?

FINDINGS OF FACT

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

1. Claimant's date of birth is August 6, 1950; his age at the time of hearing was 58 years. Employer operates a propane gas distribution business. Claimant works for employer as a yard supervisor. Claimant sustained an admitted injury from a slip and fall on ice while working in employer's yard on November 30, 2006. Claimant completed an Injury and Illness Report form, indicating he injured his head, neck, and back.
2. Claimant lost no time and continued working his regular job, until January, when he developed a 4-day history of headaches. Claimant sought medical treatment from Ann Trawick, D.O., on January 4, 2007. Claimant mentioned to Dr. Trawick that he fell while working, hit his head, and may have lost consciousness. Upon examination of claimant, Dr. Trawick found his cervical region supple and non-tender. Dr. Trawick noted that claimant had normal mental status, normal neurosensory, and normal cerebellar function examinations. Dr. Trawick suspected some intracranial process and referred claimant for a CT scan of his head and brain.
3. Claimant underwent the CT scan on January 4th, which revealed a moderate, acute, right-sided subdural hematoma. Dr. Trawick referred claimant to Neurosurgeon Thomas C. Ribovich, M.D.

4. Dr. Ribovich evaluated claimant on January 5, 2007, when claimant neither complained of any neck symptoms nor complained of any memory loss or cognitive problems. On physical examination, Dr. Ribovich noted claimant's neck was supple. Dr. Ribovich noted that Claimant exhibited full upper and lower extremity strength and normal fine motor movements of both hands. Dr. Ribovich read the CT scan as revealing new fluid mixed with preexisting fluid in the subdural space. Dr. Ribovich recommended surgical evacuation of the fluid from the subdural space the following Monday.

5. Also on January 5th, Dr. Trawick's colleague Lisa Gieseke, D.O., performed a pre-op physical examination of claimant. Claimant did not complain to Dr. Gieseke of any neck symptoms. Dr. Gieseke noted that claimant's neck was supple, non-tender and that he had full range of motion. Dr. Gieseke also noted that claimant was alert cooperative and oriented, revealing a normal mental status examination.

6. Dr. Ribovich performed a right-frontal craniotomy with evacuation of the subdural hematoma on January 8, 2007. Dr. Ribovich noted that, following evacuation of the fluid, claimant's brain re-expanded into the subdural space. A post-operative CT scan revealed a successful outcome from surgery. Dr. Ribovich discharged claimant from the hospital on January 11, 2007.

7. On January 18, 2007, Dr. Ribovich noted claimant doing quite well, other than some complaints of headaches and lightheadedness, secondary to Dilantin -- his anti-seizure medication. On February 22, 2007, Dr. Ribovich noted that claimant continued to complain of lightheadedness and slight imbalance, again secondary to the Dilantin. Another CT scan continued to reveal satisfactory evacuation of the subdural space. On March 22, 2007, Dr. Ribovich released claimant to return to work with some restrictions. Dr. Ribovich planned to keep claimant on Dilantin for another month.

8. On May 1, 2007, Dr. Ribovich discharged claimant and released him to return to full-time work. Dr. Ribovich noted that claimant had discontinued his use of Dilantin. Dr. Ribovich advised claimant to return on an "as needed" basis. Claimant did not complain to Dr. Ribovich of any neck pain or cognitive problems.

9. Claimant returned to Dr. Trawick for an evaluation on July 12, 2007, when his daughter accompanied him. Claimant complained of persistent headaches. Dr. Trawick recorded the following history of neck complaints:

> [Claimant] also notices neck pain every day and sometimes has popping, certain positions … makes (sic) him have sharp shooting pain down his arm and will get momentary tingling in his hands.

****

> **No history of recent or remote neck problems, car accidents, work injuries**.

Claimant thus did not relate his onset of neck complaints in July of 2007 to his slip and fall injury at employer the preceding November. Claimant's daughter reported that claimant's memory was not as good. Because of radicular symptoms, Dr. Trawick suspected claimant's headaches might be the result of a cervical disk problem. Dr. Trawick recommended magnetic resonance imaging (MRI) scans of claimant's cervical spine and head. Dr.

> Trawick later noted that claimant's private health insurance refused to authorize the MRIs, asserting they were for work-related conditions. The Judge infers that Dr. Trawick believed that claimant's cervical condition, by history, was unrelated to his slip and fall at employer some 7 months earlier on November 30, 2006.

10. Insurer referred claimant to Lawrence A. Lesnak, D.O., for an assessment of his permanent medical impairment from the subdural hematoma injury. Dr. Lesnak spent some 70 – 80 minutes with claimant and his daughter when examining him on August 1, 2007. Dr. Lesnak noted that claimant had returned to full-duty work at employer as a yard supervisor/forklift operator. Dr. Lesnak noted:

> [Claimant] was pleasant and cooperative throughout today's interview and evaluation. He was awake, alert, and oriented x 3 during today's evaluation. He had fluent speech patterns and showed no specific signs of semantic or phonemic language errors.
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> ****
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> He was able to perform abstract thinking without difficulty. Simple calculations seemed to be intact.
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> The only cognitive complaints claimant reported to Dr. Lesnak involved intermittent memory difficulties.

11. Dr. Lesnak also recorded a history from claimant that he developed neck and upper back pain and headache immediately following his slip and fall injury on November 30, 2006. Dr. Lesnak later testified that this history of immediate neck symptoms is inconsistent with the history established by claimant's medical records. Upon physical examination, Dr. Lesnak noted limitations in claimant's cervical range of motion due to complaints of pain. At the time of his initial report, Dr. Lesnak had an incomplete set of Dr. Ribovich's records and lacked a complete set of Dr. Trawick's reports. Dr. Lesnak thought it possible claimant had sustained a neck strain, but he lacked documentation he felt he needed to give an evidence-based, medically probable medical opinion on causation of claimant's cervical condition.

12. Dr. Lesnak placed claimant at maximum medical improvement (MMI) as of May 1, 2007, and assessed his brain impairment from subdural hematoma injury according to the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides). Dr. Lesnak rated claimant's impairment at 5% of the whole person based upon his head injury and cognitive deficits.

13. On August 15, 2007, insurer filed a Final Admission of Liability (FAL), admitting liability for permanent partial disability (PPD) benefits based upon Dr. Lesnak's impairment rating. Claimant timely objected to the FAL and requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Neurologist Bennett I. Machanic, M.D., the DIME physician. Claimant also filed an application for hearing dated September 18, 2007, specifically endorsing compensability of the neck. The hearing set on claimant's application was continued pend-

ing the results of Dr. Mechanic's DIME. All issues were reserved pursuant to order dated January 2, 2008.

14. At the request of claimant's counsel, John S. Hughes, M.D., performed an independent medical examination on September 13, 2007. Dr. Hughes also testified as an expert on Occupational Medicine. Dr. Hughes noted that claimant had returned to work and was working full duty. Claimant reported to Dr. Hughes that his main complaint was neck pain, possibly causing his headaches. Regarding his brain functioning, claimant and his daughter reported there are times when he forgets things, like where he parks his car. Based upon his evaluation, Dr. Hughes assessed persistent disturbance of complex integrated cerebral function, secondary to his closed-head injury. Dr. Hughes wrote:

> I agree completely with Dr. Lesnak that [claimant] manifests a disturbance of his complex integrated cerebral function. However, **findings that I note on examination today seem measurably worse than those that were noted six weeks ago by Dr. Lesnak**.

(Emphasis added). While Dr. Hughes recommended a neuropsychological evaluation to assess the magnitude of claimant's post subdural hematoma brain injury, Dr. Hughes estimated claimant's permanent impairment at 15% of the whole person according to the AMA Guides. Dr. Hughes based this estimate upon what claimant and his daughter reported to him on September 13, 2007.

15. Dr. Hughes opined that claimant had not reached MMI because he needed treatment for the cervical spine component of his injury. Dr. Hughes recommended a MRI scan of claimant's cervical spine to assess for impingement of the neural foramina. Dr. Hughes provisionally assessed impairment of claimant's cervical spine at 9% of the whole person.

16. Dr. Machanic evaluated claimant on December 20, 2007, when he obtained the following history from claimant and from his daughter.

> [Claimant] has a good deal of difficulty with cognitive function. His daughter feels she must care for him almost constantly. She says that he is forgetful. He has poor focus and concentration. He loses items. He has a poor sense of humor. He is moody and irritable. He is restless. He often forgets one task, and when he attempts to multitask, he becomes very confused, indeed. [Claimant's] daughter tells me that not only does he have difficulty with his memory and intellectual function but also with his behavior. She says he is "not the same as he was before this injury".
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> The **daughter further freely expresses her disappointment** regarding the sequence of events.

> (Emphasis added). The above-quoted history given by claimant's daughter is markedly inconsistent with what she and claimant gave to Dr. Lesnak and to Dr. Hughes. Dr. Hughes remarked some 6 weeks after Dr. Lesnak's evaluation that claimant and his daughter had given him a history of cognitive problems markedly worse than what they gave Dr. Lesnak. The above-quoted history is markedly worse than what they gave Dr. Hughes.

17. While Dr. Machanic agreed that claimant had reached MMI for his head injury as of May 1, 2007, he opined that claimant should undergo neuropsychological testing. Dr. Machanic's recommendation for neuropsychological testing mirrors the recommendation of Dr. Hughes. The Judge interprets this recommendation as a request for neuropsychological testing to more accurately determine the extent of claimant's cognitive impairment. Dr. Machanic nonetheless rated claimant's cognitive impairment at 20% of the whole person, based upon the history he received from claimant and his daughter.

18. Dr. Machanic determined that claimant's cervical spine condition is causally related to his slip and fall at employer on November 30, 2006. Dr. Machanic opined that claimant had not reached MMI for the cervical spine component of his injury. Dr. Machanic recommended that claimant undergo a MRI scan of his neck. Dr. Machanic provisionally rated the impairment to the cervical region of claimant's spine at 13% of the whole person. Dr. Machanic's determination that claimant's cervical spine condition is causally related to his work injury, that he sustained cognitive impairment rated at 20% of the whole person, that he sustained impairment to the cervical region of his spine rated at 13% of the whole person, and that the 13% and 20% values combine into an overall rating of 30% under the AMA Guides is presumptively correct unless overcome by clear and convincing evidence.

19. Clinical Neuropsychologist Gregory A. Thwaites, Ph.D., performed an independent neuropsychological evaluation of claimant on April 11, 2008. Claimant told Dr. Thwaites he believes his cognitive problems began with the surgical evacuation of the subdural hematoma. Dr. Thwaites however noted from the medical records that claimant's subdural hematoma evacuation was performed without anesthetic or surgical complications; that hospital records fail to suggest any cognitive complaints or signs of cognitive problems; and that follow-up visits with Dr. Ribovich and Dr. Trawick fail to reflect any neurocognitive complaints or observations. Dr. Thwaites noted that claimant's complaints of cognitive problems were mild to Dr. Lesnak but increasingly severe with each subsequent evaluator. Dr. Thwaites noted that claimant displayed a significant level of impairment during his evaluation that is incongruent with his reported level of vocational functioning – claimant reported to Dr. Thwaites that he continues to drive and works full-time. Dr. Thwaites thus noted that claimant exhibited response bias and that his reported level of functioning was inconsistent with his continued ability to perform his supervisory position for the employer. Dr. Thwaites testified that claimant did not appear to have any cognitive problems and again cautioned that he would only assess the claimant with a very mild cognitive impairment if he even had any cognitive impairment at all.

20. At respondents' request, Neurologist Peter S. Quintero, M.D., examined claimant for a neurological consultation on May 16, 2008. Dr. Quintero also testified as an expert

in General Neurology. Claimant reported to Dr. Quintero that he feels forgetful and tends to misplace things. Claimant told Dr. Quintero he might plan something and then forget what he planned. Dr. Quintero reported:

> In spite of the problems [claimant] described with memory, headache, neck and back pain, he has continued to function on a fairly normal level. [Claimant] awakens in the morning with an alarm …. He gets up before his wife. He takes a shower. He does not eat breakfast nor does he prepare coffee. He did relate that he did eat breakfast prior to the accident. **[Claimant] then drives to work. He drives a van**.
>
> [Claimant] has continued to work full-time. He still works in the capacity of a supervisor and forklift operator. He stated that he is not aware of any problems doing his work. His work does require that he do paperwork which he has been able to do without difficulty. [Claimant] has not received any criticisms or bad reviews for his work.

(Emphasis added). This history of continuing to drive is consistent with what claimant reported to Dr. Thwaites, but contrary to what claimant's daughter told Dr. Hughes when she reported they did not allow claimant to drive anymore.

21. Dr. Quintero documented other discrepancies between what claimant reported to him and what the medical records supported. For instance, claimant reported to Dr. Quintero that his headaches were constant and gradually worsening since the slip and fall accident. The medical records however showed claimant initially reporting in January of 2007 that his headache following the accident dissipated until 4 days prior to January 4th. And claimant told Dr. Machanic that his headache was intermittent, lasting 45 to 60 minutes, rather than a constant headache. Dr. Quintero cited other discrepancies in his report. Dr. Quintero opined:

> Taking into account what is documented in the medical records in comparison to what [claimant] now describes, I strongly suspect an **underlying problem with symptom magnification**.
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> ****
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> A complete battery of neuropsychological testing would help to clarify the etiology of [claimant's] cognitive symptoms and would help to rule out symptom magnification as a contributing factor.

(Emphasis added). Like Dr. Machanic and Dr. Hughes, Dr. Quintero recommends neuropsychological testing to answer the inconsistencies between cognitive problems claimant was reporting to evaluators of permanent impairment and the absence of cognitive problems he reported to his treating physicians. At the time he prepared his report, Dr. Quintero did not have Dr. Thwaites's report. Dr.

Quintero found no basis for functional impairment based upon the medical records and his nuerological evaluation.

22. Dr. Quintero noted that Claimant reported that he was able to complete his supervisory job duties, including paperwork and reports, without any problems. Claimant further reported to Dr. Quintero that he was able to do his job effectively and had not received any complaints about his work. Dr. Quintero opined that Claimant's delay in developing headaches after the accident was understandable; however, there was no explanation for the delay in developing neck symptoms or cognitive problems. Dr. Quintero suspected an underlying problem with symptom magnification.

23. On May 23, 2008, claimant underwent a MRI scan of his cervical spine. Crediting Dr. Quintero's medical opinion, the MRI scan revealed spondylosis – a chronic, progressive degenerative disease of the cervical spine. Crediting Dr. Hughes's medical opinion, the cervical pathology and degenerative changes revealed on the MRI scan are more consistent with the idea that claimant's neck problems are related to an aging process instead of an injury process.

24. Dr. Thwaites testified to the following as an expert in Clinical Neuropsychology: Dr. Thwaites had no problem communicating with claimant. Dr. Thwaites administered a battery of tests to claimant to determine how he measured against his peer group of the same gender and age. Dr. Thwaites weighed inhibiting factors such as the amount of sleep claimant got the night before and other factors that affect his performance on the testing. Claimant performed quite poorly on testing to assess the effort he was giving; he scored lower than he should have on a very easy test. The course of claimant's symptoms immediately following his concussion was typical because symptoms resolved on November 30th. Claimant reported to Dr. Thwaites no cognitive problems until after the surgical procedure to evacuate the subdural hematoma. What claimant told Dr. Thwaites however was inconsistent with the medical records, which show no evidence of cognitive difficulty.

25. According to Dr. Thwaites, claimant's reported pattern of recovery is inconsistent with the typical pattern for patients with brain injuries. The typical brain-injured patient has worse symptoms after the injury, which improve with the passage of time. Claimant's report of more severe symptoms with the passage of time fails to make neurologic sense. Dr. Quintero's testimony that claimant's report of symptoms is contrary to the normal progression of patients with subdural hematomas supports the testimony of Dr. Thwaites. Dr. Quintero agrees that claimant's cognitive symptoms typically would be present while the hematoma is pressing upon the brain – just prior to surgery.

26. Dr. Thwaites further stated: Claimant's poor scoring on motivation and other cognitive tasks is inconsistent with his performance vocationally at work. Claimant's work also involves driving heavy equipment. Claimant's level of performance was further inconsistent with the fact that claimant drove himself to the evaluation. Dr. Thwaites thus opined that claimant presented worse on testing than he functions in everyday life. Dr. Thwaites thus disagrees with Dr. Machanic's assessment of claimant's cognitive impairment. Dr. Thwaites believes claimant sustained a moderate brain injury, with possible mild cognitive impairment.

27. According to Dr. Hughes, brain-injured patients often need help from family members to provide a complete history of cognitive functioning. Dr. Hughes however

cautioned that such help from family members can also be problematic, depending what they are advocating for. In response to Dr. Quintero's opinion concerning what claimant's ability to return to his regular job demonstrates about his cognitive functioning, Dr. Hughes testified:

> [Claimant's] job is a very automatic type of job and that much of his behavior during that job is in a very well rehearsed, repetitive pattern, wherein he deals with people that he deals with all the time in ways that occur over and over again in the same fashion.
>
> And so that particular type of repetitive job is well retained by people with measurable deficits in complex integrated cerebral functioning.

28. Dr. Hughes testified that he and Dr. Quintero have a mere difference of opinion concerning claimant's rating for cognitive losses under the AMA Guides. Dr. Hughes stated:

> [Dr. Quintero and I] have both agreed that a rating is appropriate. We both agree that a rating is within this particular severity classification, outlined by the AMA Guides. We just disagree with where on this sliding scale of 5 to 15 percent the assignment should be.

Dr. Hughes explained that Dr. Machanic used the range of 20 to 45% as outlined on Page 105 of the AMA Guides based upon his opinion that claimant requires some level of supervision in some activities of daily living.

29. Dr. Hughes testified that Dr. Ribovich's description of claimant's neck as supple and non-tender involved screening for pathology other than for a neck injury. By contrast, Dr. Lesnak testified what Dr. Ribovich likely meant when he described claimant's neck as supple and non-tender:

> [I]f Dr. Ribovich says that his neck is supple, nontender, it's from a neurosurgical standpoint, looking at the posterior portion of the neck, looking for musculoskeletal or neurological deficits.
>
> ****
>
> [I]n neurosurgical training when you talk about the neck being supple, you're trained to look at range of motion and look at function of the neck.

Here, the Judge credits Dr. Lesnak's opinion over that of Dr. Hughes.

30. Dr. Quintero testified that claimant did not complain of any neck symptoms for some 7 months after his injury. When asked if Exhibit 9, showing claimant reported to employer on November 30, 2006, that he injured his neck, changed his opinion, Dr. Quintero stated:

> No. It does not alter my conclusions with this case. The reason being for the time delay between the date of the accident, when he

> may have had those initial complaints, and the time when he began to complain of them, evidently on a more regular basis, in July of 2007.
>
> ****
>
> [W]hat happened initially was a strain injury, … which he recovered from, both in the neck and the back and the subsequent later development is a reflection of the chronic degenerative process that's going on.
>
> ****
>
> [T]he degenerative disk disease became the precipitator of the pain, at least documented in the July 12th, 2007, record of Dr. Trawick. I don't know exactly when the pain in the neck stopped after the accident, but there's no mention of any neck pain in the January 4, 2007, record of Dr. Trawick ….
>
> ****
>
> And also, in Dr. Ribovich's records there's no documentation of the neck being a problem.

Dr. Quintero thus opined that, at most, claimant sustained a neck strain that resolved shortly after his injury on November 30, 2006.

31. At his deposition, Dr. Lesnak reviewed the reports of Dr. Trawick and Ribovich, which he had not previously had at the time he issued his original report. Dr. Lesnak opined that the absence of reports of neck symptoms by claimant in the records supported the conclusion that the claimant's neck problems were not part of the original injury. Dr. Lesnak also reviewed Dr. Hughes deposition and agreed with Dr. Hughes that the absence of any neck complaints or neck problems until six months post-injury makes it highly unlikely that claimant's neck symptoms are causally related to his industrial injury on November 30, 2006.

32. Respondents showed it highly probable that Dr. Machanic incorrectly determined that claimant has not reached MMI. As found, Dr. Machanic based his MMI determination upon his finding that claimant's cervical complaints are causally related to his slip and fall injury. Dr. Machanic lacked the May 23, 2008, MRI scan of claimant's cervical spine, which showed evidence of spondylosis – a chronic, progressive degenerative disease of the cervical spine. The Judge credited Dr. Hughes's medical opinion in finding the cervical pathology and degenerative changes revealed on the MRI scan are more consistent with chronic neck problems naturally due to an aging process instead of an acute injury process. The Judge found that Dr. Trawick believed claimant's cervical condition, by history, was unrelated to his slip and fall at employer some 7 months earlier on November 30, 2006. Although Dr. Lesnak initially thought it possible claimant had sustained a neck strain, he stated he needed medical records to review before to

he felt comfortable giving an evidence-based, medically probable medical opinion on causation of claimant's cervical condition. Once he had medical records, Dr. Lesnak opined that claimant's cervical condition is not causally related to his injury at employer. The Judge credited Dr. Lesnak's opinion that Dr. Ribovich's physical examination findings ruled out neck symptoms during the months he examined claimant. The Judge credits Dr. Quintero's opinion in finding that claimant's neck symptoms began in July of 2007 and are a result of the progressive degenerative disease in his cervical spine. The Judge further credits Dr. Quintero's opinion in finding that claimant, at most, sustained a neck strain from the slip and fall that resolved shortly after his injury on November 30, 2006.

33. Respondents showed it highly probable that Dr. Machanic incorrectly determined the impairment rating for claimant's brain injury. Dr. Machanic, Dr. Hughes, and Dr. Quintero all agreed that claimant should undergo a neuropsychological evaluation to assess his cognitive functioning. The Judge thus credits Dr. Thwaites's neuropsychological opinion and testimony as evidence-based and persuasive. The Judge credits the medical opinion of Dr. Quintero as consistent with Dr. Thwaites's opinion and as consistent with record-evidence showing claimant failed to complain of symptoms of cognitive problems to Dr. Trawick or to Dr. Ribovich during his treatment for his subdural hematoma. The Judge credits the opinions of Dr. Quintero and Dr. Thwaites in finding that claimant's report of cognitive symptoms is contrary to the normal progression of such symptoms in the typical patient with a subdural hematoma. The Judge credits the testimony of Dr. Quintero in finding that Dr. Machanic failed to weigh in his report the inconsistencies between the record-evidence and the history of cognitive problems claimant's daughter reported to him. Dr. Machanic failed to verify claimant's report of his symptoms with the medical records. And the Judge credits Dr. Quintero's testimony in finding Dr. Machanic's rating alike unsupported by Dr. Thwaites's neuropsychological testing and by the fact that claimant is largely independent with his work and with his activities of daily living. The history claimant's daughter gave Dr. Machanic that claimant needs supervision is inconsistent with credible evidence showing claimant able to drive, work, and supervise others.

34. The Judge finds it more probably true than not that the 5% whole person rating given by Dr. Lesnak and by Dr. Quintero appropriately assesses claimant's impairment from his subdural hematoma injury according to the AMA Guides. The Judge notes that Dr. Hughes reported that his 15% rating was an estimate based upon the history given by claimant and his daughter. Dr. Hughes recommended a neuropsychological evaluation to more truly assess claimant's impairment from his brain injury. Dr. Thwaites provided a neuropsychological evaluation and persuasively explained inconsistencies in claimant's presentation on testing and evidence of his actual cognitive functioning in activities of daily living. Dr. Thwaites's opinion shows that the history claimant and his daughter provided Dr. Hughes is unreliable. Dr. Thwaites's opinion thus fails to support Dr. Hughes's estimated rating of 15%. Dr. Quintero relied upon Dr. Thwaites's opinion and other evidence in assessing claimant's impairment at 5% of the whole person. Dr. Quintero's rating is consistent with Dr. Lesnak's opinion, wherein he rated claimant's impairment at 5%.

CONCLUSIONS OF LAW

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

A. Maximum Medical Improvement:

Respondents argue they overcame Dr. Machanic's determination of MMI by clear and convincing evidence. The Judge agrees.

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*. 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. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the 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. Bing Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and

evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

Here, the Judge found respondents showed it highly probable that Dr. Machanic incorrectly determined that claimant has not reached MMI. Respondents thus overcame Dr. Machanic's determination of MMI by clear and convincing evidence.

As found, Dr. Machanic based his MMI determination upon his opinion that claimant's cervical complaints are causally related to his slip and fall injury. Dr. Machanic lacked the May 23, 2008, MRI scan of claimant's cervical spine, which showed evidence of a chronic, progressive degenerative disease of the cervical spine.

The Judge credited medical opinions of Dr. Hughes, Dr. Lesnak, and Dr. Quintero in finding the cervical pathology and degenerative changes revealed on the MRI scan are more consistent with chronic neck problems naturally due to an aging process instead of an injury process. The Judge also credited Dr. Quintero's opinion in finding that claimant's neck symptoms began in July of 2007 and are more probably a result of the progressive degenerative disease process in his cervical spine. And the Judge credited Dr. Quintero's opinion in finding that claimant, at most, sustained a neck strain from his slip and fall at employer that resolved shortly after November 30, 2006.

The Judge concludes that claimant reached MMI as of May 1, 2007. The Judge further concludes that claimant's request for workers' compensation benefits related to his cervical spine should be denied and dismissed.

B. Permanent Partial Disability Benefits:

Respondents argue they overcame Dr. Machanic's determination of claimant's permanent impairment by clear and convincing evidence. The Judge agrees.

The DIME physician's finding under §8-42-107(8)(c), *supra*, is generally the impairment rating. *DeLeon v. Whole Foods Market, Inc.*, W.C. No. 4-600-477 (ICAO November 16, 2006). Once a party sustains the initial burden of overcoming the DIME physician's impairment rating by clear and convincing evidence, the judge's determination of the correct rating is then a matter of fact based upon the lesser burden of a preponderance of the evidence. *DeLeon v. Whole Foods Market, Inc.*, *supra*. The judge is not required to dissect the overall impairment rating into its component parts and determine whether each part has been overcome by clear and convincing evidence. *DeLeon v. Whole Foods Market, Inc.*, *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).

Here, the Judge further found respondents showed it highly probable that Dr. Machanic's impairment rating for claimant's brain injury is incorrect. Respondents thus overcame Dr. Machanic's determination of MMI and whole person impairment rating by clear and convincing evidence.

As found, Dr. Machanic, Dr. Hughes, and Dr. Quintero all agreed that claimant should undergo a neuropsychological evaluation to assess his cognitive functioning. The Judge credited the opinions of Dr. Thwaites and Dr. Quintero in finding: (1) Claimant failed to report any cognitive problems to Dr. Trawick or to Dr. Ribovich during his treatment for his subdural hematoma; and (2) claimant's report of cognitive symptoms is contrary to the normal progression of such symptoms in the typical patient with a subdural hematoma.

The Judge found that Dr. Machanic failed to weigh in his opinion the inconsistencies between record-evidence of no symptoms and the history of cognitive problems claimant's daughter reported to him. Dr. Machanic failed to verify claimant's report of his symptoms with the medical records. The Judge found that the history claimant's daughter gave Dr. Machanic of claimant requiring supervision was inconsistent with credible evidence showing claimant able to drive, work, and supervise others. The Judge found Dr. Machanic's rating alike unsupported by Dr. Thwaites's neuropsychological testing and by the fact that claimant is largely independent with his work and with his activities of daily living.

Because respondents overcame Dr. Machanic's rating by clear and convincing evidence, the burden shifts to claimant to establish his permanent impairment by a preponderance of the evidence.

The Judge found it more probably true than not that the 5% whole person rating given by Dr. Lesnak and by Dr. Quintero appropriately assesses claimant's impairment from his subdural hematoma injury according to the AMA Guides. Respondents thus proved by a preponderance of the evidence that claimant's permanent partial disability benefits should be based upon medical impairment of 5% of the whole person.

The Judge found that Dr. Hughes estimated claimant's brain injury impairment at 15% based upon an unreliable history given by claimant and his daughter. The Judge instead credited Dr. Thwaites's opinion as persuasively explaining inconsistencies between claimant's presentation on testing and evidence of his actual cognitive functioning in activities of daily living. Dr. Thwaites's opinion failed to support Dr. Hughes's estimated rating of 15%. Dr. Quintero however relied upon Dr. Thwaites's opinion and other evidence in assessing claimant's

impairment at 5% of the whole person. Dr. Quintero's rating was consistent with Dr. Lesnak's rating at 5%.

The Judge concludes that claimant sustained permanent medical impairment of 5% of the whole person for his brain injury. Because respondents admitted liability for permanent partial disability (PPD) benefits based upon impairment of 5% of the whole person, the Judge concludes claimant's claim for additional PPD benefits should be denied and dismissed.

ORDER

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

1. Claimant reached MMI as of May 1, 2007.

2. Claimant's request for workers' compensation benefits related to his cervical spine condition is denied and dismissed.

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

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

DATED: Michael E. Harr

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-764-577

ISSUE

The issue for determination is permanent partial disability benefits. Claimant seeks an award based on the whole person.

FINDINGS OF FACT

1. Claimant sustained an injury on January 17, 2008, after slipping on ice and falling on his right side. Claimant reached maximum medical improvement (MMI) on May 16, 2008.
2. Claimant underwent an MRI of the right shoulder on February 6, 2008. The MRI showed rotator cuff tears involving the distal anterior aspect of the rotator cuff, primarily affecting the supraspinatus tendon.

3. R. Baptist, M.D., an authorized treating physician, assessed Claimant with a rotator cuff tear and sprain to the right shoulder. At MMI, he measured a loss of range of motion of Claimant's shoulder. He rated Claimant's impairment at 16% of the upper extremity or 10% of the whole person.

4. Kathy McCranie, M.D., examined Claimant on October 28, 2008, prepared a report, and testified by deposition. It is her opinion that Claimant sustained an injury to his right shoulder.

5. Claimant testified that he continues to have pain in his shoulder. At times, the pain runs from his elbow to the base of his neck. He stated that he has felt a sharp pain in his chest when raising his arm over his head.

6. The testimony of Claimant and the opinions of Dr. Baptist and Dr. McCranie referred to above are credible and persuasive.

7. The situs of Claimant's functions impairment is his shoulder. Claimant's impairment is not limited to the arm.

CONCLUSIONS OF LAW

1. The question of whether the claimant sustained a "loss of an arm at the shoulder" within the meaning of Section 8-42-107(2)(a), C.R.S., or a whole person medical impairment compensable under Section 8-42-107(8)(c), C.R.S., is one of fact for determination by the ALJ. 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). Although a physician's impairment rating is not dispositive, it may be considered in determining the situs of the functional impairment. *Strauch v. PSL Swedish Healthcare System, supra*. That issue is separate and distinct from the claimant's medical impairment rating. In fact, upper extremity impairment ratings contained in the American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition, Revised (AMA Guides) are inconsistent with the scheduled injury ratings contained in Section 8-42-107(2), C.R.S. *See Mountain City Meat Co. v. Oqueda,* 919 P.2d 246 (Colo. 1996).

2. Claimant has established by a preponderance of the evidence that the situs of his impairment is not limited to the arm at the shoulder. Claimant's impairment is not on the schedule. Claimant shall receive permanent partial disability benefits based on an impairment of 10% of the whole person. Sections 8-42-101(8)(c) and (d), C.R.S.

ORDER

It is therefore ordered that Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 10% of the whole person. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

DATED: Bruce C. Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-397

ISSUES

The following issues were raised for consideration in claim numbered, W.C. #4-723-172:

1. Temporary total disability benefits (TTD);
2. Medical benefits; and
3. Penalties.

The following issues were raised for consideration in claim numbered, W.C. #4-751-397:

1. Compensability;
2. Medical benefits;
3. Average weekly wage;
4. TTD; and
5. Penalties.

Respondents assert that, on September 10, 2008, a General Admission of Liability (GAL) was filed in W.C. # 4-751-397 admitting liability for medical benefits only. Respondents contend that the filing of the GAL renders moot the issues raised in this claim. Respondents' assertion regarding the admission of liability was made in a cover email attached to the Respondents' September 29, 2008 post hearing position statement. No evidence was received that a GAL was filed by Respondents. Claimant filed a position statement on September 29, 2008 addressing all issues raised by the two claims. Claimant did not acknowledge Respondents' assertion that the claim in W.C. # 4-751-397 is rendered moot by Respondents' post hearing filing of the GAL.

On October 29, 2008, the ALJ entered a Summary Order finding that Claimant suffered a compensable injury in W.C. # 4-751-397. With regard to this claim, it was further found that Respondents are liable for reasonably necessary and related medical benefits and Claimant was responsible for her wage loss and, therefore, was not entitled to indemnity benefits. With regard to claim numbered W.C. # 4-723-172, an admitted claim, it was determined that Claimant was entitled to reasonably necessary and related medical benefits and Respondents were not liable for a penalty for directing medical treatment.

On November 6, 2008, Claimant moved for reconsideration of the Summary Order. Claimant seeks reconsideration of the determination that Claimant was responsible for her wage loss and the she is not entitled to a penalty. Claimant's motion for reconsideration is granted and these findings follow.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant injured her right ankle on May 9, 2007, when she stepped in a hole in the floor at work, in claim numbered W.C. 4-723-172. She treated with Dr. Andrew Plotkin and Dr. Barat Desai. She was treated by Dr. Plotkin on May 11, 2007. Dr. Plotkin advised work restrictions of walking or standing only 30 minutes per hour. On June 21, 2007, Dr. Plotkin returned Claimant to regular duty. Claimant was also released to regular duty by Dr. Plotkin on July 6 and July 31, 2007. Claimant was then referred to Dr. Desai. She saw Dr. Desai on August 10, 2007, September 24, 2007, February 25, 2008, and March 13, 2008. He diagnosed arthrosis of the ankle joint. Dr. Desai did not recommend restrictions in his reports of these dates.

2. On November 14, 2006, January 6, 2007, and February 21, 2007, the Employer issued to Claimant warnings concerning her attendance. In each warning, management listed numerous instances of tardiness and absenteeism. On May 18, 2007, Claimant was given a termination notice citing her inability to correct her attendance issues. This last notice recounted 9 tardies and 2 unexcused absences. It also referred to a situation occurring on May 11, 2007, wherein Claimant was noted to have failed to call in to advise the Employer she was going to see the doctor about her ankle. Claimant's testimony concerning the May 11, 2007 incident was not credited. Nor were Claimant's testimony and the testimony of her witness JS credited with regard to the five minute grace period and N J's alleged effort to set Claimant up for termination.

3. The evidence of three warnings concerning Claimant's attendance supports the conclusion that she was responsible for her termination from employment on May 18, 2007 and is not entitled to TTD in W.C.# 4-723-172.

4. On October 1, 2007, Dr. Desai's office sent to the Insurer a fax stating "see following office note, with surgery request. surgery rt foot calcaneocuboid debridement, sural nerve release and exostectomy. please call with any questions. Thanks, lori". The attached report stated, in regard to the right ankle:

> "Right foot MRI: … Lesser spurring of the distal abductor digiti minimi musculotendinous junction. Nonspecific subcutaneous soft tissue edema associated with his surrounding the 5th metatarsophanlangel joint, particularly laterally. Mild peroneus longus tendinosis."

5. Under "Plan" in the report, it provided, "Treatment plan is to proceed with the consented surgery, consisting partially of a joint arthrotomy,

synovectomy, and possible osteophyte removal." The diagnosis was "Villonodular synovitis ankle and foot … uncontrolled; Location: right". This was the totality of the information in the report regarding the right ankle.

6. On February 21, 2008, a second fax was sent to the Insurer with precisely the same request for surgery. However, this request was not accompanied by any medical documents, except the surgical consent form signed by Claimant. The Insurer did not respond with an authorization.

7. Dr. Desai's office then sent to the carrier on March 13, 2008, a report stating the doctor was recommending a compression stocking to address the swelling and observing that, if successful, this would obviate the need for any surgery. The report concludes:

> "Impression: unchanged; no immediate surgical indication at this time".

8. On May 7, 2008, Dr. Desai's office sent a fax message to the Insurer stating, "see following office note from dr. desai with surgery request". This time the report diagnosed "loose body in joint Phalanges, foot". Dr. Desai's impression was:

> "Pt still has pain despite conservative measures. Pt has had intermittent locking in her calcaneocubooid joint which has not improved despite conservative TX and her Peronea lpalp is the same. I feel she may be subluxing at the peroneal tendon causing her symptoms and would explore and repair if necessary. These are related to her work injury".

9. On May 15, 2008, the claims adjuster for the carrier faxed a written authorization to Dr. Desai's office, stating: "Lori, Please accept this authorization for the recommended surgery: joint arthrotomy, synvectomy and possible osteophyte removal". The authorized surgery was completed on July 8, 2008.

10. Claimant alleges entitlement to a penalty on the grounds that Respondents attempted to direct medical treatment with regard to the procedure, which was performed on July 8 2008. Based on the foregoing findings, it cannot be concluded that Respondents directed medical care.

11. The claim reflected in W.C. No. 4-751-397 regards claimant's alleged carpal tunnel syndrome. Claimant alleges that her repetitive work over time for the employer caused her carpal tunnel syndrome. Claimant filed a workers' compensation claim reflecting an injury date of May 18, 2007, Claimant's last

day of employment. Medical records show that she initially saw Dr. Eppler for problems with her upper extremities on October 5, 2005.

12. Dr. Stephen Eppler diagnosed claimant with carpal tunnel syndrome. Dr. Eppler related the carpal tunnel syndrome to claimant's work for employer. Dr. Eppler stated that the employer would not comply with the restrictions. Dr. Eppler testified, as follows:

> Q. Doctor, did you ever advise her to get another job?
>
> A. No, but I'm not certain I see the relevance because she was employed at an employer who – and had sustained an injury during the course of her employment that had failed to be resolved and I was trying to continue to work with her employer in good faith and she also tried to work with her employer in good faith, but there was no evidence at any point that [the Employer] did anything other than hinder her ability to seek medical attention and, furthermore, that they purposefully did not acknowledge medical restrictions and conducted themselves in a fashion to either force her to quit or to create a situation where they could fire her.

13. Dr. Eppler's testimony concerning the Employer's failure to comply with work restrictions was deemed credible and persuasive, particularly, in light of Ms. NJ's corroborating testimony. (Findings concerning NJ's corroborating testimony are found below.) Dr. Eppler testimony concerning the Employer alleged effort to cause Claimant to quit or to fire her was not credited in light of Claimant's history of tardiness and absenteeism.

14. Dr. Tracy Wolf confirmed the diagnosis of bilateral carpal tunnel syndrome.

15. Dr. David Orgel noted that "if [Claimant's] story is confirmed, then some of her symptoms probably are related to her extensive use of her hands and arms."

16. Dr. Eppler further testified that Claimant's condition was aggravated by her continued work for the employer. He testified, as follows:

> Q. So is it your opinion within a reasonable degree of medical probability that her upper extremity symptoms are related to her work at [the Employer]?

> A. Yes. Furthermore, their negligence in terms of their management of this case has caused her ongoing disability and significantly affected her ability to recover from this and it remains to be seen whether she ever will recover. There may be permanent disability on the basis of this to both upper extremities.
>
> Q. And would her work have continued to aggravate those symptoms until she left there on May 18th 2007?
>
> A. Yes, absolutely.

17. NJ, the Employer's general manager and Claimant's supervisor, testified at hearing. Ms. J admitted that she received the doctor's notes regarding the work restrictions for Claimant. Ms. J testified that after Claimant returned to the store after being off work pursuant to the Family Medical Leave Act, Ms. J did not schedule Claimant within her work restrictions. Ms. J testified that Claimant's work for the Employer exceeded the work restrictions provided by Claimant's physician.

18. Dr. Eppler testified that the Employer worked claimant beyond the restrictions he provided.

> NJ was still her general manager and that she'd immediately been scheduled for six days and – in a row and that if she was full-time that they will not file any work restriction and indicated that they wouldn't schedule any eight-hour days, but that she worked four days in a row this week and that she was feeling worn out. She indicated that she had increased pain in her right hand and wrist associated with this change in her schedule, and that when she had scheduled her for so many days that she was unable to work and actually had called in the previous day and that she was off for two days and then called in the next; and that she was told that her employer stated that it wasn't a doctor who decided the duration of her work schedule or any restrictions, but it was the employer.

19. Claimant credibly testified that she was constantly scheduled to work outside of her work restrictions. Further, Claimant credibly testified that she repeatedly gave her work restrictions to her employer. Claimant testified that the work continued to aggravate her pain until she was terminated.

20. Dr. David Orgel placed Claimant on restrictions of no repetitive motion and no lifting over two pounds. Dr. Eppler provided similar restrictions, which changed over time. On August 10, 2006, Dr. Eppler provided a four-hour daily work limit, 16 hours a week work limit, no working for more than two consecutive days, no repetitive tasking and no lifting over five pounds. These restrictions continue to be in force.

21. Medical records reflect that Claimant started seeing a physician for her carpal tunnel syndrome on October 5, 2005. As of that date, Claimant's earnings decreased. Claimant's average weekly wage is fairly calculated prior to October 5, 2005. Taking the compensation Claimant earned from June 10, 2005, to the compensation she received through October 8, 2005, reveals that Claimant earned $5,246.78 over a period of 134 days. Dividing $5,246.78 by 134 days reveals a daily wage rate of $39.16, which translates to an average weekly wage of $274.12.

22. Claimant filed a workers' claim for compensation in W.C. # 4-751-397 for carpel tunnel syndrome on February 22, 2008. Neither an admission nor a notice of contest was ever filed by Respondents. Claimant is entitled to a penalty under Section 8-43-203, C.R.S. from March 13, 2008 and continuing as a result of the Respondents' failure to admit or deny the claim.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado 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 litigation. Section 8-42-102(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.

2. 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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. The credibility of witness testimony and the weight to be given their testimony is within the ALJ's authority to determine. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. The respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Claimant is entitled to reasonably necessary and related medical benefits to cure and relieve her of the effects of the industrial injuries in WC nos. 4-751-397 & 4-723-172, including the surgery performed on Claimant's foot on July 8, 2008.

5. Claimant is seeking an award of TTD benefits in W.C. 4-723-172. Respondents contend that Claimant is responsible for her wage loss and, therefore, is not entitled to an award of TTD under Section 8-42-105(4), C.R.S. Respondents further contend that Claimant was released from medical care by her physicians without restrictions and therefore she is not entitled to TTD.

6. To obtain TTD benefits, a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, she left work as a result of the disability, and the disability resulted in an actual wage loss. *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 639 (Colo. App. 1997). A claimant must establish a causal connection between a work-related injury and a subsequent wage loss. Section 8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546, 546 (Colo. 1995). The term "disability" connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earnings capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.,* 964 P.2d 595, 597 (Colo. App. 1998).

7. If the evidence establishes that the claimant is responsible for her wage loss, then she may be prevented from recovering indemnity benefits. Under Sections 8-42-105(4) and 8-42-103(1)(g), C.R.S., the claimant is precluded from receiving TTD if she is found to be responsible for her wage loss. The concept of "responsibility" in Sections 8-42-105(4) and 8-42-103(1)(g), is similar to the concept of "fA" under the previous version of the statute. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). "FA" requires a volitional act or the exercise of some control in light of the totality of the circumstances. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994). FA does not require willful intent.

Richards v. Winter Park Recreational Association, 919 P.2d 933 (Colo. App. 1996)(unemployment insurance). The claimant is not at fA if the termination is due to claimant's physical or mental inability to perform assigned duties, but poor job performance can be claimant's fA. *Johnston v. Deluxe/Current Corporation*, W.C. No. 4-376-417 (Industrial Claim Appeals Office, June 7, 1999).

8. In W.C. no. 4-723-172, Claimant is responsible for her wage loss. Her excessive tardiness and absenteeism was shown to be a volitional act, which brought about her termination from employment. Furthermore, in W.C. no 4-723-172, work restrictions were not imposed on Claimant for the ankle injury. Therefore, there was no medical reason which prevented Claimant form working.

9. Also, in W.C. no. 4-723-172, Claimant is not entitled to an award of penalties because the evidence did not establish that Respondents directed Claimant's medical care.

10. In W.C. 4-751-391, involving Claimant's claim for carpel tunnel syndrome, Claimant sustained her burden of proof to establish a work related injury.

11. The evidence further established that Claimant was disabled by her work injury and that her authorized treating physicians imposed work restrictions which were not honored by Respondents. The evidence established that Claimant was never offered a position within her restriction and therefore Claimant's wage loss commencing May 18, 2007 was not attributable to a volitional act. Accordingly, it is concluded that Claimant is entitled to TTD commencing May 18, 2007 and continuing.

12. Claimant contends entitled to a penalty against Respondents for failure to admit or deny the claim. The evidence established in W.C. # 4-751-397 Respondents had a duty to admit or deny the claim commencing March 13, 2008. Under Section 8-43-203(2)(a), C.R.S., a penalty in the amount of one day's compensation for each day's failure to admit or deny can be assessed against Respondents for a period not to exceed one year with 50% of the penalty paid to the Subsequent Injury Fund and 50% paid to Claimants.

13. It is found and concluded that Claimant's average weekly wage is $274.12.

ORDER

It is therefore ordered that:

1. In W.C. no. 4-723-172, it is found and concluded that Claimant is not entitled to a penalty nor is entitled to an award of indemnity benefits.

2. In W.C. # 4-751-397, Respondents shall be liable for a penalty under Section 8-43-203(2)(a) for failure to admit or deny the claim, commencing

March 13, 2008 and continue for a period not to exceed one year. Fifty percent of the penalty shall be paid to Claimant and 50% to the Subsequent Injury Fund.

3. Respondents shall be liable to Claimant for TTD benefits commencing May 18, 2007 and continuing until terminated by force of law.

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

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

DATED: Margot W. Jones
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-705-137

ISSUES

1. Whether Claimant has overcome by clear and convincing evidence the Division Independent Medical Examination (DIME) physician's determination that she reached Maximum Medical Improvement (MMI) on January 10, 2006.

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

3. Whether Claimant has established by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits from August 17, 2006 until terminated by statute.

STIPULATION

The parties agreed that Claimant earned an AWW of $305.00.

FINDINGS OF FACT

35. Claimant worked for Employer as a housekeeper. She cleaned between 12-17 hotel suites each day. Claimant's duties involved making beds, cleaning bathrooms and kitchens, moving furniture, mopping floors, vacuuming carpets, washing dishes, and changing linens and towels.

36. On August 5, 2005 Claimant lifted a "roll away" bed and injured her lower back. On October 11, 2007 ALJ Felter issued Findings of Fact, Conclusions of Law and Order

in the present matter. He concluded that Claimant suffered a compensable injury as a result of the incident.

3. Employer referred Claimant to Rosalinda Pineiro, M.D. for treatment. Dr. Pineiro determined that Claimant had suffered a lumbosacral strain. She imposed restrictions that included no repetitive lifting greater than 20 pounds, no pushing/pulling in excess of 20 pounds and no repetitive bending more than six times each hour.

4. Claimant subsequently returned to modified duty employment. On October 14, 2005 Dr. Pineiro released Claimant to return to full duty employment.

5. Claimant continued to obtain treatment from Dr. Pineiro through the remainder of 2005 and into the early part of 2006. During the period, Dr. Pineiro referred Claimant for physical therapy, chiropractic treatment, massage therapy and a physiatry consultation. Dr. Pineiro determined that Claimant reached MMI on January 10, 2006 without any impairment or restrictions.

6. Between December 2005 and mid-May 2006 Claimant worked part-time for Employer. During the period Claimant assisted her daughter with child-care responsibilities.

7. On June 1, 2006 Claimant reported that she had sustained a new work-related injury to her lower back. However, she acknowledged that she did not suffer a specific injury at work and did not know whether her back pain was related to her original injury on August 5, 2005. In ALJ Felter's October 11, 2005 Findings of Fact, Conclusions of Law and Order, he determined that Claimant failed to establish that she suffered a compensable injury on June 1, 2006 and dismissed her claim.

8. Although Respondents denied liability for a June 1, 2006 injury, they referred Claimant to Dr. Pineiro for additional treatment. On August 8, 2006 Claimant visited Dr. Pineiro for an evaluation. Dr. Pineiro recommended physical therapy to relieve Claimant's lower back pain. Claimant subsequently attended three physical therapy sessions before Respondents terminated authorization for treatment. Claimant testified that she benefited from the physical therapy treatment.

9. Beginning in May 2007 Claimant obtained additional physical therapy treatment at her own expense. She explained that physical therapy relieved her lower back symptoms but terminated treatment in August 2007 for financial reasons.

10. On February 1, 2008 Hendrick J. Arnold, M.D. conducted a Division Independent Medical Examination (DIME) of Claimant. He agreed with Dr. Pineiro that Claimant had reached MMI on January 10, 2006 with no impairment or restrictions. Dr. Arnold reviewed Claimant's medical history, considered her current symptoms, conducted a physical examination and performed range of mo-

tion measurements. He diagnosed Claimant with the following: (1) lumbosacral and cervical strain; and (2) somatization and symptom magnification. Dr. Arnold did not impose any work restrictions and stated that Claimant did not require medical maintenance benefits.

11. Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Arnold's January 10, 2006 MMI determination was incorrect. Dr. Arnold reviewed Claimant's medical history, considered her current symptoms, conducted a physical examination and performed range of motion measurements. He diagnosed Claimant with the following: (1) lumbosacral and cervical strain; and (2) somatization and symptom magnification. Claimant testified that her physical therapy treatment in May 2006 and August 2007 relieved her lower back symptoms. However, her statements do not constitute unmistakable evidence that Dr. Arnold's MMI determination was incorrect.

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 worker's 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 worker's 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 worker's 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 (2005).

4. MMI exists when "any medically determinable physical or mental impairment as a result of injury has become stable and no further treatment is reasonably expected to improve the condition." §8-40-201(11.5), C.R.S. Fur-

thermore, 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 [MMI]." *In Re Bson-Rausin,* W.C. No. 3-101-431 (ICAP, Oct. 21, 2004).

5. 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).

6. As found, Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Arnold's January 10, 2006 MMI determination was incorrect. Dr. Arnold reviewed Claimant's medical history, considered her current symptoms, conducted a physical examination and performed range of motion measurements. He diagnosed Claimant with the following: (1) lumbosacral and cervical strain; and (2) somatization and symptom magnification. Claimant testified that her physical therapy treatment in May 2006 and August 2007 relieved her lower back symptoms. However, her statements do not constitute unmistakable evidence that Dr. Arnold's MMI determination was incorrect.

ORDER

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

1. Claimant reached MMI on January 10, 2006.

2. Because Claimant has failed to overcome the DIME physician's MMI determination, she is not entitled to receive TTD benefits subsequent to January 10, 2006.

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

Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-615-836

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that the insurer should be penalized pursuant to § 8-43-304(1) for violation of the rules of procedure concerning timely payment of medical bills?

¬ Did the claimant prove by a preponderance of the evidence that the insurer should be penalized pursuant to § 8-43-304(1) for violation of the rules of procedure concerning prior authorization for medical treatment?

¬ Did the claimant prove by a preponderance of the evidence that the insurer should be penalized pursuant to § 8-43-304(1) for violation of the statutory provisions governing the maintenance of workers' compensation insurance?

¬ Did the claimant prove by a preponderance of the evidence that compensation should be increased fifty percent under 8-43-408(1) for failure to maintain workers' compensation insurance as required by the Act?

¬ Did the claimant prove by a preponderance of the evidence that the insurer is liable to reimburse her mother for expenses the mother incurred while providing assistance to the claimant while she was hospitalized?

¬ Did the claimant prove by a preponderance of the evidence that the insurer is liable to pay the claimant's mother for "essential services" that the mother provided to the claimant after she was released for the hospital?

¬ Did the claimant prove by a preponderance of the evidence that the insurer is liable to provide vocational rehabilitation services because such services were "deemed authorized" by the insurer's failure to comply with the rules of procedure concerning prior authorization for medical treatment?

FINDINGS OF FACT

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

1. On May 23, 2004, the claimant sustained serious injuries arising out of and in the course of her employment when the car she was driving was "t-boned" by a police car driving at a high rate of speed. The claimant sustained a traumatic brain injury, various internal injuries, pelvic fractures and low back injuries.

2. The claimant was originally hospitalized at Denver Health and was in a coma for approximately ten days. At some point the claimant was flown to the Vanderbilt Stallworth Rehabilitation Hospital in Tennessee. Although the claimant has some difficulty recalling, she credibly testified that her total hospi-

talization lasted approximately six weeks from the date of injury, and that she was released by July 4, 2004.

3. The claimant testified that while she was hospitalized in Denver, her mother flew from Tennessee to Colorado, and her stepfather drove to Colorado. While in Colorado the claimant's mother and stepfather took care of the claimant's personal affairs such as paying bills, caring for the claimant's cats, and placing the claimant's belongings in storage. The claimant also testified that while she was in the hospital in Denver her mother gave her showers, got food for her and provided "puzzle books."

4. After the claimant was released from the Stallworth Rehabilitation facility the claimant moved to her mother's house in Tennessee. Initially the claimant was confined to a bed and was moved in a wheelchair. Later the claimant progressed to a walker. The claimant's mother provided services to the claimant including cooking, assisting the claimant with showers, changing the bedding, assisting the claimant with clothing, and paying bills. The claimant was unable to perform these activities for herself, but slowly developed the ability to care for herself. By "Halloween" of 2004 the claimant could perform most of these activities for herself.

5. William H. Hartwick testified as an expert witness for the claimant. Mr. Hartwick is a certified vocational rehabilitation specialist and a "certified life care planner." A life care planner has specialized experience and knowledge with respect to providing for the needs of persons that have suffered catastrophic injuries.

6. Mr. Hartwick credibly testified that he would consider the claimant's injury to be catastrophic. Mr. Hartwick credibly testified that based on his experience as a life care planner and his review of the medical records, including those from Stallworth Rehabilitation facility, that after her release from the hospital the claimant needed six months' of assistance with activities of daily living. These services were necessary while the claimant participated in outpatient rehabilitation activities. Mr. Hartwick noted that the Stallworth records stated the claimant needed "supervision in all areas of self care." Mr. Hartwick credibly opined that if the claimant's mother had not provided assistance with activities of daily living at home, it would have been necessary for the claimant to be transferred to a nursing facility or rehabilitation facility while completing rehabilitation. Mr. Hartwick admitted that he did not see a formal "prescription" for "essential services." However, he credibly testified that he has seen a "recommendation" from Dr. Grooms, one of the claimant's physicians at Stallworth Rehabilitation, that she was in need of "supervision in all areas."

7. Mr. Hartwick credibly testified that personal care providers who render the type of care provided by the claimant's mother, are paid $18 to $20

per hour. Mr. Hartwick opined the claimant would have needed care, on the average, for 4 hours per day for six months.

8. The insurance adjuster, Sandra Shefman, credibly testified, that she never received any request for payment of "essential services" from the claimant's parents. She did receive a number of requests for reimbursement of expenses related to meals, gasoline and motels. The ALJ infers these requests related to expenses that were incurred while the claimant's parents were in Denver during the claimant's hospitalization.

9. The services rendered to the claimant by her mother and stepfather, including caring for the claimant's pets, storing her possessions, and paying her bills, do not relate to the claimant's personal health, and do not treat the physical or emotional effects of the injury. Neither did the mother and stepfather render these services as an incident to the provision of medical treatment that the claimant was receiving in the hospital.

10. The ALJ finds the services provided by the claimant's mother while the claimant was in the hospital, such as assisting the claimant with showers and providing food and books were not reasonably necessary. The ALJ infers that because the claimant was hospitalized, these services would have been provided by hospital staff had the mother not provided them herself. Therefore, the mother was not providing any service that would not otherwise have been provided to the claimant and paid for by the respondents, and the provision of the services by the mother did not enable the claimant to be treated, nor were the services incidental to the treatment provided by the hospital. It follows that the expenses incurred by the mother were not incidental to the provision of medical treatment.

11. The ALJ finds from the credible testimony of Mr. Hartwick that Dr. Grooms, one of the claimant's treating physicians at Stallworth Rehabilitation, "recommended" that she receive "supervision" in all activities of daily living. The ALJ construes this "recommendation" as a general referral for medically necessary home health care attendant services. Because of the general nature of the referral, the claimant was authorized to select her mother to provide the services.

12. The ALJ finds that the home healthcare or attendant services provided by the claimant's mother from July 4, 2004, through October 24, 2004, constituted medically necessary attendant care services. The ALJ is persuaded by the recommendation of Dr. Grooms that the claimant receive "supervision" in activities of daily living, as well as Mr. Hartwick's credible testimony that such services were necessary considering the claimant's physical condition and inability to perform many on the basic functions of personal hygiene necessary to continue and augment her recovery. The ALJ is further persuaded of the necessity for these services by Mr. Hartwick's credible testimony that the claimant would have required treatment at a nursing facility or rehabilitation hospital if her mother had not been providing services at home. The ALJ is also persuaded by Mr.

Hartwick's testimony that the claimant needed the services for an average of 4 hours per day, and that the reasonable value of the services is $18 per hour as measured by the pay scale for personal care providers.

13. On August 7, 2007, ALJ Nancy Connick entered an Order Dismissing Application Without Prejudice and Denying Claimant's Motion to Compel. In this order ALJ Connick denied the claimant's request to compel "a copy of the insurance policy and other documents regarding coverage for risk of liability for workers' compensation or of a self-insurance permit." ALJ Connick stated that the claimant was requesting production of these items to "confirm whether the respondents have complied with the insurance provisions of Articles 40-47," and whether compensation should be increased fifty percent for failure to insure. ALJ Connick noted that the claimant had previously received the declarations page of the insurance contract, establishing that the employer was covered on the date of injury. Citing *United States Fidelity & Guaranty, Inc. v. Kourlis,* 868 P.2d 1158 (Colo. App. 1994), and *McManus v. Industrial Claim Appeals Office,* 81 P.3d 1074 (Colo. App. 2003), ALJ Connick ruled that the claimant was not entitled to further discovery because the statutory "language has not been interpreted to allow the penalty claimant seeks under the circumstances alleged, and thus the discovery request does not meet the required relevancy standard."

14. At hearing on October 20, 2008, counsel for the claimant admitted on the record that the he could not prove, without access to the declarations sheet of the insurance policy, that the policy for workers' compensation failed to comply with the insurance provisions of the Act found in § 8-44-101(1), C.R.S., and § 8-44-111(1), C.R.S. As a result, the ALJ granted the respondents' "motion for a directed verdict" dismissing the claim for penalties based on the employer's alleged failure to procure insurance, and the claim for increased compensation based on § 8-43-408(1), C.R.S.

15. On November 11, 2005, the claimant was treated for her industrial injuries at the Center for Neurorehab Service (CNS). The claimant was also treated at CNS on December 13, 2005.

16. The record contains two Health Insurance Claim Forms (HICF) pertaining to November 11, 2005. These HCIF's were signed by Dr. Bennett of CNS and dated May 12, 2006, and September 14, 2006.

17. The record contains two HCIF's pertaining to December 13, 2005. These were signed by Dr. Bennett for CNS on May 12, 2006, and September 14, 2006.

18. The record contains an Explanation of Review (EOR) for the November 11, 2005 service provided by CNS. This EOR reflects four different services were provided on November 11, 2005. The EOR reflects that the bill for services was received by the insurer on October 9, 2006, was forwarded to Cov-

entry WC Services (Coventry) for review and fee scheduling on October 9, 2006, and was reviewed on October 11, 2006.

19. The record contains and EOR for the December 13, 2005 service provided by CNS. The EOR reflects that the bill for service was received by the insurer on October 9, 2006, was forwarded to Coventry for review and fee scheduling on October 9, 2006, and was reviewed on October 11, 2006.

20. The insurance adjuster, Sandra Shefman, credibly testified that CNS would sometimes submit more than one billing for a single date of service, and that CNS did not "always consider them rebilling but additional billings for the same dates of service." This was true because CNS "felt that the HCPC codes did not adequately reimburse them or show the amount of work that they did." Ms. Shefman also explained that the insurer's file contains many EOR forms that were not submitted into evidence.

21. On June 29, 2006, respondents' counsel wrote to claimant's counsel concerning allegedly unpaid medical bills. These included CNS billings for November 11, 2005, and December 13, 2005. Counsel for respondents asserted that the billings for November 11, 2005, and December 13, 2005, had in fact been paid by check.

22. The claimant failed to prove it is more probably true than not that the insurer failed to pay any bills submitted by CNS within 30 days of the date of submission. The ALJ infers from the totality of the evidence and the credible testimony of Ms. Shefman, that CNS probably submitted at least two bills for the dates of service of November 11, 2005, and December 13, 2005. However, the ALJ is not persuaded that the insurer failed to pay any of these bills in a timely manner. Rather, the ALJ is persuaded the insurer paid all bills in a timely fashion, but determined to pay additional amounts after CNS submitted supplemental information concerning the services it provided on these dates.

23. On May 9, 2006, PA-C Douglas Hornberger, PA-C, issued a "To Whom it May Concern" letter. The letter referenced a "recommendation" for a functional capacities evaluation and vocational rehabilitation. In this letter, PA-C Hornberger stated the claimant had "progressed to a level of a Return to Work Plan" and her "therapy team" wished to clarify her work capacity by having her undergo a functional capacities evaluation. He also stated that the claimant would "benefit from vocational rehabilitation services as well." There are no attachments to this letter. The letter bears a stamp stating that claimant's counsel "sent" the document to "respondents" on November 10, 2006.

24. The insurance adjuster, Sandra Shefman, credibly testified that she received PA-C Hornberger's letter dated May 9, 2006, request, although she could not recall when. Ms. Shefman credibly testified that she responded to the letter and that the insurer did not pay for vocational rehabilitation services. Ms.

Shefman explained that she declined to pay for vocational rehabilitation services based on Dr. Pitzer's February 1, 2006, report that the claimant was at MMI, and the absence of any recommendation for vocational rehabilitation services as a form of ongoing treatment after MMI. Ms. Shefman admitted that Dr. Pitzer's examination and opinion concerning MMI was rendered before the date that PA-C Hornberger recommended vocational rehabilitation services.

25. The claimant failed to prove it is more probably true than not that the insurer violated the rules governing prior authorization for medical treatment. The ALJ finds that PA-C Hornberger's May 9, 2006, letter did not constitute a "complete" request for prior authorization as specified by WCRP 16-9 (E). In particular, the letter does not indicate that PA-C Hornberger was requesting the insurer to grant "prior authorization" for vocational rehabilitation. Instead the letter merely contains a "recommendation" of vocational rehabilitation to whoever might be concerned with that issue. Further, the letter contains no detailed explanation of the medical necessity for vocational rehabilitation, but instead contains the bare assertion that the claimant would "benefit" from such services. Finally, the letter does not incorporate any medical documentation relied upon by PA-C Hornberger when making his recommendation for vocational rehabilitation.

26. Further, the claimant failed to prove when the insurer received PA-C Hornberger's May 9, 2006, letter. The stamp on the letter indicating it was "mailed to respondents' does not establish any presumption that the letter was properly mailed to the insurer or any of its agents. Consequently, the evidence is not sufficient to establish when the insurer received the letter and triggered its alleged duty to respond in accordance with WCRP 16-9 (B).

27. At the hearing on July 1, 2008, the parties stipulated that the claimant's average weekly wage is $737.99. The parties agreed to reserve the issue of whether the average weekly wage should be further increased based on health insurance costs. The parties also stipulated that the issue of SSDI offset should be reserved. The ALJ accepted the parties' stipulations.

CONCLUSIONS OF LAW

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

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

LAW PERTAINING TO IMPOSITION OF PENALTIES UNDER § 8-43-304(1)

The claimant seeks the imposition of three penalties for alleged violations of the Act and rules of procedure. The claimant argues these penalties should be imposed under § 8-43-304(1), C.R.S. In evaluating the requests for penalties the ALJ has considered and applied general principles of law. Thos principles are as follows.

Whether statutory penalties may be imposed under § 8-43-304(1) involves a two-step analysis. The statute provides for the imposition of penalties of up to $500 per day where the employer, insurer, or an officer or agent of either "violates any provision of article 40 to 47 of [title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or the panel, for which no penalty has been specifically provided, or fails, neglects or refuses to obey any lawful order made by the director or panel…" Thus, the ALJ must first determine whether the insurer's conduct constitutes a violation of the Act, a rule, or an order. Second, the ALJ must determine whether any action or inaction constituting the violation was objectively unreasonable. The reasonableness of the insurer's action depends on whether it was based on a rational argument based in law or fact. *Jiminez v. Industrial Claim Appeals Office,* 107 P.3d 965 (Colo. App. 2003); *Gustafson v. Ampex Corp.,* W.C. No. 4-187-261 (ICAO August 2, 2006), *but see, Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005) (standard is less rigorous standard of "unreasonableness"). However, there is no requirement that the insurer knew that its actions were unreasonable. *Pueblo School District No. 70 v. Toth,* 924 P.2d 1094 (Colo. App. 1996).

The party seeking the imposition of penalties bears the burden of proof to establish that there was a violation of the Act or an order. *See Pioneers Hospital v. Industrial Claim Appeals Office, supra*. A party establishes a prima facie show-

ing of unreasonable conduct by proving that an insurer violated a provision of the Act or rule of procedure. If the claimant makes such a prima facie showing the burden of persuasion shifts to the respondents to show their conduct was reasonable under the circumstances. *Pioneers Hospital v. Industrial Claim Appeals Office, supra, Human Resource Co. v. Industrial Claim Appeals Office,* 984 P.2d 1194 (Colo. App. 1999).

PENALTIES FOR DENIAL OF PRIOR AUTROIZATION FOR VOCATONAL REHABILITATION

In her position statement, the claimant argues that the insurer should be penalized under § 8-43-304(1) because it violated the rules of procedure governing prior authorization for medical treatment contained in WCRP 16. The only alleged violation specifically identified in the claimant's position statement is insurer's alleged failure to "appropriately contest" PA-C Hornberger's May 9, 2006, recommendation that the claimant receive vocational rehabilitation services. (Claimant's proposed Finding of Fact 10, and proposed order paragraph 6). The ALJ concludes the claimant failed to prove a violation of the rules of procedure governing prior authorization.

WCRP 16-9(B) provides that a payer "shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request as defined in Rule 16-9(E)." WCRP 16-9(E) states as follows:

> To complete a prior authorization request, the provider shall concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

As determined in Finding of Fact 25, PA-C Hornberger's May 9, 2006, letter does not qualify as a "completed request" for prior authorization of vocational services as contemplated by WCRP 16-9(B) and WCRP 16-9(E). The letter does not indicate on its face that it is a request for prior authorization, it is not specifically directed to the insurer, it does not contain any explanation of the necessity for vocational rehabilitation, and it is not accompanied by medical documentation supporting the recommendation. Because the May 9, 2006, letter does not constitute a completed request for prior authorization, the timing and nature of the insurer's responses to this letter cannot constitute a violation of the rules concerning prior authorization. No completed request was ever made so as to trigger the insurer's duty to respond under 16-9(B). It follows that no penalty may be imposed under § 8-43-304(1). See *Skelly v. Wal-Mart Stores, Inc.,* W.C. No. 4-632-887 (ICAO July 31, 2008).

Moreover, the claimant failed to prove when the insurer received the May 9, 2006, letter. The law creates a rebuttable presumption that a letter properly addressed, stamped and mailed was delivered to the addressee. *See Campbell v. IBM Corp.,* 867 P.2d 77 (Colo. App. 1993). Evidence of a business custom may be sufficient to establish that a notice was sent. *EZ Building Components Mfg., LLC v. Industrial Claim Appeals Office*, 74 P.3d 516 (Colo. App. 2003).

Here, the May 9, 2006, letter does not indicate that PA-C Hornberger mailed a copy to the insurer or its agents at their proper addresses, or that it was even mailed to anyone. The stamp on the letter is inadequate because it does not show that the letter was properly addressed to the insurer or its agents, and is not, by itself, sufficient to establish the business practice of the claimant's counsel when mailing documents.

Consequently, although the insurance adjuster admitted that she received the letter at some point in time, the evidence is not sufficient to establish when she received it. Therefore, the claimant failed to prove when the seven-day response period specified in WCRP 16-9(B) commenced. Because the claimant failed to establish when the insurer allegedly began violating the rule, it is impossible to establish a commencement date for the alleged violation.

PENALTIES FOR FAILURE TIMELY TO PAY FOR MEDICAL SERVICES

The claimant contends the insurer violated WCRP 16-11 by failing to make timely payment for medical bills. Although the claimant originally alleged multiple violations of this rule, the only late payments identified by the claimant in her position statement occurred with respect to services provided by CNS on November 11, 2005, and December 13, 2005. (Claimant's proposed Finding of Fact 11, proposed order paragraph 5

Although not entirely clear, the claimant apparently alleges a violation of WCRP 16-11(A)(2) [formerly WCRP XVI (K)(1)(b)]. That rule provides that unless contested, "all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within thirty (30) days after receipt of the bill by the payer."

As determined in Finding of Fact 22, the claimant failed to prove it more probably true than not that the insurer violated the rule of procedure concerning timely payment of medical bills. The ALJ has inferred from the credible testimony of the insurance adjuster that CNS submitted more than one bill for these dates of service, and that each bill submitted was paid in a timely fashion. The ALJ is persuaded that the additional bills were submitted for the two dates of service because CNS wished to provide supplemental information to the insurer concerning the services performed on those dates.

Because the claimant failed to prove any violation of the rule, no penalty may be imposed under § 8-43-304(1).

PENALTIES FOR FAILURE TO PROCURE PROPER INSURANCE

The claimant contends that she is entitled to the imposition of penalties under § 8-43-304(1) for the employer's alleged failure to secure workers' compensation insurance as required by the Act. Specifically, the claimant alleges that the insurance procured by the employer from the insurer does not comply with the requirements of § 8-44-101(1), C.R.S., and § 8-44-111(1), C.R.S. The claimant concedes that the employer procured workers' compensation insurance that covered the injury she sustained in May 2004. This concession is fully supported by the FAL that the insurer filed on June 29, 2006. However, the claimant argues that the insurance policy may not comply with the Act because it was not procured from any of the entities mentioned in § 8-44-101(1), and/or because the deductible may exceed the $5000 per claim limit established by § 8-44-111(1).

The claimant candidly admits in her position statement, as she did at hearing, that she cannot prove that the policy procured by the employer failed to comply with the insurance requirements contained in the Act. Indeed, the claimant's position statement states that, "prior orders entered in this claim preclude the Claimant from seeking discovery of any insurance documents related to the claim, other than the declarations page." The claimant states that the declarations page is not sufficiently detailed to resolve her contentions.

The ALJ concludes the claimant failed to prove it is more probably true than not that the employer violated any provision of the Act by failing to procure insurance in compliance with § 8-44-101(1) and/or § 8-44-111(1). The claimant failed to produce any credible or persuasive evidence that there was a violation of these sections of the Act. Because the claimant failed to prove any violation, no penalty may be imposed under § 8-43-304(1). *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623 (Colo. App. 1995). Therefore, the ALJ concludes that it was appropriate to grant the respondents' "motion for a directed verdict" dismissing the claim for penalties based on failure to procure complying insurance. That order is reaffirmed here.

INCREASE IN COMPENSATION FOR FAILURE TO INSURE

The claimant asserts that admitted compensation should be increased fifty percent under § 8-43-408(1), C.R.S., because the insurer failed to comply with the insurance provisions of the Act. The foundation for this argument is the same as that offered for the imposition of penalties for failure to obtain a complying insurance policy. Therefore, the ALJ reaffirms the denial of the claimant's request for increased compensation for the same reasons that he denied the penalty claim.

COMPENSATION FOR EXPENSES INCURRED BY AND FOR SERVICES PROVIDED BY THE CLAIMANT'S MOTHER AND STEP-FATHER

The claimant contends that the expenses that her parents incurred while in Denver constitute compensable medical expenses. The claimant further seeks compensation for the services that her mother provided while the claimant was staying in her mother's home "though October 31, 2004." The respondents argue that the services were not authorized because there was no request for prior authorization.

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).

Section 8-43-404(5)(a), C.R.S. gives the respondents the right in the first instance to select the authorized treating physician (ATP). Authorization refers to a physician's legal status to treat the industrial injury at the respondents' expense. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006); *Popke v. Industrial Claim Appeals Office,* 944 P2d. 677 (Colo. App. 1997). Once an ATP has been designated the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the insurer or an ALJ. If the claimant does so, the respondents are not liable for the unauthorized treatment. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

Our courts have held that in order for a service to be considered a "medical benefit" it must be provided as medical or nursing treatment, or incidental to obtaining such treatment. *Country Squires Kennels v. Tarshis,* 899 P.2d 362 (Colo. App. 1995). A service is medically necessary if it cures or relieves the effects of the injury and is directly associated with the claimant's physical needs. *Bellone v. Industrial Claim Appeals Office,* 940 P.2d 1116 (Colo. App. 1997). A service is incidental to the provision of treatment if it enables the claimant to obtain treatment, or if it is a minor concomitant of necessary medical treatment. *Country Squires Kennels v. Tarshis, supra.* The determination of whether services are medically necessary, or incidental to obtaining such service, is a question of fact for the ALJ. *Bellone v. Industrial Claim Appeals Office, supra.*

The ALJ concludes the expense incurred by the claimant's mother and stepfather while in Denver does not constitute medical treatment for purposes of § 8-42-101(1)(a). As determined in Finding of Fact 9, the activities of paying the claimant's bills, caring for her pets, and storing her possessions were not medical in nature because they did not treat the effects of the injury, nor were they incidental to providing such treatment. Indeed, the claimant was hospitalized in a full-care treatment facility. Since the services were not medical in nature, or incidental to receiving such services, the expenses incurred while providing them are not compensable. *Kuziel v. Pet Fair, Inc.,* 931 P.2d 521 (Colo. App. 1996).

Neither are the expenses compensable because the mother rendered some services to the claimant while she was hospitalized in Denver. As determined in Finding of Fact 10, the ALJ finds that the hospital personnel would have provided these services to the claimant as part of her overall treatment at the facility had the mother not intervened. While the claimant's mother's activities may have been decent and caring, they were duplicative of services already available to the claimant and paid for by the respondents. Thus, the mother's activities at the hospital do not constitute reasonable and necessary medical or nursing services, and did not enable the claimant to receive treatment she would not otherwise have received.

In light of these determinations the ALJ need not consider whether the expenses incurred by the claimant's parents while in Denver were "authorized."

The claimant also seeks compensation for the "essential services" provided by her mother after she was released from the rehabilitation hospital and moved into the mother's home. For their part, the respondents argue that such services were not authorized because there was no request for prior authorization, and because there was no "itemization" of amounts claimed.

Authorized providers include those medical providers to whom the claimant is directly referred by the employer, as well as providers to whom an ATP refers the claimant in the normal progression of authorized treatment. *Town of Ignacio v. Industrial Claim Appeals Office,* 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). Whether an ATP has made a referral in the normal progression of authorized treatment is a question of fact for the ALJ. *Suetrack USA v. Industrial Claim Appeals Office,* 902 P.2d 854 (Colo. App. 1995). A referral may be general in nature in that it need not be to a specific provider. *Stadig v. Porter Memorial Hospital,* W.C. No. 4-152-098 (ICAO May 16, 2001, *aff'd., Porter Memorial Hospital v. Industrial Claim Appeals Office,* (Colo. App. No. 01CA1027, October 24, 2002) (not selected for publication).

As determined in Finding of Fact 11, the ALJ concludes that Dr. Grooms, an ATP at Stallworth, made a "general referral" for the claimant to receive "supervision" in activities of daily living. The ALJ concludes this referral was made in the normal progression of authorized treatment. The ALJ further concludes that because of the general nature of the referral the claimant was empowered to select her mother as an authorized provider of the services.

The ALJ is not persuaded by the respondents' argument that the failure of Stallworth Rehabilitation, the claimant's mother, or the claimant herself to procure "prior authorization" for the home health services rendered them non-compensable and unauthorized as a matter of law. It is true, as the respondents contend, that former WCRP XVI (E)(1)(b) [currently WCRP 16-5(A)(2)] requires non-physician providers, such as the claimant's mother, to "comply" with the rules regarding prior authorization "when providing all services." However, no rule states that failure to comply with the rules of prior authorization negates the ef-

fectiveness of an otherwise valid legal referral such that reasonable and necessary services rendered by a "non-physician provider" must be denied. To the contrary, it appears that the only explicit sanction for failure to follow the rules regarding prior authorization is imposed on a *payer,* such as the insurer. Specifically, former WCRP XVI (J)(5) [currently WCRP 16-10(E)] provides that "failure of the payer to comply in full with the requirements" of the rules regarding prior authorization "shall be deemed authorization for payment of the requested treatment unless a hearing is requested" within the designated time. The respondents point to no comparable rule that states failure of a provider or the claimant to request prior authorization in accordance with the rule requires that the treatment be "deemed" unauthorized.

The ALJ does not consider the cases cited by the respondents to be supportive of their argument. In *Cross v. Microglide Inc.,* W.C. No. 4-355-764 (ICAO September 2, 2003), the ICAO held that an insurer did not "waive" its right contest authorization for essential services by failing to comply with the rules regarding prior authorization. The ALJ found that the medical provider had never completed a valid request for prior authorization. In these circumstances the ICAO upheld the ALJ's determination that the insurer's failure to contest the defective "request" for prior authorization did not mean that the services were "deemed authorized" under WCRP XVI (J)(5). Thus, *Cross* is concerned with the effect of an insurer's alleged failure to comply with the rules regarding prior authorization, not the effect of the provider's failure to request prior authorization.

Moreover, the ALJ concludes that the holding in *Galacia v. Pietraszek Enterprises, Inc.,* W.C. No. 4-610-668 (ICAO May 9, 2008), supports the conclusion that failure to request prior authorization does not preclude a finding that services were authorized. Insofar as pertinent, the ALJ in the *Galacia* case found that the claimant received three periods of home health care services, and that there was no request for prior authorization for any of these services. However, after the services had been provided, authorized physicians rendered opinions that the services were reasonable and necessary. The ALJ in *Galacia* noted that because the providers were non-physician providers the treatment was subject to the rules governing requests for prior authorization, and the ALJ denied the treatment. Citing *Suetrack USA v. Industrial Claim Appeals Office, supra*, the ICAO stated that it was the "ALJ's prerogative to determine whether the home health care services at issue was authorized treatment." The ICAO further noted that referrals in the normal progression of authorized treatment may render care authorized, but stated that as it read the ALJ's order "he did not find a contemporaneous referral was made in the normal progression of authorized treatment." In these circumstances, the ICAO stated that the ALJ was persuaded that there was no request for prior authorization as required by the applicable regulations, and that it was "apparent from the ALJ's decision that he was not persuaded that the periods of home health care at issue were authorized by rule, estoppel, or otherwise." The ICAO was careful to note that the "existence of evidence which,

if credited," might have supported a contrary result afforded no basis for relief on appeal.

The ALJ infers from the holding in *Galacia* that the ICAO does not view the mere failure to request prior authorization as required by the rules to *require* the conclusion that the disputed treatment was unauthorized. If the ICAO held such a view, it would merely have affirmed the ALJ's conclusion that the treatment was not authorized because there was no request for prior authorization. Instead, the ICAO also considered whether the ALJ found that the treatment had been authorized by some other means, such a "estoppel or otherwise." In *Galacia* the ICAO determined that the ALJ found there was no alternative mechanism of authorization, and concluded that determination was supported by substantial evidence.

Here, in contrast to the *Galacia* case, the ALJ has found that there was a valid referral for home health services rendered by Dr. Grooms *before* the claimant's mother provided the services. The ALJ infers from the holding in *Galacia* that the mere fact that prior authorization was not requested for the services provided by the claimant's mother, as it should have been, does not mean that the services were unauthorized as a matter of law.

As determined in Finding of Fact 12, the ALJ concludes that the services rendered by the claimant's mother commencing July 4, 2004, through October 31, 2004, constituted reasonable and necessary home medical services designed to relieve the claimant from the effects of the injury and assist her in recovering from the injury. The ALJ, crediting the opinion of Mr. Hartwick, concludes these services were reasonably necessary for an average of 4 hours per day, and that they are reasonably valued at $18 per hour. Thus, the insurer shall pay the claimant's mother $8640 for essential services rendered to the claimant (120 days x 4 hours per day x $18 per hour = $8640).

In light of these determinations the ALJ need not consider the claimant's argument that the services provided by her mother were authorized because the insurer refused to designate a provider willing to render the services.

CLAIM FOR VOCATIONAL REHABILITATION AS A MEDICAL BENEFIT

The claimant argues that the request for vocational rehabilitation services was "deemed authorized" by the insurer's failure to respond to the request for prior authorization. Therefore, the claimant argues that the insurer should be ordered to provide vocational services. The ALJ disagrees with this argument.

It is true that WCRP 16-10(E) provides that a payer's failure to "comply in full with the requirement of Rule 16-10(A) or (B) shall be deemed authorization for payment of the requested treatment unless a hearing is requested" within the time prescribed for responding as set forth in Rule 16-10(A) or (B). Rules 16-10(A) and (B) create duties on the part of the payer to take certain actions to contest a "request for prior authorization." The prescribed duties vary depending on

whether the request is contested for medical or non-medical reasons, but the actions must be taken within seven business days of receipt of the "completed request" for prior authorization. Rule 16-10(A) explicitly states that Rule 16(9) (E) defines the term "completed request".

As determined in Finding of Fact 25, and as detailed above, PA-C Hornberger's May 9, 2006, letter did not constitute a "completed request" for prior authorization of vocational services within the meaning of WCRP 16-9(E). It follows that the insurer has not violated WCRP 16-10(A) or (B), and the requested services are not "deemed authorized" within the meaning of WCRP 16-10(E).

The ALJ does not understand the claimant to be arguing that there is any other legal theory that would justify and an award of vocational services as a form of medical benefit. The claimant's position statement does not advance any other argument.

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

3. The claimant's requests for the imposition of penalties pursuant to § 8-43-304(1), C.R.S., are denied and dismissed.

4. The claimant's request that compensation be increased fifty percent based on failure to maintain insurance is denied and dismissed.

5. The claimant's request that the insurer reimburse her mother for expense incurred during the claimant's hospitalization is denied and dismissed.

6. The insurer shall pay the claimant's mother the sum of $8640 for essential services provided to the claimant.

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on October 8 and November 10, 2008, in Denver, Colorado. Both sessions of the hearing were digitally recorded (refer-

ence: 10/8/08, Courtroom 4, beginning at 1:36 PM, and ending at 2:12 PM; and, 11/10/08, Courtroom 4, beginning at 8:38 AM, and ending at 9:28 AM). Jesse Moran served as the official Spanish/English interpreter.

At the conclusion of the last session of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Claimant's counsel, to be submitted electronically in 10 working days, or by the close of business on November 25, 2008. None was timely submitted and the ALJ hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern Respondents' challenge to the Division Independent Medical Examination (DIME) of David Yamamoto, M.D., and apportionment. Respondents' burden of proof is by clear and convincing evidence on permanent impairment. Respondents' burden on apportionment is by a preponderance of the evidence.

FINDINGS OF FACT

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

1. The Claimant sustained a work-related occupational disease to his neck with an onset date of April 22, 2002. ALJ Michael Harr entered Findings of Fact, Conclusions of Law and Order on January 2, 2003, determining that Claimant suffered from an occupational disease with an onset date of April 22, 2002; awarding medical benefits; and, awarding the Claimant temporary total disability (TTD) benefits from April 22, 2002. Subsequently, ALJ Bruce Friend, on July 12, 2004, found that Claimant suffered from thoracic outlet syndrome (TOS) and awarded the Claimant medical benefits for this condition. There were no timely appeals of either decision, and both decisions establish the law of the case.

2. The medical records establish that Claimant first report neck pain in 2000 when she was working for a different company. There is no indication that Claimant was off work, or disabled, until April 22, 2002, when she worked for the present Employer. Based on the 2000 manifestation of neck pain, Respondents argue for apportionment. Since ALJ Harr's and ALJ Friend's decisions have established the law of the case, the doctrine of "issue preclusion" prohibits a consideration of this argument.

3. Claimant proved an injurious and disabling exposure to neck problems while employed by the present employer and ALJ Harr so found five years ago. If she had a preexisting neck condition, her employment with the present Employer substantially and permanently aggravated it.

4. On May 6, 2004, J. Stephen Gray, M.D., performed an Independent Medical Examination (IME) of Claimant. Dr. Gray was of the opinion that Claimant was not a maximum medical improvement (MMI), however, he assigned her a tentative rating of 25% whole person.

5. John J. Aschberger, M.D., performed an IME on March 31, 2008, indicating that Claimant was at MMI and rating her permanent medical impairment at 24% whole person. Dr. Aschberger not that "a specific disorder apportionment of 7% is **quite arguable** (emphasis supplied)." The ALJ infers and finds that despite his indication that apportionment was "quite arguable," Dr. Aschberger did not actually apportion 7% out of his 24% whole person rating.

6. David Yamamoto, M.D., performed a DIME on April 22, 2008. Dr. Yamamoto was of the opinion that Claimant reached MMI on February 15, 2007, with ratings of 26% whole person impairment for physical injury, and 4% whole person for psychological injury. When confronted with the medical records indicating neck problems as early as 2000, when Claimant had been working for another employer, Dr. Yamamoto steadfastly declined to apportion.

7. The ALJ finds that Respondents have failed to prove that it is highly probable and free from serious and substantial doubt that Dr. Yamamoto's permanent medical impairment ratings are in error. Therefore, Respondents have failed to overcome Dr. Yamamoto's DIME ratings by clear and convincing evidence.

8. The ALJ further finds that no previous injury has been sufficiently identified, treated and evaluated and rated as a contributing factor in order to trigger an apportionment. Respondents have failed to prove that it is more likely than not that their affirmative defense of apportionment has been proven. Therefore, Respondents have failed to prove apportionment by a preponderance of the evidence.

CONCLUSIONS OF LAW

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

a. 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 and whole person rating 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 (8), C.R.S. (2008). "Clear and convincing evidence" is evidence, which is stronger than preponderance, is unmistakable, makes a fact or facts highly prob-

able 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, the whole person rating of the DIME, and whether these determinations have been overcome are factual determinations for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, *supra.* As found, Respondents have failed to overcome the DIME physician's determinations of MMI and rating of 26% whole person for physical injury and 4% whole person for psychological injury.

b. Section 8-42-107 (7) (b) (III), C.R.S. (2008), provides that mental or emotional stress shall not be combined with a scheduled or nonscheduled injury. Section 8-41-301 (2) (b) limits claims for permanent mental impairment to twelve weeks of medical impairment benefits.

c. An "occupational disease" is a disease resulting directly from the employment as a proximate cause and one that does come from a hazard to which the employee would have been equally exposed outside of the employment. Section 8-40-201 (14), C.R.S. (2008). *See City of Colorado Springs v. Industrial Claim Appeals Office,* 89 P. 3d 504 (Colo. App. 2004). As found, ALJ Harr, in an un-appealed decision of January 3, 2002, determined that Claimant suffered from a compensable occupational disease with an onset date of April 22, 2002.

d. The purpose of Section 8-41-304(1), C.R.S. (2008), is to assign liability for an occupational disease where a claimant has been exposed to the hazards of the disease during successive employments. *Robbins Flower Shop v. Cinea,* 894 P.2d 63 (Colo. App. 1995); *Seyhouwer v. Kristin F. Robbins, D.D.S.* W. C. Nos. 4-462-729, 4-471-878 [Industrial Claim Appeals Office (ICAO), May 20, 2003]. If a claimant proves an injurious exposure with the employer, then she must prove by a preponderance of the evidence that her preexisting condition was substantially and permanently aggravated. *See Monfort Inc. v. Rangel,* 867 P.2d 122 (Colo. App. 1993)*; Fisher v. United Parcel Service,* W.C. Nos. 4-114-768 & 4-221-453 (ICAO, May 8, 1996); *aff'd,* (Colo. App. No. 96CA0943, February 20, 1997) [not selected for publication]. As found, Claimant has proven an injurious exposure while working for the Employer herein; and, she has proven that this injurious exposure substantially and permanently aggravated her preexisting neck condition.

e. Under Section 8-41-304(1), C.R.S. (2008), a injured worker is not required to exactly pinpoint which period of employment most injuriously exposed her to the hazards of the occupational disease; instead, the worker is allowed to recover from the last employer in whose employ the last injurious exposure oc-

curred and resulted in an aggravation that is both permanent and substantial. *Monfort, Inc. v. Rangel*, *supra*. The length of employment with a particular employer continues to be immaterial to a finding of liability; the focus is on both the harmful nature of the concentration of the exposure and the magnitude of the effect of the exposure. As found, Claimant's exposure to the aggravating factors of her neck condition with the Employer herein had a substantial impact on the aggravation of her previous (to beginning work with the Employer herein) neck condition.

f. Section 8-41-304 (1), C.R.S. (2008), also provides that the employer in whose employment the employee was last injuriously exposed and suffered a substantial permanent aggravation of the occupational disease shall alone be liable for the substantial permanent aggravation, without right of contribution. *See Monfort, Inc. v. Rangel, supra*; *Robbins Flower Shop v. Cinea, supra*. Also, where an occupational disease is the proximate cause of the disability, there exists an occupational disease with no apportionment. *Anderson v. Brinkoff,* 859 P.2d 819 (Colo. 1993). This is also true for a substantial, permanent aggravation of a preexisting occupational disease. The *Anderson v. Brinkoff* rule, however, only applies to occupational diseases not accidents. *Lindner Chevrolet v. industrial Claim Appeals Office,* 914 P.2d 496 (Colo. App. 1995). Indeed, there is no right of contribution even though there were other **injurious** exposures with previous employers. *Claimants in the Matter of the Death of Garner v. Vanadium Corp. of America,* 194 Colo. 358, 572 P.2d 1205 (1977). As found, Claimant sustained a **substantial, permanent aggravation** of her previous neck condition, while working for the Employer herein and her date of onset was April 22, 2002.

g. Apportionment is appropriate when a prior injury has been sufficiently identified, treated, evaluated and rated as a contributing factor. *See Askew v. Industrial Claim Appeals Office,* 927 P. 2d 1333 (Colo.1996). Indeed, where successive injuries contribute to disability and the need for medical treatment, an apportionment, based on medical opinions, was held appropriate. *See Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo.App.2004). As found, although a previous neck condition was identified and treated in 2000, it was not sufficiently evaluated and rated as a contributing factor to the April 22, 2002 onset of the compensable occupational disease as determined by ALJ Harr in January 2003.

h. The proponent of a proposition has the burden of proof, by a preponderance of the evidence, of establishing that proposition. Sections 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). Also, 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). 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, "apportionment" is in the nature of an affirmative defense and Respondents have failed to prove, by a preponderance of the evidence, that it is warranted in this case.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents having failed to overcome the Division Independent Medical Examination of David Yamamoto, M.D., the degree of Claimant's permanent medical impairment is 26% whole person for physical injury, and 4% whole person for psychological injury. Claimant reached maximum medical improvement on February 15, 2007.

B. Respondents affirmative defense of apportionment is hereby denied and dismissed.

C. Respondents shall pay permanent medical impairment benefits, based on 26% whole person physical injuries, and twelve weeks for 4% psychological impairment, from February 15, 2007 and continuing until paid in full. Respondents are entitled to credit for any permanent disability benefits previously paid

D. 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.

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

DATED this_____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-745-218

ISSUES

The issues for determination are compensability and medical benefits.

FINDINGS OF FACT

1. On December 3, 2007, Claimant was injured during a physical agility test as part of Employer's pre-hire screening for employment. Claimant was at the Employer's employment training center in Salt Lake City, Utah, participating in a physical agility test. During the test, she was required to lift a sixty (60) pound bag with unsecured weights a minimum of four times. Claimant was also required to lift a forty-five (45) pound bag and thirty (30) pound bag as well. When Claimant attempted to lift the sixty pound bag above her shoulders, the weight in the bag shifted and the bag struck her in the chest, leg, and face.

2. Claimant applied for the position as a Cross-Utilized Agent in Grand Junction, Colorado. As part of the application process for Cross-Utilized Agents, candidates are required to submit online applications, undergo a series of interviews, complete criminal background checks and FBI fingerprinting, drug tests, a physical agility test, written examinations, and confirmation of passage of all tests and background checks for Federal Aviation Administration ("FAA") and Transportation Security Administration ("TSA") security clearances. A prospective applicant must complete all of these steps in order to be considered for potential employment with Employer. If an applicant fails any of these steps, the applicant is removed from the application pool for the desired position. Furthermore, per FAA and TSA regulations, employment does not begin for airline employees until the security clearances have been confirmed to allow individuals to work at airport sites. Consequently, if Employer wishes to select an applicant, Employer does not provide an offer of employment until their application requirements are fulfilled and security clearance has been granted.

3. After conducting the interview steps of the applicant process, Claimant was given a "conditional offer of understanding" which identified that she was being considered as a candidate for employment and that she understood the selection process. Additionally, Claimant received a pre-hire policy manual containing information and preparation materials for the additional application steps necessary for all candidates. At no time was a written offer of employment given to Claimant.

4. The application process for Employer included the following: (1) submission of an online application for the position desired; (2) series of interviews by local managers following receipt of an application; (3) required attendance at one of Employer's employment centers in order to conduct the criminal background tests, inclusive of FBI fingerprinting, a physical agility test, and written examinations; and (4) confirmation of passage of all tests, background checks and security clearances.

5. Employer's policy manual indicates that during the application process, all attendees are pre-hire applicant's and are not considered employees. As part of the application process, the applicants are given what is known as the PAR, which is a handbook for the testing and subjects given specific to their position. The PAR manual provides Employer's policies for the application process and other information to be studied for written testing as part of that application process. Specifically, the PAR manual iden-

tifies that applicants receiving and reviewing the manual are "prospective employees." Claimant initialed that she received the PAR manual on November 6, 2007.

6. A "Conditional Offer Understanding" was provided to Claimant as part of the application process. Claimant signed and agreed to the terms on this form. Claimant stated that this is not an offer of a position to an applicant. It is a form used by Employer to provide notice to applicants of the remaining application process. Additionally, Claimant indicated that the form specifically provides that applicants agree that they are being considered for employment and that they must complete the application process in order to receive a position with Employer.

7. Employer's "Orientation/Employment Center's" policy handbook states, "[a]n offer of employment will not be made without successful completion of an [employment center] session (including all required clearances)…."

8. An applicant would not be given any schedules or work assignments until they receive an offer of employment following selection and completion of the application process.

9. A prospective candidate is not considered an employee of Employer until the "bright line" moment where it confirmation is made that a prospective candidate has passed all the tests and background checks in order to have security clearance to work at airport sites. The Department of Transportation ("DOT"), FAA and TSA require that such clearances be confirmed prior to the issuance of any security badge and prior to allowing Employer to permit prospective candidates to become employees and begin work at an airport.

10. Employer uses a hiring procedure checklist as part of its application process. As identified on Employer's hiring checklist, local managers are not allowed to inform the applicants that they can begin work and become employees until after "the applicant's clearance and employee number" is received from Employer. The "hire date" is considered the employee's first day of employment following the application process. During that "new hire date" or first day of employment, a "New Hire I-9" Form is to be completed by a manager and sent to Employment Administration.

11. Claimant pursued employment with Employer by filling out an online application. Claimant applied for the position of a Cross-Utilized Agent.

12. Employer further did not guarantee a position based on passing the agility test or any other single test or part of the application process. No position would be offered to any applicant for a Cross-Utilized Agent position until an applicant would complete all criminal background checks, FBI fingerprinting, DOT drug tests, physical agility tests, written examinations for the position, and basic station training. Failure to pass any of these tests and checks would disqualify a prospective candidate from the application pool. If all tests and checks were completed satisfactory, Employer would offer a position to the candidate.

13. Claimant failed to complete any of the criminal background checks, written tests and exercises. On the first day at the Employment Center, Claimant failed the physical agility test. Claimant did not complete the rest of the application process at the Utah employment center, which included the criminal background checks, the FBI fingerprinting, drug test, and written examinations for the cross-utilized agent position. Claimant was disqualified from the application pool following her failure of the physical agility test.

14. Claimant failed the physical agility test on the first day at the Employment Center. Claimant did not participate in nor complete the BST at the end of the week while in Utah. As a result, Claimant was not paid any wages or any bonus during the application process at the Salt Lake City Employment Center.

15. Claimant was not given either a New Hire form or a written offer of employment from Employer. No badge has been issued by Employer identifying that Claimant had passed the security clearances and was allowed to begin employment with Employer.

16. An applicant is paid for the appliction process when they complete the process and are selected for employment. Payment for the application process, including the process in Utah, is considered a "bonus". Employer's policy states that wages for the application process at the employment center is considered a "bonus because you haven't officially been hired by Employer at the end of BST. Your official Date of Hire…is your first day in the station after you completed BST."

17. Claimant was at Employer's facility in Utah when she was injured under an implied contract of employment. The implied contract was that if she successfully completed the required tests and checks she would be hired by Employer as a Cross-Utilized Agent and would receive a "bonus" for her attendance in Utah. Claimant was an employee when injured, and the claim is compensable.

18. Claimant did not report her injury to an employee of Employer on the day it occurred. Claimant's testimony that she did report her injury to the physical therapist who was conducting the test is credible. Claimant did report the injury to her physician shortly after her return to Colorado, and did report the injury to a supervisor of Employer in Colorado with whom Claimant had interviewed in connection with her application. It is found that Claimant did sustain an injury during a test at Employer's facility in Utah.

19. Claimant was examined on December 10, 2007, by Dr. Craig Stagg. Claimant stated that she had sustained an injury lifting during an agility test. Dr. Stagg described the problem as anterior chest and leg contusion "and question of facial contusion." Dr. Stagg prescribed physical therapy.

20. Claimant had a face lift one year prior to her compensable injury.

21. Dr. Stagg referred Claimant to Dr. Peterson on December 19, 2007.

22. Steven L. Peterson, M.D., examined Claimant on January 2, 2008. He noted that Claimant had "asymmetric marionette lines with markedly increased prominence on right." He stated that correction would require surgical intervention.

23. Kent Hughes, M.D., examined Claimant on February 27, 2008. Dr. Hughes had performed the previous facelift in December 2006. Dr. Hughes noted that Claimant now had facial asymmetry to the right side of her face due to impact from luggage. He stated that Claimant needed additional surgery.

24. Additional surgery to repair the facial asymmetry to the right side of Claimant's face is reasonably needed to cure and relieve Claimant from the effects of the December 3, 2007, compensable injury.

CONCLUSIONS OF LAW

1. Claimant went to Salt Lake City to continue the application process for employment with Employer. On December 3, 2007, Claimant proceeded to take the physical agility test, but failed the test as she was not able to lift the sixty (60) pound bag the required test height. Due to her failure to pass the physical agility test, Claimant was dismissed by Employer and sent home that same day. Claimant did not complete the rest of the application process during the rest of the week at the Utah Employment Center, which included the criminal background checks, the FBI fingerprinting, drug test and written examinations for the cross-utilized agent position. Claimant was removed from the applicant pool and not offered a position at Employer.

2. There was no contract of hire for Claimant to work for Employer as a Cross-Utilized Agent. However, there was an implied contract of hire. Claimant was to be paid a bonus for her attendance at Employer's Utah facility and was to be hired as a Cross-Utilized Agent should she successfully complete the required tests and checks.

3. Respondents argue that Claimant is not an employee under the case of *Younger v. City & County of Denver*, 810 P.2d 647(Colo. 1991). In *Younger*, the claimant was injured while undergoing a pre-employment physical test. The claimant in *Younger* was not guaranteed a position should he have successfully completed the test. Further, even if eventually hired into the position for which he was applying, there was no agreement that the City and County of Denver would pay him for his participation in the test. The facts in this claim are more similar to the facts in *Shields v. Colorado Springs Club Venture,* W.C. No. 4-529-550 (ICAO, 2005). In *Shields*, the claimant was injured during a training program that the employer required the claimant to undergo before beginning work. The employer controlled the time, place and nature of the program. The claimant in *Shields* was determined to be an employee.

4. At the time of her injury, Claimant was in the service of Employer under an implied contract of hire. Section 8-40-202(1)(b), C.R.S. The claim is compensable.

5. Insurer is liable for the medical care Claimant receives from authorized physicians that is reasonably needed to cure and relieve her from the effects of the compensable injury. Section 8-42-101(1), C.R.S. Drs. Stagg and Peterson, and others to whom Claimant was referred in the normal progression of authorized treatment. are authorized. *City of Durango v. Dunagan,* 939 P.2d 496 (Colo.App. 1997). Claimant has established by a preponderance of the evidence that the recommended surgery is reasonably needed to cure and relieve Claimant from the effects of the December 3, 2007, compensable injury. Insurer will be liable for the costs of such surgery, should it be performed by an authorized provider. Liability is limited to amounts established by the Division of Workers' Compensation fee schedule. Section 8-42-101(3), C.R.S.

ORDER

It is therefore ordered that:

1. The claim is compensable.
2. Insurer is liable for the costs of the medical care Claimant receives from authorized medical providers that is reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Insurer will be liable for the proposed facial surgery if an authorized provider performs the surgery.
3. All matters not determined herein are reserved for future determination.

DATED: *December 1, 2008*

Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr. Administrative Law Judge (ALJ), on November 18, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 11/18/08, Courtroom 3, beginning at 1:30 PM, and ending at 2:30 PM).

At the conclusion of the hearing, the ALJ ruled from the bench to referred preparation of a proposed decision, to be submitted electronically, to Claimant's counsel, giving Respondents 3 working days within which to file objections. The proposed decision was filed on November 24, 2008. No timely objections were filed. After a consideration of the proposed decision, the ALJ has modified the proposal and hereby issues the following decision.

ISSUE

The issue to be determined by this decision concerns post maximum medical improvement (MMI) medical maintenance benefits, specifically, whether the Claimant is entitled to an MRI (magnetic resonance imaging) procedure of

her lumbar spine as ordered by Robert I. Kawasaki, M.D., the authorized treating physician (ATP); and, whether the MRI procedure constitutes reasonably necessary maintenance medical care as provided for in *Grover vs. Industrial Comm*, 759 P.2d 705, 711(Colo. 1988).

FINDINGS OF FACT

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

1. Dr. Kawasaki is the Claimant's ATP, and is of the opinion that the Claimant is in need of a repeat lumbar MRI for diagnostic purposes. The ALJ infers and finds that the diagnostic purposes are to prevent the Claimant's condition from deteriorating and to maintain the Claimant at MMI,, as opposed to mere scientific curiosity.

2. Pursuant to the Final Admission of Liability (FAL), dated January 7, 2008, Respondents admitted liability for reasonably necessary medical care related to this claim, as authorized by the ATP.

3. The ALJ finds that the recommendation for an MRI by Dr. Kawasaki constitutes reasonably necessary maintenance medical care related to this claim.

4. Claimant has proven, by a preponderance of the evidence, that a repeat MRI as ordered by the ATP is reasonably necessary post-MMI maintenance medical care.

CONCLUSIONS OF LAW

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

a. An employee is entitled to continuing medical benefits after MMI if reasonably necessary to relieve the employee from the effects of an industrial injury. *See Grover v. Industrial Commission of Colorado*, 759 P.2d 705 (Colo. 1988). The record must contain substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve a claimant from the effects of an injury or to prevent further deterioration of his condition.
Stollmeyer v. Industrial Claim Appeals Office, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, supra*. Such evidence may take the form of a prescription or recommendation for a course of medical treatment necessary to relieve a claimant from the effects of the injury or to prevent further deterioration. *Stollmeyer v. Industrial Claim Appeals Office, supra*. "Substantial evidence" is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App.

1995). Indeed, as found, there is no conflicting evidence and the Claimant's ATP has recommended a repeat MRI for diagnostic purposes to prevent a deterioration of her condition.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits, including *Grover* medical benefits. Sections 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 met her burden of proof with respect to the reasonable necessity of the repeat MRI ordered by her ATP.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. In addition to other authorized, causally related and reasonably necessary medical benefits, Respondents shall pay the costs of the repeat MRI recommended by Claimant's authorized treating physician, Robert I. Kawasaki, M.D.

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

DATED this _____ day of December 2008.

_____
EDWIN L. FELTER, JR.

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-396

ISSUES

The issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant was employed by the employer as a certified nursing aide ("CNA") since July 2001. Since 2004, she has worked the graveyard shift from 11:00 p.m. to 6:30 a.m.
2. Claimant had extensive disciplinary problems, including suffering a reduction in pay at one time. Claimant had been notified that she had to improve her attendance. Claimant also had been notified that she had other performance related problems.
3. On May 5, 2008, Ms. A, the R.N. supervisor, gave claimant a written write-up.
4. On May 8, 2008, claimant received written notification of a Rule 6-10 meeting with the administrator, Mr. B, to discuss her performance problems.
5. Claimant alleges that she suffered an injury at approximately 11:40 p.m. on May 9, 2008, while lifting a patient in bed with a draw sheet. Claimant alleges that she appeared for work at the start of her 11:00 p.m. shift and that she worked with Ms. P to move several patients, but that Ms. P failed to lift her share of a large patient. Claimant alleges that she suffered immediate low back pain and leg pain. She alleges that she cried while continuing to work for another hour before reporting her work injury.
6. Ms. P testified that claimant appeared late for work and had to catch up with Ms. P in the room of the large patient. Ms. P testified that claimant was upset about receiving the notice of the Rule 6-10 meeting and failed to help Ms. P lift the large patient. Ms. P did not see claimant cry at any time.
7. At 12:05 a.m. on May 10, 2008, claimant reported to her supervisor, Ms. V, that she had suffered an injury while working with Ms. P. Ms. Velasquez interviewed Ms. P, who denied that claimant had even helped move the large patient.
8. On May 9, 2008, claimant filed a leave request form, stating that she could not find her badge and had been unable to clock in. Claimant stated that she started work at 11:00 p.m. Ms. V approved the modification to the automated timekeeping system to show that claimant started at 11:00 p.m.
9. On May 13, 2008, Mr. B conducted the Rule 6-10 meeting. On May 15, 2008, Mr. B sent claimant written notification that her employment had been terminated.
10. On May 13, 2008, Dr. McFarland examined claimant, who reported a history of a work injury on May 9 while lifting a large patient. Dr. McFarland noted that claimant was in no acute distress. He diagnosed a lumbar strain, prescribed medications, and excused claimant from work.
11. May 22, 2008, x-rays of the lumbar spine were negative.
12. Claimant's testimony is not credible. The testimony of Ms. P and Ms. V is credible. Claimant had a long history of disciplinary problems. She received notice on May 8, 2008, that she had a Rule 6-10 meeting, which was a pre-disciplinary meeting. Claimant had a motive to fabricate an injury. She did not appear for work at 11:00, contrary to her testimony. She appeared for work late and did not assist Ms. P in lifting the large patient. She did not cry while continuing work. The preponderance of the evidence does not demonstrate that claimant suffered an accidental injury arising out of and in the course of her employment on May 9, 2008.

CONCLUSIONS OF LAW

1. Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App.

2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove 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). 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's testimony is incredible. As found, claimant has failed to prove by a preponderance of the evidence that she suffered an injury arising out of and in the course of her employment.

ORDER

It is therefore ordered that:

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

DATED: December 4, 2008 Martin D. Stuber, Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-726-043

ISSUES

¬ Did respondents overcome by clear and convincing evidence the determination of Thomas Fry, M.D., that claimant has not reached maximum medical improvement?
¬ Did claimant prove by a preponderance of the evidence that her average weekly wage should be increased based upon concurrent employment?
¬ Did claimant prove by a preponderance of the evidence that she is entitled to temporary disability benefits based upon her wage loss from concurrent employment?

FINDINGS OF FACT

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

1. Employer operates an office cleaning business. Claimant worked as a custodian for employer. OM is employer's area manager. Claimant sustained an admitted injury to her right upper extremity while working for employer on February 4, 2007. Claimant continued working for employer until the last week of October, 2007.

2. Claimant initially sought treatment at the Emergency Department of HealthOne (ER) on February 5, 2007. The ER physician diagnosed a right forearm sprain and applied a splint to claimant's right wrist. The ER physician restricted claimant from using her right hand for work over the following 3 days.

3. Employer referred claimant to Craig Anderson, M.D., who first examined her on February 7, 2007. Claimant reported to Dr. Anderson she experienced immediate pain in the fingers of her right hand radiating into her wrist while attempting to forcefully remove the lid of a container of contaminated substances. Dr. Anderson reviewed reports from the ER and noted:

> Nurse at ER noted [claimant] was observed to use the right hand to answer cell phone and dig through purse with no signs of pain.

Dr. Anderson noted claimant's right hand and wrist appeared normal to inspection. Dr. Anderson diagnosed a right hand and wrist strain, rule out wrist tendonitis, and rule out median nerve neuritis. Dr. Anderson imposed physical activity restrictions precluding claimant from working with her right hand.

4. Dr. Anderson referred claimant to Physiatrist Barry A. Ogin, M.D., who examined her on April 16, 2007. By that time, claimant reported that her primary symptoms involved aching and stabbing pain along her anterior and superior shoulder. During his examination of claimant's shoulder, Dr. Ogin observed her guarding her right arm and displaying extreme pain behaviors. Dr. Ogin noted:

> It is … surprising that she still has fairly severe pain despite the fact that she has not been utilizing her right arm at work.
>
> ****
>
> Neither her mechanism of injury nor her current examination is consistent with rotator cuff pathology.

Dr. Ogin thus ruled out clinical evidence right shoulder pathology but recommended electrodiagnostic testing to rule out peripheral nerve entrapment or radiculopathy.

5. Dr. Ogin performed electrodiagnostic (EMG) testing of the nerves in claimant's bilateral upper extremities on May 1, 2007. Dr. Ogin found evidence of moderate carpal tunnel syndrome (CTS) bilaterally. Dr. Ogin found no electrodiagnostic evidence of cervical radiculopathy or brachial plexus injury. Dr. Ogin suspected claimant's shoulder pain was myofascial in nature. Because claimant's complaints had not improved with treatment, Dr. Ogin referred her for a magnetic resonance imaging (MRI) scan of her right shoulder, which she underwent on May 8, 2007.

6. Dr. Ogin reviewed the results of the MRI scan with claimant on May 9, 2007. Dr. Ogin noted:

> Again her symptom description is quite vague, with pain beginning in her fingers and shooting up to her shoulders.

Dr. Ogin reported that the MRI scan showed no evidence of an acute lesion, but instead showed arthritic changes of the acromioclavicular (AC) joint, tendinopathy, and an old fracture of the glenoid. Dr. Ogin injected claimant's right AC joint with lidocaine, but that failed to provide much relief. Because claimant reported failure of treatment, Dr. Ogin referred her to Orthopedic Surgeon Mark S. Failinger, M.D., for evaluation.

7. Dr. Failinger examined claimant's right shoulder on May 14, 2007, when she reported a different mechanism of injury:

> [Claimant] was **pushing a lot of buckets and just picking them up repetitively** and she had some pain and discomfort in her hand and seemed to go up toward the shoulder. She has had pain since then.

(Emphasis added). Upon examination of claimant's shoulder, Dr. Failinger noted:

> She is fairly dramatic in all presentations, just gentle palpation ….

Dr. Failinger offered a trial injection of cortisone, which claimant rejected. Dr. Failinger noted he had no treatment options to offer, other than surgery. But Dr. Failinger recommended that claimant undergo a psychological evaluation before he would consider any surgical option.

8. Dr. Anderson referred claimant to Psychologist Suzanne Kenneally, Psy.D., for a psychological assessment on June 14, 2007. Claimant reported yet another history of the mechanism of her injury:

> On 02/04/2007, while at work, [claimant] was **taking out 30 gallon trash bins**. She stated there were "35 of them." [Claimant] was again tearful and then stated "I started to get anxious to do a good job and not have any problems." She notes that she began to experience right arm pain after emptying 8-10 of the garbage bins.

(Emphasis added). Dr. Kenneally noted that claimant's affect was labile, ranging from flat to tearful, and that she cried periodically throughout the interview without specific triggers. Dr. Kenneally's testing showed claimant prone to over-report her symptoms, indicative of exaggeration of pain and symptoms, and having a significant contribution of non-physiological factors to her report of pain. Dr. Kenneally reported:

> The over-reporting of psychological and physical symptomatology seen on [claimant's] psychological testing further indicates that **she is a poor candidate for any invasive medical treatment.**

(Emphasis added). Dr. Kenneally cautioned claimant's physicians:

> All treaters are advised to **obtain objective measures of [claimant's] pain symptom and report** and to provide conservative treatment.

(Emphasis added). Dr. Kenneally diagnosed long-standing, preexisting major depressive disorder and anxiety disorder. Based upon Dr. Kenneally's assessment, Dr. Anderson determined claimant is not a surgical candidate.

9. Dr. Anderson prescribed Paxil. According to Dr. Anderson, claimant responded dramatically to the Paxil medication and to psychological intervention with Dr. Kenneally. On August 3, 2007, Dr. Kenneally reported to Dr. Anderson that claimant had markedly improved from counseling for her anxiety and depression. Dr. Anderson planned to restart biofeedback treatment to encourage mobilization of the shoulder and work conditioning. On August 29, 2007, claimant told Dr. Anderson she was interested in another lidocaine injection, which Dr. Ogin performed.

10. With the agreement of Dr. Ogin, Dr. Anderson placed claimant at maximum medical improvement (MMI) on September 5, 2007. Through the course of her medical treatment, Dr. Anderson and Dr. Ogin had referred claimant for physical therapy, biofeedback therapy, shoulder MRI, surgical consultation, and psychological counseling. Dr. Anderson rated claimant's permanent medical impairment at 10% of the upper extremity, based upon abnormal motion. Dr. Anderson opined that claimant's bilateral CTS is unrelated to her work-injury.

11. Insurer filed a Final Admission of Liability on September 19, 2007, admitting liability for permanent partial disability (PPD) benefits based upon Dr. Anderson's 10% upper extremity injury.

12. On September 1, 2007, claimant began working for Solis Cleaning Company performing janitorial work. Although claimant denied any ownership interest in Solis Cleaning Company, the company address and office is located in claimant's residence. The Judge finds that claimant's testimony here lacks credibility and that she became self-employed doing business as Solis Cleaning Company on September 1st, 2007.

13. Claimant requested a leave of absence and last worked for employer during the third week of October, 2007. Claimant wanted leave to help her father through a medical condition. Mr. M testified that he persuaded claimant to allow him to hire someone else to work under claimant's name and social security number. Claimant denied any knowledge of this. Mr. M hired someone who worked under claimant's name and social security number from October through March 14, 2008. During that period of time, Mr. M cashed the other employee's payroll checks, which were made payable to claimant. Mr. M also had another employee work under claimant's name during the 2 to 3 weeks she missed from work following her work-injury. Although Mr. M's testimony was offered to discredit claimant, the Judge finds such manifestly fraudulent conduct on the part of Mr. M instead discredits him and employer.

14. Dr. Kenneally continued to provide psychological counseling to claimant after MMI. On December 20, 2007, Dr. Kenneally recorded the following history from claimant:

> [Claimant] described at great length mopping for an hour at work last Friday. She then experienced significant swelling of her right

> shoulder area and reported being significantly worried. [Claimant] noted using ice and rest on Friday, Saturday and Sunday and she was able to return to her modified duty work on Monday.

Dr. Kenneally counseled claimant to pace herself while working. On January 10, 2008, Dr. Kenneally noted claimant presented in noticeably increased distress, tearful, and emotionally labile throughout the session. Dr. Kenneally noted:

> The cause for [claimant's] heightened distress was reported as the recent relapse in her shoulder pain and swelling following the incident of extensive mopping at work approximately three weeks ago. **[Claimant] was catastrophizing this relapse and focused on a permanent setback in her physical recovery.**

(Emphasis added).

15. Dr. Kenneally testified about the December 20th session with claimant:

> I do remember this fairly clearly because she went over it, certainly twice, if not more than that during the session. She did what she described to me as an entire cafeteria setting, took her at least an hour, maybe a little longer than that.
>
> I don't believe she paced herself or took appropriate breaks. She was under some sort of additional pressure, a coworker hadn't turned up or they were shorthanded … there was some incentive to do this well and to do it quickly. And certainly **her sense was that she pushed herself too far and then had a significant flare-up.**

(Emphasis added). Dr. Kenneally was unaware that claimant had been working for Solis Cleaning Company at the time of the mopping incident.

16. Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Thomas Fry, M.D., the DIME physician. Dr. Fry examined claimant on January 21, 2008, when she reported the following mechanism of injury:

> Acute onset R hand, wrist, forearm, and elbow pain and right paresthesia when **she had to forcefully lift the top of a plastic trash can** that holds contaminated substances (30-40 gallon container) **patient would pull on the top while holding the container down**. She relates that **she felt a very severe sharp burning pain with tingling needles** … sensation in the arm. **This was immediate and shot all the way down the arm**. She relates there wasinability (sic) to move the arm followed by some recurrence of strength.

(Emphasis added). It appears that the earliest medical record provided Dr. Fry was the February 28, 2007, report of Dr. Anderson. Dr. Fry lacked the ER record and earlier records from Dr. Anderson. It appears from his report that Dr. Fry did

not review Dr. Kenneally's June 14, 2007, psychological assessment of claimant. Claimant failed to report to Dr. Fry any history of the December 2007 mopping incident. Dr. Fry had neither Dr. Kenneally's December 20, 2007, report nor her January 10, 2008, report to review.

17. Dr. Fry ruled out a shoulder injury, but found evidence of a neck injury; he assessed the following:

> [Claimant's] history and physical examination are most consistent with a brachial plexus or neuritic problem. **History of mechanism of injury** are most suggestive of an acute cervical HNP [disk herniation].
>
> ****
>
> I do not think [claimant] has significant shoulder pathology of rotator cuff, biceps tendon or labrum. [Claimant] may have some mild degenerative changes of the [AC] joint which probably are not a significant factor in her current radiating pain.

(Emphasis added). Dr. Fry relied upon the history claimant gave him suggesting a neck injury in determining that she had not reached MMI. Dr. Fry recommended a cervical MRI study and cervical evaluation. Dr. Fry's determination regarding MMI is presumptively correct unless overcome by clear and convincing evidence.

18. Claimant's counsel referred her to John S. Hughes, M.D., for and independent medical examination on June 6, 2008. The earliest medical record provided for Dr. Hughes to review was the February 28, 2007, report of Dr. Anderson. Claimant reported another and different mechanism of injury to Dr. Hughes, this time from <u>closing</u> a container:

> [Claimant] was working in a place that required containerizing bio waste. She describes **closing** up 30-60 pound **containers** …. **She demonstrates that closing these containers requires a strong jerking motion** and **that day, she did not think much of her symptoms** but the following day she recalls "pain was unbearable."

(Emphasis added). Dr. Hughes opined in his report that claimant sustained 2 distinct injuries that led to her persistent symptom complex: A more minor right shoulder strain and a cervical spine injury. Claimant had not told Dr. Hughes about the December 2007 mopping incident. Dr. Hughes agreed with Dr. Fry's determination that claimant had not reached MMI and with Dr. Fry's treatment recommendations.

19. Dr. Hughes testified that claimant is not a good historian and that he prefers a precise description of the mechanism of injury as the basis for his causality analysis. Dr. Hughes stated that Dr. Anderson's initial evaluations of claimant in February of 2007 document different findings from what he and Dr. Fry found. Dr. Hughes stated that

there were no objective findings supporting a cervical spine injury prior to the time Dr. Anderson placed claimant at MMI in September of 2007.

20. Based upon the totality of the evidence, the Judge finds it more probably true that claimant's report of her symptoms and mechanism of injury is unreliable and lacking credibility. The above findings reflect claimant reporting numerous, different mechanisms of injury and resulting symptoms. The Judge credits the psychological assessment of Dr. Kenneally in finding claimant prone to exaggerate her symptoms. Claimant thus lacks credibility.

21. Crediting Dr. Anderson's testimony, the May 1, 2007, EMG testing by Dr. Ogin is the gold standard for testing for cervical radiculopathy. In addition, Dr. Anderson repeatedly performed clinical testing for signs of cervical, thoracic outlet, or brachial plexus injury, all of which were negative during the course of treatment through MMI. When Dr. Anderson examined claimant on November 5, 2007, he found no clinical evidence of any cervical or thoracic outlet injury. According to Dr. Anderson, Dr. Fry used the same testing maneuvers as he had throughout his treatment of claimant. However, Dr. Fry's exam findings were positive, and thus different from the exam findings Dr. Anderson noted throughout his treatment of claimant prior to MMI. Dr. Anderson testified that it is probable claimant had an intervening injury between MMI and the time Dr. Fry examined her on January 21, 2008. Dr. Anderson testified:

> [T]here is such a **marked discrepancy between what [Dr. Fry] has written here and what my findings were and what Dr. Ogin's findings were,** both clinically and with testing, that if [claimant] did suffer an acute cervical disk herniation, it had to have been … a result of … some other incident, but certainly not something that would have occurred at the time I was actively treating her.

(Emphasis added). Dr. Anderson and Dr. Hughes alike testified that the mopping incident could cause claimant's cervical symptoms. Dr. Anderson's testimony was persuasive.

22. Respondents showed it highly probable Dr. Fry erred in determining claimant has not reached MMI. As found, claimant lacks credibility. Because Dr. Fry relied upon claimant's report of a new and different mechanism of neck injury as the basis for his medical opinion that claimant had not reached MMI, his medical opinion lacks credibility and is unpersuasive. As found, Dr. Anderson's medical opinion was more persuasive in showing claimant had no cervical symptoms or findings to support a cervical injury until after his evaluation of claimant on November 10, 2007, *i.e.*, after the mopping incident. Respondents thus overcame Dr. Fry's MMI determination by clear and convincing evidence.

23. Crediting Dr. Anderson's medical opinion, claimant reached MMI on September 5, 2007.

24. Claimant worked for employer and for Liborio Markets at the time of her work injury. Claimant's average weekly wage for employer based upon an average work week of 30.5 hours and the hourly wage of $9.20 plus average overtime, and holiday pay of $53.20 per week for an average weekly wage of $366.80. Claimant average weekly wage from Liborio Markets was $366.52. Claimant showed it more probably true that

her average weekly wage, based upon concurrent employment is $733.32. Claimant last worked for Liborio Markets on February 4, 2007. Liborio Markets terminated claimant on April 11, 2007.

25. Claimant however failed to show it more probably true than not that the no use of the right hand restriction precluded her from performing her regular employment at Liborio Markets after February 4, 2007. Claimant failed to present any persuasive evidence to support a claim for temporary disability benefits.

CONCLUSIONS OF LAW

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

The purpose of the Workers' Compensation Act of Colorado (Act), §§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*. 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. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

A. Overcoming the DIME:

Respondents argue they overcame Dr. Fry's determination on the issue of MMI by clear and convincing evidence. The Judge agrees.

Sections 8-42-107(8)(b)(III) and (c), *supra*, 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. Bing Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

Here, the Judge found respondents showed it highly probable Dr. Fry erred in determining claimant has not reached MMI. Respondents thus overcame Dr. Fry's MMI determination by clear and convincing evidence.

The Judge found that claimant lacks credibility. Because Dr. Fry relied upon claimant's report of a new and different mechanism of neck injury as the basis for his medical opinion that claimant had not reached MMI, the Judge found that his medical opinion was unpersuasive. The Judge instead credited Dr. Anderson's medical opinion in finding that claimant had no cervical symptoms or findings to otherwise support a cervical injury until after the mopping incident at Solis Cleaning Company. The Judge thus upheld Dr. Anderson's determination that claimant reached MMI on September 5, 2007.

The Judge concludes that claimant's request for an award of workers' compensation benefits related to her cervical condition should be denied and dismissed.

B. Temporary Disability Benefits:

Claimant argues she has proven by a preponderance of the evidence that she is entitled to temporary disability benefits based upon her wage loss from concurrent employment. The Judge disagrees.

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).

Earnings from concurrent employment may be included in a claimant's AWW where the injury impairs earning capacity from such employment. *Jefferson County Schools v. Dragoo*, 765 P.2d 636 (Colo. App. 1988). Section 8-42-

103(1), *supra*, 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).

The Judge found that claimant showed it more probably true that her average weekly wage, based upon concurrent employment is $733.32. Claimant however failed to show it more probably true than not that the no use of the right hand restriction precluded her from performing her regular employment at Liborio Markets after February 4, 2007. Claimant failed to present any persuasive evidence to support a claim for temporary disability benefits.

The Judge concludes claimant's request for temporary disability benefits based her wage loss from Liborio Markets 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 request for an award of workers' compensation benefits related to her cervical condition is denied and dismissed.

2. Claimant's request for temporary disability benefits based her wage loss from Liborio Markets is denied and dismissed.

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

DATED: _December 8, 2008_

Michael E. Harr,
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-696-533

ISSUES

1. Whether Claimant constitutes a "statutory employee" of Employer pursuant to §8-41-401(1), C.R.S.

2. Whether Claimant's claim is precluded by the two-year statute of limitations in §8-43-103(2), C.R.S.

3. Whether Claimant has established by a preponderance of the evidence that she sustained a compensable injury on December 18, 2003 during the course and scope of her employment with Employer.

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

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

6. Whether Claimant has established by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits from December 18, 2003 through March 31, 2004 and from September 13, 2006 until terminated by statute.

FINDINGS OF FACT

1. Claimant worked as a painter for FSP. FSP was a painting company that assigned Claimant to various job locations, dictated her hours of employment and provided her with the necessary equipment and materials to complete her duties. Claimant earned $15.00 per hour and worked 40 hours each week.

2. FSP contracted with Employer to paint a restroom at Employer's store in the Southwest Plaza Mall. FSP directed Claimant and another employee to perform the painting job. On December 17, 2003 Claimant went to Employer's store and observed that the restroom walls were covered in graffiti. She then prepared the restroom for painting.

3. On December 18, 2003 Claimant returned to Employer's store. Claimant and another employee of FSP entered a utility room in Employer's store because the room contained a sink. They intended to run hot water over cans of paint in order to warm them to room temperature. Claimant explained that she was facing the sink with her back to the door. An employee of the company that removes trash for Employer then pushed an empty, wheeled trash cart into the utility room. The trash cart struck Claimant in the back and knocked her to the floor. Claimant testified that she injured her back, neck and shoulder as a result of the incident.

4. Claimant reported her injury to Employer on the day of the incident. Employer prepared a "Non-Associate Accident Report" and an accompanying "Narrative Report of Investigation." The Non-Associate Accident Report specified "in storage room filling paint bucket with water when I was struck from behind with no warning by a large trash bin on rollers into my mid-back." The Narrative Report of Investigation further detailed Claimant's description of the incident and noted that her claim had been reported to Insurer.

5. On December 18, 2003 Claimant visited Jeffrey N. Gerber, M.D. for an evaluation. Dr. Gerber noted that Claimant had suffered "[b]lunt trauma to the posterior thorax and right rib cage areas, moderate to severe" and a "cervical sprain." He prescribed medications, recommended x-rays and excused Claimant from work. Claimant never returned to work for FSP.

6. On December 23, 2003 Claimant obtained medical treatment from personal physician Tracy Saffer, M.D. Claimant reported that she suffered from shoulder and back pain as a result of the December 18, 2003 incident.

7. Claimant testified that she operated her own painting company from approximately April of 2004 until November of 2005. She hired others to perform painting duties while she primarily engaged in sedentary tasks that included payroll and bookkeeping responsibilities.

8. On March 31, 2005 Claimant visited Jeffrey Kleiner, M.D. for an evaluation. Claimant recounted that she had been injured on December 18, 2003 when she was struck from behind by a trash container. In the days immediately after the incident Claimant experienced pain in her low back, neck, left buttocks and leg. Claimant also noted that she began to experience severe migraine headaches as a result of the incident. Dr. Kleiner concluded that Claimant "sustained a whiplash type injury as a consequence of her work-related accident on 12/18/03. She likely has sustained an internal disc disruption problem in her cervical spine which is responsible for the headache symptoms and referred pain to the scapular areas." An April 6, 2005 MRI of Claimant's cervical spine revealed a broad-based bulging of the C5-6 disc.

9. On August 31, 2006 Claimant filed a Workers' Claim for Compensation against FSP as a result of the December 18, 2003 incident.

10. On September 22, 2006 E. Jeffrey Donner, M.D. performed surgery on Claimant. She underwent an anterior cervical C5-6 discectomy, bilateral nerve root decompression and interbody fusion. In his preoperative history and physical evaluation, Dr. Donner noted "the patient is a 41-year-old female who had a work related injury in December 2003. She has had progressive, severe pain unresponsive conservative treatment. An MRI showed a central C5-6 disc herniation."

11. On December 14, 2006 Claimant filed a Workers' Claim for Compensation against Employer regarding the December 18, 2003 incident.

12. On September 7, 2007 Claimant filed a Workers' Claim for Compensation against the Southwest Plaza Mall regarding the December 18, 2003 incident.

13. SS, the General Manager of Southwest Plaza Mall testified through an evidentiary deposition in this matter. Ms. S is responsible for leasing, operations, security, janitorial services, marketing and customer service at the Mall. She credibly explained that Southwest Plaza Mall never contracted with FSP to perform painting services at the Mall. Because Southwest Plaza Mall did not have any contractual relationship with FSP, the Mall did not constitute Claimant's "statutory employer" pursuant to §8-41-401(1), C.R.S.

14. Ms. S also testified that Southwest Plaza Mall contains four "anchor stores," including Employer, that are "stand-alone" businesses responsible for their own interior maintenance. Ms. S explained that all of the "anchor stores" are large retail businesses. Employer specifically sells clothing, hardware and appliance items. Employer does not provide services in the nature of painting houses or businesses.

15. Claimant has failed to establish that Employer constituted her "statutory employer" pursuant to §8-41-401(1), C.R.S. Claimant has not demonstrated that Employer subcontracted out its "regular business," as defined by its "total business operation," to FSP. Ms. S credibly testified that all of the "anchor stores" in the Southwest Plaza Mall, including Employer, are large retail businesses. Employer specifically sells clothing, hardware and appliance items. Employer does not provide painting services. Employer contracted with FSP to remove graffiti and paint a bathroom within its store. Based on Ms. S's credible testimony, the painting of bathrooms was not a routine or regular aspect of Employer's total business operations. Painting the bathroom also was not integral to Employer's business of retail sales. Although Employer determined that the bathroom required painting, the importance of painting the bathroom was ancillary to Employer's business of selling clothing, hardware and appliances. Moreover, the record is devoid of evidence that Employer would have been required to use its own employees to paint the bathroom. Finally, consistent with the purpose of §8-41-401(1)(a), C.R.S., Employer did not seek to avoid workers' compensation liability by contracting out its typical business operations to FSP.

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 in-

jured 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 (2005).

4. Claimant contends that she is entitled to recover workers' compensation benefits through Employer as a result of the December 18, 2003 incident because Employer constituted her "statutory employer." Pursuant to §8-41-401(1)(a), C.R.S. a company that contracts out its work to a subcontractor is the statutory employer of the subcontractor and the subcontractor's employees. The purpose of the statute is to preclude employers from "avoiding responsibility under the workers' compensation act by contracting out their regular work to uninsured independent contractors." *Finlay v. Storage Technology Corp.*, 764 P.2d 62, 64 (1988).

5. The test for whether a contractor that has subcontracted out its work constitutes a statutory employer is satisfied if the contracted services are part of the contractor's regular business as defined by its "total business operation." *In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002). In evaluating a contractor's "total business operation" factors to be considered include "routineness, regularity, and the importance of the contracted services to the contractor's business operations." *Id.*; *see M&M Management Company v. Industrial Claim Appeals Office,* 979 P.2d 574, 577 (Colo. App. 1998). There is no specific formula for defining "regularity" and "routineness" in terms of frequency. *Shumiloff v. Frey,* W.C. No. 4-005-377 (ICAP, Apr. 24, 1992). Instead, a service is "regular" and "routine" if it is "an integral part of the contractor's total business operation." *In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002). The importance of the contracted services may be ascertained by determining whether the contractor would be required to perform the services using its employees. *Finlay,* 764 P.2d at 66; *Campbell v. Black Mountain Spruce, Inc.,* 677 P.2d 379, 381 (Colo. App. 1983). Application of the "regular business test" is dependent on the facts of each case. *In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002).

6. As found, Claimant has failed to establish that Employer constituted her "statutory employer" pursuant to §8-41-401(1), C.R.S. Claimant has not

demonstrated that Employer subcontracted out its "regular business," as defined by its "total business operation," to FSP. Ms. S credibly testified that all of the "anchor stores" in the Southwest Plaza Mall, including Employer, are large retail businesses. Employer specifically sells clothing, hardware and appliance items. Employer does not provide painting services. Employer contracted with FSP to remove graffiti and paint a bathroom within its store. Based on Ms. S's credible testimony, the painting of bathrooms was not a routine or regular aspect of Employer's total business operations. Painting the bathroom also was not integral to Employer's business of retail sales. Although Employer determined that the bathroom required painting, the importance of painting the bathroom was ancillary to Employer's business of selling clothing, hardware and appliances. Moreover, the record is devoid of evidence that Employer would have been required to use its own employees to paint the bathroom. Finally, consistent with the purpose of §8-41-401(1)(a), C.R.S., Employer did not seek to avoid workers' compensation liability by contracting out its typical business operations to FS P. *See In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002) (concluding that the claimant failed to demonstrate that child placement agency was his statutory employer because agency did not contract out part of its regular business to the claimant's uninsured direct employer).

ORDER

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

Claimant's request for workers' compensation benefits is denied and dismissed.

DATED: December 8, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-499-564 and WC 4-524-611

ISSUES

Whether Respondent-Insurer/Fremont is responsible for Claimant's left total knee replacement surgery on September 17, 2007?

Whether Respondent-Insurer/Pinnacol is responsible for Claimant's right total knee replacement surgery on September 17, 2007?

FINDINGS OF FACT

1. Claimant suffered admitted knee injuries one to the left knee and one to the right knee.

2. The left knee injury is the subject of WC 4-499-564, for which Respondent-Insurer/Fremont was responsible and the right knee is the subject of WC 4-524-611, for which Respondent-Insurer/Pinnacol was responsible.

3. On or about September 17, 2007 Claimant underwent bilateral total knee replacement surgery conducted by Dr. Timothy O'Brien. In neither claim was proper prior authorization sought by the Claimant. In the one attempt at prior authorization Claimant's counsel wrote to counsel for the Respondent-Insurer/Fremont indicating that Claimant was scheduled to undergo bilateral knee replacement surgery on September 17, 2007 and requesting authorization. This request did not comply with the Workers' Compensation Rules of Procedure. Respondents' counsel wrote to Claimant's counsel the next day and delivered the letter by facsimile that day, indicating that prior authorization was denied.

4. Dr. O'Brien is not an authorized treating physician in either claim. Claimant did not seek approval for a change in physician to Dr. O'Brien in either claim.

5. Claimant's bilateral total knee replacement took place when each of the claims was closed. The claims were reopened pursuant to a hearing that occurred three and a half weeks *after* the surgery, by order dated November 28, 2007. Claimant underwent bilateral total knee replacement surgery conducted by an unauthorized physician and without properly seeking prior authorization.

6. The bilateral total knee replacement that Claimant underwent on September 17, 2007, was not authorized by either the Respondent-Insurer/ Fremont or by Respondent-Insurer/Pinnacol.

CONCLUSIONS OF LAW

Once a claim is closed, no further benefits may be awarded unless the claimant establishes grounds to reopen the claim. *Burke v. Industrial Claim Appeals Office*, 905 P. 2d 1 (Colo. App. 1994). Section 8-43-303 C.R.S. 2007, allows reopening upon proof the claimant's physical condition from the industrial injury worsened after MMI. *Anderson v. Longmont Toyota Inc.*, 102 P.3d 323 (Colo. 2004). Here, Claimant independently sought, and underwent total knee replacement surgery while both of the claims hereunder were closed and without seeking proper prior authorization from either of the Respondent-Insurers. Claimant's hearing on reopening occurred after the Claimant had the total knee replacement surgeries.

Claimant has failed to establish by a preponderance of the evidence that Respondent-Insurer/Fremont is responsible for payment of the Claimant's left total knee replacement surgery and attendant care.

Claimant has failed to establish by a preponderance of the evidence that Respondent-Insurer/Pinnacol is responsible for payment of the Claimant's right total knee replacement surgery and attendant care.

ORDER

It is therefore ordered that:

1. Claimant's request to hold Respondent-Insurer/Fremont responsible for payment of the Claimant's left total knee replacement surgery and attendant care is denied and dismissed.

2. Claimant's request to hold Respondent-Insurer/Pinnacol responsible for payment of the Claimant's right total knee replacement surgery and attendant care is denied and dismissed.

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

December 4, 2008
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-736-478

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered industrial injuries during the course and scope of his employment with Employer on September 17, 2005.

2. Whether Claimant's claim is precluded by the two-year statute of limitations in §8-43-103(2), C.R.S.

3. Whether Claimant is precluded from receiving workers' compensation benefits because Colorado lacks jurisdiction over his claim.

4. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries.

FINDINGS OF FACT

1. On February 1, 2003 Claimant began working for Employer as a field interviewer and data collector. The contract of employment was formed in Nevada.

2. Claimant traveled approximately 48 weeks each year in order to perform his job duties. His extensive travel schedule required him to stay in hotels each night.

3. On September 16, 2005 Claimant traveled from Salt Lake City, Utah to Denver, Colorado to perform his job duties. He checked into the Town Place Suites based on instructions from his Employer.

4. Claimant noticed that the bed in his hotel room was in poor condition. He credibly testified that he fell asleep in the bed but was awakened at approximately 2:00 a.m. by a loud popping in his right arm. Claimant experienced numbness from his right shoulder down to his hand.

5. Two days after the incident Claimant reported the injury to his supervisor. However, the supervisor did not refer Claimant for medical treatment.

6. Claimant did not initially obtain medical treatment because he believed his symptoms would improve. He first sought treatment for his symptoms on October 25, 2005. Claimant's complaints included "wrenched back 4 weeks past" and "3 weeks past R arm went numb." He was diagnosed with back pain.

7. Claimant next sought medical treatment on November 30, 2005 with Richard Graham, M.D. in Long Beach, California. Claimant explained that his problems with his right arm began approximately nine weeks earlier upon abruptly awakening. Dr. Graham diagnosed Claimant with right inferior brachial plexopathy. Dr. Graham stated, "[p]resumed transient compressive process related to sleep posture with marked deficit onset upon awakening."

8. On December 7, 2005 Claimant again visited Dr. Graham for an evaluation. Dr. Graham opined "all signs, symptoms and history suggestive of right inferior brachial plexopathy caused by prolonged sleeping positioning."

9. From March 23-28, 2006 Claimant received physical therapy treatment for his right arm and back symptoms. The physical therapist's notes reflect

that Claimant reported a pinched nerve in his right arm that had been caused by sleeping with his right arm over his head in September 2005.

10. On May 17, 2007 Claimant filed a Claim for Compensation in Nevada. He credibly explained that he filed the claim in Nevada because he was instructed by Employer's human resources specialist to file the claim in the state in which he lived. Claimant was a resident of Nevada at the time.

11. Claimant subsequently discovered through research that he should have filed his claim for compensation in Colorado because that was the state in which his injury occurred. He filed his Colorado claim on September 21, 2008. The time of filing was several days after the two-year anniversary of his injuries.

12. On August 22, 2008 Claimant underwent a medical evaluation with John S. Hughes, M.D. Dr. Hughes opined that Claimant sustained a back strain injury that caused a lower trunk brachial plexopathy. He noted that Claimant's injury "commonly occurs with impaction of the shoulder."

13. Claimant has demonstrated that it is more probably true than not that he suffered compensable industrial injuries to his right upper back. neck and arm during the course and scope of his employment with Employer on September 17, 2005. Employer required Claimant to travel extensively and stay in specified hotels in order to complete his job duties. Claimant credibly explained that he went to sleep on September 16, 2005 but was awakened at approximately 2:00 a.m. by a loud popping in his right arm. He experienced numbness from his right shoulder down to his hand. The medical records of Dr. Graham are consistent with Claimant's account of his injury and reflect that Claimant suffered right inferior brachial plexopathy caused by a prolonged sleeping position. Moreover, the physical therapist's notes are also consistent with Claimant's account of the injury. Although Claimant was sleeping at the time of his injury, his activity was reasonably incidental to the conditions of his employment. Respondents have not demonstrated that Claimant engaged in a distinct departure that resulted in a personal deviation from the scope of his employment.

14. Employer's human resources specialist misadvised Claimant to file his claim for workers' compensation in Nevada because he lived in Nevada. The erroneous information from Employer constituted a reasonable excuse for Claimant to file his claim in Colorado several days after the expiration of the two-year deadline. Moreover, Employer's rights were not prejudiced by Claimant's minimal delay in filing his claim in Colorado. Because Claimant filed his claim within three years after September 17, 2005, his claim is not precluded by the statute of limitations in section 8-43-103(2), C.R.S.

15. Claimant promptly notified his supervisor of the September 17, 2005 industrial injury, but Employer failed to designate a medical provider. The right to select an Authorized Treating Physician (ATP) thus passed to Claimant.

16. Claimant has established that it is more probably true than not that he received medical treatment that was reasonable and necessary to cure and relieve the effects of his industrial injuries. The medical records reveal that Claimant's medical treatment beginning October 25, 2005, continuing with Dr. Graham and culminating with physical therapy were designed to alleviate the effects of his industrial injuries.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson*, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). An employee whose business requires travel away from the employer's premises is considered to be continuously acting within the course of his employment throughout the trip unless he makes a "distinct departure on a personal errand and is therefore engaged in a substantial, personal deviation." *In Re Torres*,

W.C. No. 4-701-752 (ICAP, Sept. 6, 2007); *see Phillips Contracting, Inc. v. Hirst*, 905 P.2d 9, 11 (Colo. App. 1995). An employee is not required to be actually engaged in job duties in order to suffer a compensable injury while in travel status. *Hirst*, 905 P.2d at 12. Instead, a traveling employee suffers a compensable injury "if the injury arises out of a risk which is reasonably incidental to the conditions and circumstances of the particular employment." *Id.* When the claimant is in travel status, the burden of proof is on the respondents to establish a distinct departure resulting in a personal deviation from the scope of employment. *In Re B*, W.C. No. 4-657-213 (ICAP, May 11, 2006); *Pacesetter Corp. v. Collett*, 33 P.3d 1230, 1233 (Colo. App. 2001). The existence of a substantial, personal deviation is a question of fact for the ALJ. *See In Re Torres*, W.C. No. 4-701-752 (ICAP, Sept. 6, 2007).

5. As found, Claimant has demonstrated by a preponderance of the evidence that he suffered compensable industrial injuries to his right upper back. neck and arm during the course and scope of his employment with Employer on September 17, 2005. Employer required Claimant to travel extensively and stay in specified hotels in order to complete his job duties. Claimant credibly explained that he went to sleep on September 16, 2005 but was awakened at approximately 2:00 a.m. by a loud popping in his right arm. He experienced numbness from his right shoulder down to his hand. The medical records of Dr. Graham are consistent with Claimant's account of his injury and reflect that Claimant suffered right inferior brachial plexopathy caused by a prolonged sleeping position. Moreover, the physical therapist's notes are also consistent with Claimant's account of the injury. Although Claimant was sleeping at the time of his injury, his activity was reasonably incidental to the conditions of his employment. Respondents have not demonstrated that Claimant engaged in a distinct departure that resulted in a personal deviation from the scope of his employment.

Statute of Limitations

6. Section 8-43-103(2), C.R.S. provides that a notice of a claim for compensation must be filed with the Division of Workers' Compensation within two years from the date of the injury. However, the two-year time limitation may be extended to three years if there is a reasonable excuse for the late filing and the employer's rights have not been prejudiced by the delay.

7. As found, Employer's human resources specialist misadvised Claimant to file his claim for workers' compensation in Nevada because he lived in Nevada. The erroneous information from Employer constituted a reasonable excuse for Claimant to file his claim in Colorado several days after the expiration of the two-year deadline. Moreover, Employer's rights were not prejudiced by Claimant's minimal delay in filing his claim in Colorado. Because Claimant filed his claim within three years after September 17, 2005, his claim is not precluded by the statute of limitations in section 8-43-103(2), C.R.S.

Improper Jurisdiction

8. Relying on Denver Truck Exchange v. Perryman, 134 Colo. 586, 307 P.2d 805 (1957), Respondents assert that Claimant is ineligible to receive workers' compensation benefits because Colorado lacks jurisdiction over his claim. However, Respondents' reliance is misplaced because *Perryman* involves whether Colorado has jurisdiction over injuries that are suffered out of the state. *Perryman* provides that Colorado does not have jurisdiction over an "out-of state injury" unless the claimant proves two of the following three criteria: (1) a contract of employment created in Colorado; (2) employment in Colorado under a contract created outside the state; and (3) substantial employment in Colorado. *See In Re Clendening,* W.C. Nos. 4-724-056 & 4-724-057 (ICAP, Aug. 6, 2008). Because it is undisputed that the September 17, 2005 incident occurred while Claimant was staying in a Denver, Colorado hotel, Respondents' contention of "improper jurisdiction" fails.

Medical Benefits

9. 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 his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

10. If an employer is notified of an industrial injury and fails to designate an 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).

11. As found, Claimant promptly notified his supervisor of the September 17, 2005 industrial injury, but Employer failed to designate a medical provider. The right to select an ATP thus passed to Claimant.

12. As found, Claimant has established by a preponderance of the evidence that he received medical treatment that was reasonable and necessary to cure and relieve the effects of his industrial injuries. The medical records reveal that Claimant's medical treatment beginning October 25, 2005, continuing with Dr. Graham and culminating with physical therapy were designed to alleviate the effects of his industrial injuries.

ORDER

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

1. Claimant suffered compensable injuries on September 17, 2005 during the course and scope of his employment with Employer.

2. Claimant is entitled to receive medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries.

3. Any issues not resolved in this order are reserved for future determination.

DATED: December 9, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-491-883

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that she suffered a worsened condition that would justify reopening the claim?
¬ If the claim is reopened, did the claimant prove by a preponderance of the evidence that Botox injections constitute reasonable and necessary medical treatment to cure and relieve the effects of the injury?

FINDINGS OF FACT

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

1. The claimant sustained an admittedly compensable injury on March 17, 2000, when she was involved in a motor vehicle accident (MVA). This injury affected the claimant's neck and back, and she experienced headaches.

2. In August 2000, an MRI was performed on the low back. It revealed early degenerative changes at L4-5 and mild annular bulging at L1-2. A cervical MRI was performed in September 2000. The cervical MRI indicated "reversal of the normal mid-cervical lordosis secondary to fairly advanced mid-cervical spondylosis." In November 2000 the claimant underwent a cervical dis-

cogram and the impression was “negative discography for pain reproduction” and “multi-level degenerative change.”

3. In July 2001, the claimant first came under the care of Dr. Edwin Healey, M.D. Dr. Healey is board certified in occupational medicine and neurology. Dr. Healey diagnosed severe lumbar, thoracic and cervical myofascial pain.

4. In April 2002, Dr. David Wong, M.D., performed surgery on the claimant’s low back. This surgery consisted of a fusion at L5-S1 with instrumentation and decompression at L4-5.

5. On January 13, 2003, Dr. Healey placed the claimant at maximum medical improvement (MMI) with 28 percent whole person impairment of the spine. Dr. Healey opined the claimant should be restricted to lifting, carrying, pushing or pulling 20 pounds occasionally, sitting for 30 minutes and standing for 10 to 15 minutes. Dr. Healey recommended medical maintenance care to include three years of trigger point injections for the claimant’s myofascial pain, and psychiatric care.

6. In April 2003, Dr. George Kohake, M.D., performed a Division-sponsored independent medical examination (DIME). Dr. Kohake noted the claimant continued to have “diffuse back complaints involving both the upper and lower back” three years after the work-related MVA. The claimant reported her pain ranged from 5 to 8 on a scale of 10 (5-8/10), and that it had increased since she returned to work as a “closing escrow coordinator.” The claimant was taking Mobic twice per day and Flexeril three timed per day. Dr. Kohake placed the claimant at MMI on January 17, 2003, and assigned 25 percent whole person impairment for her spinal condition and 1 percent impairment for a psychological disorder.

7. In 2004, Dr. Wong performed additional surgery to remove the hardware installed during the 2002 surgery. Dr. Healey continued to treat the claimant until December 2004, when he left to work for a different medical provider.

8. On November 9, 2004, Dr. Healey noted the claimant had again reached MMI after surgical removal of the hardware with no change in her permanent impairment rating. Following Dr. Healey’s report, the insurer filed a Final Admission of Liability (FAL) on March 3, 2005. This FAL admitted for ongoing medical benefits (*Grover* medicals) after MMI.

9. In 2005 Dr. Kristin Mason, M.D., became the authorized treating physician for purposes of providing *Grover* medical treatment to the claimant. The claimant continued to experience back pain. Dr. Mason prescribed an extensive course of physical therapy and trigger point injections. On May 8, 2006, during the course of the treatment, the claimant advised Dr. Mason that she was

experiencing a pain level of 5-6/10. In June 2006, the claimant advised Dr. Mason that she was continuing to experience back spasms when walking, and had aching in her legs. In November 2006, the claimant advised Dr. Mason that she had experienced increased pain after accepting a new job that required more sitting and computer work. In March 2007, the claimant reported that she experienced severe spasms on the right side of her back, which she attributed to her sedentary work as a mortgage closer. In September 2007, the claimant reported that her pain level was 5 or 6/10. Additional trigger point injections were performed. On November 19, 2007, the claimant reported pain at a level of 6/10.

10. In February 2008, the claimant advised Dr. Mason that she was working a new job that was even more sedentary than her previous job, but was experiencing "some exacerbations of pain above the level of her fusion." On March 3, 2008, the claimant reported to Dr. Mason that she had improved some after additional physical therapy, but was now worse and had cut her work hours to 32 per week. On March 24, 2008, the claimant advised Dr. Mason that she was "worse by 15%" and had quit her job because she was too symptomatic to continue.

11. On April 2, 2008, Dr. Healey performed and independent medical examination (IME) at the request of the claimant's attorney. Dr. Healey reported the claimant's thoracolumbar pain had become much more severe over the last year, and that the claimant reported an average pain level of 5-6/10. Dr. Healey diagnosed a "recent increase in thoracolumbar myofascial pain, with increased spasms and trigger points, and chronic cervicothoracic myofascial pain with secondary headaches and underlying diagnosis of cervical spondylosis." Dr. Healey opined the claimant had a "noticeable increase in the spasms in her thoracolumbar musculature" and gave a "subjective history of an increase in her symptoms." Dr. Healey recommended that the claim be reopened to provide the claimant a trial of Botox injections that "might result in significant improvement in both her pain and functional status." However, Dr. Healey noted that the claimant's "lumbar range of motion is essentially unchanged from the time I performed an impairment rating in 2003."

12. On April 15, 2008, the claimant filed a petition to reopen the claim based on a worsened condition. The petition was supported by Dr. Healey's April 2008 report.

13. On April 8, 2008, Dr. Wong examined the claimant upon referral from Dr. Mason. The claimant reported that her pain ranged from 5 to 8/10, and that it was 5-6/10 on the date of the examination. Dr. Wong noted "minor spasms" and opined the claimant was "primarily having mechanical low back pain secondary to multilevel degenerative changes in the thoracic and lumbar area." Dr. Wong also noted a "moderate scoliosis which has increased over time," and minor residual radicular radiation that "has not substantially changed."

Dr. Wong noted the claimant was "feeling much better with less activity now she is off work," and opined she "should continue symptomatic care."

14. On June 16, 2008, Dr. Jeffrey Sabin, M.D. performed an IME at the request of the respondents. Dr. Sabin is board certified in orthopedic surgery and focuses on treatment of the spine. Dr. Sabin reviewed the claimant's medical records, except there was a "gap" of 19 months between Dr. Kohake's April 2003 DIME report and November 14, 2005. Dr. Sabin opined the claimant remained at MMI.

15. On July 28, 2008, the claimant underwent a lumbar MRI. The impression was "postoperative changes from L4-5 and L5-S1 laminectomy with apparent removal of reported fusion hardware." The report also noted mild multilevel degenerative joint disease without focal protrusion or high grade stenosis, with the exception of a shallow broad-based protrusion at T11-12 producing effacement of the CSF space."

16. On August 21, 2008, Dr. Wong reviewed the July 2008 MRI. Dr. Wong stated that the MRI scan demonstrated "desiccated discs at all lumbar segments," unchanged scoliosis, and a mild bulge at T11-12 with "no major impingement." Dr. Wong diagnosed mechanical low back pain secondary to multilevel degenerative changes above the old fusion.

17. On August 19, 2008, Dr. Mason expressed uncertainty as to whether the T11-12 disc protrusion to the industrial injury. Dr. Mason also stated that the claimant's reported increase in symptoms "may indicate an overall worsening of her myofascial pain." The ALJ concludes that this statement is equivocal and does not amount to a persuasive opinion that the claimant has sustained a worsened condition.

18. Dr. Sabin reviewed the MRI results and they did not change his opinion expressed on June 16, 2008.

19. On October 22, 2008, Dr. Healey performed an additional examination of the claimant. The claimant reported her thoracolumbar pain ranged between 6-7/10. Dr. Healey reiterated the opinion that Botox injections might relieve some of the claimant's thoracolumbar myofascial pain. He also opined that the claimant's permanent medical impairment had increased since Dr. Kohake placed the claimant at MMI in April 2003. Dr. Healey stated that claimant's lumbar impairment had increased 7 percent, based on 1 percent impairment for the hardware removal and 6 percent additional impairment for reduced range of motion. Dr. Healey also opined the claimant's thoracic impairment had increased 1 percent based on reduced range of motion.

20. Dr. Healey testified at the hearing on November 20, 2008. Dr. Healey opined the claimant was no longer at MMI because of an increase of

symptoms that was not responsive to the previous forms of treatment, and that further treatment could allow her to return to work. Dr. Healey opined the claimant's major problems have been severe trigger points and spasms. According to Dr. Healey, recent medical literature indicates that the claimant would benefit from a trial of lumbosacral injections of Type A Botox neurotoxin. Dr. Healey opined that the increase in the claimant's cervical and thoracolumbar symptoms was directly related to the industrial MVA in March 2000.

21. Dr. Healy also testified that between 2003 and 2008 the claimant's permanent medical impairment has increased 7 percent. Dr. Healey attributed the increase to the additional surgery to remove the hardware and a reduction in the claimant's lumbar ranges of motion.

22. On cross-examination Dr. Healey stated that the benefits of Botox injections usually last about 3 months, and that the claimant could require such injections indefinitely.

23. Dr. Sabin testified for the respondents at the hearing on November 20, 2008. Dr. Sabin testified that because the claimant's principal diagnosis is myofascial pain without identification of any specific pain generator, it is reasonable to expect the claimant's symptoms to wax and wane, and it is reasonable to expect the claimant to experience "exacerbations" of her pain. Dr. Sabin explained that the mere exacerbation of pain does not require the conclusion that the claimant is no longer at MMI. Dr. Sabin opined there is no real objective evidence that the claimant's condition has changed since she was put at MMI, that she remains at MMI, and that she needs maintenance care.

24. The claimant failed to prove it is more probably true than not that her physical condition has worsened. The persuasive evidence demonstrates that the claimant's symptoms and condition have not significantly worsened since she was placed at MMI in November 2004, after she underwent the surgery to remove the instrumentation. The ALJ credits medical reports showing that, although the claimant subjectively believes her symptoms have become worse since she was placed at MMI, she has rather consistently reported pain in the range of 5 to 7 on a scale of 10, both before and after MMI. Indeed, when Dr. Healey examined the claimant on October 22, 2008, she stated her thoracolumbar pain was 6 to 7 on a scale of 10. This is not significantly different than the pain levels of 5 to 8 on a scale of 10 that she reported to Dr. Kohake in April 2003, or the levels of pain that she reported to Dr. Mason from 2005 through 2007. Moreover, the medical records demonstrate the claimant has consistently experienced varying levels of back spasms since she was placed at MMI. The claimant reported back spasms to Dr. Mason in 2006, and severe spasms in 2007.

25. The ALJ credits the opinion of Dr. Sabin that the claimant remains at MMI, and does not need any additional treatment except for "maintenance

care." Dr. Sabin credibly testified that considering the claimant's history and diagnoses, including myofascial pain and degenerative disc disease, it is reasonable to expect that her symptoms will wax and wane, and that the she will experience exacerbations of pain. Dr. Sabin credibly stated that there is no real objective evidence that the claimant's condition has changed since she was placed at MMI.

26. The ALJ is not persuaded by Dr. Healey's opinions that the claimant's condition has worsened, and that she needs Botox treatments to return to MMI. In this regard the ALJ notes that Dr. Healey has stated that the claimant may need Botox treatments every three months for the remainder of her life, and that these injections would allow her to return to work. The ALJ infers from this testimony that the objective of the proposed Botox treatments is not to provide any curative or lasting improvement of the claimant's underlying myofascial pain and degenerative disc disease, but instead to provide the same temporary and palliative relief she previously received from maintenance care in the form of physical therapy and trigger point injections. In this sense, the proposed Botox treatments would not amount to any more than maintenance care designed to alleviate the ongoing effects of the injury, for which the respondents have already admitted liability.

27. The ALJ is not persuaded that the claimant has sustained any increase in permanent impairment that evidences a worsened condition. Dr. Healey stated that some of the increase in permanent impairment between 2003 and 2008 was attributable to the surgery for removal of the hardware performed in 2004. However, the claimant was placed at MMI for the hardware removal in November 2004, and an FAL was filed in 2005. Thus, if the claimant wished to contend that there was a worsening of condition caused by the surgery, and that she was entitled to additional permanent partial disability benefits, she was free to challenge the FAL at that point in time. The alleged increase in impairment from the surgery does not represent any worsening of condition since the claimant was last placed at MMI in November 2004.

28. Neither is the ALJ persuaded that the claimant has sustained any reduced range of motion that evidences a worsened condition. Although Dr. Healey opined that the claimant's lumbar range of motion measurements were worse in October 2008 that they were in 2003, and that this difference warranted an increased impairment rating, the ALJ is not persuaded that these differences represent an actual worsening of the claimant's condition. Instead, the ALJ has credited the opinion of Dr. Sabin that the claimant's symptoms wax and wane, and that she will experience exacerbations of pain. The ALJ therefore infers that the claimant's range of motion measurements may vary from time to time, depending on her current level of symptoms. Indeed, in April 2008 Dr. Healey expressly stated the claimant's lumbar range of motion *had not changed* since 2003.

29, The claimant failed to prove it is more probably true than not that she has sustained a worsening of condition that has resulted in a greater "industrial disability" than she experienced at the time of MMI. The ALJ is persuaded by the testimony of Dr. Sabin that the objective medical evidence does not support the conclusion that the claimant's condition is any worse than it was at the time of MMI. Although the claimant may have subjectively experienced a worsening of her symptoms, such exacerbations are to be expected considering the claimant's condition. The ALJ is not persuaded that the claimant's decision to stop working is more than a personal decision based on her reaction to her symptoms, and is certainly not credible and persuasive evidence that the claimant's condition has in fact worsened.

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

CONCLUSIONS OF LAW

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

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

REOPENING BASED ON WORSENED CONDITION

Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. The claimant shoulders the burden of proving her condition has changed and her entitlement to benefits by a preponderance of the evidence. Section 8-43-201; *Berg v. Industrial Claim Appeals Office,* 128 P.3d 270 (Colo. App. 2005); *Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that can be causally related to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985).

If the claimant proves a worsening of condition, reopening is warranted if the claimant establishes that additional medical treatment and/or disability benefits are warranted. *Richards v. Industrial Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000); *Dorman v. B & W Construction Co.,* 765 P.2d 1033 (Colo. App. 1988). However, a mere recommendation for additional medical treatment does not require the ALJ to conclude that the claimant's condition has worsened so as to warrant reopening. This is true because there is a difference between care needed to assist the claimant in obtaining MMI by curing and relieving the effects of the injury, and post-MMI maintenance care designed to relieve symptoms or prevent further deterioration of the claimant's condition. *Story v. Industrial Claim Appeals Office,* 910 P.2d 80 (Colo. App. 1995).

As determined in Findings of Fact 24 through 26, the ALJ concludes the claimant failed to prove it is more probably true than not that her condition has worsened since she was most recently placed at MMI in November 2004. The ALJ credits the medical records showing that, although the claimant may have experienced a subjective worsening of her condition, her overall pain complaints and symptoms have not significantly changed since November 2004. Moreover, Dr. Sabin credibly testified that it is reasonable to expect that a person with the claimant's history and medical diagnoses will experience symptoms that wax and wane over time. Dr. Sabin credibly opined the claimant remains at MMI and does not need any additional treatment except maintenance care.

As determined in Finding of Fact 26, the ALJ is not persuaded that the claimant has proven a worsened condition because, as suggested by Dr. Healey, she needs a course of Botox treatments in order to reach MMI. Although the ALJ takes no position on whether Botox treatments might be reasonable and necessary, he does conclude that such treatments would represent nothing more than *Grover*-style maintenance treatments designed to afford relief from the ongoing effects of the injury. The ALJ notes from the testimony of Dr. Healey that the proposed Botox treatments would be given every three months and might last indefinitely. The ALJ infers from this testimony that the Botox treatments would not produce any curative or lasting improvement in the claimant's myofascial pain and degenerative disc disease, but would merely provide another form of palliative care designed to provide temporary relief from the effects of the underlying

conditions. Consequently, the Botox treatments would simply replace other forms of palliative care for which the respondents have already admitted liability, and do not prove the claimant's condition has worsened so as to warrant additional treatment. *See Richards v. Industrial Claim Appeals Office, supra* (fact that claimant's condition temporarily deteriorated while undergoing a change in post-MMI medications did not require finding of worsened condition); *Nunn v. JAD Electric,* W.C. No. 4-205-093 (ICAO August 23, 2005) (reopening not required where ALJ found claimant's condition waxed and waned and there was nothing that could be done other than provide maintenance treatment for which respondents had admitted liability).

As determined in Findings of Fact 27, the ALJ concludes the claimant has not shown an increase in medical impairment that would warrant the conclusion that the claimant sustained any worsening of condition. As a general matter, the fact that a physician has opined that the claimant's impairment rating has increased does not require the ALJ to conclude as a matter of law that the claimant's condition has worsened and she is entitled to reopen the claim. *See Heinicke v. Industrial Claim Appeals Office*, __P.3d__ (Colo. App. No. 07CA1640, September 8, 2008).

With respect to the alleged increase in impairment resulting from the 2004 surgery to remove the hardware, this increase in impairment should have been known to the claimant before the insurer filed the FAL in March 2005. If the claimant had desired to challenge the impairment rating, it was incumbent upon her to object to the FAL and seek a hearing. *See* § 8-43-202(2)(b)(II), C.R.S. In any event, the fact that the claimant did not challenge the impairment rating based on the surgery certainly does not establish that her condition worsened between November 2004, when she was last placed at MMI, and 2008.

As determined in Finding of Fact 28, the ALJ concludes that Dr. Healey's testimony concerning the change in the claimant's lumbar range of motion measurements does not establish that the claimant's condition worsened between November 2004 and 2008. The ALJ has credited Dr. Sabin's testimony that the claimant's symptoms are likely to wax and wane. The ALJ infers from this fact that the claimant's range of motion measurements may vary from time to time, based on the severity of the claimant's symptoms. This inference is corroborated by the fact that in April 2008, Dr. Healey himself noted there had been no change in the claimant's lumbar range of motion measurements since 2003. The claimant has not shown it is more probably true than not that her condition has worsened so as to warrant additional medical impairment benefits.

As determined in Finding of Fact 29, the claimant failed to prove it is more probably true than not that her condition has worsened so as to cause an increase in her "industrial disability." The ALJ is persuaded that although the claimant may have subjectively believe her condition is worse, that conclusion is

not supported by the weight of the medical evidence concerning her symptoms, and is not supported by the credible testimony of Dr. Sabin.

In light of the ALJ's determination that the claimant failed to prove that she sustained a worsened condition that would warrant reopening, the ALJ need not consider the parties' other arguments, including those concerning the cause of the claimant's condition. Further, the ALJ was not asked to rule on whether Botox injections constitute reasonable and necessary *Grover* medical treatment, and has not considered that issue. The ALJ merely determines the claimant failed to prove that the claimant has suffered a worsened condition as shown by the alleged need for Botox. The issue of Botox treatments as a form of maintenance care is reserved for future determination.

ORDER

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

1. The claimant's petition to reopen W.C. No. 4-491-883 is Denied and Dismissed.

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

DATED: December 9, 2008

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-763-571

ISSUES

The following issues were raised for consideration at hearing:

1. Compensability; and

2. Medical benefits.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant testified that on the afternoon of May 16, 2008 he was walking from his car into the Employer's offices after a break. As he walked

across a drain cover set in the sidewalk outside the building, it flipped up, collapsed, and caused him to fall and injure himself. At hearing, Claimant further testified that he injured his left ankle, left hip and knee. The ALJ found Claimant's testimony not to be credible.

2. Claimant provided several different statements to different sources about the mechanism of injury, location of the injury and the body parts affected. This undermined Claimant's credibility. There were no witnesses to Claimant's alleged fall. Claimant's claim for compensation, signed and dated by him, states that he walked on the drain structure when it collapsed and he landed forward. Other reports state that Claimant fell backward. When initially reporting the claim to his supervisor CR, Claimant identified several different areas inside the building where he fell on the carpet. Not until the following day did Claimant state he fell outside the building. At the time he initially reported an incident to Mr. R, he complained only of a scratch on his knee, and not of an ankle, back, or hip injury. At hearing, Claimant stated that he was not pursuing a claim for back injury or hip injury. However, his Workers' Claim for Compensation, signed and dated by him, and several medical reports indicate his assertion that those body parts were affected. Diagnostic testing was done in these additional areas, presumably because of Claimant's assertion to his physicians that they were affected by the work incident. Claimant's removal of these body parts as at issue at hearing brings into question both his motivation and sincerity at hearing and with the physicians treating his alleged work injury.

3. At hearing, Claimant testified that he had no prior injury to his ankles, back or hip. The records show reports of pain, treatment, and history of prior injury to these body parts, along with conflicting prior statements made by claimant. Records show prior left hip complaints. The medical evidence is replete with prior back complaints and treatment. Claimant's testimony regarding the lack of prior injury is not credible. In fact, despite his clear and repeated denial of prior left ankle injury, Claimant, in the context of another injury claim, stated that he was previously in a wheelchair six months as a result of two broken ankles. Claimant was confronted with a recorded statement made by him that provided this information of prior severe ankle injury. Mr. R testified that Claimant told him that he injured his ankles and was in a wheelchair several years prior to May 16, 2008. Several medical records from separate providers reflect that Claimant had previous arthroscopic surgery to his left ankle. This fact may explain why Claimant's ankle appeared swollen to examiners after the alleged fall on May 16, 2008.

4. At hearing, Claimant removed his socks, shoes, and an air cast he wore on his left ankle in order to show the absence of operative scars. It is difficult for the ALJ to conclude whether there was a scar present or not. However, medical records reflect that examinations by physicians throughout the course of several years have led those medical professionals to conclude that surgery did occur. In any case, this display did not bolster Claimant's credibility; for either he

was telling untruths about his left ankle medical history to the court, or had been telling untruths to various medical professionals for years.

5. Respondents' witness, GS, was credibly surprised to learn that Claimant wore an air cast, as he never saw Claimant wear an air cast following the alleged accident. Mr. R gave similar credible testimony regarding the absence of an air cast at work following the alleged injury. In addition to the inconsistencies in Claimant's testimony and the medical record, cross-examination revealed that Claimant entered into a settlement agreement in relation to a claim for injuries to his low back and bilateral ankles. This was done just a few weeks prior to this hearing on September 19, 2008, and approved October 20, 2008.

6. Mr. R credibly testified at hearing. He was claimant's supervisor on May 16, 2008. He stated that Claimant came into his office on May 16, 2008. At that time, Claimant had a scrape on his knee, below the kneecap, which was approximately as big as a fifty-cent piece. Claimant first told Mr. R that he fell outside the office due to a bump or tear in the carpeting. Mr. R suggested that he and Claimant go to the bathroom and wash off Claimant's knee. Mr. R testified that he saw no dirt or debris in Claimant's knee. On the way down the hall to the bathroom, Mr. R asked Claimant to show him where he fell. Claimant first indicated he fell outside the doorway to the Employer's office. As they progressed down the hall, Claimant pointed to an area outside the elevators and stated that was, instead, where he had fallen. Mr. R accompanied Claimant to the restroom, dampened a towel and handed it to Claimant. Claimant balanced himself on one leg, brought his left ankle up to the counter, and held his weight on the left ankle as he blotted off the scrape on his knee. He did not have difficulty doing this, and did not complain of pain as he held his weight on the left ankle. Mr. R testified that during the course of their discussion on May 16, 2008, Claimant did not complain of ankle, back or hip pain. He also testified that that there was no blood on any of the various areas of carpeting that Claimant identified as the site(s) of the fall during that first discussion on May 16, 2008. Mr. R credibly testified that Claimant asked for a band-aid, and there was none available at the office. Mr. R testified that the time was approximately 3:00 p.m., and that Claimant's shift was over at 4:00 p.m. Claimant asked permission to leave work to get a band-aid, and Mr. R allowed him to do so. Mr. R testified that he did not provide a referral for medical treatment because Claimant did not appear to need medical treatment and did not ask for a referral.

7. Claimant's testimony concerning his referral to his family physician on May 16, 2008 was considered and deemed not to be credible. The ALJ finds that any visit Claimant made to his physician and physical therapist was not reasonable or necessary to cure and relieve the effects of any incident at work that occurred on May 16, 2008.

8. Mr. R testified that his next discussion with Claimant about the alleged injury was the next day, Saturday, May 17, 2008. In the morning, Mr. R

was sitting outside the building smoking, when Claimant arrived at the building. Claimant was not scheduled to work. Claimant had no work-related reason to be at the building. Claimant got out of his car and sat on the curb, next to the drain cover. At that time, Claimant changed his story regarding the mechanism and location of his alleged fall, and told Mr. R that he fell outside the building, at that spot, due to the drain cover. After a discussion with Claimant, Claimant took photographs of the area with his cell phone.

9. DL testified that he is a maintenance employee of the building owner. He testified credibly that it was not possible for the drain cover in question to flip up or collapse as Claimant described.

10. Mr. L testified that it was his job to take remedial action when a fall was reported on the premises. Consequently, he covered the area with a cone where Claimant alleged he tripped, to prevent any other falls.

11. Claimant was in an automobile accident (MVA) on May 23, 2008, and claimed to have a whiplash injury, chipped upper tooth, pain in the upper jaw, daily headaches, and lower back pain. Dr. Rhim saw Claimant on the same day, May 23, 2008, for his initial evaluation of Claimant. Dr. Rhim dictated two separate reports on May 23, 2008, one discussing the MVA, and one discussing the alleged trip and fall at work of May 16, 2008. Many of the same symptoms and complaints attributed to the MVA were later attributed by Claimant to his alleged workers' compensation injury

12. Co-worker GS testified credibly at hearing. He testified that Claimant appeared at work following the alleged fall using a cane and used the cane only sporadically over the next few weeks. Mr. S testified that, on one occasion, while using the cane due to Claimant's alleged workers' compensation injury, Claimant was distracted by a police chase and ran across the street to observe the activity.

13. The totality of the credible and persuasive evidence presented at hearing causes the ALJ to conclude that Claimant failed to sustain his burden of proof to establish that a compensable work injury occurred on May 16, 2008 in the course and scope of Claimant's employment for the Employer.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. (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's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4, For a claim to be compensable under the Act, a claimant has the burden of proving that he or she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. 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. The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undesigned occurrence. Section 8-40-201(1), *supra*. By contrast, an "injury" refers to the physical trauma caused by the accident. Thus, an "accident" is the cause and an "injury" the result. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one, which results in an injury requiring medical treatment or causing disability. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990).

6. Here, the Judge found Claimant failed to show it more probably true than not that he sustained an injury requiring medical treatment or causing disability, which arose out of the course and scope of his employment on May 16,

2008. Claimant thus failed to prove by a preponderance of the evidence that he sustained a compensable injury.

ORDER

It is therefore ordered that:

1. Since Claimant failed to sustain his burden of proof, his workers' compensation claim is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: _____

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-766-218

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that on July 23, 2008, he sustained an injury arising out of and in the course of his employment?
¬ Did the claimant prove by a preponderance of the evidence that his disability and need for medical treatment were proximately caused by the alleged injury?
¬ Did the claimant prove by a preponderance of the evidence that he is entitled to temporary total disability benefits commencing July 26, 2008, and continuing?
¬ What is the claimant's average weekly wage?
¬ Did the claimant prove by a preponderance of the evidence that he is entitled to reasonable, necessary and authorized medical treatment as a result of the alleged injury?
¬ Did the respondents prove by a preponderance of the evidence that they are entitled to an offset for unemployment insurance benefits received by the claimant?

FINDINGS OF FACT

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

1. The claimant was employed as a plumber for the employer. He was assigned to work with his supervisor, JH.

2. The claimant testified that on Wednesday, July 23, 2008, he and Mr. H were installing a water cooler at a business. The claimant stated that the box containing the cooler was just below his belt line. The claimant recalled that he leaned over the box to lift the cooler. As he was lifting the cooler out of the box he twisted to the right and felt the immediate onset of groin pain. According to the claimant, he immediately told Mr. H that he thought he had hurt himself inside. The claimant testified that Mr. H told him to "take it easy" for the remainder of the day.

3. The claimant testified that on July 23, 2008, he developed a "bulge" in his groin area.

4. The claimant testified that he returned to work on Thursday, July 24, 2008, and told Mr. H that he had hurt himself yesterday and did not know what was wrong. The claimant stated that Mr. H allowed him to perform light duty.

5. The claimant testified that he did not have any trouble performing his job until the incident of July 23, 2008.

6. The claimant testified that on Friday, July 25, 2008, he again returned to work, but told Mr. H that he might not be able to complete the entire day. The claimant recalled that he was allowed to go home early on July 25, 2008.

7. The claimant testified that on Saturday, July 26, 2008, Mr. H came to his home to check on him. According to the claimant Mr. H directed him to see his doctor because neither of them knew what was wrong. The claimant recalled that he still had the bulge in his groin area, but the bulge would become smaller when he took a hot bath.

8. The claimant testified that on Monday, July 28, 2008, he advised Mr. H that he was in too much pain to work. The claimant stated that Mr. H directed him to call BW, the owner of the company. The claimant called Mr. W who told the claimant to see his own doctor.

9. The claimant's wife made an appointment for the claimant to see his personal physician, "Dr. Stephanie," at South Federal Family Practice, P.C. (SFFP).

10. The claimant was examined a SFFP on Monday, July 28, 2008. The ALJ is unable to ascertain from the record of this visit the name and qualifications of the person that examined the claimant. The note states the claimant reported that he experienced "Thursday pain in right leg, testicle swollen, numbing & tingling pain." The note further states the claimant "was lifting something heavy on Wednesday," and that the claimant "lifted water cooler @ work foreman

observed" the claimant. The claimant was noted to be walking with a cane, was suffering tenderness along the right groin, and had no palpable mass. The claimant was referred back to the employer's "work comp clinic" for treatment of a "work comp injury" with a possible hernia.

11. The employer referred the claimant to Health One Occupational Medicine and Rehabilitation for treatment of the alleged injury. On Tuesday July 29, 2008, Dr. John W. Dunkle, M.D., examined the claimant at Health One.

12. Dr. Dunkle's note from July 29, 2008, records that the claimant gave a history significantly different than the claimant's testimony at the hearing. According to Dr. Dunkle's July 29 note, the claimant reported that he sustained an injury on Wednesday when pulling a drinking fountain from a box. Dr. Dunkle noted that the claimant stated that he "felt fine" at the time of the incident, and that he first experienced symptoms when he woke up on Thursday with pain in the front of the right leg at the groin. The claimant reported that he performed his "normal work" on Thursday and "felt okay." Dr. Dunkle recorded that on Thursday night the claimant reported he could not sleep, but then contradicted himself by saying that he had to sleep on his left side. The claimant advised Dr. Dunkle that on Friday he was dragging his leg and his supervisor asked him what had happened. The claimant replied that he "did not know." The claimant advised Dr. Dunkle that on Saturday he had a "big lump in the groin area" that resolved after a hot bath. Dr. Dunkle further noted that on Saturday the claimant spoke with a "coworker" who advised the claimant that "he had seen [the claimant] straining himself when taking the water cooler out," and advised the claimant to "turn it in to workers' compensation since he did not have insurance." The claimant told Dr. Dunkle that he had no insurance and did not know what he was going to do.

13. The claimant advised Dr. Dunkle that he had bilateral hernia surgeries in 1989, and that this was not the result of a work related injury.

14. Dr. Dunkle recorded the results of his July 29, 2008, physical examination of the claimant. On examination thee claimant reported pain over the medial groin, pain over the right buttocks, and high pain over the gluteal area which the claimant had not previously noticed. There was also pain along the right thigh that the claimant was not previously aware of. Examination of the abdomen and genitalia was normal, and there was no hernia deficit, bulge or evidence of weakness.

15. Dr. Dunkle assessed a transient and painful inguinal bulge without "an objective finding for which to provide a diagnosis." Dr. Dunkle noted the claimant did not report experiencing any symptoms until July 24, 2008, and was "not able to report any straining incident." Dr. Dunkle stated the claimant began to associate his condition with lifting the water cooler "after talking with a coworker, who told him he was straining to do this." Dr. Dunkle further assessed resolving high pain in the posterior pelvis, hip and right lower extremity, of grad-

ual onset, associated with no accident, injury, or abnormal activities at his job." Considering the circumstances, Dr. Dunkle stated that he could not "deem probable causality for work-relatedness."

16. At hearing, the claimant testified that he did not recall Dr. Dunkle asking him a lot of questions at their first appointment. The claimant also disputed the history recorded by Dr. Dunkle in his note of July 29, 2008. The claimant stated that he first experienced symptoms on July 23, 2004, not July 24 as recorded by Dr. Dunkle. The claimant stated that he did not know where Dr. Dunkle got the idea that he told his supervisor that "he did not know" what had happened. The claimant stated that Mr. H had known what caused the problem since Wednesday, July 23, 2008.

17. In August 2008, the claimant returned to Dr. Dunkle to obtain a release to return to work. Dr. Dunkle declined to release the claimant.

18. After Dr. Dunkle declined to treat the claimant, the claimant sought treatment from Denver Health.

19. In November 2008, Rosa Nunez, a physician's assistant at Denver Health, authored a "To Whom It May Concern" letter. The note stated that the claimant had been receiving treatment at Denver Health since September 2008. PA Nunez stated the claimant's evaluation had been "extensive" and that he had been diagnosed with atherosclerosis and partial occlusion of the right femoral artery, multi-level disc protrusions, and small bilateral inguinal hernias. PA Nunez noted the claimant had been evaluated by a surgeon for his "peripheral vascular disease" and was scheduled to see an orthopedic surgeon concerning his back problems.

20. The record does not contain any other medical records or reports concerning the claimant's evaluation and treatment at Denver Health.

21. The claimant admitted that he has been receiving treatment from Denver Health for atherosclerosis, a partial occlusion of his right femoral artery, and that he has been diagnosed with vascular disease. The claimant stated that he has severe pain from his right knee to his groin. The claimant stated that he has received "pills" for treatment of these conditions. The claimant also admitted that he has been diagnosed with multi-level disc protrusions, and has been referred to an orthopedic surgeon for an examination.

22. The claimant failed to prove it is more probably true than not that he sustained an injury arising out of and in the course of his employment when he lifted the water cooler out of the box on July 23, 2008. The ALJ finds that the claimant's testimony that he sustained an injury on July 23, 2008 is not credible. Although the claimant states that he immediately suffered pain after lifting the water cooler and told his supervisor that he believed he had hurt himself, this tes-

timony is contradicted by important passages contained in the medical records. The SFFP note from July 28, 2008, does not mention that the claimant reported suffering any immediate pain upon lifting the water cooler. To the contrary, the SFFP note does not mention the occurrence of any pain or symptoms until "Thursday."

23. The ALJ is persuaded that Dr. Dunkle accurately reported the history that the claimant gave during the examination of July 29, 2008. The ALJ finds there is no credible or persuasive evidence in the record that would establish a motive or reason for Dr. Dunkle to falsify his report concerning the history given to him by the claimant. The history the claimant gave to Dr. Dunkle contradicts the claimant's testimony in several important ways. The claimant testified to immediate symptoms after lifting the water cooler. However, he told Dr. Dunkle that he did not have any immediate symptoms after he lifted the cooler, and did not experience any symptoms until Thursday morning when he woke up with right leg pain. Although the claimant testified he was allowed to work limited duty on Thursday, the claimant told Dr. Dunkle that he performed his usual duties on Thursday and did "okay." The claimant testified that Mr. H was fully aware of the injury from the time it happened, and had allowed the claimant to work limited duties on Thursday and Friday. However, the claimant told Dr. Dunkle that on Friday his supervisor asked why he was dragging his leg and the claimant replied that he did not know. Moreover, Dr. Dunkle noted the claimant did not connect his symptoms to lifting the water cooler until Saturday, after he spoke with a co-worker (presumably Mr. H) who thought the claimant was straining to lift the cooler.

24. The claimant also failed to prove it more probably rue than not that if there was an incident on July 23, 2008, that the incident was the proximate cause of his subsequent disability and need for medical treatment. Dr. Dunkle credibly and persuasively opined that the claimant's condition could not with any degree of probability be linked to the alleged injury of July 23, 2008. Dr. Dunkle persuasively notes that the claimant did not report sustaining any symptoms until the day after the alleged incident. Moreover, the report from PA Nunez provides several alternative explanations for the claimant's symptoms, including peripheral vascular disease resulting in an occlusion of the right femoral artery, and/or protruding discs in the back. Significantly, PA Nunez does not opine that the claimant's multiple diagnoses are in any way related to an alleged injury on July 23, 2008. Moreover, the claimant told Dr. Dunkle that he did not have any insurance, providing the claimant with motivation to testify that the symptoms were immediately associated with the incident on July 23, 2008.

25. At the hearing the parties stipulated that if the claim is found compensable that the claimant's average weekly wage is $680. The parties further stipulated that if the claimant is found compensable the claimant would return to Health One for authorized treatment, but would not be treated by Dr. Dunkle. The parties further agreed that they would file a stipulation concerning any appli-

cable offset for unemployment insurance. No stipulation concerning unemployment has been filed.

CONCLUSIONS OF LAW

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

The purpose of the Workers' Compensation Act of Colorado (Act), §§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. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

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

COMPENSABILITY OF ALLEGED INJURY

The claimant contends that he proved by a preponderance of the evidence that he sustained and injury arising out of and in the course of his employment on July 23, 2008, when he lifted the water cooler from the box. The claimant further contends he proved by a preponderance of the evidence that this injury was the proximate cause of his subsequent need for treatment and alleged disability. The ALJ disagrees.

The claimant was required to prove by a preponderance of the evidence that at the time of the injury he was performing service arising out of and in the course of the employment, and that the alleged injury was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S. A pre-

existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). The question of whether the claimant met the burden of proof to establish a compensable injury is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

The ALJ concludes the claimant failed to prove it is more probably true than not that he sustained any injury on July 23, 2008, when he lifted a water cooler while performing service arising out of and in the course of his employment. As determined in Findings of Fact 22 and 23, the claimant's testimony that he sustained an injury on July 23, 2008, is not credible. As found, the claimant's testimony is contradicted by the history he gave at SFFP on July 28, 2008, and even more significantly contradicted by the history he provided to Dr. Dunkle on July 29, 2008. While the record does not contain any persuasive evidence that would lead the ALJ to believe that Dr. Dunkle falsified his report concerning the claimant's history, the claimant himself admitted to Dr. Dunkle that he did not have insurance and was worried about paying for treatment. Thus, the claimant had a significant incentive to testify that there was an immediate temporal relationship between his symptoms and his work activities on July 23, 2008. even through the claimant told Dr. Dunkle there were no immediate symptoms. Moreover, the ALJ is persuaded that he claimant did not begin alleging any relationship between his symptoms and lifting the water cooler until this idea was suggested to him by Mr. H on Saturday, July 26, 2008.

The ALJ further concludes that, even if the claimant did feel some "strain" when he lifted the water cooler out of the box, the claimant failed to prove that this incident was the proximate cause of his subsequent disability and need for treatment. As determined in Finding of Fact 24, Dr. Dunkle credibly opined that there is probably not any relationship between the claimant's work activities and the symptoms. Moreover, the evidence, including the report of PA Nunez, demonstrates there are alternative explanations for the claimant's symptoms including vascular disease and/or a degenerative back condition. Finally, the claimant has a substantial motive to link his symptoms to his employment because he admitted to Dr. Dunkle that he did not have insurance to pay for treatment.

The claim for workers' compensation benefits must be denied. In light of this conclusion the ALJ need not address the other issues raised by the parties, including entitlement to medical and temporary disability benefits.

ORDER

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

1. The claim for workers' compensation benefits in W.C. No. 4-766-218 is Denied and Dismissed.

DATED: December 10, 2008

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-734-252

ISSUES

The issues of reasonably necessary and related medical benefits were raised for consideration at hearing.

FINDINGS OF FACT

Having considered the evidence presented at hearing and considered the parties' post hearing position statements, the following Findings of Fact are entered.

1. On September 1, 2007, Claimant sustained admitted injuries during the course and scope of her employment. Claimant was working when she twisted her right ankle, lost balance, and fell to the ground on her right shoulder. She immediately knew something was wrong with her right ankle and right shoulder. Claimant was taken to the emergency room.

2. After the September 1, 2007, fall, the problems in Claimant's right shoulder have been continuous. Claimant was initially reluctant to have surgery and worked to rehabilitate the right shoulder with physical therapy and exercises. After therapy was discontinued, Claimant began to get worse. Claimant and her physicians made the decision that surgery for her right shoulder was her only option. Claimant proceeded with the surgery, because her shoulder was getting worse, even though the Insurer denied payment. Claimant had improvement in her right shoulder since her surgery on September 17, 2008.

3. Claimant had problems while she was being treated for her work related injuries at Heritage Park Nursing Home (Heritage Park), a skilled nursing care facility. At Heritage Park, Claimant pulled herself up with the pole beside the bed. Her right shoulder was in a sling, her leg was in a cast, and she was having abdominal pain related to some difficulties with medications. She pulled herself up by the pole with her left arm, pulling on her left shoulder, and causing some pain and discomfort. Then, while Claimant used crutches, the crutches caused further problems with her left shoulder and neck. Claimant was in physical therapy for some time and was taught how to use muscles in her chest, back, and

neck to compensate for the loss of her right rotator cuff. The therapy also caused an aggravation of her neck and shoulder muscles due to overcompensation.

4. Claimant did have preexisting underlying degenerative disease of her shoulder and cervical spine. However, before her fall on September 1, 2007, Claimant did not have the problems she currently has. In 2002, she had a small tear of her right rotator cuff but she only had difficulty with the right shoulder when she overused it, especially when using crutches. She obtained therapy or injections, and the problems resolved.

5. Claimant requires ongoing physical therapy for her right shoulder to rehabilitate her shoulder following the arthroplasty and also for her left shoulder and neck. Claimant also requires treatment for her neck, including injections, which she had undergone prior to the shoulder replacement. These injections helped her neck discomfort.

6. X-rays of Claimant's right shoulder, taken on September 1, 2007, showed a bony fragment believed to be a fracture of the greater tuberosity of the humerus. Claimant was also diagnosed with a spiral fracture of the lateral malleolus with widening of the medial mortise, based upon an x-ray of her right ankle, taken on September 1, 2007.

7. Claimant was admitted to Heritage Park and prescribed treatment for activities of daily living, therapy, and activity exercises. On September 6, 2007, a Heritage Park nurse reported that Claimant complained of numbness and tingling, needed someone to assist with transfers and ambulation, used a crutch on the left side to ambulate, and had multiple bruising to the left arm.

8. September 10, 2008, Dr. Derkash opined that in addition to the two fractures, Claimant possibly had a rotator cuff tear as her right shoulder was significantly stiff. On September 17, 2007 a nurse at Heritage Park reported that Claimant was complaining of pain behind her right shoulder. On September 19, 2007 the Heritage Park nursing notes reported that Claimant was having problems of the left acromioclavicular (AC) joint. On September 21, 2007 the therapist noted problems with the left rotator cuff tendon.

9. On October 18, 2007, an MRI of Claimant's right shoulder revealed, the following: 1. arthrosis of the acromioclavicular joint; 2. a large tear of the supraspinatus infraspinatus tendons with muscular atrophy. There was a focus of ossification attached to the superior aspect of the medially retracted infraspinatus tendon likely due to an avulsion fracture of the greater tuberosity. 3. lobular foci of fat with surrounding edema in the proximal humeral shaft and metaphysic that may be related to the avulsion fracture of the infraspinatus tendon.

10. Kathleen Ann Denson, the president and owner of the Employer, credibly testified corroborating Claimant's testimony about the work injury, Claimant's treatment, and Claimant's efforts at recovery.

11. On October 19, 2007, Dr. William Sterett stated that his advice to Claimant was to continue with rehab for a couple of months until she got over her ankle fracture. Dr. Sterett stated, "If in fact she does not do well from non-operative means and she is off of crutches from her ankle injury than [sic] I think her only reasonable option would be a reverse shoulder arthroplasty." In another note of October 19, 2007, Dr. Sterett stated, "If physical therapy fails to work at that point her only option would be for a reverse total shoulder arthroplasty." On October 29, 2007, Dr. Sterett noted that Claimant was there for a left shoulder injection. Dr. Sterett noted that he had been following Claimant for her right shoulder and right ankle, but her left shoulder had become more of a problem.

12. On December 12, 2007, Dr. Sterett stated that because of the significant fatter infiltration into Claimant's rotator cuff muscles and the marked retraction, he thought there was only a 50% chance that her function would be significantly improved by repairing her rotator cuff. Dr. Sterett stated, "Her only other option surgically would be for a reverse total shoulder plasty." Dr. Sterett stated that if Claimant had persistent decreased function an arthroscopic evaluation and attempt to repair could and should be the next step; however, he stated that Claimant may end up with a reverse shoulder prosthesis.

13. On December 17, 2008, Mr. David Honda noted in his physical therapy notes that Claimant was having left greater than right shoulder pain secondary to overuse. On January 14, 2008, in a progress note Mr. Honda indicated that Claimant was complaining of left shoulder pain due to overuse.

14. On January 21, 2008, Dr. Sterett stated, "Regarding her right shoulder it is [sic] a very large tear with an infraspinatus avulsion. It may not be repairable [sic] lesion. I think I have given her a counsel that it has about a 50%-60% chance of staying intact, however, that may be a reasonable option given the fact that her left shoulder is now bothering her significantly." Dr. Sterett noted that Claimant underwent an open rotator cuff repair on the left shoulder in 1992. It did well until recently when Claimant was lifting herself up on a pole and now had both pain and weakness. Dr. Sterett stated that he needed to get an MRI of Claimant's left shoulder and follow-up on her rotator cuff to see what kind of tear she had and the quality of tissue. Dr. Sterett stated, "Based on the results of the MRI on her left shoulder it may be more beneficial to repairing the right shoulder than her left since she has a history of infection and open rotator cuff repair in the distant past."

15. On January 25, 2008, an MRI of Claimant's left shoulder revealed an area of discontinuity of the distal supraspinatus tendon extending for 8 mm anterior posterior and 18 mm medial to lateral. The defect was not filled with fluid, but rather granulation tissue. There was also moderate glenohumeral chondromalacia.

16. On January 29, 2008, Dr. Steven Yarberry noted that Claimant's left shoulder is being bothered by compensation.

17. On February 3, 2008 David Honda, PT, noted that Claimant's left shoulder was injured when she pulled herself up in bed with an overhead trapeze bar while she was in the extended care facility immediately following her injury in September 2007. He noted that the shoulder had also been aggravated by using crutches and by general overuse since she could not at that time, and still could not fully use her right arm in daily activities. Mr. Honda also noted that Claimant had complaint of short-term lumbar and cervical pain due to upper and lower extremity compensation. Mr. Honda reported that Claimant could not elevate her arm above her head in any plane with a straight elbow past 45 degrees. He stated, "This latter maneuver is also accomplished with moderate scapular substitution." Mr. Honda noted that Claimant could not comb or wash her hair without severe cervical compensation. Subsequent notes entered by Dr. Honda in February 2008 reflect that Claimant is experiencing neck pain with reaching, overhead use, and right upper extremity use.

18. On February 29, 2008, Dr. Steven Yarberry noted that Claimant was in a pretty good mood in that she had somewhat of a breakthrough at physical therapy and can move both her right and left shoulders much better than she had in the last several months. Dr. Yarberry stated that Claimant should continue physical therapy three times weekly as per Dr. Sterett's advice.

19. In April 2008, Dr. Sterett noted improvement with physician therapy and recommended continued therapy. He also continued his recommendation for reverse shoulder arthroplasty as Claimant's only option. In April 2008, Mr. Honda noted Claimant's complaints of short-term lumbar and cervical pain due to upper and lower extremity compensation. On April 25, 2008, Claimant was active in her work at the Employer and at her home. When Claimant saw Dr. Steven Yarberry on April 25, 2008, he noted that Claimant was not at MMI. Dr. Yarberry recommended continuing physical therapy. On April 28, 2008 Dr. Sterett referred Claimant for physical therapy evaluation and treatment for her bilateral shoulders.

20. On May 15, 2008, Mr. Honda noted he was transitioning Claimant into a fully independent in her exercise program through July 2008. Claimant was making slow, but steady progress in her ability to raise her right arm above her head. Mr. Honda noted improvement in both Claimant's arms and leg.

21. On June 9, 2008, Dr. William Sterett wrote a prescription for physical therapy for the right shoulder and trapezius pain. On June 23, 2008 Dr. William Sterett noted that Claimant had had some cervical spine issues. Dr. Sterett's impression was that Claimant had cervical spine degenerative disc disease with acute muscular strain. The doctor recommended continued work with physical therapy for the right shoulder and referred Claimant to Dr. Peter Millett for evaluation for possible right shoulder reverse shoulder replacement secondary to rotator cuff arthropathy. Dr. Sterett further recommended for Claimant's cervical

spine, an MRI to further delineate any pathology and then referral to Dr. David Karli for the cervical spine issue. On June 24, 2008 Dr. Steven Yarberry noted that Dr. Sterett recommended continuous physical therapy and Dr. Yarberry recommended continued physical therapy three times a week.

22. Based on Dr. Sterett's June 2008 request, a cervical spine MRI was performed on August 8, 2008. A cervical spine MRI revealed degenerative disc disease, fusion of the C3-4 vertebral body, and broad-based osteophyte formation at the C6-7 level.
In August 2008, Claimant was experiencing pain symptoms in the right shoulder, neck, and upper back. On August 27, 2008 Dr. Peter Millett recommended rotator cuff repair surgery.

23. A September 2008 MRI of Claimant's right shoulder showed a humeral head shaft superiorly luxated, touching acromial undersurface. There was also a full-thickness tear defect of the supraspinatus and infraspinatus tendons with increased medial retraction and about 5 cm wide defect. It was reported that there may be increased fatty replacement and atrophy about the retracted muscles and muscle tendon junctions at the medical field of view.

24. On September 8, 2008, Claimant was seen by Dr. David Karli for her cervical spine/neck pain. He performed facet blocks. On September 12, 2008 Dr. Peter Millet evaluated claimant for her greater tuberocity avulsion fracture that displaced the rotator cuff and produced deficiency and weakness. He reviewed the MRI, which showed a large rotator cuff tear through the supraspinatus and infraspinatus tendons as well as the displaced greater tuberosity avulsion fracture and chondral changes in the glenohumeral joint. He recommended arthroscopic debridement and rotator cuff repair. Dr. Millet opined that if repair was not possible, then total shoulder arthroplasty was needed.

25. Based on the totality of the record, including Claimant's hearing testimony, it was established that Claimant could not lift her right arm with any weight in her hand due to the significant pain, she learned to use other muscle structures including neck muscles to compensate for the loss of the rotator cuff in performing range of motion of her shoulder and arm, however, she still could not use the right arm functionally, and Claimant could no longer stand the pain. Claimant had no more options other than proceed with surgery.

26. Dr. Millet gave a postoperative diagnosis of right shoulder chronic greater tuberosity fracture with massive rotator cuff tear. The doctor proceeded with reverse total shoulder replacement to restore function to right shoulder.

27. Dr. Sterett credibly opined in his deposition on October 1, 2008 that Claimant's September 1, 2007 injury caused the fracture and the tearing of the tendon off the bone where the rotator cuff attached to the bone. He further credibly opined that the work injury turned a small tear into a massive or irreparable tear. The doctor further credibly opined that the need for the total shoulder replacement was caused by the Claimant's September 1, 2007 fall. He opined that

when a patient has this kind of massive injury to a joint such as the shoulder, it causes overuse of other parts of the body. Dr. Sterett noted that physical therapy for Claimant's shoulder caused an aggravation of her underlying neck conditions. Dr. Sterett referred Claimant to treat for the neck problems with Dr. Karli who provided injections, a standard type of treatment for the neck.

28. Dr. Sterett credibly testified in his deposition that Claimant has not reached maximum medical improvement. The doctor opined that Claimant requires further physical therapy for the ankle to improve range of motion and reduce swelling; for the shoulder for strengthening and range of motion; and for the neck to decrease the inflammation of the soft tissue surrounding the neck.

29. Dr. Jeffrey Wunder is not persuasive in his opinion. His opinion that Claimant does not require further medical treatment related to her injuries sustained on September 1, 2007 and any subsequent aggravations of her pre-existing conditions was not supported by the medical records or the testimony of witnesses, both lay and expert.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. (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'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. The respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The issue of whether medical treatment is necessitated by a compensable aggravation or a worsening of the claimant's pre-existing condition is one of fact for resolution by the ALJ based upon the evidentiary record. *See Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970); *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). "Compensation is not dependent on the state of an employee's health or her freedom from constitutional weakness or latent tendency." *Peter Kiewit Sons' Co. v. Industrial Commission*, 124 Colo. 217, 236 P.2d 296, 298 (1951). "When a pre-existing condition is aggravated by an employee's work, the resulting disability is a compensable industrial disability." *Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. 1990).

5. In this case, claimant clearly had an underlying degenerative arthritic condition to her right shoulder. However, further treatment is needed to cure and/ or relieve the claimant of the irreparable rotator cuff tear caused by the industrial injury and will serve to also treat some of the underlying arthritis condition.

6. It is concluded that even though Claimant fell because she twisted her ankle, her shoulder would not have been injured to the degree that it was, including breaking of the greater tuberosity and the massive rotator cuff tear, but for the fact of the fall. But for the fall, Claimant would not have needed the total shoulder arthroplasty according to Dr. Sterett. Claimant's left shoulder and neck aggravations arose out of her admitted work-related injury and are therefore causally related to the September 1, 2007 work injury.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for reasonably necessary and related medical benefits as a result of the September 1, 2007 work injury. Respondents shall be liable for medical benefits for Claimant's bilateral shoulders and neck caused by Claimant's September 1, 2007 injury.

All matters not determined herein are reserved for future determination.

DATED: December 10, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-756-024

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment?

FINDINGS OF FACT

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

1. Employer manufactures safety equipment. BP is employer's operations manager. Claimant's date of birth is August 20, 1964; her age at the time of hearing was 44 years. Claimant works for employer assembling such safety equipment as glow-worms and goggle protectors. Overall, claimant has worked for employer for some six years; her most recent period of employment has lasted some four years. Claimant however was off work from May through August of 2007 because of a pregnancy. The Judge adopts the stipulation of the parties in finding that claimant's average weekly wage is $667.00.

2. Claimant's workstation is comprised of a height-adjustable chair, where she sits while assembling and gluing small plastic pieces on a table directly in front of her. Claimant uses both upper extremities to assemble the safety equipment. Crediting claimant's testimony, the Judge finds: Claimant began experiencing symptoms of aching pain in her right upper extremity after returning from leave in August 2007. Claimant's symptoms were unassociated with any acute trauma; her symptoms increased over time from August 2007 through December of 2007. Claimant noticed that her symptoms were more associated with assembling the goggle protectors.

3. Employer referred claimant to Arbor Occupational Medicine, where Physicians Assistant Paul V. Springer, PA-C, examined her on January 10, 2008. Claimant reported the following history to PA-C Springer:

> [Claimant] comes in today complaining of pain in her upper right extremity. There was no associated injury with this. The patient states it just seemed to start with aching up in her shoulder and now the whole arm is aching, but a lot of it seems to be up in the shoulder and neck muscles.

PA-C Springer diagnosed shoulder/arm syndrome secondary to repetitive motion at work. PA-C Springer recommended a work-site evaluation, referred claimant

for physical therapy, and imposed work restrictions, which allowed her to take a 10-minute break from repetitive tasks every hour.

4. At Arbor, several physicians in addition to PA-C Springer examined claimant over the ensuing months. Those physicians were William Alexander, M.D., Sander J. Orent, M.D., and Marc-Andre Chimonas, M.D. Claimant's diagnoses included myofascial pain, shoulder bursitis, rotator cuff tendonitis, and lateral and medial epicondylitis. On March 5, 2008, claimant reported to PA-C Springer that physical therapy was helping. PA-C Springer administered an injection of anesthetic medication into the subacromial space of claimant's right shoulder, which only relieved her pain for several days. On April 3, 2008, PA-C Springer recommended that claimant undergo a magnetic resonance imaging (MRI) scan of her right shoulder. Claimant underwent the MRI arthrogram of her right shoulder on April 4, 2008, which showed mild degenerative changes of the acromioclavicular (AC) joint, mild tendinosis of the biceps tendon, and a large tear of the supraspinatus tendon.

5. Dr. Chimonas reviewed the MRI findings with claimant on April 8, 2008; he recommended evaluation by an orthopedic surgeon. Orthopedic Surgeon Joseph Hsin, M.D., evaluated claimant's right shoulder on April 16, 2008, and recommended arthroscopic surgery to repair the rotator cuff and to decompress the shoulder. Dr. Hsin scheduled surgery for May 1, 2008.

6. On April 23, 2008, insurer wrote a letter to Dr. Chimonas asking for his medical opinion concerning causation of claimant's torn rotator cuff. Insurer questioned how claimant could sustain a rotator cuff tear without a discreet injury and whether it was medically probable the tear was pre-existing and not work-related. Insurer pointed out that the MRI scan showed what could be a complete rotator cuff tear with scarring and granulation, possibly indicating a preexisting tear.

7. In response to insurer, Dr. Chimonas authored a letter of April 24, 2008. Dr. Chimonas wrote that PA-C Springer and Dr. Orent initially questioned whether claimant's shoulder condition was work-related and thus requested a work-site evaluation to objectively assess causation. According to Dr. Chimonas, employer stonewalled their repeated requests for a work-site evaluation. Dr. Chimonas therefore interviewed claimant by telephone to obtain her description of her job duties and the nature of her injury. Dr. Chimonas learned that claimant began having problems with her right shoulder a year before she came to the clinic. Claimant's symptoms initially involved pinching sensation in her right shoulder which would only occur at work for the first few months. Later, the pain in her shoulder got worse and would also occur with forceful movements at home when performing her with activities of daily living.

8. Dr. Chimonas reported the following based upon his conversation with claimant:

> [Claimant] said although the parts were small and did not weigh much, often they did not fit very well and she would require a lot of strength to force them together. Often she would have to stand up and use her entire weight and shoulder to push down on a part to get it to fit. She would do this repeatedly throughout the day. Although the objects were not over her head, they were in front of her and she would use her shoulder a lot and have to rotate internally in order to actually get the part to fit appropriately. She would also have to do some lifting of 10 to 20 pounds throughout the day, however this was infrequent. She would frequently have to assemble these parts that did not fit appropriately. Sometimes she would even require pliers to get a better hold on the piece to force it into place.

Based upon this history, Dr. Chimonas opined that claimant's right shoulder condition arose out of her work activities. Dr. Chimonas explained:

> This rotator cuff tear is secondary to a long-standing impingement syndrome which was ultimately caused by her having to do **repeated forceful movements of the shoulder**. It is well documented that the leading cause of a rotator cuff tear is in fact impingement and not an acute injury.
>
> ****
>
> **Based on the history that [claimant] gives me about using forceful motions over and over and over again at work, not having to do this motion at home**, and the gradual buildup of pain in her shoulder, I do believe that her rotator cuff tear is secondary to an impingement.

(Emphasis added). Dr. Chimonas thus determined that claimant's work activity presented a hazardous exposure involving repeated forceful movements of the shoulder.

9. Claimant and Mr. P demonstrated at hearing how to assemble the glow-worms and goggle protectors – plastic loops that fit on fire helmets to retain safety goggles. Crediting Mr. P's testimony, an average employee produces some 50 to 75 glow-worms per day. Assembling glow-worms is a three-step process, where each step requires a day. The most difficult stage is gluing the cap on the glow-worms. Employees typically glue caps on the glow-worms every third working day, but sequencing is left to the discretion of the assembler. Claimant is one of employer's highest producers.

10. When assembling glow-worms, claimant sits at her table working immediately in front of her. The work involves constant reaching and grasping

with her upper extremities to put together small pieces of plastic. Claimant forcefully manipulates the caps she glues onto the glow-worms by using her hands to twist them or by pounding them on the table, sometimes more than once to make them fit snugly. This is done repeatedly throughout the day when performing this stage of the assembly.

11. When assembling goggle protectors, claimant uses a vise-like tool, which is some eight inches high and attaches to her worktable. Claimant uses the vise to clamp a piece of plastic stripping so that she can work on each end. This requires claimant to reach at shoulder height and above twice per loop in order to attach each end of the stripping to the next piece.

12. Nicholas K. Olsen, D.O., performed an independent medical examination of claimant on September 26, 2008. Dr. Olsen attended the hearing, listened to the lay testimony, and observed claimant and Mr. P demonstrate how one assembles a glow-worm and a goggle protector. Dr. Olsen testified as an expert in Physical Medicine and Rehabilitation and electrodiagnostic medicine. Dr. Olsen agrees with Dr. Chimonas opinion that rotator cuff tears often occur without trauma.

13. Dr. Olsen persuasively explained: Claimant's right shoulder impingement syndrome more probably is the result of age-related changes that occur in the general population from age 30 onward as blood supply decreases. Reduced blood supply to the shoulder decreases the subacromial space, causing a decrease in the functioning space of the rotator cuff. With use of the shoulder over time, impingement typically causes tears to the rotator cuff. The Judge infers from Dr. Olsen's testimony that claimant's impingement syndrome involves an underlying, progressive disease process that eventually causes tearing of the rotator cuff.

14. Dr. Olsen and Dr. Chimonas disagree about the cause of claimant's rotator cuff tear. Dr. Olsen testified that the work activity claimant demonstrated at hearing was markedly different from the history she reported to Dr. Chimonas. The Judge credits Dr. Olsen's testimony here as persuasive in finding that the history claimant gave Dr. Chimonas fails to comport with what she demonstrated at hearing. Because he relied upon that history as the basis for his medical opinion, Dr. Chimonas's medical opinion regarding causation of claimant's rotator cuff tear is unreliable and unpersuasive.

15. Dr. Olsen relied upon the *Shoulder Injury Medical Treatment Guidelines* (Treatment Guidelines) promulgated by the Division of Workers' Compensation as the basis for his causation opinion. Crediting Dr. Olsen's medical opinion, the Judge finds: The Treatment Guidelines advise physicians that a history of sudden trauma or one of repetitive overhead work is necessary to find a causal relationship between work and a shoulder injury. All physicians agree that, by history, claimant's shoulder injury is not the result of sudden trauma at work. The

causation analysis next focuses on the type of motion involved in claimant's work activities to determine if her work presents a special hazard of employment associated with increased likelihood of tearing the rotator cuff. Repetitive motion that causes a shoulder injury must involve repetitive work with the arm extended above 60 degrees. Claimant performs the majority of her work using her upper extremities below the 60-degree level. While claimant occasionally reaches above the 60-degree level, that reaching is not sufficiently frequent to be considered repetitive. The Judge credits Dr. Olsen's medical opinion in finding it medically improbable that claimant's use of her upper extremities at work is associated with causing, intensifying, or, to a reasonable degree, aggravating the progressive disease process in her right shoulder.

16. Claimant failed to show it more probably true than not that her upper extremity activities at work present a hazard of employment that caused, intensified, or, to a reasonable degree, aggravated the progressive disease process in her right shoulder. Analysis of the cause of claimant's rotator cuff tear largely involves a question of medical causation. The Judge credited the medical opinion of Dr. Olsen over that of Dr. Chimonas. The Judge found it medically improbable that claimant's use of her upper extremities at work caused, intensified, or, to a reasonable degree, aggravated the progressive disease process in her right shoulder.

CONCLUSIONS OF LAW

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

Claimant argues she has proven by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (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 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. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), *supra*, as:

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

(Emphasis added). This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993).

The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

Here, the Judge found that claimant failed to show it more probably true than not that her upper extremity activities at work presented a hazard of employment that caused, intensified, or, to a reasonable degree, aggravated the

progressive disease process in her right shoulder. Claimant thus failed to prove by a preponderance of the evidence that she sustained a compensable occupational disease type injury.

As found, analysis of the cause of claimant's rotator cuff tear largely involved a question of medical causation. The Treatment Guidelines advise physicians that a history of sudden trauma or one of repetitive overhead work is necessary to find a causal relationship between work and a shoulder injury. All physicians agreed that, by history, claimant's shoulder injury was not the result of sudden trauma at work. The Judge instead found that claimant's impingement syndrome represents an underlying, progressive disease-process that eventually causes tearing of the rotator cuff.

The causation analysis next focuses on the type of motion involved in claimant's work activities to determine if her work presents a special hazard of employment associated with increased likelihood of tearing her rotator cuff. Repetitive motion that causes, intensifies, or, to a reasonable degree, aggravates a shoulder injury necessarily involves repetitive work with the arm extended above 60 degrees. Claimant performs the majority of her work using her upper extremities below the 60-degree level. While claimant occasionally reaches above the 60-degree level, that reaching is not sufficiently frequent to be considered repetitive. The Judge thus found it medically improbable that claimant's use of her upper extremities at work is associated with causing, intensifying, or, to a reasonable degree, aggravating the progressive disease process in her right shoulder.

The Judge concludes claimant's claim for workers' compensation benefits should be denied and dismissed.

ORDER

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

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

DATED: _December 11, 2008__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-768-753

ISSUES

The following issues were raised for consideration at hearing:

1. Compensability; and
2. Medical benefits.

The parties stipulate and agree that, if the Claimant's claim is found compensable, Concentra is the authorized medical provider.

FINDINGS OF FACT

Having considered the evidence presented at hearing, and the parties' closing arguments, the following Findings of Fact are entered.

1. On August 15, 2008, Claimant was employed by the Employer as a leadman in a business that constructs roof tresses. Claimant was supervised by JR.

2. In September 2007, Claimant suffered a low back injury in the course and scope of his employment for the Employer. Claimant had worked for the Employer for three years at the time of the 2007 injury. In 2003 or 2004, Claimant was involved in a motor vehicle accident in which he was not injured.

3. On August 15, 2008, Claimant suffered another injury in the course and scope of his employment for the Employer when he was carrying six or seven pieces of eight foot long wood. He jumped from one table to another table, and when placing weight on his right foot he felt back pain in the same location as he experienced during the September 2007 back injury.

4. Claimant reported the injury to his supervisor, Mr. R, who referred Claimant for medical treatment at Concentra. Claimant was taken off work by a Concentra physician. Claimant remained off work under the care of the authorized provider of medical care, and did not return to the workplace until September 15, 2008 when he was released from medical care without restrictions.

5. Claimant credibly testified that he continues to require medical attention for his back as a result of the August 15, 2008 work injury. Claimant's need for continued medical treatment was shown to be reasonable, necessary, and related to the August 15, 2008 work injury. Respondents are liable for this treatment.

6. Respondents presented evidence through the testimony of JR, which was found to be less credible and persuasive than the testimony of Claimant. Mr. R could not speak directly to the issues raised for consideration at hearing. Respondents argued, through counsel, that it was suspicious that Claimant was scheduled to be laid off and that he claimed a work injury. It was further argued as suspicious that Claimant is alleged by Mr. R to have inquired whether he could be laid off, if he had a work injury. Further, Respondents asserted that other suspicious occurrences point to secondary gain as Claimant's motivation

for claiming a work injury. Because Mr. R' testimony was largely built on suspicions, it was not deemed to carry sufficient weight to rebut Claimant's credible and persuasive testimony concerning a work injury and the continued need for medical treatment.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1.The Workers' Compensation Act is intended to be "remedial and beneficent in purpose, and should be liberally construed" in order to accomplish these goals. *Davison v. Industrial Claim Appeals Office & Mobley v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflict in the evidence, make credibility determinations, determine the weight to be accorded to the expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002).

2.The injured worker has the burden of proof, by a preponderance of the evidence, of establishing all aspects of his claim and entitlement of benefits. Section 8-43-201 and 8-43-210, C.R.S. *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).

3.In determining credibility of witnesses, the fact finder should consider, among other things, the consistency 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); Colorado Jury Instructions Civil, 3:16 (2005).

4.The Act provides that every employer shall furnish such medical, surgical, dental, or nursing, and hospital treatment and supplies as may be reasonably needed at the time of the injury or occupational disease and during the disability to cure and relieve the employee from the effects of the injury. Section 8-42-101, C.R.S. Respondents are liable for medical treatment, which is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for reasonably necessary and related medical benefits to cure and relieve Claimant of the effects of the August 15, 2008 work injury to his back.

All matters not determined herein are reserved for future determination.

DATED: December 12, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-702-503

ISSUES

The issues determined herein are petition to reopen, medical benefits, and temporary total disability ("TTD") benefits.

FINDINGS OF FACT

1. In 1991, claimant began work for the employer as a crew leader.
2. In February 2001, claimant suffered a back injury in a motor vehicle accident. Dr. Jenks provided treatment for disc injuries at L4-5 and L5-S1. Dr. Lazar provided a surgical consultation, but recommended only that claimant change jobs. A September 26, 2002, magnetic resonance image ("MRI") showed a bulge at L1-2 and a normal disc at L2-3. The MRI also showed bulges and disc dessication at L3-4 through L5-S1. In October 2002, Dr. Nichols recommended surgery at L5-S1, but claimant declined. Dr. Jenks continued to provide treatment, including epidural steroid injections through November 10, 2005.
3. On October 5, 2006, claimant suffered an admitted industrial injury to his low back when he moved a spa.
4. An October 20, 2006, MRI showed a large disc herniation at L1-2 with severe central canal stenosis, retrolisthesis of L2 over L3, moderate degenerative changes at L4-S1.
5. On January 23, 2007, Dr. Jatana performed surgery at L1-2. The surgery relieved the groin pain that claimant had experienced since the work injury, but claimant continued to have back and leg pain.
6. Claimant returned to light duty work in the warehouse for the employer until his employment was terminated.
7. Dr. Ford continued to provide epidural steroid injections and facet injections.

8. Dr. Ford requested authorization to perform a rhizotomy at L5-S1. Dr. Shih provided a record review for respondents and approved the rhizotomy. Claimant continued to suffer leg and back pain.
9. On December 3, 2007, Dr. Jatana recommended fusion surgery at L4 through S1, but claimant declined.
10. On December 4, 2007, Dr. Reasoner determined that claimant was at maximum medical improvement ("MMI") with 25% impairment for disc injuries at L1-2 and L4-S1. Dr. Reasoner imposed permanent restrictions against lifting over 50 pounds or carrying over 20 pounds. He recommended continuing post-MMI medical treatment.
11. On January 28, 2008, the insurer filed a final admission of liability for the permanent partial disability benefits and for post-MMI medical benefits.
12. Dr. Maisel provided post-MMI medical care. In May 2008, claimant suffered a flareup of symptoms that never resolved. On May 20, 2008, Dr. Maisel noted that claimant had suffered an acute exacerbation, although he remained at MMI.
13. On June 16, 2008, Dr. Jatana reexamined claimant and recommended a repeat MRI. The MRI showed worsened retrolisthesis at L2-3.
14. On June 27, 2008, Dr. Jatana recommended trial of a spinal cord stimulator. Dr. Maisel agreed with this recommendation.
15. Dr. Scott performed a record review for respondents. Dr. Scott was of the opinion that claimant only injured L1-2 in the work injury. Consequently, Dr. Scott recommended denial of the trial of the spinal stimulator.
16. On July 25, 2008, claimant filed his petition to reopen based upon a change of condition.
17. On September 24, 2008, Dr. Lambden performed an independent medical examination for respondents. Dr. Lambden concluded that claimant's current symptoms were not related to the work injury because claimant injured only his L1-2 disc in the work injury. Dr. Lambden agreed that claimant was worse, especially at L2-3. Dr. Lambden did not recommend a spinal stimulator for claimant because he suffered mechanical as well as neuropathic pain and he had multi-level degenerative disc disease. Dr. Lambden agreed that some treatment was still needed for the work injury.
18. At hearing, Dr. Lambden admitted that claimant was substantially worse than at MMI, although Dr. Lambden thought that the worsening was not due to the work injury. He recommended selective nerve root blocks, flexion-extension x-rays, and a psychological evaluation.
19. Dr. Reasoner testified by deposition that claimant was worse and that the L2-3 injury was part of the work injury. Dr. Reasoner noted the absence of retrolisthesis until after the work injury and he noted that claimant had been able to work full-time at a heavy job until the work injury. Dr. Reasoner agreed that claimant needed a psychological evaluation before determination of the feasibility of a spinal stimulator trial.
20. Claimant has proven by a preponderance of the evidence that he suffered a change of condition since MMI and that the change was a natural consequence of the admitted work injury. Claimant's testimony is credible. The opinions of Dr. Reasoner are persuasive. Claimant injured his L2-3 disc in the admitted work injury. That level has suffered rapid progression and needs additional treatment.
21. The parties stipulated that claimant needed medications, x-rays, lower extremity electromyography studies, nerve blocks, and a psychological evaluation.

22. Claimant has failed to prove by a preponderance of the evidence that trial of a spinal stimulator is reasonably necessary at this time. Even Dr. Reasoner agreed that claimant needed a psychological evaluation before proceeding with the trial.
23. Claimant has failed to prove by a preponderance of the evidence that he suffered increased disability in spite of his change of condition. Dr. Reasoner provided the permanent restrictions. No physician has offered new restrictions. Claimant never attempted to return to work in any occupation. The record evidence does not show that he has increased loss of labor market access compared to his status at MMI.

CONCLUSIONS OF LAW

1. Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996) (noting that change in condition has been construed to mean a change in the physical condition of an injured worker). Claimant must prove that his change of condition is the natural and proximate consequence of the industrial injury, without any contribution from another separate causative factor. *Vega v. City of Colorado Springs,* W.C. No. 3-986-865 & 4-226-005 (ICAO, March 8, 2000). As found, claimant has proven by a preponderance of the evidence that he suffered a change of condition as a natural consequence of his admitted work injury.

2. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The parties stipulated to various medical treatments. As found, claimant has failed to prove by a preponderance of the evidence that he is entitled to a trial of a spinal stimulator at this time.

3. *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 637 (Colo. App. 1997) bars additional TTD benefits as of June 16, 2008, unless claimant demonstrates increased temporary disability since the original MMI date. As found, he has failed to prove by a preponderance of the evidence that he suffered increased disability since MMI. Consequently, he is not entitled to additional TTD benefits. The offset request pursuant to *Donald B. Murphy Contractors, Inc. v. Industrial Claim Appeals Office*, 916 P.2d 611 (Colo. App. 1995) is moot.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is granted.
2. The insurer shall pay for all of claimant's reasonably necessary medical treatment from authorized providers, including medications, x-rays, lower extremity electromyography studies, nerve blocks, and a psychological evaluation.
3. Claimant's request for an order to provide a trial of a spinal stimulator is denied.
4. Claimant's request for TTD benefits commencing June 16, 2008, is denied and dismissed.
5. All matters not determined herein are reserved for future determination.

DATED: December 15, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-991

ISSUES

1. Did Claimant prove by a preponderance of the credible evidence that his low back, neck and right shoulder conditions are related to the admitted industrial injury?
2. Did Claimant prove by a preponderance of the credible and persuasive evidence that he was entitled to Temporary Total Disability (TTD) benefits from May 19, 2008 and ongoing?
3. What is Claimant's Average Weekly Wage (AWW)?

FINDINGS OF FACT

1. Claimant worked a total of 117.75 hours during the months of October and November 2007 and April and May 2008. During this time Claimant earned $838.07. Thus, his average hourly rate was $7.12 during this period.
2. Claimant worked sporadically for the Respondent-Employer over this period of time. Claimant worked 26.75 hours in October 2007, 8 hours in November 2007; Claimant did not work in December 2007, January 2008, February 2008, or March 2008. Claimant then worked 42 hours in April 2008 and 41 hours in May 2008.
3. Claimant agreed to perform modified duty on May 12, 2008 at the rate of $7.16 for a 22-hour week amounting to $157.52 per week. This closely matches the Claimant's work history with the Respondent-Employer.
4. The ALJ finds that an AWW of $157.52 is a fairly determined AWW for the Claimant.
5. Claimant sustained a work-related injury to his right ankle, neck, right shoulder and low back on May 8, 2008 while carrying very heavy partition board for Respondent-Employer. Claimant incurred the injuries when he fell into a hole that was approximately 2 feet deep and 2 feet wide which caused him to fall to the ground on his buttocks and the wall that he had been carrying came down on top of him pushing his head to the left.
6. CD, Branch Manager for Respondent, offered the Claimant modified duty on May 12, 2008. Claimant began working modified duty on May 13, 2008.
7. An employee's work restrictions and specific work duties while on modified duty for Respondent-Employer are determined based on the work restrictions provided by the employee's physician. Claimant's work restrictions included sitting 95% of the time. Claimant was given a chair with rolling wheels on the bottom that he was to use in completing his job duties. Claimant stood no more than 2-3% of the time in completing his modified duties.

8. All transitional (modified) duty employees are paid on the 15th and last day of each month by the Respondent-Employer. Claimant received his first modified duty paycheck according to this schedule. Claimant received his first modified duty paycheck after he had worked only two (2) days of modified duty.

9. On May 16, 2008 Claimant questioned Ms. D regarding why he was paid for only two (2) days of work in his first modified duty paycheck when according to the Transitional Duty Offer he was supposed to receive $157.52 per week. Ms. D explained that because he had only worked two (2) days he would only be paid for two (2) days. The remainder of the week would be paid to him on his next paycheck. Claimant became very upset about the paycheck and left the office. Claimant has not returned to the office since, has not called the office since and has not had any contact with Ms. D or her staff since walking out on May 16, 2008.

10. Claimant is still considered an "active" employee. Respondent-Employer has not terminated Claimant's employment. Claimant merely walked out and up to the date of the hearing has voluntarily not returned to work.

11. Modified duty continued to be available to Claimant after May 16, 2008 at his pre-injury rate of pay and pre-injury hours.

12. Had Claimant continued to work the modified duty available to him, instead of walking out and not returning, Respondent would have had modified duty available for him at his pre-injury rate of pay and pre-injury hours after October 9, 2008 when Claimant's restrictions were made less restrictive.

13. The ALJ specifically finds Ms. D's testimony on all points to be credible and persuasive.

14. Dr. Albert Hattem testified, via deposition, that the specific modified duty offered to Claimant by Respondent-Employer was within his work restrictions. Dr. Hattem opined

> If he was able to do his job duties in a rolling chair, his injuries should not have precluded him from carrying out those job responsibilities.

The ALJ specifically finds that the modified duty offered to Claimant by Respondent-Employer was within Claimant's work restrictions.

15. The ALJ specifically finds Dr. Hattem's testimony to be credible.

16. The ALJ specifically finds the Claimant credible with respect to the extent and nature of his work-related injuries and, in conjunction with the medical evidence including Dr. Albert Hattem's opinions as expressed in his deposition in this matter, finds that Claimant's injuries to his low back, neck, and right shoulder are proximately caused by his work-related injury and are compensable.

17. The ALJ specifically finds that Claimant voluntarily abandoned his modified duty position by failing to return to the Respondent's workplace subsequent to May 16, 2008. The ALJ finds that Respondent was no longer responsible for TTD benefits once Claimant returned to modified employment. Subsequent to his return to modified employment Claimant then abandoned his position. The ALJ finds that Claimant in this matter is less credible than evidence introduced by Respondent.

CONCLUSIONS OF LAW

1. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-43-201, C.R.S. (2008). 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*, 529 P.2d 792 (Colo. 1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). 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 employer's rights. §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 issue involved; the Judge does not need to address every piece of evidence that might lead to a conflicting conclusion, or he has rejected evidence contrary to the findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course of employment. §8-41-301(1)(c), C.R.S. "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 (Colo. App. 2000).

4. Whether a claimant has sustained his burden of proof is a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). In deciding whether or not an injured worker has met his burden of proof, the ALJ is empowered to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the record. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999).

5. 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 (1936).

6. Section 8-42-102(2), C.R.S. sets forth certain methods of calculating the AWW. Section 8-42-102(3), C.R.S. permits the ALJ discretion in the method of calculating the AWW if the nature of employment or the fact that the injured employee has not worked a sufficient length of time, has been ill or self-employed, or for any other reason, the specific methods do not fairly compute the AWW.

7. A claimant is entitled to TTD benefits where he has proven that he suffered an industrial injury that causes total disability that lasts more than three (3) working days duration. §8-42-105(1), C.R.S. Entitlement to TTD benefits terminates once the employee returns to regular or modified employment. §8-42-105(3)(b), C.R.S.

8. It is specifically concluded as a matter of law based on the credible evidence in the record that Claimant met his burden of proof concerning causation of his alleged injuries. The preponderance of the credible evidence supports Claimant's claim that his low back, neck and right shoulder conditions are related to the admitted industrial injury.

9. It is specifically concluded as a matter of law based on the credible evidence in the record that Claimant did not meet his burden of proof concerning the issue of TTD benefits. Claimant was offered and accepted modified duty within his work restrictions and he began modified duty on May 13, 2008. Claimant has not proven that he did not voluntarily abandon his employment with Respondent. The preponderance of the credible evidence does not support Claimant's claim that he is entitled to TTD benefits.

10. It is specifically concluded as a matter of law based on the credible evidence in the record that Claimant's AWW on the date of injury was $157.52.

ORDER

It is therefore ordered that:

1. Respondent-Insurer is responsible for Claimant's medical care of his low back, neck, and right shoulder symptoms as are reasonable and necessary to cure or relieve Claimant from the effects of his work-related injury.
2. Claimant's request for TTD benefits is denied and dismissed.
3. Claimant's AWW is $157.52.
4. Respondent-Insurer shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.
5. All matters not determined herein are reserved for future determination.

DATE: December 15, 2008
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-712-593

ISSUES

1. Does the ALJ have jurisdiction in this matter?

2. Has claimant established by a preponderance of the evidence that she is entitled to permanent partial disability (PPD) benefits?

FINDINGS OF FACT

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

1. Claimant, age 55 at the time of the hearing, began working for employer in 1995 as a cashier at the parking facility at Denver International Airport. She worked as a traffic agent from 1997 to 2005, when she resumed her duties as a cashier.

2. In approximately 2006, claimant began experiencing problems in her upper extremities. She reported these problems to her employer in May, 2006, and was referred to Denver Health Medical Center at Denver International Airport. Rick Artist, M.D., claimant's authorized treating physician, first evaluated claimant on May 30, 2006. Dr. Artist is Level II accredited, has been licensed since 1983, and has been an instructor at Colorado University School of Medicine since 1995. Dr. Artist diagnosed claimant with bilateral carpal tunnel syndrome and mild right lateral epicondylitis.

3. Jurisdictional Findings. On April 27, 2007, Respondents filed a General Admission of Liability.

4. On January 11, 2008, Dr. Artist found claimant to be at maximum medical improvement (MMI) with no permanent impairment. Claimant filed a Physician's Report of Worker's Compensation Injury (first impairment rating).

5. On January 22, 2008, in response to the first impairment rating, Respondents filed a Final Admission of Liability (FAL). Respondents denied liability based on Dr. Artist's rating. Pursuant to Section 8-43-203(2)(b)(II), C.R.S., the FAL provided in part "If you disagree with the benefits admitted or not admitted you must do the following: 1. Within 30 days, complete the attached objection form…stating that you object to this admission. You must also file an application for hearing with the Office of Administrative Courts on any disputed issues. 2. Within the same 30 days, if you disagree with the date of MMI or whole person impairment rating, complete the attached Notice and Proposal to Select an Independent Medical Examiner Form and send it to the insurance carrier or self-insured employer and the Division. 3. If an IME is requested, you are not required to file an application for hearing until after the IME is completed."

6. After the first impairment rating, claimant telephoned Dr. Artist and talked to him on the telephone twice. She questioned why he had issued a zero permanent impairment rating and pointed out to him her symptoms. Dr. Artist performed no additional physical examination.

7. On January 26, 2008, Dr. Artist filed a revised impairment rating, finding permanent impairment of 50% upper extremity, converted to 30% whole person (revised impairment rating). Dr. Artist now believes that the revised impairment rating most accurately reflects the claimant's condition.

8. In issuing the revised impairment rating, Dr. Artist used Table 15 of the American Medical Association Guides to the Evaluation of Permanent Impairment, 3rd Ed. Rev. (AMA Guides). He found an entrapment neuropathy, right radial nerve, of 10% and right median nerve 25% upper extremity impairment. He combined that for a 33% right upper extremity impairment. He found a left arm radial nerve impairment of 8% and median nerve of 20%, which he found to yield a 26% upper extremity impairment. He then combined 33% right upper extremity with 26% left upper extremity to yield a 50% upper extremity impairment. Using Table 3, he found that this yields a 30% whole person impairment. Dr. Artist noted claimant's complaints of pain and stated that she was using ibuprofen and Tylenol frequently and may need strong pain medicine on occasion.

9. Respondents did not file any revised or second FAL or request for an independent medical examination (IME) in response to the revised impairment rating.

10. On February 15, 2008, in relation to the first impairment rating, claimant filed an Objection to Final Admission of Liability and a Notice and Proposal to Select an Independent Medical Examiner.

11. On June 2, 2008, claimant filed an Application for Hearing.

12. On June 8, 2008 Respondents filed a Notice of Failed IME negotiation.

13. Claimant never obtained a DIME and agreed to proceed to hearing without having a DIME.

14. Respondents filed a Motion to Strike Claimant's Application for Hearing. Respondents contended that claimant's failure to respond to the FAL or to seek a DIME within 30 days after the failure of the parties to agree on an IME physician deprived the ALJ of jurisdiction and closed the case subject to a Petition to Re-Open.

15. Claimant filed a Response arguing that Respondents' obligation to file a Notice of Failed Negotiation within 30 days of the parties' failure to agree on an IME physician procedurally preceded claimant's obligation to file an Application for IME and that the matter never became ripe for hearing.

16. On June 20, 2008, Judge Friend entered an Order denying Respondents Motion to Strike.

17. <u>Treatment History and Evaluations.</u> After his initial treatment of claimant, Dr. Artist referred claimant to Dr. In Sok Yi of Hand Surgery of Colorado. Dr. Yi first examined Claimant on August 10, 2006, and diagnosed her with bi-lateral carpal tunnel syndrome, bi-lateral CMC arthritis and right lateral epicondylitis. On January 19, 2007, Dr. Yi performed a left carpal tunnel release.

18. Claimant progressed well after her surgery. On January 25, 2007, claimant reported to Dr. Yi that her numbness and tingling were significantly better on her left side. On March 15, 2007, claimant reported to Dr. Yi no numbness or tingling and continuing improvement of the soreness around the incision site.

19. Dr. Yi performed a right carpal tunnel release on April 6, 2007. By April 18, claimant reported an absence of night pain. By May 24, 2007, claimant reported no numbness or tingling but some soreness around the incision site with some weakness. Dr. Yi's physical examination revealed good sensation to touch in the median nerve distribution.

20. By July 5, 2007, 13 weeks after the surgery, Dr. Yi noted that claimant was experiencing no numbness or tingling and was pleased with the surgical results for her right carpal tunnel release. Claimant was continuing to experience some elbow pain. Claimant stated that her left hand was doing well. Dr. Yi noted that claimant was "mildly tender over the right lateral epicondyle with some pain with resisted wrist extension." Dr. Yi discharged claimant to full work status on July 5, 2007, with a plan for her to use her hand as tolerated since the elbow pain is something she could tolerate.

21. On December 6, 2007, Dr. Yi last evaluated claimant for a follow-up of her upper right lateral epicondylitis. Claimant reported to Dr. Yi that the pain was constant, 3 on a scale of 10. On physical examination, Dr. Yi found tenderness over the later epicondyle but good sensation to touch in the median nerve distribution. Dr. Yi found some pain with resisted wrist extension.

22. Claimant returned to restricted duty following the second carpal tunnel release surgery. She received physical therapy. Claimant continued to receive treatment from Dr. Artist after her surgeries and to demonstrate continued improvement, with some complaints. On May 8, 2007, Dr. Artist noted that claimant was not taking Vicodin for pain and Claimant had good strength in left and fair strength in her right hand. On June 14, 2007, Dr. Artist noted full range of motion of the wrist, pretty good grip strength, no wincing when she squeezed tightly. At this time, claimant reported to Dr. Artist that the sensation in her fingers was a little dull and fuzzy and some weakness with heavier objects.

23. On July 20, 2007, claimant reported to Dr. Artist that her carpal tunnel symptoms continued to improve albeit slowly and that most of the time she did not have any numbness and tingling. She did report occasional, intermittent numbness and tingling in three fingers on both hands and some difficulty with strength. Both were more prominent in her left hand. Objectively, Dr. Artist noted "good range of motion of the wrist, good grip strength bilaterally, tenderness over the right lateral epicondylar area particularly superior portion of the lateral epicondyle." On August 21, 2007, Dr. Artist noted "left hand pretty good, right had still a little achy, sore, particularly with writing and mouse activity." Objectively, Dr. Artist noted "well-healed scars on the wrist. Very difficult to actually see. Good grip strength bilaterally."

24. On October 19, 2007, Dr. Artist noted that the carpal tunnel surgeries and symptoms were doing quite well, although a little funny sensation persisted at night. He also noted pain and soreness in the right lateral elbow. In general, he noted that symptoms were doing quite well. Objectively, "good range of motion of both hands and wrists. Good grip strength." The following week, October 24, 2007, claimant told Dr. Artist that her "wrists are doing okay." Objectively, "good range of motion at the wrists and hand. Good grip strength." Dr. Artist noted claimant's condition was stable. On November 16, 2007 Dr. Artist noted "good range of motion at wrists. Good grip strength."

25. Dr. Artist examined claimant numerous times before he issued the first impairment rating on January 11, 2008. He changed the impairment rating because claimant called to his attention her symptoms.

26. Dr. Artist's revised impairment rating was based on his assertion of an entrapment neuropathy at the right radial nerve, right median nerve, left arm radial nerve impairment, and median nerve. Dr. Artist admits that there is no objective evidence to support an entrapment neuropathy of claimant's right radial nerve, right median nerve or left radial nerve.

27. At the request of respondents, Allison M. Fall, M.D. performed an independent medical examination of claimant on July 24, 2008. Dr. Fall is Level II accredited and an expert in physical medicine and rehabilitation and in rating those with carpal tunnel syndrome and epicondylitis. The ALJ found Dr. Fall's testimony to be persuasive. Dr. Fall opined, and the ALJ finds, that claimant did not have a permanent impairment based on her surgically-treated carpal tunnel syndrome. Both carpal tunnel releases were successful and eliminated any nerve entrapment. Further, it is improper to rate for an entrapment that has been successfully relieved by surgery.

28. Dr. Artist's revised impairment rating was not supported by objective evidence on physical examinations. According to Dr. Fall, Level II training strongly recommends against use of Table 15, and thus Dr. Artist improperly used this table in rating claimant. The ALJ adopts this opinion.

29. Based on the testimony of Dr. Fall, an impairment rating based on pain alone is inappropriate. There was no documentation of objective abnormalities such as sensation loss, weakness of muscles or other test results. With regard to the carpal tunnel syndromes, no permanent medical impairment for claimant was appropriate because there was no documented objective abnormality. Dr. Artist's revised impairment rating of January 26, 2008 was improper and not supported by credible evidence.

30. Based on her review of medical records and her independent medical examination, Dr. Fall opined and the ALJ finds that there is objective evidence of a permanent medical impairment due to the right lateral epicondylitis. Pursuant to the Cumulative Trauma Disorder Matrix, Dr. Fall determined a 6% upper extremity impairment but no objective evidence of a functional limitation beyond the situs of the injury. The ALJ adopts Dr. Fall's opinion in this regard and finds that claimant sustained a permanent medical impairment, that is, a 6% scheduled upper extremity impairment, as a direct and proximate result of her occupational disease.

31. Claimant failed to establish by a preponderance of the evidence that her functional limitation went beyond the arm at the shoulder. As such, her impairment is limited to a scheduled impairment.

32. In January, 2008, the time of the revised impairment rating, claimant was experiencing some pain in her hands and wrists. Since 2007, she has been working a modified work assignment as a traffic agent making courtesy traffic calls and as a receptionist answering the telephone. She was having trouble sleeping, although she was not experiencing tingling or numbness in her hands. She was also experiencing pain in her elbow.

CONCLUSIONS OF LAW

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

1. Jurisdiction. Respondent contends that the ALJ lacks jurisdiction to hear the issue of PPD as raised in the claimant's application for hearing because the case was automatically closed as to benefits admitted or not admitted in the FAL as of February 23, 2008. Respondents therefore contend that claimant must file a petition to reopen pursuant to Section 8-43-303. Respondents assert that pursuant to Section 8-43-203(2)(b)(II), C.R.S., claimant's failure to file an application for hearing within 30 days of the January 22, 2008 FAL resulted in the closure of the case as of February 23, 2008.

The ALJ disagrees. Section 8-43-203(2)(b)(II) provides that a case will "automatically be 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 are ripe for hearing, including the selection of an independent medial examiner pursuant to section 8-42-107.2 if an independent medical examination has not already been conducted." It further provides, however, that "[i]f an independent medical examination is requested pursuant to section 8-42-107.2, the claimant is not required to file a request for hearing on disputed issues that are ripe for hearing until after completion of the divisions' independent medical examination."

On February 15, 2008, claimant filed a timely Notice and Proposal to Select an Independent Medical Examiner, as outlined in Section 8-42-107.2. She therefore *requested* a DIME, as specified in Section 8-43-203(2)(b)(II). Under these circumstances, she was not required to file an application for hearing within 30 days of the January 22, 2008 FAL. Claimant's application for hearing on June 2, 2008, was therefore timely. The case did not automatically close.

Claimant had a right in this matter to request a DIME. She objected to the January 22, 2008 FAL's determination of no permanent impairment. At the same time, claimant was asserting, based on Dr. Artist's revised impairment rating, a whole person impairment. There was thus a significant dispute at the time claimant requested the DIME as to whether claimant had a non-scheduled impairment. *See Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo.App. 2000). The fact that claimant ultimately did not obtain a DIME is irrelevant, as the Act only refers to a request for a DIME.

2. Applicability of *Res Judicata.* Claimant relies on the doctrine of *res judicata* to argue that the Order Re: Motion to Strike Application For Hearing dated June 20, 2006 precludes respondents from raising the above jurisdictional argument, which was asserted in their Motion to Strike Application for Hearing. At hearing on September 10, 2008, the undersigned ALJ ruled that ALJ Bruce Friend's Order of June 20, 2008, was not a final judgment the merits. ALJ Friend

ruled in part that "Respondents seek to close the case and deny clmt further benefits, not merely a procedural order. Respondents must file a Motion for Summary Judgment to obtain an order foreclosing further benefits. Rule 17 OACRP."

The doctrine of *res judicata,* or claim preclusion, does not apply here. Claim preclusion bars relitigation of matters that were decided in a prior proceeding, as well as matters that could have been decided in the prior proceeding but were not. Application of the doctrine requires, among other things, the finality of the first judgment. *Holnam, Inc. v. Industrial Claim Appeals Office,* 159 P.3d 795 (Colo. App. 2006). ALJ Friend's Order did not constitute a final judgment on the issue of jurisdiction. Rather, ALJ Friend only ruled that respondents had chosen an inappropriate procedural vehicle to bring this matter before the tribunal.

3. Effect of Respondents' Failure to File Second FAL. Claimant contends that respondents are precluded from challenging the revised impairment rating because it failed to file a second or revised FAL within 30 days of the revised impairment rating. In support of this contention, claimant cites Rules 5-5 (E) and (H), WCRP, which require insurers for medical impairments and scheduled injuries to either file an admission of liability or set the matter for hearing with the Office of Administrative Courts within 30 days. Claimant also cites *Leprino Foods, Inc. v. Industrial Claims Appeals Office,* 134 P.3d 475 (Colo.App. 2005), which precludes an insurer who did not either contest the DIME report within 30 days or admit in accordance with the report from thereafter challenging the report before an ALJ.

The situation addressed in *Leprino Foods* in not directly analogous to that presented here. The insurer here did file a FAL in relation to the first impairment rating, and claimant then filed an objection to that FAL and a Notice and Proposal to Select an Independent Medical Examiner in relation to the first impairment rating. The workers' compensation statutes and rules do not directly address the insurer's responsibility in relation to the revised impairment rating. While claimant seeks to bar respondents from disputing that rating based on their failure to file a second FAL, they point to no specific statutory or regulatory requirement for respondents to do so. In the absence of such a requirement, the ALJ declines to impose this sanction. Claimant has requested that the revised impairment rating be deemed admitted, and that request is denied.

4. Due Process Claim. Claimant contends that respondents' failure to admit or deny the revised impairment rating deprives her of her due process right to a hearing. Since claimant agreed to proceed to hearing in this matter and had a full and fair opportunity to present evidence and cross-examine witnesses, the ALJ finds this contention unpersuasive.

5. PPD. Section 8-42-107, C.R.S., establishes different methods of compensating medical impairment. Subsection (2) provides a schedule of disabilities and subsection (8) provides a DIME process for whole person ratings. The threshold issue is the appli-

cation of the schedule and is a determination of fact for the ALJ based upon a preponderance of the evidence. *Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo. App. 2001); *Johnson-Wood v. City of Colorado Springs,* W.C. No. 4-536-198 (ICAO June 20, 2005). At issue here is subsection (2)(a), which provides for scheduled compensation based on "loss of an arm at the shoulder." Claimant bears the burden of proof by a preponderance of the evidence to establish functional impairment beyond the arm at the shoulder and the consequent right to PPD benefits awarded under Section 8-42-107(8)(c).

In relation to the alleged entrapment neuropathy, the ALJ found unpersuasive Dr. Artist's opinion of such a permanent impairment. Dr. Artist had examined and evaluated claimant numerous times before his initial impairment rating. The initial and revised impairment ratings reflect a very dramatic change. Dr. Artist's explanation for his change of opinion from a zero impairment rating on January 11, 2008, to a 30% whole person impairment rating on January 26, 2008, is that claimant explained to him her symptoms. This is not convincing. Further, the ALJ found persuasive Dr. Fall's testimony that Dr. Artist's revised opinion was based on an improper table, one not designed for surgically-treated carpal tunnel syndrome. In addition, the lack of objective evidence to support entrapment neuropathy is significant. Further, claimant failed to establish by a preponderance of the evidence functional limitation that went beyond the arm at the shoulder. In contrast, the ALJ found persuasive the testimony of Dr. Fall, who examined claimant and found that she had no permanent impairment associated with her treated carpal tunnel syndrome. While claimant has some pain symptoms, she has failed to establish permanent medical impairment in relation to entrapment neuropathy.

The only permanent medical impairment established by claimant is that due to the right lateral epicondylitis. The ALJ found credible Dr. Fall's determination at 6% upper extremity impairment. There is no objective evidence of a functional limitation beyond the situs of the injury. Claimant has therefore sustained a 6% scheduled impairment and is entitled to PPD based on that permanent impairment.

ORDER

It is therefore ordered that:

1. The ALJ has jurisdiction to hear this matter.
2. Insurer shall pay claimant PPD benefits for her occupational disease based on a 6% scheduled impairment of the right upper extremity.
3. All matters not determined herein are reserved for future determination.

DATED: December 15, 2008

Nancy Connick
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-761-816

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he sustained compensable industrial injuries during the course and scope of his employment with Employer.

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

3. Whether Claimant has proven by a preponderance of the evidence that he is entitled to recover Temporary Total Disability (TTD) benefits from August 1, 2008 until terminated by statute.

STIPULATION

The parties agreed that Claimant earned an Average Weekly Wage (AWW) of $842.14.

FINDINGS OF FACT

1. Employer is an on-line school that teaches students from around the state of Colorado. On August 21, 2004 Claimant began working as a teacher for Employer. He was promoted to a lead teacher position in 2006.

2. Claimant testified that on May 28, 2008 he was carrying two suitcases of tests and curriculum down a flight of stairs as part of his job duties for Employer. While shifting his legs in order to hold onto the suitcases, his arms and hands became numb. He also experienced a sharp pain in the middle of his back approximately two inches above his belt line.

3. On August 22, 2008 the parties conducted the evidentiary deposition of Claimant is this matter. Although Claimant maintained that he suffered an injury at work on May 28, 2008, he could not identify an incident that caused his back pain. He stated that his back bothered him on many days and his pain became unbearable in January 2008. Claimant explained that he took pain relievers to control the pain.

4. Claimant reported his injuries to Employer and was referred to Concentra Medical Centers. On the date of the incident Claimant visited Joel Boulder, M.D. for an evaluation. Dr. Boulder noted that Claimant began to experience back pain in February 2008 as a result of sitting at his work desk. Claimant's back pain subsequently fluctuated in severity. However, on May 28, 2008

he was carrying "a heavy box of portfolios down a flight of stairs" and began to experience back pain and spasms. Dr. Boulder determined that Claimant suffered a back strain and "right and left upper extremity sensory disturbances." He prescribed medications, physical therapy and an EMG study. Dr. Boulder also issued work restrictions of no lifting, pushing or pulling in excess of 10 pounds.

5. Dr. Boulder referred Claimant for additional medical evaluations and treatment. However, Claimant never completed his treatment because Insurer filed a Notice of Contest on June 13, 2008 to conduct additional investigation. Insurer subsequently denied further medical treatment.

6. Claimant continued to perform his job duties as a teacher for Employer until June 6, 2008. He was paid through the end of the school year on July 31, 2008. However, Employer did not ask Claimant to return to work for the following academic year.

7. Employer's school principal SA testified at the hearing in this matter. Ms. A explained that Employer evaluates teachers' performances at the end of every school year and makes decisions about whether they should return for the following academic year. Ms. A explained that Claimant had exhibited a substandard work performance during the 2007-08 academic year. She thus notified Claimant approximately one week prior to his May 28, 2008 injury that he would not be asked to return to Employer for the following academic year.

8. Claimant has established that it is more probably true than not that he suffered industrial injuries to his back, arms and hands during the course and scope of his employment with Employer on May 28, 2008. Claimant credibly explained that while he was carrying two suitcases of tests and curriculum down a flight of stairs he experienced pain in his back and numbness in his arms and hands. Claimant's account is consistent with his report to Dr. Boulder on the date of the incident. Although Claimant could not identify a specific incident that caused his injuries during his evidentiary deposition, he nevertheless maintained that he suffered an injury on May 28, 2008 that caused back pain. Claimant's credible testimony is thus sufficient to demonstrate that he suffered injuries during the course and scope of his employment with Employer on May 28, 2008.

9. Claimant has demonstrated that it is more probably true than not that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries. On the date of the incident, Employer referred Claimant to Concentra Medical Centers for treatment. Dr. Boulder determined that Claimant suffered a back strain and "right and left upper extremity sensory disturbances." He prescribed medications, physical therapy and an EMG study. Dr. Boulder also issued work restrictions of no lifting, pushing or pulling in excess of 10 pounds. He subsequently referred Claimant for additional evaluations and medical treatment. Claimant's treatment with Dr. Boulder and subsequent referrals constituted reasonable and necessary medical

treatment that was designed to cure and relieve the effects of Claimant's May 28, 2008 industrial injuries.

10. Claimant has failed to prove that it is more probably true than not that he suffered a wage loss as a result of the May 28, 2008 incident. Claimant acknowledged that he was paid for his teaching duties until the conclusion of the academic year on July 31, 2008. Ms. A credibly testified that Employer evaluates teachers' performances at the end of every school year and makes decisions about whether they should return for the following academic year. Based on Claimant's substandard job performance issues, Ms. A notified Claimant approximately one week prior to his May 28, 2008 injuries that he would not be asked to return to Employer for the following academic year. Because Employer did not ask Claimant to return to work for the next academic year, he has not established a causal connection between his May 28, 2008 injuries and a wage loss subsequent to August 1, 2008. He is thus not entitled to receive TTD benefits.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §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 determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. As found, Claimant has established by a preponderance of the evidence that he suffered industrial injuries to his back, arms and hands during the course and scope of his employment with Employer on May 28, 2008. Claimant credibly explained that while he was carrying two suitcases of tests and curriculum down a flight of stairs he experienced pain in his back and numbness in his arms and hands. Claimant's account is consistent with his report to Dr. Boulder on the date of the incident. Although Claimant could not identify a specific incident that caused his injuries during his evidentiary deposition, he nevertheless maintained that he suffered an injury on May 28, 2008 that caused back pain. Claimant's credible testimony is thus sufficient to demonstrate that he suffered injuries during the course and scope of his employment with Employer on May 28, 2008.

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 his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

7. As found, Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries. On the date of the incident, Employer referred Claimant to Concentra Medical Centers for treatment. Dr. Boulder determined that Claimant suffered a back strain and "right and left upper extremity sensory disturbances." He prescribed medications, physical therapy and an EMG study. Dr. Boulder also issued work restrictions of no lifting, pushing or pulling in excess of 10 pounds. He subsequently referred Claimant for additional evaluations and medical treatment. Claimant's treatment with Dr. Boulder and subsequent referrals constituted reasonable and necessary medical treatment that was designed to cure and relieve the effects of Claimant's May 28, 2008 industrial injuries.

Temporary Total Disability Benefits

8. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546 (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, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair a claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595, 597 (Colo. App. 1998).

9. As found, Claimant has failed to prove by a preponderance of the evidence that he suffered a wage loss as a result of the May 28, 2008 incident. Claimant acknowledged that he was paid for his teaching duties until the conclusion of the academic year on July 31, 2008. Ms. A credibly testified that Employer evaluates teachers' performances at the end of every school year and makes decisions about whether they should return for the following academic year. Based on Claimant's substandard job performance issues, Ms. A notified Claimant approximately one week prior to his May 28, 2008 injuries that he would not be asked to return to Employer for the following academic year. Because Employer did not ask Claimant to return to work for the next academic year, he has not established a causal connection between his May 28, 2008 injuries and a wage loss subsequent to August 1, 2008. He is thus not entitled to receive TTD benefits.

ORDER

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

1. Claimant suffered compensable injuries to his back, arms and hands during the course and scope of his employment with Employer on May 28, 2008.

2. Respondents are financially responsible for all of Claimant's reasonable and necessary medical treatment that is related to his May 28, 2008 injuries.

3. Claimant's request for TTD benefits is denied.

4. Any issues not resolved by this Order are reserved for future determination.

DATED: December 15, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-746-176

ISSUE

The issue raised for consideration at hearing is compensability.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant was employed by North Suburban Medical Center as a staff registered nurse in the neonatal department on December 28, 2007 when she aggravated her pre-existing low back condition. Claimant's job involved attending to premature babies and well babies, and she typically worked the 7 a.m. to 7 p.m. shift.

2. Claimant credibly testified that on Friday, December 28, 2007 she was in the supply room preparing to restock cribs for the next shift. Claimant also credibly testified that the stock room is extremely narrow making movement in the room difficult. She was in the process of bending over to pick up a bag of diapers for newborns when she experienced a pull in her low back. She yelled out and her co-worker, AW, came to her aid. Ms. W credibly testified that she heard Claimant yell "ow" and asked her what was wrong. Claimant told Ms. W that she had "pulled something in her back." Claimant was holding her back and Ms. W finished stocking the supplies for the next shift. Claimant completed the usual paperwork required at the end of her shift.

3. Claimant also credibly testified that the resupplying and restocking of the cribs for the next shift did involve working in the narrow stock room twisting, bending, and scanning supplies. Claimant was in the act of bending over to access supplies for the cribs when she felt pain in her back.

4. Claimant treated the year before with Dr. Stephen Shogan and underwent surgery on December 12, 2006 to repair her disc at L5-S1. Claimant was released at regular duty on January 31, 2007. The surgery that Dr. Shogan performed at L5-S1 was a microdiscectomy performed to fix Claimant's herniated disc.

5. On January 1, 2008, the Claimant was taken to Rose Medical Center Emergency Department by ambulance for her acute low back pain. Claimant was seen by Dr. Sho-

gan in the Emergency Room on January 2, 2008 and he reported that she was standing and reaching for an object when she experienced the onset of severe pain in her low back. The MRI of January 1, 2008, showed either a residual or recurrent disc herniation at L5-S1.

6. Claimant reported to the adjuster in this matter, Monica Westlund, on January 9, 2008 that she was bending down to pick up supplies when she experienced pain in her low back. Further, Claimant completed a form for the adjuster asking what had caused her injury, and she reported that she was bending over.

7. Claimant underwent a second surgery by Dr. Stephen Shogan to her L5-S1 disc on January 3, 2008. Dr. Shogan noted the procedure to be a "re-do right-sided L5-S1 disc excision." The pre-operative diagnosis was a recurrent herniated disc at L5-S1 and the post-operative diagnosis was a recurrent herniated disc at L5-S1. Claimant continued to see Dr. Shogan for treatment after the surgery and he noted on April 8, 2008 that the Claimant had been asymptomatic with regard to her lumbar spine since her surgery in 2006 until she was at work and began to experience significant low back pain. Dr. Shogan concluded that it would be "entirely possibly" that the Claimant's most recent disc herniation occurred at work

8. Claimant saw Dr. John Hughes at the request of Respondents for an independent medical evaluation on April 30, 2008. Dr. Hughes concluded that Claimant had sustained a natural progression of her pre-existing lumbar spondylosis post-hemilaminotomy and discectomy at L5-S1. Dr. Hughes testified further at hearing that it is more common for a recurrence of a disc herniation after a microdiscectomy procedure. Dr. Hughes's testimony was found less credible than the testimony of the Claimant with regard to whether her injury arose out of her employment.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 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 by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), C.R.S.; *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 truer 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 the favor of the rights of 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 that is disposi-

tive 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 witnesses' 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 interests. *See Prudential Insurance Co. v. Cline,* 98 Colo. 275, 57 P.2d 1205 (1936)

4. An injury is compensable if it "arises out of" and "in the course of" employment. Section 8-41-301, C.R.S.; *Price v. Industrial Claims Appeals Office of the State of Colo.,* 919 P.2d 207 (Colo. 1996). The "course of employment" requirement is satisfied when it is shown that the injury occurred within the time and place limits of the employment relationship. However, the "arising out of" requirement is narrower than the course of employment, and is a test of causation which requires that the injury have its origin in an employees work related function and be sufficiently related thereto so as to be considered part of the employees' service to the employer. *Gutierrez v. Wal-Mart Store, Inc*., (W.C. # 4-432-838) (November 30, 2000). The determination of whether there is a sufficient causal relationship between the Claimant's employment and the injury is one of fact, which the ALJ must determine, based on the totality of the circumstances. *Gutierrez, supra, citing, In re question submitted by the U.S. Court of Appeals*, 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Company v. Del Valle*, 934 P.2d 861 (Colo. App. 1996).

5. Special rules apply in the event an injury is "precipitated" by some preexisting condition brought by the claimant to the workplace. Where the precipitating cause of an injury is a pre-existing condition suffered by the claimant, the injury is not compensable unless a "special hazard" of the employment combines with the pre-existing condition to cause or increase the degree of injury. *See National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 763 (Colo. App. 1992). This principle is known as the "special hazard" rule. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989). In addition, to be considered an employment hazard for this purpose, the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered. *See Ramsdell v. Horn* 781 P.2d 150 (Colo. App. 1989) (high scaffold constituted special employment hazard to worker who suffered epileptic seizure and fell); *Gates Rubber Co. v. Industrial Commission, supra* (hard level concrete floor not special hazard because it is a condition found in many non-employment locations). The rationale for this rule is that unless a special hazard of employment increases the risk or extent of injury, an injury due to the claimant's pre-existing condition does not bear sufficient causal relationship to the employment to "arise out of" the employment. *Gates v. Rubber Co. v. Industrial Commission*, 705 P.2d 6 (Colo. App.

1985); *Gaskins v. Golden Automotive Group, L.L.C.,* W.C. No. 4-374-591 (August 6, 1999) (injury when pre-existing condition caused the claimant to stumble on concrete stairs not compensable because stairs were ubiquitous condition).

6. In this case, the special hazard rule, described above, does not have application. Here, Claimant's injury arose out of her employment to the extent that Claimant aggravated her pre-existing condition while performing the action of bending over in the narrow supply room to reach for supplies for the cribs, an action which was required by her employment.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for Claimant's compensable work injury of December 28, 2007 to her back.

All matters not determined herein are reserved for future determination.

DATED: December 16, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-749-423

ISSUES

The following issues were raised for consideration at hearing:

1. Whether the Respondents shall have the right to withdraw their Admission of Liability;

2. Temporary total disability benefits (TTD) from March 22, 2008, through August 24, 2008; and

3. Medical benefits, reasonable and necessary.

FINDINGS OF FACT

Having reviewed the evidence presented at hearing and the parties post hearing position statements, the following Findings of Fact are entered.

1. Claimant is a fifty-four (54) year old married engineer with two children who began working as a project manager for Employer in June 2008. Employer was in the business of doing the cement structural frame for commercial buildings. The particular building for which Claimant was hired was scheduled to have three (3) stories underground and eight (8) stories above ground. Claimant testified and Respondents' General Admission admits that Claimant's average weekly wage is $1,515.

2. Prior to Claimant's work injury, which is the subject of this claim on October 15, 2007, Claimant led an active lifestyle both on the job and off the job. He typically arose around 5:00 a.m. and went to the gym, which opened at 5:30 a.m. At the gym, Claimant exercised, including walking on a treadmill. Thereafter he would return home, have breakfast with his family, and then go to work. After work and on weekends, he recreated including long walks with his family, hikes in the mountains, mountain biking, skiing, and other recreational activities.

3. On October 15, 2007, Claimant was attempting to move a concrete stressing machine weighing approximately one hundred (100) pounds from the back of his SUV to a pickup truck. During the process of moving this concrete stressing machine, he felt a pull in his back and began to experience low-level back pain. Claimant did not report this to his supervisor because he assumed he would improve with time. Additionally, Claimant had been told by one of the owners of Employer that there were too many employees complaining of work injuries and claiming workers' compensation benefits. At a later meeting, the safety manager of the Employer told Claimant that when someone had a work injury, as soon as the workers' compensation process was completed, the Employer let the employee go.

4. After his work injury of October 15, 2007, Claimant continued to exercise and stretch in the mornings and he continued to work. Claimant's condition, however, gradually worsened. On November 13, 2007, Claimant saw his private doctor, Dr. John Hudson, complaining of an earache. At that time, Claimant mentioned he was experiencing some low-back pain and that the onset of the pain had been approximately a week before. Claimant testified that the conversation with Dr. Hudson about his back and the onset of disability was an after thought and that the doctor did not ask him how he had hurt his back. Nor did Dr. Hudson offer any treatment for Claimant's back. Claimant credibly testified that he made a mistake about his onset of disability. The mistake was premised on several factors including: the seeming insignificance of the back pain, the lack of any immediate need for treatment, the extremely busy schedule Claimant kept, and the fact that with aging the Claimant compressed time.

5. Claimant's back pain continued to gradually worsen. Claimant continued to go to the gym and stretch and exercise every morning, but his after work walks with his family got shorter and shorter. Claimant had customarily

purchased a ski pass, but did not in the fall of 2007 because of increasing back pain.

6. In early January 2008 during one of his regular morning workouts, at a period of time when his pain had increased to the point where it was very bothersome, he was walking on the treadmill trying to loosen up. A few minutes into his workout on the treadmill, Claimant realized that his pain and stiffness was not loosening up. The pain was significant enough that Claimant stopped his workout. Thereafter he made an appointment with his private doctor, Dr. Kevin Boehm, whom he saw on January 16, 2008. Dr. Boehm's medical note of January 16, 2008, indicates that the onset of the pain was four (4) months ago (i.e. October 2007), that the severity level was seven (7), that it occurred occasionally, and that the problem was worsening.

7. Dr. Boehm referred Claimant for a lumbar spine MRI, which took place on January 28, 2008. The MRI note indicates the onset of disability as October 2007. The MRI demonstrated significant multi-level problems. The radiologist asked Claimant, for the first time, what had caused his onset of disability. When Claimant explained that the onset occurred while moving a concrete stressing machine for his job, the radiologist advised him to immediately notify his Employer.

8. When Claimant notified his employer of his work injury, his Employer wanted to know the exact date. In order to designate the exact date, Claimant credibly testified that he reviewed records he kept in his desk to pinpoint the time he moved the concrete stressing machine. Based on those records, Claimant pinpointed October 15, 2007 as the exact date of his onset of disability. The Respondents filed a General Admission of Liability on February 11, 2008, admitting for medical benefits.

9. Claimant was seen at Employer's designated clinic, Mile Hi Occupational Medicine, which later merged with Concentra, on the same day he reported his injury, January 29, 2008. Claimant was prescribed Darvocet and was advised to take "precaution on safety sensitive activities while taking pain meds". Ongoing medical records from Mile Hi Occupational Medicine indicated Claimant was working "most" of his regular duties but felt unsteady on ladders. On February 22, 2008, he was given a restriction advising "minimal use of ladders".

10. Claimant was slow in his job performance because of his pain medications and his pain. The restriction of only minimal use of ladders made Claimant's job difficult to perform adequately since ladders were the only method of getting from deck to deck in the unfinished project he was in charge of. When Claimant missed work in order to get authorized epidural steroid injections (ESI), his supervisor was unhappy with him and left Claimant with the perception that Claimant was expected to return to work immediately after getting the injection. Claimant was given ESI on February 1, 2008; February 7, 2008; February 15, 2008; and March 13, 2008. Dr. Robert Kawasaki gave Claimant written instructions to be

driven to the office for each injection and then to be driven home from the office after each injection.

11. On March 21, 2008, seven (7) days after his fourth ESI, Claimant was laid off with the single explanation that the Employer was going in a "different direction". Claimant testified that he believed that his lay off was due to his slower speed at work, his restrictions regarding ladders, and the amount of time he had to miss work as a result of his ESI's. Based on the totality of the evidence, it is found and concluded that Claimant's termination was due to his diminished job performance caused by his work injury.

12. Claimant applied for and received unemployment benefits at the rate of $450 per week beginning April 6, 2008. Unemployment benefits continued until August 22, 2008, at which time the Claimant was re-employed. Claimant's new employment paid him a higher AWW than he was earning at Employer, so Claimant was no longer suffering a wage loss as of August 25, 2008.

13. Claimant's daughter credibly testified at hearing corroborating Claimant's testimony about his limitations on recreational activities with his family.

14. Claimant was seen by various doctors through the workers' compensation system. Dr. Andrew Castro saw Claimant for a surgical consultation. In Dr. Castro's last note of June 12, 2008, Dr. Castro commented that the Claimant was still having some ongoing back and leg pain, which he describes as "intolerable, and difficulty getting around." . . . Dr. Castro continued that "because of the advanced nature of the degenerative changes in his lumbar spine, correction of all these problems may entail one or two levels of fusion as I am not sure a decompressive procedure could fully alleviate the foraminal stenoses."

15. Claimant was then seen for a psychological examination by Dr. Ron Carbaugh on June 25, 2008. Dr. Carbaugh noted that "Mr. Clark would be considered a fair surgical candidate".

16. Prior to embarking on a surgical course of action, Claimant was seen for a second opinion by Dr. David Wong on July 3, 2008. In Dr. Wong's evaluation, Dr. Wong stated: "Patient dates onset of his present difficulties to an incident which occurred 10/5/07 [sic]. He was apparently dragging a one hundred twenty (120) pound stress machine from one vehicle to another when he noted onset of low back pain. His symptoms were exacerbated around 1/08 possibly related to working out on a treadmill. . . ."

17. After receiving Dr. Wong's second opinion report indicating Claimant's symptoms were possibly exacerbated by working out on the treadmill, Respondents filed an Application for Hearing on July 23, 2008, seeking to withdraw their admission of liability.

18. The medical note of Dr. Matt Miller dated July 14, 2008, indicated "we did place the patient on work restriction. We have not had him on restrictions but he is reporting that he has tried to find work but cannot work secondary to the pain." Claimant's new work restriction was "no lifting over 15 pounds".

19. On September 25, 2008, Brian Lambden, M.D., performed an independent medical evaluation (IME) on Claimant at Respondents' request. Dr. Lambden's IME report indicated the Claimant told him about the worsening of symptoms that occurred in January 2008 while working on a treadmill. Dr. Lambden characterized it in his note as a severe increase in back pain. Dr. Lambden's IME noted that Claimant stated his low back pain was variable and "waxes and wanes". The IME characterized the Claimant as being "pleasant and cooperative" with "no obvious pain behaviors" and "no positive non-organics". Dr. Lambden's Medical Summary Opinion as set forth in paragraph four of his IME was that Claimant had suffered a "Work-related incident 10/15/07 when he reports lifting a 120 pound stress analysis machine with mild lumbar strain and then gradually increasing low back pain over the next several months."

20. Dr. Lambden testified that although it was possible to suffer an injury while walking on a treadmill, that an injury such as Claimant's was more likely to happen as described by the Claimant in the stress machine lifting incident of October 15, 2008. Dr. Lambden commented on Page 9 of his IME report that "if I was going to relate pathology to his recent incident [the October 13, 2007, injury], I would relate it to his L1-2 disc protrusion." In the Recommendations Section of his IME, Dr. Lambden did not state that no treatment should be rendered since the claim was not a work-related injury. Instead he recommended "more aggressive exercise to include some form of aerobic exercise, as well as lumbar stabilization." He also indicated "if symptoms are not improving over the next 4 to 6 months, I would consider decompression of the right L1, L2 nerve roots." It is clear based on both the testimony and the IME report of Dr. Lambden, that Dr. Lambden did not consider the treadmill incident to be an intervening injury. In fact, in his testimony and his report, Dr. Lambden's opinion was that walking and exercise was the best thing that Claimant could be doing for his back injury.

21. Dr. Lambden did not have the medical records of Dr. Hudson and Dr. Boehm at the time he examined the Claimant and then dictated his IME report. When questioned regarding the onset of disability dates referenced in the medical records of Dr. Boehm and Dr. Hudson, Dr. Lambden stated his opinion that the date discrepancy could be significant and that it was unusual to have such a date discrepancy. He also testified that it was unusual to not ascribe a cause to the onset of the disability.

22. Dr. John Burris, one of Claimant's treating doctors at Concentra, indicated in his report of October 21, 2008, that he felt the inconsistency in onset of disability dates in the medical notes of Dr. Hudson and Dr. Boehm was significant and he would expect the cause of the disability would have been passed

along to the primary care physician at the initial visit on November 13, 2007, and at the follow up two (2) months later on January 16, 2008. Dr. Burris did not ascribe any importance to the supposed treadmill incident as an intervening cause.

23. Claimant was seen by Dr. David Yamamoto for an IME requested by Claimant on September 9, 2008. Dr. Yamamoto commented in his report, "It is my opinion that the exacerbation referenced by Dr. Wong in his July 3, 2008, report was of minor consequence. The main injury clearly is the October 15, 2007, injury, as prior to this time he was having essentially no problems with his lower back. I am frankly quite surprised at the opinion of the insurance carrier to deny treatment based on a normal activity of walking on a treadmill that has had, in my opinion, minimal to no impact on this case".

24. Based on Claimant's credible testimony and the medical records, it is found and concluded that Claimant did not suffer an intervening event in January 2008 when he was walking on the treadmill. Claimant injured himself on October 15, 2007 when he was removing a concrete stressing machine from his vehicle. The injury progressed and worsened in the ensuing months to the point that it became debilitating in January 2008. Since there was not intervening event that caused Claimant's injury, Respondents are not entitled to withdraw the admission of liability.

25. Claimant is entitled to reasonably necessary and related medical benefits to cure and relieve him of the effects of the October 15, 2007 work injury. Respondents shall be liable for this medical treatment.

26. Claimant is further found to be entitled to indemnity benefits during the period of disability commencing March 22, 2008 and continuing to August 24, 2008 when he found employment. Claimant was not responsible for his wage loss during this period. To the contrary, it is found that his employment was terminated because of his work injury and the resulting loss of Claimant's ability to perform his job duties.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 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 by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), C.R.S.; *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 truer 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 the favor of the rights of 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 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 witnesses' 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 interests. *See Prudential Insurance Co. v. Cline,* 98 Colo. 275, 57 P.2d 1205 (1936)

4. Respondents contend that the evidence establishes that Claimant's treadmill workout in January 2008 caused his back injury and constitutes an efficient intervening cause severing the causal connection between the October 15, 2007 work injury and the claimant's need for workers' compensation benefits. All results flowing proximately and naturally from an industrial injury are compensable. *See Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622(1970). However, no compensability exists when a later accident or injury occurs as the direct result of an independent intervening cause. *Post Printing & Publishing Co. v. Erickson,* 94 Colo. 382, 30 P2d 327 (1934). Whether a particular condition is the result of an independent intervening cause is a question of fact for resolution by the ALJ. *See Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

5. In this case, the credible and persuasive evidence presented through the testimony of Claimant, his daughter, and the medical records, it is found an concluded that Claimant did not suffer an efficient intervening injury in January 2008 and therefore there is no basis to grant Respondents' request to withdraw its admission of liability.

6. The respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988).

7. Claimant is entitled to reasonably necessary and related medical benefits to cure and relieve him of the effects of the October 15, 2007 work injury. Respondents shall be liable for this medical treatment.

8. To obtain TTD benefits, a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 639 (Colo. App. 1997). A claimant must establish a causal connection between a work-related injury and a subsequent wage loss. Section 8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546, 546 (Colo. 1995). The term "disability" connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earnings capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.,* 964 P.2d 595, 597 (Colo. App. 1998).

9. Claimant established that he was disabled from his usual employment commencing March 22, 2008 and continuing to August 24, 2004. Claimant's separation from employment with the Employer was shown to be due to his failure to perform his job to the pre-injury level. Claimant's disability continued to August 24, 2008 when he found employment.

ORDER

It is therefore ordered that:

1. Respondents' motion to withdraw its admission of liability is denied.
2. Respondents shall be liable for reasonably necessary and related medical benefits for the October 15, 2007 work injury
3. Respondents shall be liable to Claimant for TTD from March 22, 2008 to August 24, 2008.

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: December 16, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-701-864

ISSUES

The sole issue determined herein is maximum medical improvement ("MMI"). The parties stipulated to medical benefits and to an average weekly wage of $905.77

FINDINGS OF FACT

1. In June 2006, claimant began work for the employer as a laborer.

2. On October 15, 2006, claimant sustained an admitted industrial left foot crush injury and a right ankle fracture when a piece of machinery ran over his legs.

3. On October 15, 2006, claimant underwent an open reduction internal fixation ("ORIF") of bimalleolar fracture of the right ankle by Dr. Steven Waskow.

4. On October 16, 2006, claimant underwent a closed reduction, external fixation of the left foot third, fourth, and fifth tarsometatarsal fracture dislocations, closed reduction, external fixation of left foot comminuted cuboid fracture, lateral column injury by Dr. John Shank.

5. Dr. Shank continued to care for claimant's right ankle and left foot injuries up to and including October 7, 2008.

6. On November 6, 2006, claimant underwent an ORIF of the left comminuted cuboid fracture, ORIF of left third tarsometatarsal fracture dislocation, ORIF of left fourth tarsometatarsal fracture dislocation, ORIF of left fifth tarsometatarsal fracture dislocation, allograft bone graft of the left cuboid fracture and revision external fixation of the left mid-foot fracture dislocation by Dr. Shank.

7. On January 11, 2007 claimant underwent deep hardware removal of the left foot lateral column K-wires, including the third, fourth and fifth tarsometatarsal wires by Dr. Shank.

8. On March 20, 2007, in a letter to claims adjuster for Gallagher Bassett Services, Inc., Amy Funderburk, Dr. Shank noted that claimant had a very severe injury to his lateral column, which might lead to eventual arthritis and arthrosis of his lateral column.

9. On April 19, 2007, claimant underwent deep K-wire removal of the left foot due to one loose K-wire causing deep-seated pain adjacent to the cuboid.

10. On June 22, 2007, claimant came under the care of Dr. Darrell Quick and Concentra Medical Centers for primary occupational physician management.

11. On October 30, 2007, Dr. Shank reexamined claimant, who complained of painful hardware bilaterally and requested hardware removal. Bilateral foot and ankle radiographs demonstrated healed fractures with some mid-foot and Lisfranc arthrosis about the left foot.

12. On November 28, 2007, claimant underwent hardware removal of his left foot by Dr. Shank.

13. On December 14, 2007, in a letter to Ms. Funderburk, Dr. Shank determined that claimant was at MMI. Dr. Shank did not anticipate any future treatment with regard to claimant's right ankle, other than the yearly office visits and radiographs to assess his progress. As to claimant's left foot, Dr. Shank indicated that possible future anticipated care included left foot arthrodesis with realignment, in addition to the yearly office visits and radiographs to assess his progress.

14. On December 18, 2007, Dr. Shank noted that radiographs showed "significant degenerative changes" noted about the left foot and early arthritic changes about the right ankle.

15. On January 14, 2008, claimant was seen by Dr. Quick and was placed at MMI, with 5% right lower extremity impairment and 4% left lower extremity impairment. Dr. Quick recommended post-MMI medical treatment in accordance with Dr. Shank's recommendations, including surgical after care, annual x-rays, and possible left foot fusion in the future. Dr. Quick ordered a Functional Capacity Evaluation ("FCE") to clarify permanent work restrictions.

16. The FCE on February 8, 2008, determined that claimant could work in a heavy level of work, walking and standing intermittently or as tolerated, crawling as tolerated, kneeling infrequently to occasionally, guarded working on a ladder, and occasional climbing stairs.

17. On February 11, 2008, Dr. Quick recommended permanent restrictions in accordance with the FCE.

18. On February 15, 2008, Dr. Shank reexamined claimant and noted that he had healed completely with no new complaints and was doing well. Dr. Shank released claimant to activity as tolerated and to follow up in October 2008 for radiographs of his right ankle and left foot.

19. In mid-February 2008, claimant began working for the U.S. Post Office as a rural carrier associate. His job duties consist of collecting, assembling, and distributing mail. He must stand and walk intermittently for 2½ to 5 hours per day to collect and assemble. He then must distribute the mail, which consists of intermittent walking and driving while getting in and out of his mail truck the remaining 3 to 4 hours per day. His job duties require him to lift 20 to 30 pounds. He has worked with no restrictions during his entire employment with the U.S. Post Office. Claimant is not taking pain medication.

20. On May 22, 2008, pursuant to claimant's request, he underwent a Division Independent Medical Examination ("DIME") with Dr. Linda Mitchell. Claimant's chief complaint was left foot pain and right ankle pain. On physical examination, his right ankle was without effusion, tenderness, or crepitus with no lateral or medial instability. Claim-

ant's left foot was without tenderness or crepitus and had trace edema present. There was no lateral or medial hindfoot instability. There was negative drawer sign and claimant had no tenderness or deformity of the MTP joints bilaterally. Claimant's stance revealed flattening of the medial arches, right greater than left. His gait was slightly broad-based, but not antalgic. He was able to do a deep squat to the floor. His heel walking, toe walking and tandem gait were normal. Romberg was negative.

21. Dr. Mitchell diagnosed right distal tibia/fibula fracture and left second and third metatarsal fractures, third, fourth and fifth tarsometatarsal dislocations and cuboid fracture. Dr. Mitchell found claimant to be at MMI as of February 11, 2008, for his right ankle and left foot fractures, finding a 9% right lower extremity impairment and a 12% left lower extremity impairment. Dr. Mitchell agreed with Dr. Shank that claimant's development of arthritis/arthrosis would require arthrodesis at some point in the future. Dr. Mitchell recommended that claimant be able to see Dr. Shank as needed for follow-up. Otherwise, no other maintenance care was indicated.

22. On June 19, 2008, the insurer filed a final admission of liability for the permanent disability benefits and for post-MMI medical benefits.

23. Claimant did not seek treatment for his right ankle and left foot fractures again until October 7, 2008, when he was seen in follow-up with Dr. Shank for repeat evaluation of his left Lisfranc fracture, dislocation of lateral column injury. Dr. Shank noted that claimant continued to have global pain mostly localized to the third, fourth and fifth tarsal metatarsal joints and a component of second tarsal metatarsal joint pain as well. Radiographs taken that day demonstrated significant end-stage arthritic changes about the second, third, fourth and fifth tarsal metatarsal joint. Dr. Shank diagnosed claimant with end-stage post-traumatic Lisfranc arthritic changes with gastroc equines, and offered claimant the option to undergo arthrodesis to relieve the pain symptoms of his arthritic condition.

24. On October 13, 2008, Dr. Shank requested authorization for left foot gastroc slide Lisfranc arthrodesis, possible tibial/calcanial autograft, and fourth and fifth tarsal metatarsal steroid injection for end-stage post-traumatic Lisfranc arthritic changes.

25. Claimant noted that he has developed balance problems due to his left foot injury.

26. Claimant has failed to prove by clear and convincing evidence that the MMI determination by the DIME, Dr. Mitchell, is incorrect. Dr. Shank, Dr. Quick, and Dr. Mitchell all determined that claimant was at MMI for his admitted work injury. Claimant did not introduce any conflicting medical record evidence. Dr. Shank, Dr. Quick, and Dr. Mitchell all noted the possibility of future left foot fusion surgery. The insurer admitted liability for the surgery. Claimant has not alleged a change of condition since MMI. He has not demonstrated that it is highly probable that Dr. Mitchell was incorrect in determining MMI on February 11, 2008. Claimant might disagree with that determination, but the record evidence does not come close to meeting the high burden of proof placed on claimant to challenge the MMI determination by the DIME.

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. Mitchell, determined that claimant was at MMI on February 11, 2008. 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 the MMI determination by Dr. Mitchell is incorrect. Consequently, pursuant to section 8-42-105(3)(a), C.R.S., claimant is not entitled to any additional TTD benefits. Claimant did not file a petition to reopen and that issue is not addressed.

ORDER

It is therefore ordered that:

1. Claimant's request for additional periods of TTD benefits is denied and dismissed.
2. The insurer shall pay for the left foot surgery requested by Dr. Shank.
3. The insurer shall pay benefits for all admitted periods of time based upon an average weekly wage of $905.77.

DATED: December 17, 2008

Martin D. Stuber
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-513-392

ISSUES

1. Whether Claimant has demonstrated that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his ulcerative colitis condition.

2. Whether Claimant has established by a preponderance of the evidence that he is entitled to recover penalties for Respondents' failure to timely pay Permanent Partial Disability (PPD) benefits.

FINDINGS OF FACT

1. On August 19, 2001 Claimant suffered an admitted industrial injury to his back during the course and scope of his employment with Employer. On November 3, 2003 he underwent an anterior discectomy and an anterior spinal fusion at the L5-S1 level. On May 19, 2004 Claimant reached Maximum Medical Improvement (MMI) and received a 24% whole person impairment rating.

2. In October 2005 Claimant began to develop recurrent back problems. A discography revealed a positive discogram at the L4-L5 level. On March 11, 2006 Claimant thus underwent a posterior spinal fusion at the L4-L5 level. Although Claimant's back condition improved after surgery, he continued to experience recurrent left-sided low back pain that radiated into his left leg.

3. Claimant testified that subsequent to his March 11, 2006 surgery he developed constipation and required laxatives to treat his condition. During August 2006 his constipation worsened and he began to experience abdominal pain. On August 16, 2006 Claimant was diagnosed with ulcerative colitis. He underwent an abdominal colectomy and ileostomy on August 17, 2006 for his condition. Although the procedures provided temporary relief, his colitis symptoms returned. Claimant subsequently underwent additional procedures to relieve his colitis symptoms.

4. On August 3, 2007 Claimant again reached MMI. He received a 16% whole person impairment after subtracting his previous rating.

5. On March 4, 2008 Claimant underwent a Division Independent Medical Examination (DIME) with Scott A. Burke, M.D. Dr. Burke agreed that Claimant had reached MMI and assigned a 28% whole person impairment rating. The impairment included a 15% rating based on diagnostic specific disorders as a result of Claimant's two back surgeries. Claimant's impairment also included a 15% rating based on range of motion deficits.

6. Dr. Burke specifically considered Claimant's ulcerative colitis condition but did not assign Claimant an impairment rating for the condition. Dr. Burke commented that Claimant suffered constipation shortly after his surgery but his symptoms resolved. Claimant then developed colitis at a later date. Dr. Burke also stated that Claimant's doctors had been unable to ascertain the cause of the ulcerative colitis. He concluded that Claimant suffered from colitis with an unknown etiology.

7. On May 14, 2008 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Burke's 28% whole person impairment rating. The FAL specifically noted "Claimant previously paid $50,001.56 in PPD benefits. No further PPD benefits due."

8. On June 4, 2008 the Division of Workers' Compensation (DOWC) sent a letter to Insurer regarding Insurer's PPD calculation. The letter stated that, because Claimant was a minor at the time of his industrial injury, his PPD benefits required a recalculation. The DOWC mailed additional correspondence to Insurer about the matter on June 27, 2008 and July 1, 2008.

9. On June 17, 2008 Claimant filed an application for a lump sum payment of his PPD benefits. On July 2, 2008, based on a recalculation, Insurer paid Claimant lump sum PPD benefits in the amount of $55,279.95. On July 3, 2008 Insurer filed an amended FAL based on the recalculation of PPD benefits.

10. Insurer sent the PPD payment directly to Claimant's old address. However, Claimant instructed Insurer to stop payment on the check and issue a new check in the care of his attorneys. In accord with Claimant's instructions, Insurer issued a new PPD check on July 15, 2008 directly to Claimant's attorneys.

11. On August 1, 2008 Claimant filed an objection to the amended FAL and an application for hearing. Claimant requested the payment of medical benefits related to his ulcerative colitis condition and sought penalties for Insurer's failure to timely pay his PPD benefits.

12. Claimant has failed to demonstrate that he is entitled to reasonable and necessary medical treatment to cure and relieve the effects of his ulcerative colitis condition. DIME physician Dr. Burke determined that Claimant suffered a

28% whole person impairment rating. The impairment included a 15% rating based on diagnostic specific disorders and a 15% rating based on range of motion deficits. However, Dr. Burke concluded that Claimant suffered from colitis with an unknown etiology and did not assign him an impairment rating for the condition. His determination constituted a part of his diagnostic assessment that comprises the DIME process. Dr. Burke's impairment rating is thus entitled to deference and must be overcome by clear and convincing evidence. Although Claimant attributed his ulcerative colitis to his March 11, 2008 spinal fusion surgery, the ulcerative colitis did not begin until approximately five months after the surgery and he has failed to present any medical evidence demonstrating a causal connection between his colitis and his surgery. Claimant's testimony is thus simply insufficient to overcome Dr. Burke's determination by clear and convincing evidence. Because Claimant's ulcerative colitis condition was not caused by his industrial injury, he is not entitled to medical benefits to treat the condition.

13. Claimant has failed to prove that it is more probably true than not that he is entitled to recover penalties pursuant to §8-43-304(1), C.R.S. and WCRP 5-6(c) for Respondents' failure to timely pay PPD benefits. WCRP 5-6(c) is inapplicable because Insurer's initial FAL did not award PPD benefits. The May 14, 2008 FAL specifically noted "Claimant previously paid $50,001.56 in PPD benefits. No further PPD benefits due." Because the FAL did not specifically award additional PPD benefits, WCRP 5-6(c) did not require payment of PPD benefits within five days. Furthermore, even if Respondents' somehow violated WCRP 5-6(c) in the May 14, 2008 calculation of PPD benefits, Claimant has failed to demonstrate that any deficiency in the initial calculation was objectively unreasonable. Therefore, Claimant is not entitled to recover penalties pursuant to §8-43-304(1), C.R.S. for a violation of WCRP 5-6(c).

14. Claimant has failed to establish that it is more probably true than not that he is entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S. for Respondents' failure to timely pay TPD benefits. On June 4, 2008 the DOWC sent a letter to Insurer regarding Insurer's PPD calculation. The letter stated that, because Claimant was a minor at the time of his industrial injury, his PPD benefits required a recalculation. Based on the DOWC's letter, Insurer had notice that a recalculation of PPD benefits was required. Insurer subsequently recalculated Claimant's PPD benefits and paid Claimant lump sum PPD benefits in the amount of $55,279.95 on July 2, 2008. However, because Insurer sent the PPD payment directly to Claimant's old address, Claimant instructed Insurer to stop payment on the check and issue a new check in the care of his attorneys. In accord with Claimant's instructions, Insurer issued a new PPD check on July 15, 2008 directly to Claimant's attorneys. The chronology of events reveals that Insurer paid Claimant additional PPD benefits in accord with the DOWC's notice within 30 days as required by §8-43-401(2)(a), C.R.S. Although the payment was made to Claimant's old address, Claimant has failed to demonstrate that Insurer acted with deliberate intent and willfully withheld the payment of PPD bene-

fits by mailing the payment to an incorrect address. Claimant is thus not entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S.

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. 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 (2005).

Medical Benefits

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). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

5. 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 DIME physician's determination that Claimant's ulcerative colitis condition was not included in his overall impairment "constituted a part of the diagnostic assessment that comprises the IME process." *See Qual-Med, Inc.,* 961 P.2d at 592.

6. As found, Claimant has failed to demonstrate that he is entitled to reasonable and necessary medical treatment to cure and relieve the effects of his ulcerative colitis condition. DIME physician Dr. Burke determined that Claimant suffered a 28% whole person impairment rating. The impairment included a 15% rating based on diagnostic specific disorders and a 15% rating based on range of motion deficits. However, Dr. Burke concluded that Claimant suffered from colitis with an unknown etiology and did not assign him an impairment rating for the condition. His determination constituted a part of his diagnostic assessment that comprises the DIME process. Dr. Burke's impairment rating is thus entitled to deference and must be overcome by clear and convincing evidence. Although Claimant attributed his ulcerative colitis to his March 11, 2008 spinal fusion surgery, the ulcerative colitis did not begin until approximately five months after the surgery and he has failed to present any medical evidence demonstrating a causal connection between his colitis and his surgery. Claimant's testimony is thus simply insufficient to overcome Dr. Burke's determination by clear and convincing evidence. Because Claimant's ulcerative colitis condition was not caused by his industrial injury, he is not entitled to medical benefits to treat the condition.

Penalties

7. Section 8-43-304(1), C.R.S. is a general penalty provision under the Act that authorizes the imposition of penalties up to $500 per day where a party violates a statute, rule, or lawful order of an ALJ. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 705, 706 (Colo. 2001). The term "order" as used in §8-43-304 includes a rule or regulation promulgated by the Director of the DOWC. §8-40-201(15), C.R.S.; *see Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176, 177 (Colo. App. 2002). WCRP 5-6(c) governs the payment of PPD benefits. The Rule provides, in relevant part, "[p]ermanent disability benefits awarded by admission are retroactive to the date of maximum medical improvement and shall be paid so that the claimant receives the benefits not later than 5 calendar days after the date of the admission."

8. The imposition of penalties under §8-43-304(1) requires a two-step analysis. *See In re Hailemichael,* W.C. No. 4-382-985 (ICAP Nov. 17, 2004). The ALJ 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 ALJ 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 an insurer'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).

9. As found, Claimant has failed to prove by a preponderance of the evidence that he is entitled to recover penalties pursuant to §8-43-304(1), C.R.S. and WCRP 5-6(c) for Respondents' failure to timely pay PPD benefits. WCRP 5-6(c) is inapplicable because Insurer's initial FAL did not award PPD benefits. The May 14, 2008 FAL specifically noted "Claimant previously paid $50,001.56 in PPD benefits. No further PPD benefits due." Because the FAL did not specifically award additional PPD benefits, WCRP 5-6(c) did not require payment of PPD benefits within five days. Furthermore, even if Respondents' somehow violated WCRP 5-6(c) in the May 14, 2008 calculation of PPD benefits, Claimant has failed to demonstrate that any deficiency in the initial calculation was objectively unreasonable. Therefore, Claimant is not entitled to recover penalties pursuant to §8-43-304(1), C.R.S. for a violation of WCRP 5-6(c).

10. Section 8-43-401(2)(a), C.R.S. is a specific penalty provision in the Act that authorizes the imposition of a penalty equal to ten percent of wrongfully withheld benefits "[i]f any insurer . . . willfully withholds permanent partial disability benefits within thirty days of when due." Penalties may be imposed pursuant to §8-43-401(2), C.R.S. even if penalties are also available under §8-43-304(1), C.R.S. *Holliday v. Bestop Inc.,* 23 P.3d 700, 706-07 (Colo. 2001).

11. Under §8-43-401(2)(a), C.R.S. "willful" is conduct that is the result of "deliberate intent" and "wrongful" means "unlawful or unjust action." *Miller v. Industrial Claim Appeals Office,* 49 P.3d 334, 336 (Colo. App. 2001). If an Insurer acts reasonably under the circumstances, its conduct is neither willful nor wrongful. *See In re Martin,* W.C. No. 4-453-804 (ICAP, Oct. 10, 2004). The question of whether a party's conduct was reasonable is a factual determination for the ALJ. *Miller,* 49 P.3d at 337.

12. As found, Claimant has failed to establish by a preponderance of the evidence that he is entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S. for Respondents' failure to timely pay PPD benefits. On June 4, 2008 the DOWC sent a letter to Insurer regarding Insurer's PPD calculation. The letter stated that, because Claimant was a minor at the time of his industrial injury, his PPD benefits required a recalculation. Based on the DOWC's letter, Insurer had notice that a recalculation of PPD benefits was required. Insurer subsequently recalculated Claimant's PPD benefits and paid Claimant lump sum PPD benefits in the amount of $55,279.95 on July 2, 2008. However, because Insurer sent the PPD payment directly to Claimant's old address, Claimant instructed Insurer to stop payment on the check and issue a new check in the care of his attorneys.

In accord with Claimant's instructions, Insurer issued a new PPD check on July 15, 2008 directly to Claimant's attorneys. The chronology of events reveals that Insurer paid Claimant additional PPD benefits in accord with the DOWC's notice within 30 days as required by §8-43-401(2)(a), C.R.S. Although the payment was made to Claimant's old address, Claimant has failed to demonstrate that Insurer acted with deliberate intent and willfully withheld the payment of PPD benefits by mailing the payment to an incorrect address. Claimant is thus not entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S.

ORDER

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

1. Claimant's request for medical benefits to cure and relieve the effects of his ulcerative colitis condition is denied.

2. Claimant's request for penalties for Respondents' failure to timely pay PPD benefits is denied.

3. Any issues not resolved in this order are reserved for future determination.

DATED: December 17, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-709-198

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant overcame the impairment rating given by the Division Independent medical examiner (DIME) by clear and convincing evidence; and

2. Whether Claimant is entitled to ongoing maintenance medical care including chiropractic and massage therapy.

FINDINGS OF FACT

Based on the evidence presented at hearing and the parties post hearing position statements, the ALJ makes the following Findings of Fact:

1. Claimant was involved in a compensable industrial motor vehicle accident on September 5, 2006. As a result of such accident, Claimant has not lost any compensable time from work.

2. Claimant's primary care provider is Jim Dudley, M.D. Dr. Dudley referred Claimant to Dr. Tobey and for physical therapy. Dr. Tobey recommended physical therapy, which Claimant declined. Dr. Dudley advised Claimant on July 12, 2007 that workers' compensation would not pay for additional chiropractic care, massage and acupuncture and Claimant "asked for me to write a script so she could pay with her own insurance."

3. Dr. Dudley is not Level II accredited and referred Claimant to Cliff Gronseth, M.D. for an impairment rating. Dr. Gronseth saw the Claimant on December 20, 2007 and agreed she was at maximum medical improvement. Dr. Gronseth noted that Claimant "reports she is improving and yet she presents with significant spine range of motion measurements, seemingly worse than when she first presented to the other physicians. There are no objective neurologic findings on examination…there may be some secondary and tertiary gain issues involved with this claim." Dr. Gronseth provided a rating of 42% as a whole person.

4. A DIME was performed by Justin Green, M.D. on April 21, 2008. Dr. Green agreed with the MMI date of November 14, 2007 and provided Claimant a rating of 28% as a whole person.

5. Respondents filed a Final Admission of Liability on June 12, 2008 admitting to the impairment rating given by the DIME doctor, which amounted to $98,345.27.

6. At the time of hearing, Claimant indicated that she is presently working for a new employer. She continues to see her chiropractor, Dr. Criste, one time per week and also sees a massage therapist in his office one time per week. She has been receiving such care for over two years. Claimant indicated that she still has daily pain and muscle spasms that cause her vertebrae to "come out of place." She is requesting ongoing weekly chiropractic and massage therapy.

7. According to Claimant, her job involves extensive driving and lifting, which causes her back to go into spasms. She complains of daily pain.

8. Claimant was involved in a new motor vehicle accident on November 18, 2008. At that time she was going sixty-five miles per hour and was hit by an-

other vehicle. As a result of such motor vehicle accident she again came under the care of Dr. Criste and additional x-rays were taken.

9. Testimony was presented from the chiropractor, Dr. Criste, who has not received Level II accreditation. Dr. Criste is not familiar with the Medical Treatment Guidelines and indicated that he has a "passing familiarity" with the *AMA Guides to the Evaluation of Permanent Impairment*, Third Edition Revised, (*AMA Guides*). He testified that he has never done an impairment rating for Claimant or any other patient. Dr. Criste acknowledged that he has been seeing the Claimant one time per week for over two years and that a massage therapist in his office has also been treating the Claimant on a weekly basis during that period of time. He indicated that the Claimant is "permanently injured in her spine and has extensive degenerative changes at all levels." He believes that she needs lifetime massage therapy and chiropractic care on a weekly basis.

10. Dr. Criste believes that the Claimant's present job is aggravating the Claimant's condition and causing her to need ongoing treatment. He feels that he actually needs to see her more than one time per week. He is now seeing her for her "severe car accident" which occurred on November 18, 2008 and has sent her for x-rays due to that new accident.

11. Dr. Dudley and Dr. Tobey did not believe that the Claimant required chiropractic and massage therapy. Dr. Tobey had recommended physical therapy, which as was previously noted, Claimant declined. Neither Dr. Gronseth nor Dr. Green has recommended ongoing and weekly massage therapy and chiropractic care.

12. Dr. Criste's opinions were not credited as he is not Level II accredited, his chiropractic opinion about Claimant's condition and need for medical treatment does not carry sufficient weight to overcome the opinions of the DIME, and Dr. Criste, as the provider of the continued treatment Claimant seeks to have ordered, has a pecuniary interest in the outcome of this claim.

CONCLUSIONS OF LAW

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

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 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 by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *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, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' 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 interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJs 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. The Colorado Workers' Compensation Act requires that all physical impairment ratings be performed in accordance with the *AMA Guides*. See 8-42-101(3.7) C.R.S. The DIME's medical impairment rating is binding unless overcome by clear and convenience evidence. *See Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(A) C.R.S. Clear and convincing evidence is that which shows that it is highly probable that the DIME's opinion was incorrect. Whether a DIME physician has correctly applied the *AMA Guide* is a question of fact for determination by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office*, 17 P.3d. 204 (Colo. App. 2002); *McClain Western v. ICAO*, 996 P.2d 263 (Colo. App. 1999).

4. In this case, Claimant failed to sustain her burden of proof by clear and convincing evidence that Dr. Green erred in providing his rating. Neither the testimony of Dr. Criste nor the testimony of the Claimant in any way indicated that Dr. Green erred in his performance of the rating or that the rating was not properly provided under the *AMA Guides*. Dr. Criste is a chiropractor and is not Level II accredited. He has not performed any impairment ratings and is not qualified under the statute to provide ratings. In addition he himself admitted he only has a "passing familiarity" with the *AMA Guide*.

5. The ALJ finds that Claimant has presented insufficient evidence to establish any error in the rating provided by Dr. Green. Although Claimant's counsel argued as to the errors in the report of Dr. Green, Claimant did not present any evidence to substantiate that any error was made. Therefore, the ALJ finds that Claimant has failed to overcome the DIME.

6. The ALJ also finds that Claimant has failed to sustain her burden of proof by a preponderance of the evidence that she is entitled to lifetime weekly chiropractic care and massage therapy. The ALJ does not find the testimony of Dr.

Criste to be persuasive. In fact Dr. Criste has indicated that the Claimant's need for ongoing treatment is due to the job activities she is performing in her present job. In addition, she was involved in a "severe" motor vehicle accident on November 18, 2008 for which she is now treating with Dr. Criste.

7. Dr. Dudley and Dr. Tobey did not believe that the Claimant required chiropractic and massage therapy. Dr. Tobey had recommended physical therapy, which the Claimant declined. Neither Dr. Gronseth nor Dr. Green has recommended ongoing and weekly massage therapy and chiropractic care. In addition, the ALJ notes that Dr. Criste is not familiar with the Medical Treatment Guidelines and has been paid for providing weekly chiropractic care for the Claimant for over two years. The ALJ does not find Claimant is in need of such ongoing care as a result of the 2006 industrial injury.

8. Section 8-42-101(1)(a), C.R.S. 2008, provides that Respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of the industrial injury. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). A Claimant may be entitled to medical benefits after MMI if there is substantial evidence in the record to support a determination that future medical treatment will be reasonable and necessary to relieve the effects of the industrial injury or prevent a deterioration of the Claimant's condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The ALJ finds that the Claimant has failed to establish by a preponderance of the evidence that she is in need of future chiropractic and massage therapy to relieve the effects of the industrial injury or to prevent a deterioration of her condition. Therefore her request for such care is denied.

ORDER

IT IS THEREFORE, ORDERED THAT:

1. Claimant failed to overcome the opinion of the DIME by clear and convincing evidence.

2. Claimant's request for ongoing weekly chiropractic care and weekly massage therapy is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 17, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-761-501

ISSUES

1. Did Claimant prove by a preponderance of the evidence that he sustained an occupational disease arising out of the course and scope of his employment?

2. Did Claimant prove by a preponderance of the evidence that he is entitled to reimbursement for medical treatment and for ongoing reasonable and necessary medical benefits?

3. Did Claimant establish by a preponderance of the evidence that he is entitled to temporary total disability benefits?

FINDINGS OF FACT

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

1. Claimant was born on May 25, 1952. Claimant began working for Employer in September of 2000. He has worked exclusively for this Employer as a pest control technician. Claimant is asserting he injured his bilateral shoulders. Claimant claims his pain began in his right shoulder and then migrated to his left.

2. Claimant claims he serviced 20% commercial, 80% residential. This testimony was contradicted by Employer. Claimant claims he made eight to twelve stops per day in the summer and six stops in the winter.

3. Claimant starts each workday at the Employer offices. He goes into the garage of the offices and punches in to a time clock. He opens his locker and obtains his tools, including his B & G sprayer and other equipment. It would take Claimant anywhere from 10 minutes to 45 minutes between the time he punches in and his arrival at his first stop. Claimant agreed most of his stops would be places he had visited previously, either on quarterly, monthly, or weekly service calls. These locations would have already had previous pest control treatments. Claimant meets with the homeowner or business owner and discusses what services need to be done and if there are any new pest complaints. Claimant uses the equipment to treat the pest at the location. Every stop is different and every application is different where buildings are different heights, have different structures, different square footage, and different pests. At the conclusion of the stop, Claimant would meet with the homeowner or business owner to discuss the findings. He also has to complete paperwork that identifies the chemical that was used, the pest controlled, the time of application and pest

location. The business owner or residential customer then signs the ticket. Claimant returns to his truck and completes paperwork for Employer and then identifies his next stop. Claimant drives his vehicle to the next stop. Claimant also has the opportunity to take a break or a lunch though he may eat in his truck. Claimant also has occasions where he goes to the jobs and the customer is not ready. Claimant calls the office and learns if he can wait until the customer is ready. If he cannot wait, the customer is rescheduled and claimant may be given a new stop. A typical application takes Claimant approximately 30-45 minutes. Performing bee jobs requires climbing up a 24-foot ladder to second story eaves. He then has to reach overhead to spray into the area where the bees are located.

4. Claimant used a B & G Sprayer for the vast majority of his work. The B&G Sprayer has a canister that is held in Claimant's left hand and a wand is carried in his right. The wand has a rubber hose, approximately 2 ½ feet long. The canister is pumped up with the left hand to increase the pressure in the can. Claimant uses his right hand to move the wand to control where the spray goes. The canister itself weighs six to eight pounds. It is then filled up with one gallon of water and weighs 13-15 pounds. Claimant also utilized ladders, dust sticks, bee suit, a fogger for roach jobs, and atom mister for crawl spaces in houses. Claimant is spraying the chemicals as fast as he can walk. The majority of the spraying applies pesticide where the wall hits the floor. Claimant sprays the ground where the wall meets the floor throughout the interior of each floor of the building and around the exterior of the building. In a basement of a residence that is unfinished, Claimant would also spray along the ceiling joists. On the exterior of the building, Claimant may also spray in the eaves or where a gutter meets the wall. The B & G sprayer permits the applicator to increase the pressure within the canister to increase the distance the chemical can be sprayed. The B & G sprayer has a fan spray and a pin spray. The applicator does not need to touch the wand where the wall meets the ceiling, but can instead use the pressure to apply the chemical some distance away from the wand tip.

5. Claimant testified he had an incident of shoulder pain beginning in July 2007. Claimant testified he went to the doctor frequently in 2007, and also underwent a surgery in 2007. When Claimant treated in 2007 for other conditions, Claimant made no mention of his shoulder pain. Claimant agreed he saw a physician at Kaiser on August 31, 2007, October 5, 2007, and December 12, 2007. Claimant agreed he did not describe any shoulder problems to his Kaiser doctors on those dates despite the fact that Claimant testified he had contemporaneous shoulder pain.

6. Claimant statements to his medical providers about when his symptoms arose have varied over time and are therefore not credible and persuasive. Claimant was seen at Kaiser Permanente on January 17, 2008 by Troy Long, M.D. for shoulder pain. Claimant stated his pain was in both shoulder, with the pain starting "three weeks ago with L then went to r as well." This is contrary to

Claimant's testimony at hearing and statement to Dr. Olsen that his pain began in his right arm and then went to his left. Claimant agreed he did not advise Dr. Long that he suffered any discrete incident and made no mention of previous episodes of pain.

7. Claimant was seen by physical therapist Kirsten Fischer on January 23, 2008 at Kaiser Permanente. Despite testimony to the contrary, Claimant also advised Ms. Fischer that his problems were in the left arm first and then the right. Claimant stated he did not recall any injury. The therapist asked Claimant what types of movements he was doing with his shoulder. Ms. Fischer's states, "Patient remembered that his shoulders may have actually started hurting when lifting ladders on and off the truck a lot at work during the summer." Claimant stated the therapist told him she thought it was overuse at work. The Claimant then advised the Employer on February 8, 2008 that he felt his condition was work-related.

8. The Employer sent Claimant to see Michael Ladwig MD and was seen on February 12, 2008. Claimant knew Dr. Ladwig was a workers' compensation physician. He had treated with Dr. Ladwig in the past and felt comfortable discussing his medical conditions with Dr. Ladwig. Claimant told Dr. Ladwig there had been no accidents at work. Dr. Ladwig's report does not state which shoulder had problems first, but simply reports problems in both shoulders. Dr. Ladwig's report stated, "He operates a spray can and wand during <u>the entirety of his shift</u>." (emphasis added). Claimant advised Dr. Ladwig there was nothing at work he could recollect which caused his injuries to his shoulders. There was no mention of problems beginning in the summer of 2007 or in October/November 2007.

9. Claimant provided a different explanation for the onset of his symptoms when answering interrogatories. Claimant agreed he advised that his <u>first</u> work-related complaints began in October or November of 2007. Claimant failed to provide in his answers to interrogatories details of pain he described which occurred in the summer of 2007. Claimant stated his pain began when he reached up to remove the Vector flytrap from the ceiling. These incidents were not described to Dr. Long, Kirsten Fischer, PT, or Dr. Ladwig.

10. Dr. Ladwig returned Claimant to full duty. When Claimant went to Kaiser Permanente on July 29, 2008, he had not returned to Dr. Ladwig. Claimant never contacted Dr. Ladwig's office to make an appointment. Claimant was never refused medical treatment by Dr. Ladwig's office despite the bills not having been paid. Claimant brought in a note to Employer dated July 29, 2008 from Kaiser Permanente assigning lifting restrictions.

11. MR has been employed with Employer since 1986. Mr. R is an owner of the business and is General Manager. Mr. R has held all of the posi-

tions at Employer and continues to do pest control application occasionally while serving as General Manager.

12. Claimant has had prior workers' compensation claims with Employer. These reports were either reported to Mr. R or eventually routed to Mr. R. Claimant was familiar with the process or reporting a work injury and being sent for treatment. Claimant was always immediately sent for treatment with Dr. Ladwig. Claimant reported the current claim to Mr. R on February 8, 2008. Claimant advised Mr. R he had gone to his personal physician through Kaiser and they indicated to him he needed to see a workers' compensation doctor. Prior to reporting the injury on February 8, 2008, Claimant had never come to Mr. R and advised that he was going to Kaiser to treat for a shoulder injury. When Claimant advised Mr. R he felt he had a work-related condition, Mr. R immediately sent Claimant to Dr. Ladwig. When Claimant reported the incident in February of 2008, he did not state it was caused by a specific incident.

13. Mr. R, who is familiar with the route done by Claimant, stated the distribution is 60% commercial and 40% residential. Claimant has a number of quarterly and monthly accounts where he is the requested technician. Mr. R has serviced most of the accounts that Claimant serviced. Mr. R also reviews the documentation that spells out Claimant's daily route. Mr. R is familiar with the account names as he reviews the documentation. Mr. R has also had to fill in for Claimant on occasion. Based on this understanding, Mr. R knows how long it takes to do the applications performed by Claimant. Mr. R credibly testified that the majority of time, it takes longer to drive to the stop than to perform the specified application. The pressure in the sprayer permits the spray to reach the ceiling without having to touch the ceiling. This allows the arm to be lower. The B & G sprayer should get lighter throughout the day as the chemical is being dispensed.

14. Katie Montoya prepared a job analysis on August 20, 2008. She noted Claimant's equipment included B & G hand-held sprayer, ladders, company vehicle, fogging device, extension pole, and protective equipment. Her report notes a pest control service technician is described and observed in the light duty work classification as defined by the Department of Labor. The position requires frequent walking and standing. There is driving required to customers' locations, totaling possibly 30% of the workday. The technician would be seated during this timeframe. Mr. R estimated there was usually about 30 minutes of drive time and then 45-60 minutes at each location. Climbing up ladders is required. There are multiple types of ladders to choose from. Twisting at the neck and waist would be occasional. Bending at the waist is occasional as well. Squatting and kneeling are occasional. Crawling is not required. Reaching above the shoulder level is required on an occasional basis when high spraying is needed or for replacement of some flytrap devices. There is no requirement for repetitive motion of the bilateral upper extremities. However, the upper extremities are used on a frequent basis. Ms. Montoya was also provided with

Claimant's interrogatory responses, and included that information in her analysis. "Occasional" is defined as "1%-32% of the work day.

15. Dr. Ladwig opined Claimant's condition is work-related. Dr. Ladwig's opinion that Claimant's condition is work related is not persuasive. Dr. Ladwig's opinion is based on the facts offered by Claimant regarding his job duties. Dr. Ladwig did not review the job analysis from Katie Montoya. He did not review the records from Kaiser Permanente. He also did not review the report from Dr. Olsen. Dr. Ladwig was under the mistaken impression that Claimant operated a spray can and wand during the entirety of his shift. However, the credible and persuasive evidence shows that Claimant spent up to 30% of his day driving between locations and spent additional time completing paperwork for each job. Finally, Dr. Ladwig's opinions were not consistent with the *Medical Treatment Guidelines* when evaluating causation for Claimant's case.

16. Dr. Nicholas Olsen testified as an expert for Respondents and his report dated August 21, 2008 was accepted into evidence. Claimant reported to the Kaiser doctor and therapist that his problems started on the left and then occurred in his right shoulder. Claimant reported to Dr. Olsen that his symptoms started in the right and moved to the left. Claimant also told Dr. Olsen that his problems started when removing the Vector flytrap. Dr. Olsen's report and testimony persuasively demonstrated the different histories Claimant offered to various health care providers concerning the onset of symptoms.

17. Dr. Olsen reviewed the *Medical Treatment Guidelines*. Dr. Olsen explained the shoulder guidelines describe a history that the provider should expect to see when evaluating causation. He also reviewed the medical literature. Dr. Olsen reviewed the National Institute of Occupational Safety and Health (NIOSH) study done in the mid to late '90s surveying the medical literature. Dr. Olsen opined the NOISH studies are often referenced by the *Medical Treatment Guidelines* and Colorado looks to these studies when considering evidence-based medicine. Dr. Olsen opined that he applies the *Medical Treatment Guidelines* and medical literature when analyzing causation of Claimant's shoulder injuries.

18. Dr. Olsen concluded this was an occupational disease. Dr. Olsen explained to evaluate whether or not a person suffers an occupational disease of the shoulders, both the *Medical Treatment Guidelines* and the literature require there be <u>chronic repetitive overhead use</u> while in the job. Dr. Olsen stated the *Medical Treatment Guidelines* refer to "highly repetitive" but does not do a good job of defining "repetitive" as is done in other sections of the *Guidelines*. He looked to the medical literature, including the NIOSH study that is referred to in the *Medical Treatment Guidelines*. Dr. Olsen explained the NIOSH studies state overhead use occurs when using the arm above eye-level and working in that posture greater than 50% of the day. In addition, the work would need to be cy-

clical where the arm would raise several times in a minute to be considered highly repetitive. Dr. Olsen stated the medical literature requires that if a worker does not have highly repetitive tasks overhead more than 50% of the day, they do not meet the definition "highly repetitive" to be causative for an occupational disease in the shoulder. Dr. Olsen's testimony in this regard is persuasive.

19. Dr. Olsen's testimony is more persuasive than that of Dr. Ladwig because he had a better and more accurate history of the job duties performed by the Claimant than did Dr. Ladwig. Dr. Olsen stated, based on the job description he received from the Claimant in the office and hearing the testimony of Claimant and Mr. R, he would agree with Katie Montoya that Claimant's overhead work was "occasional," which might be 20% of the day. "Occasional" is defined as a maximum of 33% of the day. Claimant's duties did not meet the criteria of working repetitively overhead more than 50% of the day. Dr. Olsen opined that Claimant's work overhead was not more than 50% of the time. Any work Claimant did overhead was in a comfortable posture where he was not having to use a tool or apply pressure. Since that work is less than occasional, which is less than 1/3 of the day, this would be less than the definition required by the literature and the *Medical Treatment Guidelines* to constitute repetitive.

20. Dr. Olsen persuasively opined that Claimant's job did not cause, aggravate or accelerate Claimant's preexisting degeneration arthritis found in his shoulder. Dr. Olsen noted the NIOSH studies took age into consideration and did not apply different criteria for the different ages. Even with pre-existing degenerative arthritis, the studies required there still needed to be repetitive overhead use or frequent cyclical use of the upper extremity overhead for there to be a relationship between the work activity and the shoulder problems. Dr. Olsen persuasively opined that Claimant's work did not aggravate or accelerate Claimant's underlying degenerative rotator cuff disease.

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. §8-40-102(1),C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. §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. §8-43-201, C.R.S.

2. For an injury to be compensable, the claimant has the burden to prove by a preponderance of the evidence that his injury arose out of and in the course of his employment. §8-43-201 C.R.S. "Arising out employment" deals with the causal connection between the employment and the injury. *General Cable Co. v. Industrial Claims Appeals Office*, 878 P.2d 118 (Colo. CT App. 1994). "Course of employment" deals with the time, place, and circumstances of claimant's alleged injury. *Wild West Radio, Inc. v. Industrial Claims Appeals Office*, 905 P.2d 6 (Colo. App. 1995). Under the preponderance of the evidence standard, where evidence weighs evenly on both sides in a controversy, the fact finder must resolve the question against the party who has the burden of proof. *People v. Taylor*, 618 P.2d 1127, 1135 (Colo. 1980).

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

4. The *Medical Treatment Guidelines* are applicable to this case and are found in the Department of Labor and Employment's Rule 17, 7 Code Colo. Reg. 1103-3. The statement of purpose of the *Medical Treatment Guidelines* is contained in WCRP 17-1(A), 7 Code Colo. Reg. 1101-3 at 103, which provides as follows:

> In an effort to comply with its legislative charge to assure appropriate medical care at a reasonable cost, the Director of the Division has promulgated these medical treatment guidelines. This Rule provides a system of evaluation and treatment guidelines for high cost or high frequency categories of occupational injuries received to assure appropriate medical care at a reasonable cost.

5. The use of the *Medical Treatment Guidelines* is contained at WCRP 17-2(A) and provides as follows: "All healthcare providers shall use the medical treatment guidelines adopted by the Division." The *Medical Treatment Guidelines* are regarded as accepted professional standards for care and evaluation of injuries. Rule 17, Exhibit 4, involving the shoulder, states at Subsection D that history taking should address at least the following for each shoulder injury diagnosis: "Occupational relationship and history of non-occupational injury in avocational pursuits." The *Medical Treatment Guidelines* then address what should be present to identify the "occupational relationship" based on the diagnosis. Impingement syndrome would be considered occupationally related if there is "established repetitive overuse of the upper extremity; many times this is seen with constant overhead motion." Rule 17, Exhibit 4(D)(6)(a)(i)) Similarly, the *Medical*

Treatment Guidelines with regard to the shoulder state that a rotator cuff tear would be occupationally related if there is "chronic overuse with repetitive overhead motion with internal or external rotation." Rule 17, Exhibit 4(D)(7)(a)(i)) Rotator cuff tendinitis is deemed occupationally related by the *Medical Treatment Guidelines* when there is "repetitive use of the shoulder." Rule 17, Exhibit 4(D)(8)(a)).

6. Claimant did not meet his burden of proof on compensability. Dr. Olsen's opinion on causation was found to be persuasive. Claimant did not suffer an occupational disease of the bilateral shoulders while working for Employer. Claimant did not aggravate or accelerate his preexisting arthritis while working for Employer.

ORDER

It is therefore ordered that:

1. Claimant failed to establish by a preponderance of the evidence that he suffered a compensable injury to his bilateral shoulders.

2. Claimant's claim is denied and dismissed.

DATED: December 17, 2008

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-750-935

ISSUES

¬ Did claimant prove by a preponderance of the evidence that he was performing services for employer at the time of his work-related injury?
¬ Did claimant prove by a preponderance of the evidence that employer should pay his medical and temporary disability benefits?

FINDINGS OF FACT

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

1. Employer operates an over-the-road trucking company. OF (Oscar Senior) is President. Oscar Senior's two sons, L Favela and OF (Oscar Junior),

also work for employer. L is Vice President; Oscar Junior is maintenance lead. At the time of hearing, claimant was 38 years old.

2. Claimant fractured his right ankle in an accidental fall to the ground from the bed of a dump truck on January 12, 2008. At the time of the accident, claimant was unloading the dump truck on a farm owned by NK. Claimant was working under the direction of Oscar Junior at the time of his accident. Claimant contends he was working as an employee of employer at the time of his accident. It is uncontroverted that claimant was performing work for Oscar Junior at the time of his work-related accident.

3. K transported claimant to East Morgan County Hospital in Brush, Colorado, for medical treatment. Later on January 12th, L drove claimant from Brush to Denver Health Medical Center, where claimant underwent 2 surgeries and periodic evaluations through August 29, 2008. Denver Health and various physicians have outstanding charges of some $27,300.00. Medicaid paid for a portion (some $7,600.00) of claimant's treatment at Denver Health. Claimant paid some $675.00 toward his medical expenses.

4. Crediting L's testimony, the Judge finds: While Oscar Junior can refer prospective employees or drivers to L, only L has the authority to hire employees. The process of hiring a driver takes 3 days to 1 week to complete. A prospective driver completes an application and must have a valid commercial drivers license (CDL). L then checks the applicant's motor vehicle record, places the applicant's name in a drug-screen pool, performs a criminal background check, checks references, and asks for a copy of the applicant's social security card. Employer hires drivers who allegedly agree to work as independent contractors and who are paid by the mile, with some differential pay for the number of times the driver has to place or remove a tarp over the load.

5. In the past, claimant held a CDL issued by the State of Utah, which had expired. At all times relevant to his claim, claimant lacked a valid CDL. Claimant's friend, AV, applied for a driving position with employer on November 27, 2007. While claimant accompanied V when he applied for a driving position with employer, claimant could not apply for lack of a valid CDL. Claimant told L he did not have a valid CDL. L only hired V, who worked through the Christmas Holiday. Employer does not hire teams of drivers, unless both drivers have a valid CDL.

6. Claimant testified that he accompanied V on various over-the-road trips for employer and that he helped drive the truck, even though he was unlicensed to drive a commercial vehicle. Claimant says he worked with V through the end of calendar year 2007, when they stopped working. While claimant subjectively believes he was an employee while driving with V, there was no persuasive evidence showing a contract of employment between claimant and employer.

7. Oscar Junior testified that claimant called him in January of 2008, saying that he had been unable to find work for 3 weeks, that he needed work, and that he needed money for food. Oscar Junior offered claimant work cleaning tomato vines from the ranch where Oscar Junior lived. Claimant agreed to work for Oscar Junior for $100.00 per day.

8. Oscar Senior owns the ranch, which is a separate property from the yard where employer operates its trucking business. The tomato vines were refuse from a side project Oscar Junior pursued to earn extra money. The county had ordered Oscar Junior to remove the tomato vines because they were illegal. Oscar Junior hired claimant to load the vines on a dump truck and to drive it some 40 miles to a farm across the county line.

9. Oscar Junior worked with claimant on January 11th. Claimant loaded the vines onto the truck using a front-end loader. Oscar Junior drove the truck to the farm. Claimant rode as a passenger in the truck. Because Oscar Junior had to drive one of employer's loads on January 12th, he asked claimant to work by himself on the ranch. As found, claimant was performing services for Oscar Junior at the time of his injury.

10. L testified that, when he drove claimant to Denver Health on the date of the accident, he paid claimant $300.00 in cash for his work. On January 21, 2008, L issued a check to claimant in the amount of $500.00, which was written on a check from employer's business account. L stated that claimant, his wife, and his 4 kids showed at employer's office needing money. L telephoned Oscar Junior, who told him to give claimant 50% of his salary that week to help him out. Oscar Senior signed the check, which was the only check payable to claimant from employer's business account. Claimant failed to show it more probably true that the check issued from employer's business account constitutes an admission that claimant was an employee at the time of his work-related injury.

11. Claimant failed to show it more probably true than not that he was an employee performing services for employer at the time of his injury on January 12, 2008. As found, claimant subjectively believes he was employer's employee while driving with V. Even if there were some express or implied contract of employment between claimant and employer, claimant no longer worked for employer after the end of calendar year 2007. The Judge however found no persuasive evidence showing a contract of employment between claimant and employer. Indeed, L and Oscar Junior both testified that employer never employed claimant as a driver. This testimony is supported by employer's detail of transactions from its business account, showing all payments to drivers during calendar year 2007. While the detail shows checks paid to V, there were no checks paid to claimant. When Oscar Junior hired claimant to work on the ranch, he agreed to pay claimant cash, and not to pay him by the mile as per employer's custom-

ary practice with drivers it employed. Since the hearing involved only claimant's claim against employer, and not against Oscar Junior as putative employer, the Judge does not reach the question whether Oscar Junior was an employer under the statute.

CONCLUSIONS OF LAW

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

Claimant argues he has proven by a preponderance of the evidence that he was an employee of employer at the time he sustained his work-related injury. The Judge disagrees.

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 by a preponderance of the evidence that his injury arose out of the course and scope of his employment with this employer. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). Section 8-40-202(2)(a), *supra,* provides that an individual performing services for another is deemed to be an employee. 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. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Here, the Judge found claimant failed to show it more probably true than not that he was an employee performing services for employer at the time of his work-related injury on January 12, 2008. Claimant thus failed to prove by a pre-

ponderance of the evidence that he was an employee of employer at the time he sustained his work-related injury.

Even though claimant subjectively believes he was employer's employee while driving with V, he no longer worked with V after the end of calendar year 2007. The Judge found no persuasive evidence showing a contract of employment between claimant and employer. Indeed, L and Oscar Junior both testified that employer never employed claimant as an over-the-road driver. This testimony was credible and amply supported by employer's detail of transactions from its business account, showing all payments to drivers during calendar year 2007. While the detail shows checks paid to V, there were no checks paid to claimant. And when Oscar Junior hired claimant to work on the ranch, he agreed to pay claimant cash, and not to pay him by the mile as per employer's customary practice with drivers it employed.

The Judge concludes that claimant's claim against employer for workers' compensation benefits should be denied and dismissed. Since the hearing involved only claimant's claim against employer, and not against Oscar Junior as putative employer, the Judge does not reach the question whether claimant was Oscar Junior's employee at the time of his injury on January 12, 2008.

ORDER

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

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

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

DATED: _December 17, 2008_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-742-250

ISSUES

The issue determined herein is compensability. The parties stipulated to an average weekly wage of $153.75, to medical benefits from Memorial Hospital, and to the first twelve treatments by Smith Chiropractic.

FINDINGS OF FACT

1. Claimant contacted the employer's representative on the internet in response to an advertisement for a job. On August 21, 2007, the employer's representative called claimant and described the job of making sales calls in person to local businesses. Claimant could not recall the name of the person who called her. Claimant informed the caller that claimant did not have a driver's license. The caller informed her that it did not matter as long as claimant can make all of the sales visits.
2. On August 21, 2007, LC from CPP Recruiting e-mailed claimant an application and other documents. The trier-of-fact infers that Ms. C called claimant on August 21, 2007.
3. On August 21, 2007, claimant submitted the application for employment. On the application, claimant indicated that she had a currently valid Colorado driver's license.
4. Claimant submitted signed releases for the employer to conduct a criminal background check.
5. On August 24, 2007, the employer hired claimant as a merchant sales consultant. The employer and claimant signed an employment agreement for at-will employment. The written agreement did not require that claimant drive herself to all sales visits or even that she must maintain a valid driver's license. The employer also provided claimant with a "checklist" that was not part of the employment agreement. Claimant initialed next to each item on the checklist, including the statement that claimant was responsible for maintaining a valid driver's license and insurance requirements for the state of claimant's residence. The employer also provided claimant with an employee handbook, which was designated as merely a "guide" and not part of the "written employment contract." None of the employment documents required that claimant could only travel to sales visits by driving herself.
6. The employer provided claimant with at least three contacts for sales visits each day. Claimant was also encouraged to contact any businesses for which she was a customer and also attempt to sell the employer's credit card processing services to those businesses. Her supervisor was NE, who was located in Texas. Claimant was required to call Mr. E after each sales visit that she made.
7. As a result of a conviction in 2002 for driving while abilities were impaired, claimant had lost her driver's license in Colorado.
8. Because claimant did not have a valid Colorado driver's license, she hired CC, a friend, to drive claimant to her sales visits and paid her approximately $25 per day.
9. On September 7, 2007, claimant made her first assigned sales visit to a business in Security, Colorado. Claimant then traveled to Trendzy Nails, a business for which she was a customer. The owner told claimant to come back later. Claimant then traveled to her next assigned sales visit in Colorado Springs. Claimant and Ms. C then had lunch at Latina Salsa at approximately 4:30 p.m. Claimant also tried to market the employer's services to Latina Salsa, but the manager declined. Ms. C then drove claimant back to Trendzy Nails while claimant called Mr. E to update him about her sales visits. En route to Trendzy Nails, Ms. C's vehicle was rear-ended by another vehicle, causing injury to claimant's right arm and back. The investigating police officer completed a report showing that the accident occurred at 5:00 p.m.

10. At approximately 7:00 p.m. on September 7, 2007, claimant sought treatment at Memorial Hospital. She reported a history of the motor vehicle accident at 5:00 p.m. that day. Computerized tomography ("CT") scan showed decreased disc height at C4-5. The physician diagnosed cervical strain and right shoulder contusion and prescribed medications and heat.

11. On Sunday, September 9, 2007, claimant returned to Trendzy Nails and made a sale of the employer's services.

12. On Monday, September 10, 2007, claimant informed Mr. E about the accident and her injuries. The employer did not refer claimant to a medical provider.

13. On September 18, 2007, claimant sought treatment at Smith Chiropractic. Dr. Smith was not level I certified by the Division of Workers' Compensation.

14. On an unknown date, the employer, through Mr. E, terminated claimant's employment due to her lack of a valid driver's license. Claimant informed Mr. E that she still had a few more sales visits to make and Mr. E agreed.

15. On October 3, 2007, claimant suffered additional injuries in another motor vehicle accident. She suffered increased headaches and had to seek additional chiropractic treatment.

16. On December 1, 2007, the employer completed a First Report of Injury, indicating that claimant was injured on September 7, 2007, while between sales calls.

17. Claimant has proven by a preponderance of the evidence that she suffered an accidental injury on September 7, 2007, arising out of and in the course of her employment. Claimant was engaged in the sales activities for which she was hired at the time of her accident. Although claimant misrepresented the status of her driver's license on the application, the employment agreement did not require that claimant drive herself to the mandatory sales visits as long as she was able to make all of the visits. Claimant's use of a hired driver for the sales visits was not a deviation from the contract of hire; it was only her own personal choice as to the manner of performing the services for which she was hired. Claimant's travel conferred a benefit on the employer: she made sales visits to the designated potential customers.

CONCLUSIONS OF LAW

1. Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove 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. Respondents argue that claimant's travel to sales visits by a means other than driving herself was not contemplated by the employment contract and her injuries do not arise out of and in the course of the employment. That argument is unpersuasive. As found, the contract of hire did not require that claimant drive herself to the sales visits.

The contract of hire certainly contemplated travel. *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). In fact, the entire employment agreement centered on claimant's obligation to travel. The agreement did not specify the manner of travel. Contrary to respondents' argument, claimant's travel most certainly conferred a benefit on the employer: she made sales visits to the designated potential customers. The fact that claimant misrepresented her driver's license status on the application for employment does not defeat claimant's claim for compensation. *Kraus v. Artcraft Sign Co.*, 710 P.2d 480 (Colo. 1985). As found, claimant has proven by a preponderance of the evidence that she suffered an accidental injury on September 7, 2007, arising out of and in the course of her employment.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment from authorized providers for the work injury, including Memorial Hospital and the first twelve treatments by Smith Chiropractic.
2. All matters not determined herein are reserved for future determination.

DATED: December 18, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-051

ISSUES

1. Did claimant prove by a preponderance of the evidence that he sustained a shoulder injury arising out of the course and scope of his employment on November 20, 2007, while skiing before line-up as a ski instructor?

2. Did claimant prove by a preponderance of the evidence that he is entitled to temporary partial disability benefits (TPD) from November 21, 2007, and continuing?

3. Did the claimant prove by a preponderance of the evidence that he is entitled to authorized, reasonable and necessary medical benefits for treatment of the alleged injury, including treatment provided by Breckenridge Medical Center and Dr. Abbott?

FINDINGS OF FACT

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

1. Claimant, age 56 at the time of the hearing, was a ski instructor with employer working at Breckenridge Ski Area (Breckenridge) on November 20, 2007, when he injured his right shoulder. Breckenridge is operated by employer.

2. At the time of his injury, claimant had worked as a ski instructor at Breckenridge since March, 2007, had been skiing since 1957, and had previously been a ski coach and instructor in Massachusetts. He is Level II certified with the Professional Ski Instructors Association (PSIA).

3. On Monday, November 19, 2007, the day before his injury and the beginning of Thanksgiving week, claimant gave ski lessons at Breckenridge to three individuals, including beginner skier SB. At the end of the day, Ms. B asked claimant if he would be available for a ski lesson the following day. Tuesday was claimant's day off, and claimant told Ms. B that he was unsure but would check to see if he could come in to teach her on Tuesday.

4. That afternoon claimant approached SE, Operations Supervisor, in the hallway and asked for permission to work on Tuesday, November 20, 2007, due to Ms. B's request for a return lesson. Mr. E was claimant's supervisor at the time. Mr. E told claimant he could come to work on Tuesday.

5. Claimant understood that he had no guarantee of being assigned a lesson on November 20, 2007, even if Ms. B did return for another lesson. Ski instructors report for line-up at 9:45 a.m. for lessons that begin at 10:00 a.m. The supervisor then assigns those lessons based on a seniority system. Claimant had very low seniority. One of the factors that a supervisor can consider in assigning lessons, however, is whether students have returned from a prior day. Claimant thought that there was a chance he would be assigned a lesson with Ms. B. It was reasonable for claimant to expect that he might be assigned Ms. B if she returned for a lesson on November 20.

6. Claimant never had any further contact with Ms. B after the end of her lesson on November 19, 2007. According to employer records that track lift usage, SB did not ski at Breckenridge on November 20, 2007.

7. Claimant was hopeful that he would be assigned to teach a lesson including Ms. B. Ms. B was in a Level II novice group on November 19, but she had athletic ability and had made quite a bit of progress by the end of the day on Monday. Claimant believed that Ms. B was ready, if she retained this progress, to ski an intermediate or "blue" run on November 20.

8. On Tuesday, November 20, claimant arrived at Breckenridge sometime before 8:37 a.m. He dressed in his uniform and went out to ski a blue run,

Bonanza, to scout the terrain for Ms. B (scouting run). Claimant did so because he believed it was important to check out the ski conditions on the blue runs before reporting for work in case he was assigned to teach Ms. B. As claimant was skiing down the Bonanza run, at approximately 9:10 a.m., he fell and injured his shoulder. Claimant was taken to the Breckenridge Medical Center and did not report to line-up that day.

9. After he was released from the medical center, claimant reported the accident to employer. He was told that he was "free skiing" and that his injury was not compensable. At the time, claimant accepted this answer. He returned to work several days later and taught skiing for the remainder of the season. Claimant then filed a workers' compensation claim, which employer denied based on an assertion that the injury was not work-related.

10. Claimant treated with Dr. Cunningham of Vail-Summit Orthopedics after the accident. Dr. Cunningham recommended shoulder surgery for a rotator cuff repair and possible tendon biceps tendonesis. Claimant wishes to continue treatment for his shoulder injury.

11. A ski instructor's work day at Breckenridge begins at line-up. At the time of his injury, claimant was "not on the clock" and was not receiving pay. Ski instructors do not clock-in until line-up at 9:45 a.m. Claimant did not expect to get paid while skiing the scouting run and in fact was not paid for any work on November 20, 2007.

12. Employer provides ski instructors grooming and terrain reports regarding snow conditions on the mountains by positing this information in the locker room and on supervisors' doors. These reports are generated at 5:30 a.m. daily. Snow conditions can change significantly from the time of the grooming and terrain reports until the ski instructors take their ski students out on the slopes. If there are major terrain issues, supervisors address these during the safety portion of the line-up.

13. The PSIA manual states as follows: "One of your top priorities as a snowsports instructor is to ensure your students are safe . . . . Be sure to take weather and snow conditions into account. Even the easiest terrain can be challenging under some conditions. Make a habit of checking a trail report and try and make your own warm-up runs on the slopes where you will be teaching." Breckenridge does not require its ski instructors to use the PSIA manual.

14. The Breckenridge Ski and Ride School Policy and Procedures Manual addresses ski conditions as follows: "Getting Started: Evaluate environment – snow conditions, weather forecast, grooming reports, etc." This language does not require a ski instructor to ski on the runs he or she will be using before a ski lesson begins.

15. The Breckenridge manual also contains this language: "Warm-up runs with your group- 2 warm-up runs daily: first thing in AM and after lunch; muscles need blood flow and need to be warm to prevent injuries, 'warm to perform.'" This language refers to warm-ups a ski instructor takes with his students and does not require or recommend that an instructor take a warm-up run before teaching students.

16. It is very important to employer to provide a safe and positive experience for students taking ski lessons at Breckenridge. Employer stressed safety in its orientation for ski instructors, which claimant attended. The orientation included a mock trial involving a fact situation when an instructor took a young child on terrain the instructor was unfamiliar with and that was unsuitable for the student. An accident occurred resulting in a fractured skull when the student ran into en electrical box. The lesson imparted was that the instructor should be aware of where he was bringing students and of their ability, because he was responsible for the safety of the student. The orientation did not direct ski instructors to check out the terrain by doing a ski run in advance.

17. No supervisor instructed claimant on November 20, 2007, to check out the terrain before giving a ski lesson that morning. Employer was not aware of claimant's scouting run to check out terrain and exercised no supervisory control over it.

18. Claimant was aware of employer's '"free skiing" policy for the 2007-2008 ski season, which is stated in the "Breckenridge Ski & Ride School Policy and Procedures Manual and Training Manual 2007/2008" as follows:

> Pros released from work duty for the day must change out of uniform before going free skiing or riding. <u>Free skiing/riding prior to morning line up is permitted in uniform</u>. Pros who are required to check back for afternoon line up who have a minimum Level 2 certification (or equivalent) can free ski/ride in uniform. All other pros must change out of all uniform pieces to free ski/ride. Pros told to check-in within 1 hour can remain and free ski/ride in uniform. <u>When free skiing, even if in uniform, pros are not covered by</u> <u>Workers'Comp</u>.

(Emphasis added.)

19. Procedures Manual and Training Manual 2007/2008" as follows:

> **Pros are NOT considered to be within the course and scope of their employment and, therefore, are not covered by Workers' Compensation when**:

° "Free skiing/riding," including, but not limited to, free skiing/riding before and after work assignments.

° While available and checking in with a supervisor for assignments.

20. Employer provided claimant a ski pass as part of his employment. Claimant used the ski pass on November 20, 2007, to get access to Bonanza run.

21. Claimant signed an "Employee Ski Pass/ID card from" in which he acknowledged that use of his ski pass beyond "specifically enumerated or directed employment duties" would constitute "recreational use and/or non-employment-related of the pass card". Further, he acknowledged recreational and/or non-employment-related use of the pass includes usage "(2) prior to the commencement or after the cessation of employment duties."

22. When claimant skied the scouting run on November 20, it was anticipated that he would provide a benefit to Ms. B, should he be assigned to teach her that day, and therefore to employer. He would have first-hand and up-to-date information regarding ski conditions on that run. Employer would benefit both in terms of a positive experience for Ms. B and her safety. In this case, those benefits were remote for two reasons. Employer had an established means to alert ski instructors to ski conditions. In addition, the chances of claimant's teaching a lesson to Ms. B, on this blue run, and at a time when this updated information would be relevant were low.

23. When supervisor E was a ski instructor many years before claimant was hired, he performed scouting runs before giving lessons by his own choice.

CONCLUSIONS OF LAW

Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and in the scope of his employment. Section 8-41-301(1), C.R.S. (2005); *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). *Madden v. Mountain West Fabricators,* 977 P.2d 861 (Colo. 1999); *Price v. Industrial Claim Appeals Office,* 919 P.2d 207 (Colo. 1996). The question of whether a claimant meets his burden of proof is one of fact for determination by the ALJ. *Lerner v. Wal-Mart Stores, Inc.,* 865 P. 2d 915 (Colo.App. 1993). 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).

Claimant asserts that his ski run to assess ski conditions before line-up was "sufficiently interrelated to the conditions and circumstances under which the employee usually performs his job that the activity may reasonably be characterized as an incident of employment" to be compensable. *City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985; *Lori's Family Dining, Inc. v. ICAO,* 907 P.2d 715

(Colo.App. 1995). Respondents, on the other hand, contend that claimant's ski run was voluntary, recreational "free skiing."

In weighing these arguments, the ALJ must consider the statutory definitions of "employee" and "employment" in the workers' compensation statute, which exclude persons participating in recreational activities. Sections 8-40-301(1) and 8-40-201(8), C.R.S., provide in relevant part as follows:

> (1) Employee excludes any person … while participating in recreational activity, who at such time is relieved of and is not performing any duties of employment, regardless of whether such person is utilizing, by discount or otherwise, a pass, ticket, license, permit or other device as an emolument of employment.
>
> (8) "Employment"… shall not include … the employee's participation in a voluntary recreational activity or program, regardless of whether the employer promoted, sponsored, or supported the recreational activity or program.

In applying these statutory definitions and the law regarding compensability, the Supreme Court has set forth a number of factors that should be considered: (1) whether the injury occurred during working hours; (2) whether the injury occurred on the employer's premises; (3) whether participation in the activity was required; (4) whether the employer initiated, organized, sponsored, or financially supported it; and (5) whether the employer derived a benefit from it. *Price v. ICAO, supra; Dover Elevator Company v. ICAO,* 961 P.2d 1141 (Colo.App. 1998). The first two factors are particularly strong indicators of whether an injury arose out of and in the course of employment. *Price v. ICAO, supra.*

In relation to factor (1), claimant's injury did not occur during working hours. Even had claimant been assured of working on November 20, 2007, which he was not, his work day did not begin until line-up. Claimant was injured at approximately 9:10 a.m., 35 minutes before line-up, before working hours.

In relation to factor (2), claimant's injury did occur on the employer's premises. It occurred on the Bonanza ski run at Breckenridge, a ski area operated by employer.

In relation to factors (3) and (4), whether participation in the activity was required and whether the employer initiated, organized, sponsored or financially supported it, the ALJ first concludes that claimant's activity of skiing a scouting run was voluntary. The record is clear that no one directed claimant to ski a scouting run. In fact, employer had a policy that claimant was familiar with that free skiing before line-up was not in the course and scope of employment and would not be covered by workers' compensation.

Claimant contends that a number of factors combined to making a scouting run before line-up essentially part of claimant's work duties. Claimant points to employer's emphasis on safety during orientation, the PSIA's recommendation to check the trail and make a warm up run on the slope where an instructor will be teaching, the Breckenridge policy to evaluate the snow conditions; the possibility that grooming and terrain reporting completed at 5:30 a.m. would change; and the practice of E when he was an instructor to take a scouting run. Claimant contends that despite its written policies, employer has effectively enlarged the scope of employment to include and require a scouting run.

The record does not support this contention. An employer's emphasis on safety does not translate to permitting an employee to take all actions that the employee may deem appropriate to carry out that goal. Here, employer had a system for providing information about snow conditions to instructors via terrain and grooming reports, with possible updates at line-up in case of major terrain issues. Employer had not adopted the PSIA's recommendations, as shown in the Breckenridge policy. The orientation stressed safety but did not recommend taking scouting runs. The fact that the a single instructor who later became Operators Supervisor performed scouting runs years before claimant's employment by his own choice does not support an enlargement of the scope of employment by employer. Rather, claimant's acted unilaterally in making the scouting run.

In determining whether an activity is voluntary, the ALJ should also consider evidence regarding whether the employer sponsored, promoted, or supported the recreational activity. Such evidence is relevant to a determination of whether the employer enlarged the scope of employment by its affirmative act of embracing various recreational and social activities. *Price v. ICAO, supra;* 2 *Larson's Workers' Compensation Law* §§ 22.20 and 22.24(c) (1997). The only evidence of support here is employer's provision of a ski pass to claimant. Employer was unaware of claimant's pre-line-up skiing the morning of the injury and exercised no supervisory control over his activities at that time. It had not directed claimant to scout out terrain in anticipation of a lesson. Employer took no affirmative act to embrace a recreational activity. Breckenridge policy for ski instructors specifically provides that free skiing is not covered by workers' compensation.

In relation to factor (5), whether employer derived a benefit from the activity, claimant's scouting run was expected to benefit employer, but that benefit was remote due to the circumstances. There was an existing method to alert ski instructors to ski conditions, and claimant's chances of teaching a lesson to Ms. B, on this blue run, and at a time when the updated information derived from the scouting run would be relevant were low.

Based on an analysis of these five factors as a whole and giving weight to the first two factors, the ALJ concludes that claimant has failed to establish by a

preponderance of the evidence that his scouting run was "sufficiently interrelated to the conditions and circumstances under which he employee usually performs his job that the activity may reasonably be characterized as an incident of employment, even though the activity itself is not a strict obligation of employment and does not confer a strict benefit on the employer." *City of Boulder v. Streeb*, *supra*. Claimant has failed to establish that he was in the course and scope of employment at the time of his injury. Instead, he was engaged in the voluntary recreational activity of free skiing.

ORDER

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits based on a November 20, 2007 injury is denied and dismissed.

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

DATED: December 18, 2008

Nancy Connick
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-421-048

ISSUE

The issue to be determined is whether Respondents may offset the permanent partial disability (PPD) benefits paid against the temporary disability benefits owing pursuant to Section 8-42-107.5, C.R.S., and *Murphy Contractors v. ICAP,* 916 P.2d 611 (Colo.App. 1995).

FINDINGS OF FACT

1. Claimant sustained compensable injuries on May 3, 1999. He initially reached maximum medical improvement (MMI) on October 26, 2001. At that time, Claimant had a 43% whole person impairment. Respondents admitted liability for permanent partial disability benefits based on the 43% whole person impairment. The claim was reopened as of July 19, 2004. Up to that date, Respondents paid PPD benefits in the amount of $19,468.56. The current temporary total disability (TTD) rate is $382.92 per week. TTD benefits paid to date exceed $120,000.00.

2. Claimant is not yet at MMI for his worsened condition. Peter N. Reusswig, M.D., in report dated September 17, 2008, stated that Claimant will not be able to earn any wages in the employment he held at the time of his injury or in any other employment. Robert H. Meier, III, M.D., in a report dated September 25, 2008, stated that he cannot imagine that there is any job that Claimant could consistently perform. The ALJ credits these opinions of Dr. Reusswig and Dr. Meier. Claimant will be a candidate for permanent total disability benefits when he is placed at MMI again.

CONCLUSIONS OF LAW

The facts in *Murphy Contractors v. ICAP,* 916 P.2d 611 (Colo.App. 1995) are distinguishable from the facts in this claim. First, in *Murphy Contractors*, the claimant had less than 25% impairment at the time he originally reached MMI. Accordingly, the court stated the holding of the case as follows:

> In the absence of statutory guidance, for the reasons set forth below, we conclude that, when further benefits are sought after the twenty-five percent or less limit of *§ 8-42-107.5* has been applied, the petitioners are entitled to offset any permanent partial benefits paid against temporary total disability benefits.

Murphy Contractors_ supra, 916 P2d at 614. Here, Claimant's impairment is more than 25%. The court's ruling in *Murphy Contractors* does not reach the offset issue in the more serious injury cases when a claimant's impairment at the time of initial MMI exceeds 25%.

More significantly, in *Murphy Contractors* the claimant did not allege that he would be a candidate for permanent total disability benefits upon reaching MMI. In fact, in that case, the claimant's surgeon opined that the new surgery after reopening would not significantly alter claimant's impairment rating of 17%. Here, the medical evidence from Dr. Reusswig and Dr. Meier establish that when he reaches MMI, Claimant will be a candidate for permanent total disability benefits. Therefore, the facts here militate in favor of not disrupting the flow of Claimant's benefits, the countervailing consideration to the Respondents' interest in avoiding an overpayment in the event Claimant is found not permanently totally disabled after he reaches MMI the second time. Therefore, *Murphy Contractors* does not govern the present case.

ORDER

1. Respondents may not offset the PPD benefits paid against the temporary disability benefits due.
2. Any and all issues not determined herein are reserved for future decision.

DATED: *December 18, 2008*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-773-571

ISSUES

The issues determined herein are compensability and medical benefits.

FINDINGS OF FACT

1. Claimant was employed as a caregiver for the employer. She had to wake patients, help them with dress and hygiene, transport them to the bathroom and transport them to meals.

2. On September 10, 2008, claimant suffered an injury while transferring a patient out of a wheelchair into a chair. Claimant was bending at her knees and waist over the patient and the patient had her arms around claimant's neck. The patient pulled claimant down to her chest. This caused claimant to fall to her knees on the floor, landing with her chest in the patient's lap. Claimant felt a "pull" in her neck, but the symptoms were not bad at that time.

3. Claimant told a coworker, S, about the incident, but she did not otherwise report the injury at that time.

4. Claimant worked the rest of that day and then had three days scheduled off work. During her time off, she suffered increasingly severe symptoms of pain radiating from her neck into her arm. She awoke on September 11, 2008, with pain in her neck and shoulder. By September 13, 2008, claimant was experiencing excruciating pain.

5. On September 14, 2008, claimant awoke in a lot of pain. She returned to work at 6:00 a.m. She informed her supervisor, Ms. J, about the work injury. Ms. J confirmed at hearing that claimant appeared to be in pain and had difficulty moving her neck. Ms. J telephoned her own supervisor, Ms. H-J, to report claimant's injury. Ms. H-J advised Ms. J to have claimant seek treatment for the injury. When the shift was over, Ms. J accompanied claimant to Emergicare, where Dr. Reasoner examined her.

6. Dr. Reasoner referred claimant to Colorado Springs Imaging for a magnetic resonance image ("MRI") and recommended a course of physical therapy at Excel Physical Therapy. Dr. Reasoner's office contacted Excel Physical Therapy and Excel later called claimant to set up an appointment.

7. The September 15, 2008, MRI showed mild degenerative changes of the C5-6 disc with dessicated disk bulge and mild cord compression, mild degenerative changes at C6-7 causing bilateral neural foraminal narrowing, and C4-5 degenerative changes with a minimal posterior dessicated disk bulge.

8. On October 1, 2008, Dr. Reasoner diagnosed cervical strain with radiculopathy. He imposed restrictions against lifting over 20 pounds. Ms. J received the restrictions. Claimant continued to work without missing any time. Claimant received only a portion of the scheduled physical therapy sessions. Treatment was interrupted when the insurer denied authorization for the treatment.

9. Claimant has proven by a preponderance of the evidence that she suffered an accidental injury on September 10, 2008, arising out of and in the course of her employment with the employer. Claimant's testimony is supported by the testimony of her supervisor, Ms. J, and is found credible.

10. The preponderance of the evidence demonstrates that the treatment by Dr. Reasoner, Excel Physical Therapy, Colorado Springs Imaging was authorized and was reasonably necessary to cure or relieve the effects of the work injury. Claimant reported the injury to her employer, who failed to refer her to a specific provider. Claimant was impliedly authorized to choose her provider. Dr. Reasoner then referred claimant to Excel Physical Therapy and Colorado Springs Imaging, who are also authorized providers.

CONCLUSIONS OF LAW

1. Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove 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. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial*

Commission, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. *Greager, supra*. As found, all of the treatment by Dr. Reasoner, Excel Physical Therapy, Colorado Springs Imaging was authorized and reasonably necessary to cure or relieve the effects of claimant's work injury.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers for the work injury, including the bills of Dr. Reasoner, Excel Physical Therapy, Colorado Springs Imaging, according to the Colorado fee schedule.
2. All matters not determined herein are reserved for future determination.

DATED: December 19, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-709-664

ISSUES

¬ Are the respondents relieved of liability for the claimant's back surgery, intensive care treatment, and detoxification treatment because the claimant "fraudulently" concealed pertinent medical information, concerning his use of illegal narcotics and tobacco, from his treating physicians?

¬ Did the claimant prove by a preponderance of the evidence that the intensive care treatment and the detoxification treatment were causally related to the industrial injury, and that these treatments were reasonable and necessary?

¬ Did the respondents prove by a preponderance of the evidence that the claimant's use of tobacco constituted an injurious practice justifying reduction of his temporary disability benefits under § 8-43-404(3)?

¬ Are the respondents relieved of liability for the claimant's temporary total disability benefits because the claimant's "worsened condition" was procured by fraud?

FINDINGS OF FACT

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

1. The claimant sustained an admittedly compensable low back injury on December 27, 2006. The claimant was involved in a motor vehicle accident (MVA) when his car was sideswiped by a hit and run driver.

2. The claimant was ultimately diagnosed with an L2 compression fracture and disc protrusion at L3-4.

3. Dr. Sander Orent, M.D. became an authorized treating physician (ATP) on May 14, 2007. In July 2007, Dr. Orent referred the claimant to Dr. Michael Shen, M.D. for a surgical opinion. Dr. Shen diagnosed signs of an L3-4 disc herniation and an L2 "burst fracture" resulting in spinal instability. Dr. Shen recommended surgical intervention consisting of fusion at L2 and decompression of the L3-4 disc space.

4. The respondents disputed the cause of the need for the surgery, as well as the reasonableness and necessity for the surgery. The ALJ takes administrative notice that the issue of the respondents' liability for the surgery proceeded to hearing February 13, 2008. The ALJ further takes notice that on April 15, 2008, he entered Findings of Fact, Conclusions of Law, and Order directing the respondents to pay for the proposed surgery and the reasonable and necessary expenses ancillary to the surgery.

5. The ALJ infers that there was no appeal of the April 15, 2008, order, since Dr. Shen proceeded with the recommended surgery on June 9, 2008, and the respondents have not asserted that they appealed the order.

6. Prior to the June 9, 2008, surgery the claimant's treating physicians prescribed narcotic pain medications for relief of the injury-related back and leg pain. On September 6, 2007, Dr. Orent expressed concern that because the proposed surgery had been delayed and the pain was being controlled by oxycodone, the claimant was developing an iatrogenic addiction to narcotic pain medication.

7. The claimant also smoked cigarettes for many years prior to his industrial injury. On July 20, 2007, Dr. Chen warned the claimant that it was important that he stop smoking before surgery. The claimant admitted at hearing that he "knew they would not do the surgery" if any tests demonstrated the presence of nicotine in his body and that it was important to quit smoking.

8. On September 6, 2007, the claimant advised Dr. Orent that he had quit smoking.

9. On February 19, 2008, Dr. Lawrence Lesnak, D.O., saw the claimant on referral from Dr. Orent. Dr. Lesnak had previously been involved in the claimant's care. On Feburary 19, the claimant advised Dr. Lesnak that his analgesic medications, including MS Contin, were not working as well as they had in

the past. Dr. Lesnak stated that in light of the claimant's worsening symptoms "he most likely is building up somewhat of a tolerance to his opioid medication."

10. The anesthesia record for the surgery performed on June 9, 2008, states the claimant gave a history that he quit smoking two months ago.

11. Following the surgery the medical providers had extreme difficulty controlling the claimant's pain. The claimant was transferred to the intensive care unit where he was treated with narcotic medications.

12. On June 10, 2008, Dr. Philip Emrie, M.D., examined the claimant for consultation concerning "medical critical care issues postoperatively after spine surgery." At the time of the examination the claimant was sedated and unable to give an accurate history. However, Dr. Emrie noted that the claimant's "girlfriend" gave a history of chronic severe pain for which the claimant was receiving morphine and Dilaudid, and that the claimant had been "supplementing with illegally obtained fentanyl and Oxycontin." The history further states the claimant had been consuming significant quantities of vodka (1L per day). The note further states the claimant was a long-time smoker and he "continued to smoke until this hospitalization." Dr. Emerie's impression was narcotic dependence, a history of alcohol abuse with withdrawal symptoms, and tobacco abuse."

13. On June 10, 2008, the Dr. Phillip Engen, M.D., also examined the claimant. Dr. Engen's note states that the claimant had severe postoperative pain and "on the evening of his surgical procedure he did admit to nursing staff and physicians that he utilized opioid analgesics and he obtained these from illegal sources." Dr. Engen further noted the claimant "verbalized that he obtained approximately 100 to 300 mg of morphine and an unknown quantity milligram amount of Delaudid every day from an individual that he described as a man from Germany." The claimant advised Dr. Engen that he "spent approximately $150 or $200 a day obtaining these medications and he utilized his own savings and then borrowed money from his sisters to obtain this daily opioid analgesic." Dr. Engen diagnosed primary substance abuse "opiate analgesics and/or alcohol." Dr. Engen stated that these conditions would need to be addressed before the claimant left the hospital because he would not be in a position to utilize opiod medications appropriately. Dr. Engen referred the claimant to "West Pines" for "alcohol and opioid addiction eval and detox."

14. On June 21, 2008, the claimant was treated at the Exempla Lutheran emergency department for what he believed was a wound infection. At that time the claimant gave a history of smoking .3 packs of cigarettes per day, and denied drug abuse.

15. Dr. Orent credibly testified that he advised the claimant before surgery that he needed to be off tobacco in order to maximize the likelihood of hav-

ing a successful procedure. Dr. Orent "monitored" the claimant's use of tobacco by history, but did not perform any urinary continine tests before surgery.

16. Dr. Orent credibly testified that on June 23, 2008, the claimant admitted to him that he had been "abusing pharmaceuticals" that were probably narcotic, and had been abusing alcohol.

17. Dr. Orent credibly opined that the claimant's complications after surgery, including treatment in the ICU were "in part" caused by the abuse of narcotics, some of which were prescribed and some of which were purchased "on the street." Dr. Orent explained that he believed the claimant's "opiate receptors were taken up by these narcotics and it was very difficult to get pain relief and sedation simply because he had enough on board that – or the body gets resistant to it; it develops a tolerance to these medications." Dr. Orent testified that he would have considered it a "material fact" that the claimant was using non-prescribed narcotics, and that if he had known that fact the surgery would probably have been delayed pending detoxification.

18. Dr, Orent credibly testified that if the claimant continued smoking up to the time of the surgery, and if he had known of that fact, he would have recommended that surgery be delayed until after the claimant quit smoking. Dr. Orent credibly testified that tobacco use can hamper the claimant's recovery from surgery by interfering with the process of bone fusion.

19. Dr. Shen credibly testified that chemicals in cigarettes have been shown to decrease the rate of bone fusion, and are associated with wound complications and infections.

20. Dr. Shen testified that if he had known before surgery that the claimant was using illegally obtained medications he would have considered the fact to be material information, and he probably would not have proceeded with the surgery.

21. Dr. Shen credibly testified at his deposition held on September 18, 2008, that the claimant had just undergone a drug and nicotine screen. According to Dr. Shen, the results showed the presence of prescribed medications, which Dr. Shen considered normal, as well as the presence of "traces of nicotine." Dr. Shen credibly opined that the presence of nicotine was of concern because "it could absolutely decrease his chances of successful fusion, successful outcome."

22. The claimant testified that he had quit smoking, although he admitted that he sometimes takes a few "puffs" on cigarettes provided by friends. The ALJ finds the claimant's testimony that he has stopped smoking is not credible. The claimant's testimony is not credible because he has repeatedly misrepresented the truth about his smoking habits. Although the claimant told Dr. Orent

that he had quit smoking in September 2007, the anesthesiology notes reflect the claimant gave a history that he quit smoking only two months before the June 2008 surgery. The history obtained by Dr. Emrie from the claimant's "girlfriend" shows the claimant actually continued smoking up to the date of surgery. The claimant told the Exempla emergency room staff that he was still smoking .3 packs per day 12 days after the surgery. The tests provided by Dr. Shen in September 2008 showed the presence of nicotine in the claimant's system.

23. The claimant proved it is more probably true than not that the industrial injury was a proximate cause of the need for treatment in the ICU, and for the detoxification treatment recommended by Dr. Engen. The ALJ is persuaded that, although the claimant illegally procured narcotic medication and failed to disclose this information to Dr. Orent and Dr. Shen, the claimant's activities were not the sole cause of his addiction to opioid medication and alcohol prior to the surgery of June 9, 2008. The record establishes that well before surgery Dr. Orent and Dr. Lesnak expressed concern that the claimant was becoming tolerant of and perhaps addicted to the narcotic pain medications that they were prescribing for treatment of the injury-related back and leg pain. The ALJ infers from these concerns that the claimant's addiction to narcotic pain medication, and to some extent the consequent need for treatment in the ICU and detoxification, were caused by the industrial injury. Specifically, the injury caused pain, which in turn caused the treating physicians to prescribe large amounts of narcotic medication. These prescriptions contributed to the claimant's addiction and abuse of narcotic pain medication. Although the ALJ finds that the claimant procured drugs illegally, and that these personal activities were part of the cause of the need for treatment in the ICU and for detoxification, the claimant's personal drug seeking activities combined with the effects of the industrial injury to produce the need for treatment in the ICU and for detoxification.

24. The claimant proved it is more probably true than not that the treatment at the ICU and the detoxification treatment were reasonable and necessary treatments. The medical reports of Dr. Engen, as well as the credible testimony of Dr. Orent and Dr. Shen, establish the surgery combined with the claimant's addiction to narcotic pain medication to produce a need for stabilization in the ICU, as well as the need for detoxification.

25. On June 17, 2008, the respondents filed a General Admission of Liability admitting for temporary total disability (TTD) benefits commencing June 9, 2008, the date of the claimant's surgery.

26. The respondents proved it is more probably true than not that the claimant, by continuing to smoke both before and after the surgery, has persisted in an injurious practice that tends to imperil his recovery. Dr, Shen and Dr. Orent credibly testified that smoking tends to impair recovery from fusion surgery by promoting nonunion of the affected bones. The evidence also demonstrates that smoking can increase the likelihood of infection. The claimant admitted that he

was warned that he needed to stop smoking well before the surgery. Despite this warning the claimant continued to smoke until the date of the surgery, and lied to the medical providers concerning his continued smoking. The persuasive evidence including the nicotine test performed by Dr. Shen establishes the claimant has continued to smoke since the surgery. As found, the claimant's testimony that he has stopped smoking is not credible.

CONCLUSIONS OF LAW

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

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

DENIAL OF PAYMENT FOR SURGERY BASED ON ALLEGED FRAUD

The respondents contend they are not liable to pay for the surgery performed on June 9, 2008, because the claimant fraudulently induced his physicians to perform the surgery by concealing the fact that he continued to smoke before the surgery, and by failing to disclose his alleged addiction to "illegal pain narcotics." The ALJ concludes the respondents' liability for the surgery was determined by the ALJ's order of April 15, 2008, and the issue may not be reconsidered without the filing of a petition to reopen and proceedings on the petition.

As found, the ALJ entered Findings of Fact and Conclusions of Law on April 15, 2008, that required the respondents to pay for the surgery performed on the claimant's back on June 9, 2008. The ALJ infers the respondents' did not appeal this order since the surgery was performed.

It follows that the ALJ's order became an "award" that closed the issue of the respondents' liability to pay for the surgery. An order becomes an "award" by the exhaustion of or the failure to exhaust administrative review proceedings. *Koch Industries, Inc. v. Pena,* 910 P.2d 77 (Colo. App. 1995). An order that becomes final in this manner precludes any proceedings to increase or decrease benefits beyond those granted by the order absent an appropriate order reopening the proceedings." *Feeley v. Industrial Claim Appeals Office,* __P.3d__ (Colo. App. No. 07CA1389, September 4, 2008); *B & Root, Inc. v. Industrial Claim Appeals Office,* 833 P.2d 780 (Colo. App. 1992).

Although "fraud" constitutes a ground for reopening an award of medical benefits under § 8-43-303, C.R.S., the respondents have not filed a petition to reopen the ALJ's award of April 15, 2008. The ALJ concludes that the failure to file a petition to reopen as contemplated by § 8-43-303 and WCRP 7-3 is fatal to the respondents' argument that they are not liable for the surgery because the claimant procured it by fraud. The requirement to file a petition to reopen is no mere formality in the circumstances of this case. The respondents would be required to establish not only that the claimant engaged in fraudulent conduct that induced the surgery, but also that the claimant's conduct constitutes the type of fraud that warrants exercise of the ALJ's discretionary power to reopen. *See Travelers Insurance Co. v. Industrial Commission,* 646 P.2d 399 (Colo. App. 1981); *Calderon v. SBM Cleaning Co., LLC,* W.C. No. 4-526-764 (ICAO, February 18, 2004).

The evidence presented in this case raises at least a plausible argument that even if the claimant concealed information from his physicians his conduct is not the type of "fraud" that would warrant reopening under the circumstances. There is evidence, including the October 2007 deposition of Dr. Orent, that the claimant's smoking habit was well known to his physicians, and to the respondents, long before surgery. Similarly, the September 2007 medical records of Dr. Orent express concern about the claimant's possible addiction to narcotic medications. It could be argued that these issues should have been investigated and raised at the February 2008 hearing. Because the respondents have never filed a petition to reopen the issue of their liability for surgery decided by the ALJ's order of April 15, 2008, the claimant has not been afforded a fair opportunity to present evidence and make argument with respect to the discretionary aspect of the reopening issue. Therefore, this is not a case in which the ALJ will treat the respondents' application for hearing as a *defacto* petition to reopen. *Cf. Lewis v. Scientific Supply Co., supra*.

DENIAL OF PAYMENT FOR ICU AND DETOX TREATMENT BASED ON ALLEGED FRAUD

The respondents allege that they are not liable for the ICU treatment and post-surgery detoxification treatment he received because the claimant fraudulently concealed the fact that he continued smoking before surgery, and concealed his pre-surgery addiction to narcotic pain medication. The ALJ concludes that the respondents may not avoid liability for these medical benefits on the ground of fraud because the claimant's alleged misconduct falls within the ambit of § 8-43-404(3), C.R.S., and that statute does not provide for reduction or suspension of medical benefits as a remedy for engaging in an injurious practice or refusing reasonable medical treatment.

Section 8-43-404(3) provides, in pertinent part, that:

> If any employee persists in any unsanitary or injurious practice which tends to imperil or retard recovery or refuses to submit to such medical or surgical treatment or vocational evaluation as is reasonably essential to promote recovery, the director shall have the discretion to reduce or suspend the *compensation* of any such injured employee. (Emphasis added).

Prior to 1997, the Act contained no explicit remedy for respondents in cases where a claimant procured workers' compensation benefits by committing "fraud." Rather, a remedy for fraudulent conduct existed only to the extent that such a remedy could be inferred or implied by existing provisions of the Act. *See Kraus v. Artcraft Sign Co.,* 710 P.2d 480 (Colo. 1985); *Lewis v. Scientific Supply Co.,* 897 P.2d 905 (Colo. App. 1995). The only exception to this rule existed where the claimant provided materially false information to the employer or insurer on which they relied when filing an admission of liability. In such cases the admission could be found "void *ab initio*." *Vargo v. Industrial Commission,* 626 P.2d 1164 (Colo. App. 1981). However, in 1997 the General Assembly amended § 8-43-303, the reopening statute, to provide that "fraud" is a ground for reopening, and providing that a reopening based on fraud may affect moneys already paid. 1997 Colo. Sess. Laws, ch. 45, at pp. 114–115.

The ALJ concludes that prior to 1997 § 8-43-404(3), at least implicitly, provided remedies for specific types of claimant misconduct that could be classified as "fraudulent." Specifically, in cases where a claimant misrepresented to his treating physicians material facts concerning his health, and these misrepresentations tended to imperil or retard the claimant's recovery, such conduct could be sanctioned under § 8-43-404(3) as an "injurious practice." Similarly, if a claimant misrepresented his habits or physical condition to the treating physicians, and these misrepresentations were material to the physicians' choice of treatment, such misrepresentations could be sanctioned as a deliberate "refusal" to submit to reasonably essential medical care. Indeed, it may be safely assumed that

most medical treatment is predicated, at least in part, on the patient's truthful rendition of his health history as solicited by the physician. Further, falsification or concealment of one's medical history upon request for a history by the treating physician is as much a refusal to submit to reasonable care as is intentionally missing prescribed physical therapy appointments.

Of course § 8-43-404(3) expressly limits the remedies for persisting in an injurious practice or refusing to submit to treatment to reduction or suspension of "compensation." The term "compensation" as it is used in the Act has usually been construed as excluding medical benefits, particularly where the statute in question is in the nature of a "penalty" statute. *See Support Inc. v. Industrial Claim Appeals Office,* 968 P.2d 174 (Colo. App. 1998); *Wild West Radio, Inc. v. Industrial Claim Appeals Office,* 905 P.2d 6 (Colo. App. 1995) (*Wild West* II), *reaffirming Wild West Radio, Inc. v. Industrial Claim Appeals Office,* 886 P.2d 304 (Colo. App. 1994) (*Wild West* I). As explained in *Wild West* I, the two primary purposes of a loss-distribution system such a workers' compensation are to make the victim whole and see that the loss falls on the actual wrongdoer. Further, in workers' compensation, the "policy of making the worker whole is more important than placing the cost on the wrongdoer." (*Wild West* I).

The ALJ concludes that the term "compensation" as it is used in the last sentence of § 8-43-404(3) does not authorize the reduction or suspension of medical benefits. As with the statutes at issue in *Support Inc.* and *Wild West* I & II, § 8-43-404(3) is in the nature of a "penalty" statute because it permits the reduction or suspension of compensation based on misconduct of the claimant rather than the compensability of the injury itself. Moreover, to disallow medical benefits based on the claimant's misrepresentations to a treating physician might well place the ultimate loss on the physician, not the claimant as wrongdoer.

The ALJ concludes that the fraudulent conduct alleged by the respondents in this case, the claimant's misrepresentation and/or concealment of material facts from the treating physicians, constitutes a form of "injurious practice" tending to imperil or retard the claimant's recovery from surgery within the meaning of § 8-43-404(3). Similarly, these actions constitute a form of refusal to submit to reasonable medical treatment. Indeed the respondents acknowledge this fact since the basis of their argument is that if the claimant had disclosed his smoking and drug use the surgery would not have occurred. If the surgery had not occurred then the claimant would not have needed detoxification or treatment in the ICU, and his recovery from the surgery would not have been imperiled.

It follows from this discussion that the Act now contains at least two provisions that arguably address the remedy for the particular type of fraud that is alleged to have occurred in this case. First there is the general authority to redress fraud by ordering repayment as provided in § 8-43-303. Second there is the authority to sanction injurious practices and refusal to submit to treatment as provided in § 8-43-404(3).

The question arises whether the remedy for the type of fraud alleged in this case encompasses an order absolving the respondents of all liability for the resulting medical treatment, or whether the remedy is limited to reducing or suspending "compensation" under § 8-43-404(3). As a general matter, the object of statutory construction is to effectuate the legislative intent by giving words and phrases their plain and ordinary meanings. *Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176 (Colo. App. 2002). Statutes that address the same subject matter should be construed together. *Spracklin v. Industrial Claim Appeals Office, supra*. Further, a specific statutory provision prevails over a general provision unless the general provision was enacted later in time and the General Assembly demonstrated a clear intent that the general provision should prevail. *Freemeyer v. Industrial Claim Appeals Office,* 32 P.3d 564 (Colo. App. 2000).

Here, § 8-43-303 permitting a case to be reopened based on fraud is a general statute that was enacted later than § 8-43-404(3). Section 8-43-404(3) is a specific statute providing remedies to respondents for injurious practices by a claimant that tend to imperil or retard recovery. As noted, fraudulent concealment of relevant medical information from treating physicians can constitute such an injurious practice where it imperils or retards recovery or may constitute refusal to submit to treatment. The ALJ perceives no indication that by enacting § 8-43-303 the General Assembly intended to enlarge the scope of remedies available to respondents for conduct that amounts to an injurious practice under § 8-43-404(3) merely because such conduct might also meet the technical definition of fraud. *Cf. Wild West Radio, Inc. v. Industrial Claim Appeals Office,* 905 P.2d 6 (Colo. App. 1995) (where statute provides a 50% reduction in compensation when an injury results from intoxication the General Assembly has not evidenced an intent to preclude all compensation for injuries resulting from intoxication).

Therefore, the ALJ concludes that even if the claimant fraudulently misrepresented or concealed his smoking and narcotic addiction from Dr. Orent and Dr. Shen, and these actions caused the doctors to proceed with a surgery they would not otherwise have performed, such fraud would not excuse the respondents from liability for the surgery or the subsequent ICU treatment and detoxification treatment. Rather, such concealment is a form of injurious practice that tends to imperil or retard recovery, and a form of refusal to submit to reasonable treatment, and the remedies for such actions are specifically limited by § 8-43-404(3). Those remedies do not include relief of liability for medical treatment.

CAUSE OF NEED FOR ICU AND DETOXIFICATION TREATMENT

The respondents contend the claimant failed to prove that the need for the ICU and the detoxification treatment recommended by Dr. Engen are causally related to the industrial injury. Rather, the respondents assert that the cause of the need for these treatments was the claimant's personal addiction to alcohol and narcotics. The ALJ disagrees with this argument.

Section 8-41-301(1)(c), C.R.S., requires that an injury be "proximately caused by an injury or occupational disease arising out of and in the course of the employee's employment." Thus, the claimant must prove a causal nexus between the need for treatment and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). However, the industrial injury need not be the sole cause, or even the predominant cause, of the need for medical treatment if it is a significant, direct, and consequential factor in the need for treatment. *Resources One v. Industrial Claim Appeals Office,* 148 P.3d 287 (Colo. App. 2006); *Joslins Dry Goods Co. v. Industrial Claim Appeals Office,* 21 P.3d 866 (Colo. App. 2001); *Seifried v. Industrial Commission,* 736 P.2d 1262 (Colo. App. 1986); *Nicholl v. Canino Sausage Co., Inc.,* W.C. No. 4-473-725 (ICAO March 10, 2003). The question of whether the claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

As determined in Finding of Fact 23, the claimant proved it is more probably true than not that industrial injury was a proximate cause, although not the sole cause, of the need for treatment in the ICU and for detoxification treatment. The ALJ has found that the industrial injury caused pain, which in turn caused the treating physicians to prescribe large amounts of narcotic pain medication. Indeed, prior to surgery two of the treating physicians expressed concern about the amount of addictive medication being prescribed to the claimant. Thus, the fact that the claimant became resistant to opioids was, in part, attributable to the prescribed treatment for the industrial injury. In these circumstances, the claimant established the requisite causal connection between the industrial injury and the need for treatment in the ICU and for detoxification. *Cf. White v. Platte River Plumbing,* W.C. No. 4-399-491 (ICAO July 25, 2000).

REASONABLENESS AND NECESSITY FOR ICU TREATMENT AND DETOXIFICATION TREATMENT

The respondents also argue the claimant failed to prove the ICU treatment and detoxification treatment were reasonable and necessary medical treatment. Essentially, this argument is a reiteration of the argument that the treatment was solely for purposes of treating the personal aspect of the claimant's addictions.

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 treat-

ment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

The ALJ has determined the claimant proved a causal connection between the industrial injury and need for the ICU and detoxification treatments. Further, as determined in Finding of Fact 24, the claimant proved the ICU treatment and detoxification treatment were reasonably necessary to relieve the effects of the injury.

SANCTIONS FOR INJURIOUS PRACTICE

The respondents contend the evidence establishes the claimant persists in using tobacco, and that the continued use of tobacco constitutes an injurious practice that tends to imperil or retard his recovery from the injury and surgery. Relying on § 8-43-404(3) the respondents seek an order reducing the claimant's indemnity benefits based on the injurious practice. The ALJ concludes the claimant's temporary total disability benefits should be suspended until such time as he establishes that he has stopped smoking, or that smoking no longer imperils and/or retards his recovery.

As noted above, § 8-43-404(3) grants the ALJ discretionary authority to reduce or suspend compensation where the claimant persists in any injurious practice tending to imperil or retard recovery. Because this statute provides for a reduction or suspension of compensation to which the claimant is otherwise entitled, the respondents bear the burden of proof to establish the facts permitting imposition of the statutory sanctions. *See Padillo v. F. H. Linneman Construction Co.,* 29 Colo. App. 137, 479 P.2d 990 (1971).

As determined in Finding of Fact 26, the respondents proved it is more probably true than not that the claimant persists in the practice of smoking, and this practice tends to imperil his recovery from the fusion surgery. The ALJ, in the exercise of his discretion, concludes the claimant's TTD benefits should be suspended commencing the date of this order and continuing until such time as the claimant establishes that he has stopped smoking, or that the continuance of smoking no longer imperils his recovery. The ALJ declines to impose an absolute reduction in the claimant's compensation since the ALJ is not persuaded that the continuance of the smoking has actually interfered with or damaged the claimant's recovery. The persuasive testimony of Dr. Orent and Dr. Shen is to the effect that there is a risk to the claimant's recovery, not that the risk has actually been realized.

ENTITLEMENT TO TTD BENEFITS

The respondents state that they admitted liability for TTD benefits commencing June 9, 2008, the date of surgery, based on the decision in *Anderson v. Longmont Toyota, Inc.,* 102 P.3d 323 (Colo. App. 2004). According to the respondents, they demonstrated at the previous hearing that the claimant was re-

sponsible for "his termination after he took dozens of roses from his employer's refrigerator." The respondents assert that because claimant's "surgery was procured as a result of fraudulent statements to his treating physicians," his "worsened condition can not be held to be related to his industrial injury."

This argument appears to be a reiteration of the respondents' argument that the claimant's allegedly fraudulent statements severed any causal relationship between the industrial injury and the subsequent disability and need for treatment. The ALJ has already rejected the argument on grounds that the causal interaction between the treatment for the injury and the effects of the claimant's personal misconduct does not sever the requisite causal relationship. Rather, under the Act, the claimant's injurious practices tending to imperil or retard recovery are subject to the discretionary sanctions permitted under § 8-43-404(3).

ORDER

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

1. The insurer shall pay for the claimant's surgery on June 9, 2008, his ICU treatment, and any detoxification treatment related to the surgery and its aftermath.

2. The claimant's right to receive temporary total disability benefits shall be suspended as of the date of this order, and that suspension shall continue in effect until the claimant demonstrates that he is no longer engaged in the injurious practice of using tobacco, or that tobacco use no longer imperils and/or retards his recovery.

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

DATED: December 22, 2008

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-755-149

ISSUES

¬ Has claimant proven by a preponderance of the evidence that her ongoing shoulder complaints are related to her work activities?

FINDINGS OF FACT

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

1. Since 1995, claimant has worked for employer as a data specialist at the remittance processing center, processing payment of bills. A data specialist generally operates various machines to sort customer payments and to extract payment coupons and checks from envelopes. Once the payment coupons and checks have been extracted, the information on these coupons and checks are digitally captured. Finally, a data specialist will input the digitally captured data into a computer with the use of a keyboard (keying).

2. Since January of 2006, claimant has only worked on one of the rapid extraction machines, the OPEX 51 (hereinafter referred to as the "RED" machine). Claimant has also only worked in keying. Consequently, claimant has not performed the full range of duties of a data specialist since January of 2006. Employer assigned claimant to the RED machine and to keying in order to accommodate physical activity restrictions imposed because of a prior, work-related, lower back injury.

3. On March 21, 2008, claimant filed a Workers' Claim for Compensation (WCC), claiming an occupational disease-type injury to her right shoulder and arm allegedly caused by repetitive motion from opening mail and keying. Claimant testified:

> [W]hen you extract a lot of mail and you're using your arm a lot, your hand, you're reaching out, you're constantly. **It just started aching my whole arm. And it just starting swelling up this day that I just couldn't even move it.** My hand and my arm.

(Emphasis added). Although her testimony here was vague, claimant more likely attributes her right upper extremity symptoms to constant reaching with her right arm. Claimant alleges a date of onset of symptoms of January 10, 2008.

4. BG is claimant's supervisor. Although Ms. G completed a job profile for the data specialist position, claimant's work on the RED machine and keying is physically less demanding. The job profile thus fails to adequately describe the less physically demanding work claimant has performed on the RED machine and keying since January of 2006.

5. Ms. G testified about the physical demands of working on the RED machine. Essentially, the operator sits at the station on an adjustable chair. At this station, the operator performs the majority of activity at table level. The RED machine opens each envelope, one at a time, and places the envelope at table

level directly in front of the operator. The RED machine opens the envelope in such a manner that the operator can easily pull the contents out, separate them, and place them in their respective receptacles, all at table level. This activity involves very little reaching. The operator occasionally reaches for scissors, staple remover, or other tools. This Judge finds that Ms. G's testimony regarding the physical demands of working on the RED machine is persuasive.

6. Ms. G credibly testified that, in order to comply with restrictions from her lower back injury, claimant would rotate activity every two hours between opening mail on the RED machine and keying. In performing keying, claimant's physical activities involved nothing more than using a keyboard on a computer to enter data. Claimant was required to do no reaching at or above shoulder level. Crediting Ms. G's testimony concerning the level of exposure to operating the RED machine versus keying, the Judge finds: In 2006, claimant worked less than 30% of her hours on the RED machine, and over 70% keying. In 2007, claimant worked less than 25% of her hours on the RED machine, and over 75% keying.

7. Respondents' Exhibit A is a videotape that depicts an individual performing the job activities on the RED machine and keying. Exhibit A corroborates Ms. G's testimony as to claimant's activities on the RED machine and the data entry position.

8. Respondents' submitted performance summaries for claimant's job as a data specialist for the calendar years 2006 and 2007. These performance summaries document the length of time that claimant worked on particular machines for the calendar years 2006 and 2007. A clock is installed on each piece of equipment at the remittance processing center. Each data specialist has an ID that is used when they log into work at that particular piece of equipment. The clock captures the amount of time that each employee works on each piece of equipment during the day. The performance summaries generated for claimant in 2006 demonstrated that she worked on the RED machine for no more than 30% of the time. The 2007 performance summary documents that claimant only worked on the RED machine for 25% of the time. These performance summaries corroborate Ms. G's testimony that claimant worked no more than 30% of the time on the RED machine in 2006, and no more than 25% on the RED machine in 2007. Claimant's co-worker, CZ, testified at hearing that the clocks on these machines may not provide completely accurate information at all times. However, Ms. Z's testimony failed to persuasively show that claimant's performance summaries are unreliable for purposes of providing information showing her relative exposure to certain work activities at work.

9. Claimant testified that she believed she spent her entire 8-hour shift working on the RED machine in 2007. Claimant's testimony is markedly discrepant from the performance summaries showing she at most worked some 25% of her time operating the RED machine in 2007. Claimant's testimony concerning

her exposure to certain work-related activity, such as operating the RED machine, was unreliable and contrary to the weight of other credible evidence.

10. Employer referred claimant to Julie Parsons, M.D., who first examined her on January 14, 2008. Claimant reported to Dr. Parsons a history of progressive right arm pain for several years that worsened over the prior weekend. Dr. Parsons diagnosed right shoulder, forearm, and wrist strain. Dr. Parsons referred claimant for physical therapy and restricted her from using her right upper extremity. Dr. Parsons discontinued physical therapy on January 22, 2008, when claimant reported it making her arm considerably worse. Dr. Parsons nonetheless instructed claimant to use her right arm while alternating repetitive activities. Dr. Parsons reduced claimant's restrictions to no overhead work with the right arm.

11. On February 6, 2008, claimant reported to Dr. Parsons worsening right shoulder symptoms from walking activity the previous Saturday. Claimant reported that her right wrist and forearm symptoms were resolving. Dr. Parsons recommended claimant undergo a magnetic resonance imaging (MRI) scan of her right shoulder to rule out impingement or other shoulder pathology. Dr. Parsons reevaluated claimant on February 13, 2008, and reported that the MRI showed only mild tendinosis of the anterior supraspinatus, but was otherwise a normal shoulder study.

12. Because of claimant's complaints of worsening shoulder symptoms, Dr. Parsons referred her to Orthopedic Surgeon Christopher Isaacs, D.O., for an evaluation on February 19th. Dr. Isaacs administered a diagnostic/therapeutic steroid injection and continued her physical therapy. Claimant reported to Dr. Isaacs on March 10, 2008, that the injection did not help and that physical therapy was aggravating her shoulder. Claimant reported that she was deteriorating rather than improving. Based upon the history claimant gave him, Dr. Isaacs attributed claimant's shoulder symptoms to her work at employer. Dr. Isaacs recommended arthroscopic surgery to decompress the subacromial space of claimant's right shoulder. Because Dr. Isaacs based his causation opinion upon what claimant reported, and not upon the videotape, the Judge finds Dr. Isaacs's medical opinion unreliable.

13. In a report dated March 11, 2008, Dr. Parsons stated that claimant's work activities were the cause of her shoulder symptoms. There is no suggestion in Dr. Parsons' March 11, 2008, report that, as part of the data that she used in her causality analysis, she reviewed any video of an individual performing claimant's work activities, or that she spoke directly with Ms. G to obtain Ms. G's description of what claimant was actually doing for the period of time two years before the onset of her symptoms. Because Dr. Parsons did not base her causation opinion on any video of someone actually performing claimant's job for the last two years, nor on any information obtained directly from Ms. G, the Judge finds Dr. Parsons' medical opinion unreliable.

14. Employer referred claimant to Physiatrist Nicholas K. Olsen, D.O., for an independent medical examination on June 27, 2008. Claimant reported to Dr. Olsen that she spent 90% of her time working on the RED machine and 10% using the 10-key. Claimant reported that her symptoms began in the fall of 2007. Claimant reported that the injection by Dr. Isaacs temporarily increased her pain and then did not help. Upon physical examination, claimant stated to Dr. Olsen that she was unable to raise her right arm due to pain. Claimant reported that her arm swells and turns purple at times. As part of his evaluation, Dr. Olsen also reviewed a videotape of Claimant's work activities. Dr. Olsen, in his deposition, acknowledged that Exhibit A was the same videotape that he reviewed during his evaluation. Dr. Olsen noted that the videotape of claimant's work activities allowed her to keep her upper extremities well below shoulder height. Dr. Olsen opined it medically improbable that work activity depicted on the videotape caused her shoulder symptoms; he wrote:

> One would anticipate tendonitis developing in an individual who does over-the-shoulder/head work on a repetitive basis. These type of activities are not demonstrated in the video … and not reported by [claimant].

Dr. Olsen noted that the MRI scan was benign and failed to show any surgical lesion. Dr. Olsen opined that claimant is not a surgical candidate and that her symptoms were best addressed with the physical therapy program she already underwent.

15. Employer referred claimant to Orthopedic Surgeon Mark S. Failinger, M.D., for a second opinion and examination on August 25, 2008. Dr. Failinger, during his September 12, 2008, deposition, acknowledged that he was not specifically asked to address the causality of Claimant's right shoulder problems as part of his evaluation. Rather, Dr. Failinger was only asked to provide a second opinion as to whether Claimant was a surgical candidate. Nevertheless, Dr. Failinger obtained a detailed history of claimant's work activities, which she described as reaching in front of her body and repetitively reaching to eye level or above. Based upon this history, Dr. Failinger opined it medically probable claimant could have developed supraspinatus tendonitis from this frequent reaching activity. Dr. Failinger however expressed significant concerns about claimant undergoing arthroscopic decompression. Dr. Failinger opined that claimant's symptoms were diffuse and increasing when they should be decreasing because of inactivity. Dr. Failinger further wrote:

> A further concern is her diffuse nature of pain and discomfort including tingling and numbness and **significant pain reaction from**

> **what is in general a mild to moderate problem** in the face of no major rotator cuff tears or major inflammation shown on the MRI.

(Emphasis added). Dr. Failinger opined that claimant's presentation and response to treatment militated against surgical intervention because he felt it unlikely she would improve from surgery.

16. Dr. Failinger later reviewed a videotape of claimant's work activities at the employer. During his deposition, Dr. Failinger also verified that Exhibit A was the videotape that he had reviewed. Based on his review of the videotape, Dr. Failinger changed his opinion on causation. In his September 3, 2008, report, Dr. Failinger wrote the following:

> The video appeared to contradict the history given to me by [claimant] in which she stated that she reaches consistently and repetitively, reaching to head level or above. I did not observe any reaching overhead to pick up trays …. In the videotape, the person reaching for the mail intermittently would reach to approximately 50-60 [degrees] and, otherwise, had repetitive activities with her forearms and elbows and wrists, with shoulders in very low ranges of forward flexion. In the computer data entry, I did not see any significant reaching of the shoulder except in the very low ranges.

Dr. Failinger's above-quoted description is consistent and supported by the videotape depiction. Dr. Failinger opined it medically improbable that claimant's work activities caused any persistent rotator cuff tendonitis.

17. Dr. Olsen testified as an expert in Physiatry, Electrodiagnostic Medicine, and Level II Accreditation. Dr. Olsen testified:

> We haven't really defined what pathology needs to be addressed in surgery. There was a cortisone injection performed which didn't offer a lot of help. And given that the symptoms aren't classic for rotator cuff, that there isn't really any pathology in the MRI that would respond to surgery, it really raises doubt whether or not surgery is the best step in [claimant's] case. And I really think the MRI … suggests that surgery is not appropriate because we have a normal configuration.

(Emphasis added). Dr. Failinger offered an orthopedic opinion that supports that of Dr. Olsen. Dr. Failinger wrote:

> Assuming that the MRI reading is correct, one would be concerned about the relief provided from an arthroscopic decompression, especially given the fact that [claimant] did not have relief from the cortisone injection ….

Dr. Olsen questions Dr. Isaac's diagnosis of impingement syndrome. Dr. Olsen stated that the MRI scan fails to show impingement anatomy and claimant's failure to respond to a cortisone injection, which should at least temporarily relieve the symptoms from impingement, militates against such a diagnosis.

18. Claimant failed to show it more probably true than not that her work activities caused, increased, or to a reasonable degree aggravated her right shoulder tendinosis or impingement syndrome. The Judge credits the medical opinions of Dr. Olsen and Dr. Failinger as persuasive and supported by the videotape and Ms. G's testimony concerning claimant's activities at work. Crediting the medical opinions of Dr. Olsen and Dr. Failinger, there is no persuasive medical evidence otherwise showing claimant's complaints or symptoms are the result of any lesion or other pathology in her right shoulder. Crediting the medical opinions of Dr. Olsen and Dr. Failinger, there is no persuasive medical evidence otherwise showing claimant's complaints or symptoms are reasonably caused, increased, or aggravated by her activities at work.

CONCLUSIONS OF LAW

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

Claimant argues she has proven by a preponderance of the evidence that she sustained an occupational disease-type injury to her right shoulder arising out of her work activities. The Judge disagrees.

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 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. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), C.R.S. (2002), as:

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

(Emphasis added).

This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

Here, the Judge found claimant failed to show it more probably true than not that her work activities caused, increased, or to a reasonable degree aggravated her right shoulder tendinosis or impingement syndrome. Claimant thus failed to prove by a preponderance of the evidence that she sustained a compensable occupational disease-type injury to her right shoulder.

In so finding, the Judge credited the medical opinions of Dr. Olsen and Dr. Failinger as persuasive and supported by the videotape and Ms. G's testimony concerning claimant's activities at work. The Judge credited the medical opinions of Dr. Olsen and Dr. Failinger in finding no persuasive medical evidence other-

wise showing claimant's complaints or symptoms are the result of any lesion or other pathology in her right shoulder. The Judge further credited the medical opinions of Dr. Olsen and Dr. Failinger in finding no persuasive medical evidence otherwise showing claimant's complaints or symptoms are reasonably caused, increased, or aggravated by her activities at work.

The Judge concludes claimant's claim for workers' compensation benefits related to her right shoulder condition 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 workers' compensation benefits related to her right shoulder condition is denied and dismissed.

DATED: _December 23, 2008__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-654-557

ISSUES

The sole issue determined herein is respondents' request for penalties against claimant.

FINDINGS OF FACT

Claimant suffered an industrial injury on June 8, 2005. Claimant applied for a hearing.

On March 17, 2008, the Judge granted respondents' motion to compel claimant to answer interrogatories and request for production of documents within seven days.

Claimant withdrew the application for hearing. Claimant applied for another hearing.

On September 22, 2008, the Judge granted respondents' motion to compel claimant to answer interrogatories and request for production of documents within 10 days.

On November 24, 2008, claimant informed counsel for respondents that claimant was withdrawing his petition to reopen. Respondents objected and the parties appeared for hearing. The Judge granted Claimant's request to withdraw his petition to reopen.

Respondents have failed to prove by a preponderance of the evidence that claimant committed an unreasonable violation of the March 17 and September 22, 2008, orders compelling answers to respondents' discovery requests. The record evidence consists only of the two orders and the November 24 correspondence.

CONCLUSIONS OF LAW

Respondents seek a penalty pursuant to section 8-43-304(1), C.R.S. due to claimant's alleged violation of the March 17 and September 22, 2008, orders to provide discovery answers. Section 8-43-304(1), C.R.S. provides in pertinent part for penalties of up to $500 per day if respondent "violates any provision of articles 40 to 47 of this title, or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel . . ." Analysis of the penalty under section 8-43-304(1) is appropriate. *Holliday v. Bestop, Inc.*, 23 P.3d 700 (Colo. 2001) ("*Holliday II")* held that the phrase "for which no penalty has been specifically provided" referred to the third category of violations, failing to perform a duty lawfully enjoined, but it did not refer to penalties for failure to obey a lawful order of the director or panel. *Pena v. Industrial Claim Appeals Office of the State of Colorado,* 117 P.3d 84, (Colo. App. 2004) held that the limiting phrase applied to the first three categories, not just the third category. In any event, the fourth category, violating an order of the director, subjects the violator to a possible penalty under section 8-43-304(1), C.R.S., even if specific penalties may also be available. "Order" is defined in section 8-40-201(15), C.R.S. as including a rule: "'Order' means and includes any decision, finding and award, direction, rule, regulation, or other determination arrived at by the director or an administrative law judge." Under section 8-43-304(1), respondents must first prove that the disputed conduct constituted a violation of statute, rule, or order. *Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995); *Villa v. Wayne Gomez Demolition & Excavating, Inc.*, W.C. No. 4-236-951 (ICAO, January 7, 1997). Second, if the claimant committed a violation, penalties may be imposed only if the respondent's actions were not reasonable under an objective standard. *Pioneers Hospital of Rio Blanco County v. Industrial Claim Appeals* Office, 114 P.3d 97 (Colo. App. 2005); *Jiminez v. Industrial Claim Appeals Office*, 107 P.3d 965 (Colo. App. 2003); *Pueblo School District No. 70 v. Toth*, 924 P.2d 1094 (Colo. App. 1996). The standard is "an objective standard measured by the reasonableness of the action and does not require knowledge that the conduct was unreasonable." *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676, (Colo.App., 1995). As found, respondents have failed to prove by a preponderance of the

evidence that claimant committed an unreasonable violation of the March 17 and September 22, 2008, orders compelling answers to respondents' discovery requests. The record evidence consists only of the two orders and the November 24 correspondence.

ORDER

It is therefore ordered that:

1. Respondents' request for a penalty against claimant is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATED: December 23, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-738-898

ISSUE

The issue for determination is compensability.

FINDINGS OF FACT

1. Claimant filed an Application for Hearing on August 12, 2008. Claimant listed only the issue of "Compensability." Claimant gave his address as 11876 Lafayette St, Northglenn, CO 80233. The hearing was set to occur in Denver on December 23, 2008. Notice of the hearing was mailed to Claimant at that address and Respondents' counsel on September 29, 2008.
2. Claimant did not appear for the hearing. No evidence was introduced.

CONCLUSIONS OF LAW

A claimant in a workers' compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. No evidence was introduced. Claimant has failed to show by the evidence that he was injured as a result of his employment. The claim is not compensable.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *December 23, 2008*

Bruce Friend, ALJ
Office of Administrative Courts

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-768-654

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that he suffered an industrial injury during the course and scope of his employment with Employer on July 18, 2006.

2. Whether Claimant has established by a preponderance of the evidence that he is entitled to reasonable and necessary medical benefits that are designed to cure and relieve the effects of an industrial injury.

FINDINGS OF FACT

1. Claimant worked for Employer as a computer-assisted ordering coordinator. His duties involved ordering products, reviewing grocery shelves and re-packing or counting inventory.

2. Claimant testified that on July 18, 2008 he was re-packing inventory. He lifted an approximately 20 pound case of product from the floor and twisted to place the case in a "u-boat." Claimant explained that he immediately experienced excruciating pain in his lower back, dropped the case and fell to the floor. He remained on the floor for approximately one to two minutes. Claimant then attempted to complete his job duties but was unsuccessful.

3. Claimant advised night foreman TD that he had injured his back as a result of the incident. Mr. D offered to drive Claimant to an emergency room for medical treatment. However, Claimant declined and drove himself to the Poudre Valley Hospital Emergency Room.

4. At the emergency room Claimant reported that he suffered from a history of back pain as the result of a motor vehicle accident and had undergone a laminectomy in January 2008. He explained that he had been lifting a box at work and that his "back gave way." The emergency room physician stated that Claimant had a normal neurologic examination and concluded that he had suffered a muscle spasm in his left lumbar region.

5. On July 19, 2008 Claimant returned to the Poudre Valley Hospital Emergency Room. He recounted that he had fallen at work on the previous day when his back "gave out." Claimant stated that the incident caused pain in his neck and may have jarred his previous back fusion. He did not request any additional medication but "wanted to have it noted that his symptoms had changed overnight" and he was now having "numbness and tingling down his right arm and his right leg."

6. Employer referred Claimant to Ann K. Yanagi, M.D. for additional medical treatment. On July 21, 2008 Claimant visited Dr. Yanagi for an evaluation. She explained that, approximately three to four weeks earlier Claimant had visited personal physician Monica Serrano Toy, M.D. for an evaluation. A July 3, 2008 note from Dr. Toy reflects that Claimant complained of neck and back pain. Dr. Toy recommended physical therapy and adjusted his medications.

7. Dr. Yanagi reviewed Claimant's extensive history of prior back problems. The record reveals that on September 1, 2006 Dr. Toy commented that approximately three to four weeks earlier Claimant began suffering from the insidious onset of pain in his right shoulder, arm and neck area. On September 19, 2006 John Viola, M.D. examined Claimant and determined that he suffered from "symptoms of a C6 radiculopathy on the right side related to disc and osteophyte at C5-6 and C6-7." Because Claimant reported that he was suffering worsening symptoms, Dr. Viola subsequently performed an anterior diskectomy and fusion at C5-6.

8. Claimant continued to suffer from persistent neck and back pain. On October 22, 2007 Claimant told Dr. Serrano Toy that he experienced low back pain after being involved in a motor vehicle accident. On November 5, 2007 Dr. Serrano Toy advised Claimant that he suffered from multi-level disc disease in the lumbar spine that affected his right side nerve root. On November 19, 2007 Dr. Viola noted that an MRI scan revealed Claimant suffered from degenerative disc disease predominantly at the L4-5 and L5-S1 levels. He diagnosed Claimant with "symptoms related to lumbar degenerative disc disease, most marked at L4-5, as well as some disc protrusion at the L4-5 level on the right, causing mild radiculopathy." On January 2, 2008 Claimant thus underwent surgery that consisted of a "laminectomy and discectomy." At the time of the surgery, Dr. Viola advised Claimant that the surgery had a reasonable chance of improving his symptoms but that he could "require much more extensive surgical decompression and fusion" if he could not tolerate the symptoms.

9. In a July 31, 2008 report Dr. Yanagi considered whether Claimant's back and neck symptoms were caused by the July 18, 2008 industrial incident or were related to his pre-existing condition. Dr. Yanagi thus referred Claimant to Jeffrey A. Wunder, M.D. for a causality determination.

10. Dr. Wunder evaluated Claimant on August 12, 2008 and August 26, 2008. He also testified at the hearing in this matter. Based on a review of Claimant's prior medical history, Dr. Wunder noted that Claimant suffered from pre-existing upper and lower back symptoms. He commented that Claimant's physical examination, specifically straight leg raises, yielded comparable results before and after the July 18, 2008 industrial incident. Furthermore, Claimant's subjective pain levels did not change after July 18, 2008.

11. Dr. Wunder compared Claimant's lumbar MRI's from November 2, 2007 and August 19, 2008. The August 19, 2008 MRI revealed degenerative disc disease at L5-S1. The MRI also demonstrated a broad disc bulge at L4-5 that had improved significantly as a result of Claimant's January 2, 2008 surgery. The findings at L4-5 on the August 19, 2008 MRI were thus "predominantly post-operative" and did not occur on July 18, 2008.

12. Dr. Wunder summarized that the July 18, 2008 incident caused a temporary aggravation of Claimant's symptoms but did not impact his underlying condition. Dr. Wunder thus concluded that there was no evidence that the July 18, 2008 incident caused an aggravation of Claimant's prior back and neck symptoms. He summarized that Claimant's condition was "100% preexisting."

13. Claimant has failed to demonstrate that it is more probably true than not that he suffered an industrial injury during the course and scope of his employment with Employer on July 18, 2008. Although Claimant experienced back and neck symptoms while working for Employer on July 18, 2008, his employment did not aggravate, accelerate, or combine with his pre-existing condition to produce a need for medical treatment. The record is replete with evidence that Claimant suffered an extensive history of back and neck problems. In approximately August 2006 Claimant began suffering from the insidious onset of pain in his right shoulder, arm and neck area. Subsequent testing revealed lumbar degenerative disc disease that ultimately resulted in an anterior diskectomy and fusion at C5-6. On January 2, 2008 Claimant also underwent a laminectomy and discectomy. Dr. Viola advised Claimant that the surgery had a reasonable chance of improving his symptoms but that he could "require much more extensive surgical decompression and fusion" if he was unable to tolerate the symptoms. In fact, approximately two weeks prior to July 18, 2008 Claimant visited personal physician Dr. Serrano Toy because he was experiencing neck and back pain.

14. Dr. Wunder persuasively testified that Claimant's physical examination, specifically straight leg raises, yielded comparable results before and after the July 18, 2008 industrial incident. Furthermore, Claimant's subjective pain levels did not change after July 18, 2008. Dr. Wunder also noted that the findings on an August 19, 2008 MRI were "predominantly postoperative" and did not occur on July 18, 2008. He thus summarized that the July 18, 2008 incident caused a temporary aggravation of Claimant's symptoms but did not impact his

underlying condition. Dr. Wunder credibly concluded that there was no evidence that the July 18, 2008 incident caused an aggravation of Claimant's prior back and neck symptoms and that Claimant's condition was "100% preexisting." Claimant's need for medical treatment was thus not caused by the aggravation of a pre-existing condition while working for Employer but was more likely caused by the natural progression of his chronic back condition.

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 worker's 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 worker's 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 worker's 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 (2005).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §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 determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered an industrial injury during the course and scope of his employment with Employer on July 18, 2008. Although Claimant experienced back and neck symptoms while working for Employer on July 18, 2008, his employment did not aggravate, accelerate, or combine with his pre-existing condition to produce a need for medical treatment. The record is replete with evidence that Claimant suffered an extensive history of back and neck problems. In approximately August 2006 Claimant began suffering from the insidious onset of pain in his right shoulder, arm and neck area. Subsequent testing revealed lumbar degenerative disc disease that ultimately resulted in an anterior diskectomy and fusion at C5-6. On January 2, 2008 Claimant also underwent a laminectomy and discectomy. Dr. Viola advised Claimant that the surgery had a reasonable chance of improving his symptoms but that he could "require much more extensive surgical decompression and fusion" if he was unable to tolerate the symptoms. In fact, approximately two weeks prior to July 18, 2008 Claimant visited personal physician Dr. Serrano Toy because he was experiencing neck and back pain.

7. As found, Dr. Wunder persuasively testified that Claimant's physical examination, specifically straight leg raises, yielded comparable results before and after the July 18, 2008 industrial incident. Furthermore, Claimant's subjective pain levels did not change after July 18, 2008. Dr. Wunder also noted that the findings on an August 19, 2008 MRI were "predominantly postoperative" and did not occur on July 18, 2008. He thus summarized that the July 18, 2008 incident caused a temporary aggravation of Claimant's symptoms but did not impact his underlying condition. Dr. Wunder credibly concluded that there was no evidence that the July 18, 2008 incident caused an aggravation of Claimant's prior back and neck symptoms and that Claimant's condition was "100% preexisting." Claimant's need for medical treatment was thus not caused by the aggravation of a pre-existing condition while working for Employer but was more likely caused by the natural progression of his chronic back condition.

ORDER

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

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

DATED: December 23, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-736-105

ISSUES

The issues determined herein are maximum medical improvement ("MMI"), additional surgery, and permanent partial disability ("PPD") benefits.

FINDINGS OF FACT

1. Claimant was employed by the employer as a housekeeper. On June 3, 2007, claimant sustained an admitted industrial injury to her left knee when she was kneeling down in the restroom to clean and her left knee popped and she felt pain.

2. On June 4, 2007, Dr. Dern examined claimant, who had full range of motion, negative x-rays, and was diagnosed with left knee strain.

3. On June 12, 2007, a magnetic resonance image ("MRI") of claimant's left knee revealed normal medial lateral meniscus and ligaments, but chondromalacia with focal full thickness articular cartilage defect involving the medial femoral condyle and heterogeneous signal surface irregularity involving articular cartilage of the patella, and small to moderate joint effusion.

4. On June 15, 2007, Dr. William Ciccone performed an orthopedic examination of claimant. He diagnosed left anterior knee pain with chondromalacia. Dr. Ciccone noted that most of her pain was coming from the areas of cartilage thinning about her knee. Prior to seeing Dr. Ciccone, claimant reported on the intake form that she had a previous injury to her knee three years ago, including pain when she would bend.

5. Claimant was treated only with medication and physical therapy.

6. On August 7, 2007, Dr. Ciccone reexamined claimant, who reported worsening pain in the knee. Dr. Ciccone administered an injection to the left knee and continued physical therapy.

7. On August 28, 2007, Dr. Ciccone reexamined claimant, who reported persistent pain over the anterior aspect of her knee. Dr. Ciccone noted that the MRI scan showed mild chondromalacia within the patella, but the condition was not operative. Dr. Ciccone believed that claimant's pain at that point would not respond to operative treatment. He felt that she was approaching MMI at that time.

8. On September 12, 2007, claimant was seen by J.S. Walia, M.D., at which time she was placed at MMI for left knee chondromalacia. Dr. Walia found claimant to have claimant no pain, full range of motion, and no definite tenderness or effusion. Dr. Walia determined 20% impairment of the lower extremity pursuant to *American Medical Association Guides to Evaluation of Permanent Impairment, Third Edition Revised* Table 40. Dr. Walia released claimant to return to her regular job, which she had been performing for the last few weeks without difficulty. Maintenance care in the form of continuation of home exercise program was recommended. Dr. Walia noted that no surgery was anticipated at the time of MMI.

9. In reply to correspondence from the workers' compensation adjuster, Dr. Walia declined to change his impairment rating of 20% and referred to the MRI results.

10. Claimant continued to perform her regular duty work and did not seek additional medical treatment for her left knee injury.

11. On April 2, 2008, Robert McCurry, D.O. performed a Division Independent Medical Examination ("DIME") of claimant. Dr. McCurry noted that claimant was favoring her left knee with ambulation and stiffness and, at times, an exaggerated limp and gait. She had no sign of swelling bilaterally or increased warmth about the left knee compared to the right. Dr. McCurry determined that claimant had reached MMI on September 12, 2007, as determined by Dr. Walia. Dr. McCurry, however, determined that Dr. Walia's rating of 20% impairment of the lower extremity, the highest rating that can be given for chondromalacia, was excessive. Dr. McCurry noted that claimant was able to return to a near non-painful state at modified duty post injury, the mechanism of injury from a single squat is inconsistent with patient's severity of complaints, there is a high probability that claimant was already experiencing periodic knee discomfort, the full thickness articular cartilage defect as seen on the MRI is relatively small, and claimant's diagnosis of chondromalacia indicates that the condition is a process over time rather than acute problem. Consequently, Dr. McCurry rated claimant with 10% impairment of lower extremity due to her continued knee discomfort and abnormality on the MRI scan. This extremity rating converts to 4% whole person impairment. Dr. McCurry found no impairment due to range of motion. Dr. McCurry recommended maintenance care after MMI, including anti-inflammatory medication and a patellar stabilization knee brace.

12. On April 9, 2008, Dr. Castrejon examined claimant. He noted that claimant had a normal gait with mild diffused tenderness. Her range of motion was 124 to 134 degrees, improving with distraction. He did not feel that her subjective level 10/10 pain was supported by her visual or physical examination. Dr. Castrejon diagnosed claimant with anterior knee pain consistent with chondromalacia, which is inflammation and a

wear and tear of the cartilage portion of the joint. This is a process over time rather than an acute condition. There were no new findings that would support a need for surgery. Dr. Castrejon concluded that claimant remained at MMI and he determined that 10% impairment of the lower extremity was more reasonable than the 20% determined by Dr. Walia.

13. On April 18, 2008, the employer filed a final admission of liability for PPD benefits based upon 10% of the leg, as well as for post-MMI medical benefits.

14. On May 6, 2008, David Walden, M.D., an orthopedic surgeon, examined claimant, who reported longstanding chronic problems dating back to 2005. Based upon the MRI scan taken shortly after the work related incident, Dr. Walden thought claimant's condition was indicative of osteoarthritis with acute irritation. Dr. Walden concluded that claimant had left knee acute irritation of the medial femoral condyle and patellar chondral defects. He further noted that the mechanism of injury that claimant was describing was unlikely to have produced a significant osteoarthritic change in the knee, but rather it was likely an irritation of the underlying condition. Dr. Walden did not believe that surgical intervention would make a significant difference with regard to claimant's knee, but he suggested that at some point in the future she would need a total knee arthroplasty that would not be due to the workers' compensation injury. Walden recommended viscosupplementation of the left knee, noting that he would then place claimant at MMI.

15. On July 23, 2008, Dr. Castrejon indicated that he agreed that the work injury aggravated claimant's preexisting chondromalacia, causing the need for the viscosupplementation.

16. On August 4, 2008, Dr. Hall performed an IME for claimant. He noted that the medical records did not indicate that claimant had improved with treatment after her work injury. He concluded that she was not at MMI and needed diagnostic arthroscopy.

17. On August 11, 18 and 25, 2008, claimant underwent viscosupplementation, consisting of three injections of hyalgin to attempt to improve cartilage function and joint fluid and provide symptomatic relief for arthritic changes in the knee. At the time of her first injection, her physical examination demonstrated 5 degrees flexion contracture, 130 degrees of flexion, no limp, normal neurologic and vascular exams, and full hip range of motion without pain.

18. On August 27, 2008, Dr. Castrejon indicated that additional surgery would be reasonable for claimant, but it was not due to the work injury.

19. At hearing, claimant admitted that at MMI her knee did not swell so badly and she felt much better. She further testified that she felt very well and did not have any pain until January 2008. Claimant has an active lifestyle and enjoys running, walking, cleaning the house and working. She enjoyed these activities prior to the work incident on June 3, 2007, and continued these activities after MMI on September 12, 2007. She now alleges that she is no longer able to run, walk, or clean house.

20. Dr. Castrejon testified at hearing that claimant had a preexisting problem in her left knee and that the work injury caused a temporary flareup of the preexisting condition. In his opinion, claimant returned to baseline after treatment. She has then experienced a natural progression of the preexisting condition. Dr. Castrejon noted that claimant was able to return to regular duty work for seven months prior to seeking further treatment. Consequently, the additional treatment was not due to the work injury and claimant remains at MMI.

21. Dr. Walden testified by deposition. After being informed that claimant had no pain at MMI, had full range of motion, was released to full duty, and continued to perform her job duties 100% with no pain until January 2008, her condition was stable and she was at MMI. Dr. Walden opined that claimant's current symptoms were due to the natural progression of her underlying condition. Dr. Walden recommended use of ambulatory support such as a cane, anti-inflammatory medications such as Ibuprofen, Tylenol, or similar medications, application of ice, keeping her knee as strong as possible, and altering the way she does activities, as well as a repeat course of viscosupplementation. Dr. Walden concluded that claimant was not a surgical candidate at the present time. He noted that arthroscopy is not indicated for the chondromalacia and claimant had normal menisci and ligaments.

22. Contrary to claimant's testimony that Dr. Castrejon treated her for low back pain, he did not even record any complaints of back pain.

23. No clear and convincing evidence demonstrates that the MMI determination by the DIME is incorrect. Dr. Walia determined MMI as of September 12, 2007, because claimant was stable. Dr. McCurry, the DIME physician, agreed. Dr. Walden's deposition testimony supports that same determination. Dr. Castrejon agreed that claimant was still at MMI. Dr. Hall's lone dissenting view does not demonstrate that it is highly probable that Dr. McCurry is incorrect. In spite of the provision of viscosupplementation after MMI, claimant's condition on September 12, 2007, was stable and unlikely to improve with additional treatment.

24. Claimant has failed to prove by a preponderance of the evidence that arthroscopic surgery is reasonably necessary to cure or relieve the effects of the work injury. Dr. Walden's expert opinion is most persuasive that arthroscopy is not indicated for someone with claimant's chondromalacia and normal menisci and ligaments.

25. Claimant has failed to prove by a preponderance of the evidence that she suffered functional impairment not expressed on the schedule of disabilities. Claimant alleges that she suffered low back pain from the injury, but that allegation is not supported by the medical records. In any event, claimant's permanent impairment is limited solely to the left knee, distal to the hip joint.

26. The preponderance of the evidence demonstrates that claimant suffered 10% impairment of the lower extremity due to the chondromalacia, as determined by Dr.

McCurry and Dr. Castrejon. The determination involves a judgment about the extent of the impairment within a range permitted by the *American Medical Association Guides to Evaluation of Permanent Impairment, Third Edition Revised.* The explanation by Dr. McCurry and by Dr. Castrejon are more persuasive than the unexplained rating by Dr. Walia.

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. McCurry, determined that claimant was at MMI on September 12, 2007. 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 the determination by the DIME is incorrect.

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). The employer admitted liability for post-MMI medical treat-

ment, but the employer remained free to contest the reasonable necessity of any future treatment. *Milco Construction v. Cowan*, 860 P.2d 539 (Colo. App. 1992). As found, claimant has failed to prove by a preponderance of the evidence that arthroscopic surgery is reasonably necessary to cure or relieve the effects of the work injury.

4. Section 8-42-107, C.R.S., sets forth two different methods of compensating medical impairment. Subsection (2) provides a schedule of disabilities and Subsection (8) provides a DIME process for whole person ratings. The threshold issue is application of the schedule and this is a determination of fact based upon a preponderance of the evidence. The application of the schedule depends upon the "situs of the functional impairment" rather than just the situs of the original work injury. *Langton v. Rocky Mountain Health Care Corp.,* 937 P.2d 803 (Colo. App. 1996); *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). The heightened burden of proof in Subsection (8) applies only if the threshold determination is made that the impairment is not limited to the schedule. Then, and only then, does either party face a clear and convincing evidence burden to overcome the rating of the DIME. *Webb v. Circuit City Stores, Inc.*, W.C. No. 4-467-005 (ICAO, August 16, 2002). As found, claimant has failed to prove by a preponderance of the evidence that she suffered functional impairment not expressed on the schedule of disabilities. As found, claimant suffered 10% impairment of the leg at the hip. Section 8-42-107(2)(w), C.R.S.

ORDER

It is therefore ordered that:

1. Claimant's claim for medical benefits in the form of arthroscopy is denied and dismissed.

2. Claimant's claim for additional PPD benefits is denied and dismissed.

DATED: December 24, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-358-465

PROCEDURAL BACKGROUND

Hearing in this matter was held before Administrative Law Judge (ALJ) Peter J. Cannici on September 28, 2007 at the Loveland Municipal Court in Loveland, Colorado. The proceedings were recorded in Courtroom M from approximately 2:35 p.m. until 4:00 p.m. The Judge held the record open for the parties to complete deposition testimony and submit position statements by March 25, 2008.

On April 15, 2008 ALJ Cannici issued Findings of Fact, Conclusions of Law and Order (collectively "Order") in this matter. The Order denied Claimant's request for medical benefits from personal provider Kaiser Permanente during the period February 17, 2001 until October 1, 2002 because they were not authorized. The Order awarded Claimant Temporary Total Disability (TTD) benefits for the period August 1, 2001 until November 7, 2001 but denied additional TTD benefits because Claimant failed to demonstrate that her worsened condition caused a greater impact on her work capability than she originally sustained as a result of her industrial injury.

Claimant sought review of the Order based on the denial of medical benefits and the November 7, 2001 termination of TTD benefits. On September 24, 2008 the Industrial Claim Appeals Panel (Panel) remanded the April 15, 2008 Order on two grounds. First, the Panel ordered ALJ Cannici to consider the effects of Claimant's Petition to Reopen on Claimant's entitlement to medical benefits from Kaiser Permanente. Second, the Panel required ALJ Cannici to consider whether there was a statutory condition for terminating Claimant's TTD benefits.

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that she was entitled to receive authorized medical treatment from February 17, 2001 until October 1, 2002 that was reasonable and necessary to cure and relieve the effects of her industrial injury.

2. Whether Claimant has established by a preponderance of the evidence that she was entitled to receive TTD benefits from August 1, 2001 until terminated by statute.

FINDINGS OF FACT

1. On September 17, 1997 Claimant suffered an admitted industrial injury to her lower back during the course and scope of her employment with Employer.

2. Claimant subsequently underwent extensive medical treatment for her injuries. On May 7, 1998 she reached Maximum Medical Improvement

(MMI). She was released with permanent work restrictions of no repetitive lifting in excess of 20 pounds.

3. On June 10, 1998 Claimant obtained medical treatment with personal medical provider Kaiser Permanente for the worsening of her lower back condition. On June 22, 1998 Claimant sought to obtain additional evaluations and treatment from Kaiser. However, Insurer denied the request because Kaiser was not an authorized provider.

4. On August 13, 1998 Claimant underwent a Division Independent Medical Examination (DIME) with Douglas E. Hemler, M.D. Dr. Hemler agreed that Claimant had reached MMI and assigned her a 10% whole person impairment rating. He did not recommend any additional medical care or treatment.

5. On September 3, 1998 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Hemler's 10% whole person impairment rating. Claimant did not object to the FAL and her case closed by operation of law.

6. On February 16, 2001 Claimant filed a Petition to Reopen her claim based on a worsening of her condition. Respondents were thus on notice that Claimant sought additional medical treatment for her lower back condition. Nevertheless, Respondents did not designate a physician who was willing to provide treatment to Claimant.

7. On August 1, 2001 Claimant underwent lower back lumbar fusion surgery through Kaiser Permanente. On October 8, 2002 she underwent an additional procedure through Kaiser to remove hardware from her back.

8. On October 19, 2002 Claimant suffered additional injuries to her lower back as a result of a motor vehicle accident. She received extensive medical treatment for her injuries.

9. On June 9, 2005 Claimant underwent an independent medical evaluation with John S. Hughes, M.D. Dr. Hughes concluded that Claimant suffered a worsening of condition "as a result of a natural progressive degenerative cascade" between the time she reached MMI on May 7, 1999 and her October 19, 2002 motor vehicle accident. He explained that Claimant's worsened condition included the "development of right lower extremity radiculopathy and segmental instability in conjunction with a true grade 1 spondylolisthesis at L4-L5."

10. On April 24, 2007 ALJ Barbara S. Henk entered Findings of Fact, Conclusions of Law and Order on Remand in this matter. ALJ Henk granted Claimant's Petition to Reopen her claim. ALJ Henk reasoned that Claimant suffered a worsening of her condition that was causally related to her September 17, 1997 industrial injury. She explained that the worsening of Claimant's condition

was limited to the period between the date of the FAL and the October 19, 2002 motor vehicle accident.

11. On September 7, 2007 Ranee Shenoi, M.D. conducted an independent record review of Claimant's case. Dr. Shenoi opined that, between reaching MMI and suffering the intervening motor vehicle accident, Claimant's condition did not naturally progress as a result of her industrial injury. Instead, she opined that Claimant suffered from an underlying pars defect in her lumbar spine and that the natural progression of the defect could be expected to involve periods of waxing and waning. Dr. Shenoi thus concluded that Claimant's fusion surgery through Kaiser was most likely related to the long-term pars defect.

12. On November 5, 2007 the parties conducted the evidentiary deposition of Dr. Shenoi. Dr. Shenoi reiterated her opinion that Claimant did not suffer a worsening of condition between the time she reached MMI and her October 19, 2002 motor vehicle accident. She explained that Claimant suffers from a chronic structural pars defect at L5 that is likely to cause lower back problems for the foreseeable future.

13. Dr. Hughes testified at the hearing in this matter. He explained that Claimant suffered from an L5 pars defect that remained clinically silent until her industrial injury. He noted that Claimant's industrial injury caused her to require lumbar fusion surgery on August 1, 2001. Dr. Hughes opined that Claimant was totally disabled for two weeks after her surgery and that Claimant would have had sedentary work restrictions until November 7, 2001. After November 7, 2001 Claimant would have had light duty work restrictions of no lifting in excess of 20 pounds.

14. On February 13, 2008 the parties conducted the evidentiary deposition of Dr. Hughes. Dr. Hughes explained that he agreed with Dr. Shenoi that Claimant had suffered from a pars defect prior to her September 17, 1997 industrial injury. However, he explained that Claimant became symptomatic after her industrial injury and developed a "segmental instability." The industrial injury thus caused an aggravation of the preexisting pars defect. Dr. Hughes commented that Claimant suffered a worsening of her condition based on a "well documented persistence of mechanical back pain." Claimant thus sustained a "natural progression of microinstability" at L5 and benefited from fusion surgery on August 1, 2001.

15. Claimant has established that it is more probably true than not that she received "authorized" medical treatment from personal medical provider Kaiser Permanente for the period February 17, 2001 until October 1, 2002. On February 16, 2001 Claimant filed a Petition to Reopen her claim based on a worsening of her condition. Respondents were thus on notice that Claimant sought additional medical treatment for her lower back condition. Nevertheless, Respondents did not designate a physician who was willing to treat Claimant's worsened

condition. The right to select a physician thus passed to Claimant. Claimant's treatment through Kaiser Permanente was therefore authorized.

16. The medical treatment that Claimant received from Kaiser Permanente was also reasonable and necessary to cure and relieve the effects of her industrial injury. Dr. Hughes credibly testified that Claimant suffered from an L5 pars defect that remained clinically silent until her industrial injury. He explained that Claimant became symptomatic after her industrial injury and developed a "segmental instability. She sustained a "natural progression of microinstability" at L5. Claimant subsequently suffered a worsening of her condition based on a "well documented persistence of mechanical back pain." She thus required lumbar fusion surgery on August 1, 2001. In contrast, Dr. Shenoi stated that the natural progression of Claimant's pars defect could be expected to involve periods of waxing and waning and concluded that Claimant's fusion surgery was most likely related to the long-term pars defect. However, Dr. Shenoi's opinion is not persuasive because it fails to acknowledge that Claimant did not develop any symptoms from her pars defect until after her industrial injury. Accordingly, Respondents are financially responsible for the treatment that Claimant received from Kaiser Permanente from February 17, 2001 until October 1, 2002.

17. Claimant has established that it is more probably true than not that her worsened condition caused a greater impact on her work capability than she originally sustained as a result of her industrial injury beginning on August 1, 2001. Respondents have failed to produce persuasive evidence that Claimant 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. Claimant is thus entitled to receive TTD benefits from the date of her fusion surgery on August 1, 2001 until terminated by statute.

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 (2005).

Medical Benefits

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). "Authorization" refers to the physician's legal status to treat the injury at the respondents' expense. *In Re Leibold,* W.C. No. 4-304-437 (ICAP, Jan. 3, 2008). The determination of whether treatment was rendered by an "authorized" treating physician is a question of fact for determination by the ALJ. *In Re Sincavage,* W.C. No. 4-684-642 (ICAP, Mar. 8, 2007).

5. Under §8-43-404(5), C.R.S. the respondents have the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *In Re Leibold,* W.C. No. 4-304-437 (ICAP, Jan. 3, 2008). If the claimant does not obtain proper permission, the treatment provided by personal physicians is not compensable. *In Re Cabela,* W.C. No. 4-701-794 (ICAP, Dec. 10, 2007).

6. When a claim has been closed and a claimant seeks to reopen the claim based on a worsening of condition, the claimant must notify the respondents of her desire to obtain additional medical treatment prior to obtaining the treatment. *In Re Gonzales,* W.C. No. 4-250-651 (ICAP, Nov. 27, 2000). The claimant must notify respondents of the request for treatment because an MMI determination terminates the claimant's right to medical benefits. *Id.* The claimant thus bears the burden of providing notice to the employer that additional benefits are sought. *Id.* The notice triggers the respondent's duty to designate an authorized treating physician. *Id.* The right to select a physician thus only passes to the claimant if the respondents fail to designate a physician after receiving notice that the claimant seeks to reopen the claim. *Id.*; *see Wright v. City and County of Denver,* W.C. No. 4-172-294 (Dec. 4, 1995). Whether a claimant has notified the respondents of her request to reopen the claim prior to the selection of a treating physician and whether the respondents designated a treating physician are questions of fact for the ALJ. *See Ruybal v. University Health Sciences Center,* 768 P.2d 1259 (Colo. App. 1988).

7. Claimant requests payment for the medical benefits she received from Kaiser Permanente for the period February 17, 2001 until October 1, 2002. ALJ Henk's Order concluded that Claimant had suffered a worsening of her condition and reopened her claim. However, the Order did not address whether any subsequent treatment was authorized, reasonable or necessary.

8. As found, Claimant has established by a preponderance of the evidence that she received "authorized" medical treatment from personal medical provider Kaiser Permanente for the period February 17, 2001 until October 1, 2002. On February 16, 2001 Claimant filed a Petition to Reopen her claim based on a worsening of her condition. Respondents were thus on notice that Claimant sought additional medical treatment for her lower back condition. Nevertheless, Respondents did not designate a physician who was willing to treat Claimant's worsened condition. The right to select a physician thus passed to Claimant. Claimant's treatment through Kaiser Permanente was therefore authorized.

9. As found, the medical treatment that Claimant received from Kaiser Permanente was also reasonable and necessary to cure and relieve the effects of her industrial injury. Dr. Hughes credibly testified that Claimant suffered from an L5 pars defect that remained clinically silent until her industrial injury. He explained that Claimant became symptomatic after her industrial injury and developed a "segmental instability. She sustained a "natural progression of microinstability" at L5. Claimant subsequently suffered a worsening of her condition based on a "well documented persistence of mechanical back pain." She thus required lumbar fusion surgery on August 1, 2001. In contrast, Dr. Shenoi stated that the natural progression of Claimant's pars defect could be expected to involve periods of waxing and waning and concluded that Claimant's fusion surgery was most likely related to the long-term pars defect. However, Dr. Shenoi's opinion is not persuasive because it fails to acknowledge that Claimant did not develop any symptoms from her pars defect until after her industrial injury. Accordingly, Respondents are financially responsible for the treatment that Claimant received from Kaiser Permanente from February 17, 2001 until October 1, 2002.

TTD Benefits

10. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546 (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, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair a claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595,

597 (Colo. App. 1998). Once TTD benefits have been awarded based on a worsening of condition, they continue until the 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.; *see Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 18 P.3d 790, 792 (Colo. App. 2000).

11. Claimant seeks to obtain TTD benefits beginning on August 1, 2001. ALJ Henk's Order concluded that Claimant had suffered a worsening of her condition and reopened her claim. However, the Order did not address whether Claimant was entitled to TTD benefits for any time period.

12. As found, Claimant has established by a preponderance of the evidence that her worsened condition caused a greater impact on her work capability than she originally sustained as a result of her industrial injury beginning on August 1, 2001. Respondents have failed to produce persuasive evidence that Claimant 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. Claimant is thus entitled to receive TTD benefits from the date of her fusion surgery on August 1, 2001 until terminated by statute.

ORDER

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

1. Respondents are financially responsible for Claimant's medical treatment from Kaiser Permanente for the period February 17, 2001 until October 1, 2002.

2. Respondents shall pay Claimant TTD benefits for the period August 1, 2001 until terminated by statute.

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

DATED: December 24, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-766-877

ISSUES

The issues determined herein are compensability of an occupational disease and medical benefits.

FINDINGS OF FACT

1. Claimant had preexisting problems with bilateral hand numbness and pain. On January 19, 2004, she gave her physical therapist a history of neck, mid-back, and low back pain as well as bilateral hand tingling while holding a book to read. On January 15, 2007, She reported to Dr. Tang that she had fallen a few months before and suffered pain in her upper left arm. X-rays of the left arm were negative. On June 7, 2007, Dr. Tang reexamined claimant, who reported that she had tripped two months earlier and suffered right hand pain.
2. From September 2007 to January 2008, claimant was unemployed. On January 23, 2008, she began work for the employer and was placed as an administrative assistance to collect child support payments in El Paso County. Claimant's duties were varied, but she initially did a lot of data entry work. Claimant's computer keyboard was placed on her desktop. She complained about her keyboard and chair to Ms. S, the executive administrator for the employer.
3. On an unknown date in February or March 2008, claimant awoke with right hand pain. She sought care from her personal physician, Dr. Harris, but she did not provide any medical records as part of the record evidence in the case.
4. On March 17, 2008, Dr. Pise examined claimant. He provided wrist injections, which did not help claimant's symptoms. On April 8, 2008, x-rays of the right hand at Penrose Hospital were negative. The physician suggested evaluation for possible inflammatory arthritis. Dr. Pise referred claimant to Dr. Struck.
5. On April 16, 2008, Dr. Struck examined claimant, who reported a fall in May 2007 with continued symptoms aggravated by lifting, keyboarding, knitting, and reading. Claimant also reported that she was stressed financially. Claimant had positive Tinel's and Phalen's signs bilaterally. Dr. Struck diagnosed pain syndrome with possible bilateral carpal tunnel syndrome. Dr. Struck noted that typing in poor ergonomic conditions aggravated claimant's pain syndrome. Dr. Struck recommended a workplace ergonomic evaluation. At that point, claimant first realized that she had a possible workers' compensation claim.
6. On April 18, 2008, claimant delivered the ergonomic evaluation prescription to Ms. S. Ms. S referred claimant to Memorial Occupational Health Center and later prepared an employer's first report of injury.
7. Claimant later proceeded with surgery on her hands, although no medical reports from that procedure were placed in record evidence.
8. On August 5, 2008, Dr. Lund at Memorial Occupational Health Center discharged claimant at maximum medical improvement. Dr. Lund diagnosed carpal tunnel syndrome and flexor tendonitis. Dr. Lund noted that the conditions were consistent with a work injury. Dr. Lund released claimant to return to work without restrictions.
9. On August 11, 2008, the insurer filed a notice of contest.
10. Claimant has proven by a preponderance of the evidence that she suffered an occupational disease to her bilateral hands arising out of and in the course of her employment with the employer. The record evidence is sparse. That evidence shows that

claimant had preexisting bilateral hand problems, but the poor ergonomic conditions at the employer aggravated claimant's preexisting condition and caused the need for medical treatment.

11. Claimant admitted at hearing that Dr. Pise and Dr. Struck were not authorized. She sought care from those providers before reporting to the employer that she had an alleged occupational disease. The record evidence also shows that Penrose Hospital was unauthorized. Claimant obtained tests at that facility upon referral by Dr. Pise.

12. The treatment by Memorial Occupational Health Center was authorized and was reasonably necessary to cure or relieve the effects of claimant's occupational disease.

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 this claim, claimant alleges an occupational disease. Section 8-40-201(14), C.R.S. defines "occupational disease" as:

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

This section imposes additional proof requirements beyond that required for an accidental injury. An occupational disease is an injury that results directly from the employment or conditions under which work was performed and can be seen to have followed as a natural incident of the work. Section 8-40-201(14), C.R.S.; *Climax Molybdenum Co. v. Walter*, 812 P.2d 1168 (Colo. 1991); *Campbell v. IBM Corporation*, 867 P.2d 77 (Colo. App. 1993). An accidental injury is traceable to a

particular time, place and cause. *Colorado Fuel & Iron Corp. v. Industrial Commission*, 154 Colo. 240, 392 P.2d 174 (1964); *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). In contrast, an occupational disease arises not from an accident, but from a prolonged exposure occasioned by the nature of the employment. *Colorado Mental Health Institute v. Austill*, 940 P.2d 1125 (Colo. App. 1997). Under the statutory definition, the hazardous conditions of employment need not be the sole cause of the disease. A claimant is entitled to recovery if he or she demonstrates that the hazards of employment cause, intensify, or aggravate, to some reasonable degree, the disability. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). As found, claimant has proven by a preponderance of the evidence that she suffered an occupational disease to her bilateral hands resulting directly from the employment or conditions under which work was performed and following as a natural incident of the work.

3. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). As found, the treatment by Dr. Lund and Memorial Occupational Health Center was authorized and reasonably necessary. As found, the treatment by Dr. Pise, Dr. Struck, and Penrose Hospital was unauthorized.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of the reasonably necessary medical treatment by authorized providers for claimant's occupational disease, including the bills from Memorial Occupational Health Center.

2. Claimant's claim for payment of the bills from Dr. Pise, Dr. Struck, and Penrose Hospital is denied and dismissed.

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

DATED: December 29, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-756-498

ISSUES

The issue presented for determination at hearing was Claimant's claim for temporary total disability ("TTD") benefits for the period from July 4 through and including July 27, 2008.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury to the middle or long finger of his right hand on April 8, 2008. Claimant was employed as a shop worker/ warehouseman performing inventory, maintenance and stripping of parts from airplanes for Employer.

2. Claimant initially sought medical treatment from his personal physician, Dr. John Spine, three days after the injury. Dr. Spine then referred Claimant to the emergency room at Tri-County Medical Center.

3. Claimant underwent surgery to his right long finger at Boulder Community Hospital on April 13, 2008. The surgery consisted of an irrigation and debridement of the flexor tendon sheath of the right long finger. The surgery was performed by Dr. Kelly Wear, M.D. who thereafter became Claimant's attending physician.

4. Following an office visit on May 29, 2008, Dr. Wear released Claimant to return to modified work with restrictions of no lifting over 50 pounds; frequent lifting up to 25 pounds; limited gripping and grasping; and limited climbing, bending, twisting. These restrictions are reflected in the Progress and Work Status Form dated May 30, 2008.

5. By letter dated June 17, 2008 from Insurer, Claimant was offered modified employment approved by Dr. Wear and as described in the letter of June 3, 2008 from Employer.

6. Claimant received the written offer of modified duty on June 20, 2008. Claimant then contacted JA, at Employer on June 25, 2008 to discuss his return to work. Claimant and Mr. A discussed that Claimant would be assigned to

painting and that Claimant would start work in the modified position on June 30, 2008.

7. Claimant returned to work on July 1, 2008 as was assigned to painting a large room. Claimant worked on July 2 and 3, 2008 and earned his full wages for each of the days worked from July 1 through July 3, 2008. Claimant has not worked for the Employer since July 3, 2008.

8. The ALJ credits the testimony of JA that Claimant did not show up for work on July 7, 2008 and did not call the Employer. Claimant called Mr. A on July 8, 2008 and left a message at 6:39 AM advising the Employer that his hand hurt and that he would not be in to work. In this message, Claimant did not specify which hand he was referring to as the one that was hurting.

9. Insurer filed a General Admission of Liability dated July 3, 2008 terminating Claimant's TTD benefits as of June 30, 2008 based upon a Supplemental Report of Return to Work from Employer noting Claimant's return to work on July 1, 2008.

10. Dr. Wear again examined Claimant at a follow-up visit on July 23, 2008. Dr. Wear noted that Claimant reported ongoing pain and complained that he could not fully bend or extend the digit. Dr. Wear noted on physical examination that active flexion of the proximal and distal joints of the right long finger were significantly decreased. Dr. Wear stated Claimant would likely need a capsulotomy. Claimant was instructed to continue with hand therapy. Dr. Wear did not provide any different physical restrictions from the ones previously given on May 29, 2008 and reflected in the Work Status Report of May 30, 2008. Specifically, Dr. Wear did not restrict Claimant from continuing to work in the modified position previously approved by Dr. Wear on June 16, 2008.

11. Claimant understood that Dr. Wear would determine his work status although he disagreed with her. The ALJ finds that Claimant's failure to continue the modified work provided by Employer after July 3, 2008 was due to Claimant's subjective assessment of his physical limitations and ability to work.

12. Claimant spoke with Mr. A on July 29, 2008 requesting his assistance because Claimant's TTD benefits had been discontinued. Claimant told Mr. A in this conversation that he had not been going to the doctor because he "had things to do".

CONCLUSIONS OF LAW

13. 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. *Mag-*

netic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

14. 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. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

15. The phrase "attending physician", as used in 8-42-105(3)(c), C.R.S. means a physician within the chain of authorization who assumes care of the claimant. There may be more than one "attending physician" but not all attending physicians are "the attending physician". "The attending physician" is the physician with primary control over the Claimant's treatment. *See, Popke v. Indus. Claims Appeal Office,* 944 P.2d 677, 680-681 (Colo. App. 1997). As found, "the attending physician" for Claimant's treatment for the admitted injury during the time periods at issue here was Dr. Wear.

16. Insurer properly terminated Claimant's TTD benefits effective June 30, 2008 under the provisions of Section 8-42-105(3)(b) based upon Claimant's return to modified employment offered by the Employer and approved by the attending physician, Dr. Wear. As found, Claimant then discontinued this work after July 3, 2008 based upon his own subjective assessment of his ability to continue the work. However, once the attending physician makes a determination of the Claimant's ability to perform regular or modified employment, that determination is dispositive and the Claimant's subjective assessment of his physical limitations is legally immaterial, *Burns v. Robinson Dairy, Inc.,* 911 P.2d 661 (Colo. App. 1995); *Blas Villa v. Harvest Select,* W.C. No. 4-694-064 (October 3, 2008). Therefore, Claimant's own assessment of his ability to continue the modified employment is legally insufficient to re-establish entitlement to TTD benefits after their termination based upon Claimant's return to the modified employment offered by Employer and approved by the attending physician.

ORDER

It is therefore ordered that:

Claimant's claim for TTD benefits from July 4, to and including July 27, 2008 is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 24, 2008

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-965

ISSUES

The issue to be determined by this decision concerns whether the claimant sustained a compensable injury on July 15, 2008.

FINDINGS OF FACT

Based upon the evidence presented at the hearing, the ALJ makes the following findings of fact:

1. This claim involves a dispute over whether Claimant's left knee condition was a result of the worsening of a compensable September 19, 2007 injury while employed with Harvest Meat or whether his left knee condition resulted from a compensable injury at the Employer on July 15, 2008.

2. Claimant received medical treatment for his left knee on July 16, 2008 at Complete Family Care. The medical providers' records reflect Claimant "reinjured" his left knee on July 16, 2008.

3. Claimant treated with Dr. William Cooney, M.D. on July 18, 2008 and Claimant reported that he was injured on July 16, 2008. Claimant further reported that the injury occurred at home. This history was reiterated in Dr. Cooney's July 25, 2008 report.

4. Claimant denied telling his personal care physician at Complete Family Care that he was injured on July 16, 2008. He denies telling Dr. Cooney he was injured at home. He denied telling JP, DF, BO and JH that he was injured at home. Claimant's testimony in this regard was not deemed credible.

5. Claimant testified that he did not work on July 16, 2008, that July 16, 2008 was his regular day off. He admitted that if he was injured on July 16, 2008, it was not compensable.

6. DF testified at the hearing. Mr. F testified he encountered Claimant in the hallway of the Employer on July 17, 2008. He observed Claimant limping badly and asked what happened. Mr. F credibly testified that Claimant told him not to worry, that he had injured himself the day before at home. Mr. F testified that Claimant at no time said he was injured on the job. Mr. F testified that JP handles workers' compensation paperwork for the Employer in the event that an employee reports a work injury. He testified that, if Claimant reported a work injury, he would have referred Claimant to Ms. P.

7. BO credibly testified that he met Claimant in the sales tower of the Employer. Claimant was on crutches wearing a leg brace. Mr. O asked Claimant what had happened. Claimant told O he had injured himself at home gardening. JH was standing next to O at the time of this discussion.

8. JH credibly testified over the telephone that he was in the sales tower talking with Mr. O when the Claimant arrived. Mr. H testified that Claimant denied injuring himself at work. Mr. H testified that the Claimant admitted he had injured himself at home.

9. Ms. P also testified at the hearing. Ms. P is the Human Resources person for the Employer. She credibly testified that she received a telephone call from Claimant on Friday, July 18, 2008. Claimant asked about short-term disability benefits. She asked Claimant why he was interested in short-term disability benefits. Claimant said he had injured himself at home in his garage. P advised Claimant that he did not sign up for short-term disability and, therefore, he could not receive those benefits. A couple of days later, Claimant claimed to have been injured at work.

10. During the November 18, 2008 hearing, Claimant withdrew his Petition to Reopen the September 19, 2007 claim. Claimant did not sustain his burden of proof to establish that he suffered a work injury in the course and scope of his employment for the Employer in July 2008. Claimant's testimony was not found to be credible or persuasive and the medical records and testimony of the Respondents' witnesses contradicted it.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following conclusion of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 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 by a preponderance of the evidence that his injury arose out

of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *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, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' 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 interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJs 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. Claimant failed to sustain his burden of proof to establish that he sustained a compensable injury while in the course and scope of his employment with the Employer. Medical records offered into evidence at hearing did not support Claimant's claim of a work injury. Respondents' witnesses, DF, BO, JH and JP, all credibly testified that Claimant admitted he injured himself at home, not at work.

ORDER

IT IS THEREFORE ORDERED THAT:

1. Claimant's claim in W.C. No. 4-765-965 is denied and dismissed.

2. Claimant's Petition to Reopen in W.C. No. 4-737-016 is withdrawn.

All matters not determined herein are reserved for future determination.

Dated this _26__ day of December, 2008.

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-718-270

ISSUES

The following issues were raised for consideration at hearing:

1. Division independent medical examiner (DIME) determination of Maximum medical improvement (MMI);
2. Medical benefits;
3. Change of physician;
4. Temporary disability benefits from 2/26/07 through 9/9/07; and
5. Interest

FINDINGS OF FACT

Having reviewed the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. This is an admitted case. Claimant was injured on February 23, 2007 while working as a cable puller for the Employer. She was laying out cable when she tripped over a stack of drywall and landed on her right arm resulting in shoulder pain, arm pain, and wrist pain with paresthesias.

2. Claimant's initial authorized treating physician was Brian Beatty, D.O. However, her authorized treating physician was changed to Clarence Henke, M.D., when Claimant complained that Dr. Beatty injured her upper back in the course of his treatment of her. Dr. Henke works with Dr. Beatty at the Rocky Mountain Medical Group.

3. On September 12, 2007, Claimant was placed at MMI by Dr. Henke with a 0 percent impairment rating. Claimant then requested a DIME. The DIME was performed by Caroline Gellrick, M.D. In her report dated March 18, 2008, Dr. Gellrick stated, the following:

> This examiner agrees basically with the date of MMI put forth on the claim, but what this examiner disagrees with is the entire work-up. This patient had a direct injury to the shoulder. She has crepitus and popping. She should undergo an MRI arthrogram of the right shoulder looking for any pathology that is present and depending on the pathology that is elicited from the MRI the patient should be allowed to see an orthopedic surgeon to review this to see if surgery is recommended. She has been living with the pain and wants it fixed, if it is fixable. We cannot tell this until the MRI arthrogram of the right shoulder is performed, completed and reviewed with orthopedics. If there is a definable surgical lesion that is fixable and

> the patient elects to do surgery, then the date of MMI would change and the case would have to be re-opened at the time of surgery. However, if there is no lesion that is found and there is no surgery that is needed, then the patient stays at MMI and merits consideration of impairment.

4. Dr. Gellrick in the DIME report assigned Claimant a 6% upper extremity rating, or 4% whole person rating, for the shoulder injury, and a 3% whole person rating for the thoracic spine, totaling a 7% whole person impairment.

5. It is found that Dr. Gellrick's determination with regard to MMI was clear and unambiguous in the DIME report. Dr. Gellrick determined that Claimant was at MMI on September 12, 2007 and that she required a MRI arthrogram of the shoulder and an evaluation of that arthrogram by an orthopedic surgeon. Dr. Gellrick clearly states in her report that if the orthopedic surgeon determines that the shoulder requires surgery, and if Claimant elects to undergo that surgery, then Claimant would not be at MMI. If no surgery were performed, then Claimant would remain at MMI. Claimant did not present clear and convincing evidence to overcome the DIME physician's opinion that Claimant is at MMI.

6. Dr. Gellrick's recommendation that the MRI arthrogram should be reviewed by an orthopedic surgeon is reasonably necessary and related maintenance medical benefit to which Claimant is entitled. Dr. Henke is an occupational medicine physician and it is found to be reasonable to allow Claimant to have the MRI arthrogram reviewed by a specialist in the field of orthopedic medicine. Respondents' contention in its Motion for Corrected Order that Claimant did not seek an order awarding her an FCE was found to have merit and therefore these full findings do not award Claimant a FCE.

7. On April 15, 2008, Respondents filed a Final Admission of Liability (FAL) based on the impairment ratings of Dr. Gellrick and an MMI date of September 12, 2007. Respondents also paid PPD benefits at that time. As noted on the FAL, PPD benefits for the whole person impairment were payable from September 12, 2007 through February 2, 2008 and for the scheduled impairment from September 12, 2007 through December 12, 2007. Respondents did not pay interest on these PPD benefits although they were admittedly due months prior to the time they were paid.

8. On August 13, 2008, Claimant had the MRI arthrogram of the right shoulder. According to the radiologist, M. David Solsberg, M.D., the MRI showed "a downsloping acromion which does efface the subacromial-subdeltoid bursa and would predispose to impingement..." The radiologist also noted some minimal tendinosis and a small effusion of the capsule. There was no evidence of a rotator cuff tear or a labral tear.

9. In his reports dated after the MRI, Dr. Henke noted that Claimant has a questionable positive impingement sign with external rotation motion. His assessment is that Claimant's "[r]ight distal acromion process is downsloping causing slight impingement of the subacromial-subdeltoid bursa identified on shoulder MRI examination performed on 8-13-08. This is a developmental process, not caused by any injury to her right shoulder area." Dr. Henke, who is certified in occupational medicine, refused to authorize an evaluation of Claimant by an orthopedist or an orthopedic surgeon. He continues to treat Claimant with medications.

10. Claimant requests a change of physician to a physician not connected with Dr. Henke or Rocky Mountain Medical Group. She gives several reasons for her desire to change physicians, including her lack of confidence in Dr. Henke because he delayed in ordering the shoulder MRI arthrogram as recommended by the DIME, his inconsistent statements to her – first, opining that surgery on the shoulder would not help and then that surgery was the only thing that would help, but that her problem is not work-related, and Dr. Henke's close relationship with her employer. She is also concerned that Dr. Beatty, who apparently caused the injury to her upper back, is in the same medical practice with Dr. Henke.

11. Based on the Final Admission of Liability, the parties' stipulation as to wages earned for the purpose of the Motion for Corrected Findings of Fact, Conclusions of Law and Order, and wage records made part of the record at hearing, Claimant's contention that during the 28 week period from February 26, 2007 to September 9, 2007 she was underpaid temporary partial disability benefits (TPD) was substantiated. The evidence is undisputed that Claimant's admitted average weekly wage (AWW) is 652.76. At the admitted AWW during this 28-week period, Claimant would have earned $18,277.28 ($652.76 X 28). Wage records reflect that Claimant actually earned $10,785.00 during the period from February 26, 2007 to September 9, 2007. The difference between what Claimant should have earned had she not been injured ($18,277.28) and what she actually earned during this 28-week period ($10,785.00) is $7,492.28. The TPD rate is two thirds of the difference between what Claimant should have earned and what she actually earned, or $4,997.35 ($7,492.28 X .667). Respondents admitted liability for TPD during this 28-week period in the amount of $3,611.65. Accordingly, it is concluded that Claimant was underpaid TPD in the amount of $1,385.70 during the period February 26, 2007 to September 9, 2007 ($4,997.35 - $3,611.65). Respondents shall pay Claimant TPD in the amount of $1,385.70.

12. Respondents contend in its' Motion for a Corrected Order that the ALJ's calculation of what Claimant is owed for TPD exceeds the amount that Claimant claimed to be owed in argument in her post hearing position statement. Respondents do not point to an error in the ALJ's calculation of TPD, but only asserts that it is improper to award Claimant an amount, which exceeds the amount

Claimant argued entitlement to. Respondents' argument was considered and determined to be without merit.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the foregoing Conclusions of Law are entered.

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 litigation. Section 8-42-102(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.

2. 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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. The credibility of witness testimony and the weight to be given their testimony is within the ALJ's authority to determine. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. The respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988).

5. A party has a clear and convincing burden of proof to overcome the medical impairment rating determination of the DIME. Section 8-42-107(8), C.R.S. All of the reports and testimony of the DIME are to be considered in deciding what is the determination of the DIME. Then, the party who seeks to overcome that opinion faces a clear and convincing burden of proof. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656 (Colo. App. 1998).

6. In this case, the DIME opinion with regard to MMI is clear, Dr. Gellrick determined that Claimant was at MMI on September 12, 2007. Claimant failed to present clear and convincing evidence to overcome this opinion. Dr. Gellrick further determined that Claimant needed an MRI arthrogram of her right shoulder and that she needed to have the MRI arthrogram reviewed by an orthopedic surgeon. This recommendation was shown to be a recommendation for a reasonably necessary and related maintenance medical benefits for which Respondents are liable.

7. Based on the evidence presented at hearing, as contained in the wage records, which were admitted into evidence at hearing, and the admitted average weekly wage, Claimant is entitled to TPD in the amount of $3,517.79.

8. In order to change physicians, Claimant has a statutory obligation to request that change in accordance with Section 8-43-404(5)(a), C.R.S.; *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). Pursuant to Section 8-43-404(5)(a), C.R.S., a change of physician may be ordered upon a proper showing. *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994). A change of physician is not warranted by the mere fact that a claimant has more faith in a specific doctor or lacks confidence in the employer's doctor. 5 *Larson's Workers' Compensation Law* Section 94.02[3] (1999).

9. Claimant, in this case, made a proper showing that she is entitled to a change of physicians. She not only lack confidence in Dr. Henke, but the relationship is further complicated by his conflicting opinions and his business association with Dr. Beatty, who Claimant identifies as being responsible for injuring her in the course of his treatment.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for reasonably necessary and related maintenance medical benefits. Such benefits include evaluation of Claimant and the MRI arthrogram by an orthopedic surgeon.

2. Respondents shall authorize and accept liability for Claimant's treatment by a new physician.

3. Respondents shall be liable for TPD in the amount of $1,385.70.

4. 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: December 29, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 9, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/9/08, Courtroom 3, beginning at 8:43 AM, and ending at 9:14 AM). No testimony was taken and the matter was submitted on the documentary evidence.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Respondents' counsel, to be submitted electronically and mailed to the Claimant, giving the Claimant 3 working days within which to file objections by fax. The proposed decision was filed on December 10, 2008. Allowing a presumption of 3 days for receipt of mail, objections were due, by fax, on December 18, 2008. No timely objections were filed. After a consideration of the proposed decision, the ALJ has modified the proposal and hereby issues the following decision.

ISSUES

The issues that Claimant designated for hearing and the issues to be determined by this decision concern permanent medical impairment; maximum medical improvement (MMI); and, medical maintenance benefits after MMI.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury to her left lower extremity (LLE), arising out of and in the course and scope of her employment on August 24, 2007. Respondents provided authorized medical treatment for the Claimant to cure and relieve her of the effects of the injuries.

2. The Claimant's authorized treating physician (ATP) was Nicholas Olsen, D.O., who discharged her from treatment on January 18, 2008. Dr. Olsen was of the opinion that Claimant reached MMI on January 18, 2008, and had sustained zero permanent medical impairment.

3. Respondents filed a Final Admission of Liability on February 5, 2008, based on the above referenced opinion of Dr. Olsen.

4. Claimant filed a timely Objection to the Final Admission on March 4, 2008, indicating thereon that she was proposing the name of a Division Independent Medical Examiner (DIME) and requesting a DIME. Claimant did not file the form entitled "Notice and Proposal to Select an IME" until March 10, 2008. The Notice and Proposal form did not contain the names of any physicians, it was filed more than 30-days after the Final Admission, and the negotiation process was never carried forward. The ALJ infers and finds that Claimant intended to challenge the ATP's opinion by attempting to request a DIME.

5. Respondents filed a "Notice of Failed DIME Negotiations" on September 5, 2008. Subsequent to the Notice of Failed IME Negotiations, Claimant took no further action on the claim, prior to the hearing.

6. Although Claimant objected to the Final Admission and provided notice that it was her intent to request an IME, Claimant failed to file a new and timely Notice and Proposal to Select a DIME within the 30 days of Respondents filing the "Notice of Failed DIME Negotiations" on September 5, 2008.

7. Claimant indicated on the record, but not under oath, that she felt she was permanently disabled from August 24, 2007 LLE injury. She manifested confusion over the procedural posture of her case. She is jurisdictionally precluded from pursuing a whole person rating through a DIME that differs from her ATP's rating of zero.

8. The only evidence contained within the record relating to the issues for determination is the medical report of Nicholas Olsen, D.O., dated January 18, 2008. Therein Dr. Olsen states the opinion that Claimant reached MMI on January 18, 2008, sustained no permanent medical impairment. Dr. Olsen's report is silent on whether the Claimant requires ongoing medical maintenance care. This opinion stands undisputed. Claimant has presented no additional medical evidence of any kind. She has not applied for nor obtained a DIME. The ALJ finds that the Claimant has failed to establish, by a preponderance of the evidence, that she sustained any permanent medical impairment on a whole person basis; that she has **not** reached a point of MMI; or that she requires medical maintenance treatment beyond the date of MMI.

9. Respondents argue that Claimant is now precluded from pursuing a DIME and, thus, a whole person permanent disability award because she ultimately missed the jurisdictional time limits to re-activate the DIME process after Respondents filed their "Notice of Failed DIME Negotiations" on September 5, 2008. Although Claimant may have substantially complied with the DIME procedures at the outset, she failed to substantially comply in the final analysis because she did not re-active the DIME process within 30-days after the "Notice of Failed IME Negotiations," filed on September 5, 2008. This argument is factually accurate. Respondents do **not** argue that Claimant is precluded from pursuing a

scheduled rating that differs from her ATP's schedule rating and which does not require a DIME. Indeed, the issue of permanent scheduled disability never came up at the hearing.

CONCLUSIONS OF LAW

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

a. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 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. *See* Section 8-30-102(1), C.R.S. (2008). The provisions of the Act are designed to be self-executing, with litigation by exception. For instance, an ATP's opinion on permanent medical impairment (whole person), and MMI is the last word on these two subjects unless challenged by a DIME.

b. Section 8-42-107(8)(c), C.R.S. (2008), which concerns whole person medical impairment, states in pertinent part:

> "If either party disputes the authorized treating physician's finding of medical impairment, including a finding that there is no permanent medical impairment, the parties may select an independent medical examiner in accordance with Section 8-42-107.2. The finding of such independent medical examiner shall be overcome by clear and convincing evidence. A hearing on this matter shall not take place until the finding of the independent medical examiner has been filed with the Division."

Section 8-42-107.2(2)(a)(I)(A), C.R.S. (2008) states in pertinent part:

> "…for the claimant, the time for selection of an IME commences with the date of mailing of a final admission of liability by the insurer, or self-insured employer that includes an impairment rating issued in accordance with section 8-42-107." Under subsection (2)(b) it states "if any party disputes the finding or determination of the authorized treating physician, such parties shall request the selection of an IME. The requesting party shall notify all other parties in writing of the request, on a form prescribed by the Division by rule, and shall propose one or more acceptable candidates for the purposes of entering into negotiations for the selection of an IME. Unless such notice and proposal are given within 30 days after the date of mailing of the final admission of liability or 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 physicians findings and determinations shall be binding on all parties and on the Division."

As found, although Claimant objected to the Final Admission and provided notice in the Application for Hearing that it was her intent to request a DIME, Claimant failed to file the Notice and Proposal to Select an IME within the 30 day period required by the above statute and, therefore, the ATP's findings and determinations concerning MMI and zero whole person permanent medical impairment should be binding on all parties.

c. Even if Claimant had substantially complied with the notice of DIME provisions in the statute, as found, she did not follow through and Respondents ultimately filed a "Notice of Failed DIME Negotiations" on September 5, 2008. As found, Claimant did nothing to re-activate the DIME process within 30-days after September 5, 2008. Requests for DIMEs are controlled by Rule 11-3 of the Workers' Compensation Rules of Procedure (WCRP), 7 CCR 1101-3(3):

> "The requesting party shall submit an application for an IME according to Rule 11-3(B). If the parties did not agree on the physician, the insurer shall notify the Division and the other party on a prescribed form regarding the failed negotiations within 30 calendar days of their failure to agree. The party disputing the determinations of the authorized treating physician, and seeking review of those determinations (requesting party) shall file an application for IME within 30 days of the date of the failure to agree upon an IME physician. (4)…The requesting party must complete the application for IME."

Rule 11-3(B) states:

> "<u>Form Required:</u> The prescribed form, 'Application for a Division Independent Medical Examination' shall be used in all cases to request an IME."

Therefore, the ALJ concludes that the Claimant, having failed to file the prescribed form at any time following the September 5, 2008 "Notice of Failed IME Negotiation," has failed to substantially comply with the statutory provisions and rules and she is bound by the ATP's findings and determinations, concerning MMI and lack of whole person permanent medical impairment.

d. A DIME is not necessary when the issues involve permanent disability for scheduled injuries. *See* Section 8-42-107(8)(a)-(d), C.R.S. (2008). As found, Claimant was confused concerning the requirements in the permanent disability process. Indeed, Claimant intended to challenge her ATP's zero whole person permanent medical impairment rating.

e. As found, Claimant filed a timely objection to the Final Admission of Liability, thus, preserving her right to object to Dr. Olson's zero PPD rating insofar as a scheduled rating was concerned. As found, no credible, persuasive or substantial evidence was presented to allow a rational fact finder to support a permanency award on a whole person basis above zero. Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *See Bson-Rausin v. Industrial Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005); *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995).

f. An employee is entitled to continuing medical benefits after MMI if reasonably necessary to relieve the employee from the effects of an industrial injury. *See Grover v. Industrial Commission of Colorado*, 759 P.2d 705 (Colo. 1988). The record must contain substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve a claimant from the effects of an injury or to prevent further deterioration of his condition. *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, supra*. As found, no substantial evidence to support post-MMI medical maintenance benefits (*Grover* Medicals) was presented at the hearing. Therefore, Claimant is not entitled to *Grover* medical benefits.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The findings and determinations of Nicholas Olsen, D.O., are affirmed. Claimant's claim for whole person permanent disability benefits is hereby denied and dismissed. Claimant's claim for ongoing medical maintenance care is hereby denied and dismissed.

B. Claimant reached maximum medical improvement on January 18, 2008, with no whole person permanent partial disability.

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

DATED this_____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 16, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/16/08, Courtroom 3, beginning at 8:42 AM, and ending at 9:50 AM).

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Respondents' counsel, to be submitted electronically within 5 working days, giving Claimant 3 working days thereafter within which to file objections, electronically. The proposed decision was filed on December 17, 2008. No timely objections were filed. After a consideration of the proposal, the ALJ has modified it and hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern whether Respondents overcame the Division Independent Medical Examination (DIME) opinion of Robert Mack, M.D., which found the Claimant "not at maximum medical improvement (MMI), by clear and convincing evidence; and, because causal relatedness is inextricably bound into the issue concerning the need for ongoing medical care, whether Claimant has demonstrated by clear and convincing evidence that he is entitled to ongoing medical benefits as recommended in Dr. Mack's DIME report. The issues herein give rise to a more fundamental inquiry, *i.e.,* what is the line between "issue preclusion" after an ALJ's decision and whether a DIME can supplant earlier un-appealed ALJ determinations on causal relatedness.

FINDINGS OF FACT

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

1. The Full Findings of Fact, Conclusions of Law and Order, dated January 22, 2008, are incorporated herein by reference as if fully restated herein.

2. The Employee was a geologist who injured his left shoulder in the course and scope of work on March 16, 2007. The parties went to hearing on

January 8, 2008 on the issues of compensability/causal relatedness and medical benefits. This ALJ previously found as a result of that hearing (Findings of Fact, Conclusions of Law and Order (hereinafter "Order"), dated January 22, 2008, that the Claimant had proven a compensable March 16, 2007 temporary aggravation of a pre-existing, complex left shoulder condition. ("Findings of Fact", ¶13). The ALJ further found that the Claimant failed to prove by a preponderance of the evidence that the need for treatment for extensive humeral head abnormalities and other rotator cuff abnormalities were work-related. (Order, "Findings of Fact", ¶13; *Id*.) The ALJ specifically found that the Claimant had failed to prove that the need for ongoing medical care for the left shoulder, after April 19, 2007, was causally related to the March 16, 2007 work-injury, as opposed to the underlying non-work related complex shoulder problems. (Order, "Findings of Fact", ¶12)

3. Although **not** interlocutory because medical benefits were awarded, the January 22, 2008 Findings of Fact, Conclusions of Law and Order were not appealed.

4. Following the hearing and the Order issued on January 22, 2008, Respondents filed a Final Admission of Liability, and this claim proceeded through the Division IME (DIME) process outlined in Section 8-47-107.2, C.R.S. (2008). Dr. Mack was the DIME physician selected.

5. In contradiction to the previous findings of causality set forth in ¶1, above; Dr. Mack's DIME report concluded that the Claimant was not at MMI, and Claimant needed to be treated for the ongoing shoulder complaints and other rotator cuff abnormalities, implicitly overturning the January 22, 2008 Order as to causality.

6. On September 9, 2008, the parties took the evidentiary deposition of Dr. Mack. Dr. Mack testified that he relied on the Claimant's self-reported history of trauma to form his opinion. (Deposition p. 9: lines 5-16). At the January 8, 2008 hearing, the ALJ did not find this history of trauma fully credible, and so found in the January 22, 2008 Order. Dr. Mack admitted that the he disagreed with the history that Dr. Orgel recorded in his April 19, 2007 report. (Deposition p. 10: lines 12-22). Dr. Mack reiterated that the Claimant's self-reported history was the basis for his disagreement with the reports of the authorized providers. (Deposition p. 13: lines 4-10). Dr. Mack agreed that the x-ray and MRI (magnetic resonance imaging) findings alone could not establish a date when the Claimant's extensive underlying shoulder conditions arose. (Deposition p.15: line 21 through p.16: line14). Dr. Mack maintained that his ultimate opinion and basis for his report was that the shoulder pathology was all caused by the work activity. (Deposition p. 26: lines10-17). When asked to presume the finding of a pre-existing, underlying condition, Dr. Mack declined to consider the impact of the January 22, 2008 Order and/or an underlying condition as part of his consideration of MMI status on this claim. (Deposition p. 30: line 21 through p. 33: line 3). Indeed, the ALJ finds that Dr. Mack, through the DIME process, effectively at-

tempted to overrule or circumvent an appeal of the ALJ's January 22, 2008 Order insofar as causality was concerned.

7. David Orgel, M.D., Claimant's authorized treating physician (ATP), testified at hearing. He was of the opinion that Dr. Mack's assertion that the fracture of Claimant's humeral head, not having been diagnosed by authorized providers, was incorrect. (*See* Deposition p. 5: lines 4-16; *Respondents' Ex. F,* folio no. 0019; compare with *Respondents' D*, folio no. 0013 and *Respondents'* C.) Dr. Orgel stated that nothing in Dr. Mack's report changed the opinions formed and contained in his (Dr. Orgel's) 2007 treatment notes, and as previously testified to at the January 8, 2008 hearing. He explained that pain arising from working with a fractured humeral head was similar to experiencing pain after "hobbling in to work" on a fractured ankle – the activity following a fracture will cause pain to arise, but does not render the initial injury (the fracture) a work related injury. The ALJ infers and finds that Claimant did not establish a substantial, permanent aggravation of his pre-existing condition in the injury of March 16, 2007. The ALJ finds that it is highly probable, and free from serious and substantial doubt, that Dr. Mack's DIME opinion on causality is clearly erroneous. Dr. Mack's DIME report also created a conflict with the January 22, 2008 Order regarding causal relatedness and, as found hereinabove, it was clearly erroneous.

8. The March 16, 2007 injury aggravated and combined with Claimant's pre-existing left shoulder condition to temporarily aggravate the condition until April 19, 2007. Thereafter, Claimant was back to his non-work related baseline.

9. The ALJ finds that the Claimant had a full and fair opportunity to litigate the causal relatedness of the humeral fracture and the continued impingement symptoms at the January 8, 2008 hearing, he did so at the time, and he failed to establish causal relatedness of his left shoulder problems other than a temporary aggravation thereof, which ended on April 19, 2007. The findings in the January 22, 2008 Order became final as to this claim when not timely appealed.

10. The ALJ finds that Respondents have proven, by clear and convincing evidence, that Dr. Mack's DIME finding of "Not at MMI" was in error. The ALJ further finds that it is highly probable, and free from serious substantial doubt, that Dr. Mack erred by determining that Claimant was not at MMI, based on Claimant's history of sequelae to the injury of March 16, 2007, which was rejected in the Order of January 22, 2008. Therefore, the ALJ determines that Claimant reached MMI on April 19, 2007 with no permanent medical impairment caused by the injury of March 16, 2007.

11. The ALJ finds that the Claimant has failed to prove that it is more reasonably probable than not that he requires any ongoing, causally-related

medical benefits beyond April 19, 2007 for compensable injuries sustained as a result of the March 16, 2007 incident. Therefore, Claimant has failed to prove causal relatedness of the need for treatment after April 19, 2007 by a preponderance of the evidence.

CONCLUSIONS OF LAW

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

a. The Conclusions of Law contained in the Order, dated January 22, 2008, are incorporated herein by reference as if fully restated herein.

b. By analogy, guidance may be derived from the proposition that securing a "change of physician" to circumvent the DIME process [*See Story v. Industrial Claim Appeals Office,* 910 P.2d 80 (Colo. App. 1995)] may not be done, a DIME may not be used to circumvent or overrule the previously established law of the case, which was not timely appealed, unless the DIME deals with issues beyond those contemplated in an earlier ALJ decision. As found, insofar as the DIME overturns the January 22, 2008 un-appealed Order concerning causality of continuing left shoulder problems after April 19, 2007, it would effectively circumvent the normal appeal process on the issue of causality.

c. A compensable injury is one that arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. (2008). The "arising out of" test is one of causation. If an industrial injury aggravates or accelerates a preexisting condition, the resulting disability and need for treatment is a compensable consequence of the industrial injury. Thus, a claimant's personal susceptibility or predisposition to injury does not disqualify the claimant from receiving benefits. *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). An injured worker has a compensable new injury if the employment-related activities aggravate, accelerate, or combine with the pre-existing condition to cause a need for medical treatment or produce the disability for which benefits are sought. Section 8-41-301(1)(c), C.R.S. (2008). *See Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). *Also see* Section 8-41-301(1)(c), C.R.S. (2008); *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Industrial Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). *See Merriman v. Industrial Commission,* 120 Colo. 400, 210 P.2d 448 (1949). As found, the March 16, 2007 injury aggravated and combined with Claimant's pre-existing left shoulder condition to temporarily aggravate it until April 19, 2007. Thereafter, Claimant was back to his non-work related baseline.

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). The DIME physician's determination of MMI is binding unless overcome by "clear and con-

vincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(b)-(c), C.R.S. (2008). "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, Dr. Mack's DIME opinions have been overcome by clear and convincing evidence, which includes Dr. Mack not taking into account the law of the case, established by the Order of January 22, 2008. Once the DIME opinion on causal relatedness has been overcome, it becomes the Claimant's burden, by a preponderance of the evidence, to establish entitlement to post-MMI medical benefits. *See* An employee is entitled to continuing medical benefits after MMI if reasonably necessary to relieve the employee from the effects of an industrial injury. *See Grover v. Industrial Commission of Colorado*, 759 P.2d 705 (Colo. 1988). The record must contain substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve a claimant from the effects of an injury or to prevent further deterioration of his condition. *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, supra*. As found, Claimant failed to prove entitlement to maintenance medical care, by a preponderance of the evidence.

Issue Preclusion

e. Causal relatedness of Claimant's shoulder condition was an appropriate issue, designated for the January 8, 2008 hearing. The doctrine of issue preclusion prohibits re-litigation of issues actually litigated in prior proceedings. The doctrine applies when: (1) there is an identity of an issue necessarily adjudicated in a prior proceeding; (2) there is identity of parties involved in the prior proceeding; (3) there was a final judgment on the merits; and (4) there was a full and fair opportunity to litigate the issue in the prior proceeding. *City & County of Denver v. Block 173 Assocs.*, 814 P.2d 824, 831 (Colo. 1991); *Sunny Acres Villa, Inc. v. Cooper,* 25 P.3d 44 (Colo. 2001). Indeed, the doctrine of issue preclusion also prohibits re-litigation of issues that **might** have been litigated and decided. *See Metcalfe v. Bruning Division of AMI,* 866 P.2d 877 (Colo. App. 1993). Re-litigation of an issue in a DIME opinion is encompassed by the doctrine of issue preclusion. As found, the Claimant had a full and fair opportunity to litigate the causal relatedness of his underlying shoulder complaints at the hearing on January 8, 2008. A final order was issued on January 22, 2008, which was not appealed. Therefore the doctrine of issue preclusion bars reconsideration of the causal relatedness of the underlying shoulder complaints to the March 16, 2008 work incident.

f. Recent articulations of the doctrine of "issue preclusion" do **not** yet offer a bright line between an un-appealed ALJ decision and a subsequent DIME opinion. In *Mahana v. Grand County,* W.C. No. 4-430-788 (ICAO, February 15, 2007), this ALJ declined to give preclusive effect to a previous ALJ's decision that the claimant did **not** suffer from sympathetic mediated pain (SMP) or chronic regional pain symdrome (CRPS) and was, therefore, not entitled to medical benefits based on these diagnoses because subsequently a DIME opinion determined that she did, in fact, suffer from these conditions. In *Mahana,* the ALJ noted that the burden of proof and the issues were different at the time of the DIME. ICAO noted, "affording preclusive effect to the ALJ 's previous order regarding the claimant's diagnosis of CRPS would **eviscerate** (emphasis supplied) the DIME process…." The ICAO opinion in *Mahana* contained a lengthy and well-reasoned dissent, based on the strict application of the doctrine of issue preclusion. The Court of Appeals, accepting the rationale of the dissent, reversed ICAO in *Grand County v. Industrial Claim Appeals Office* (Court of Appeals No. 07CA0424, April 24, 2008) [Not published pursuant to C.A.R. 35 (f)]. The Court held that the causal relatedness of the long-term consequences of claimant's work-related injury was identical to the issue before the DIME and this ALJ in the second hearing. The Court noted that claimant *Mahana's* incentive at both hearings was the same, payment for medical treatment of the conditions the first ALJ found not to be causally related. *Grand County, supra,* resolved the matter in the *Mahana* case, but does not answer the question concerning the legitimate place of the DIME in making presumptive determinations of causal relatedness that must be overcome by clear and convincing evidence in the face of A previous ALJ decision that was not timely appealed. *See Leprino Foods Co. v. Indus. Claim Appeals Office,* 134 P.3d 475 (Colo. App. 2005); *Qual-Med. Inc. v. Indus. Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). The underlying rationales of these opinions indicate that "causal relatedness" in the long-term is part and parcel of MMI and permanent impairment determinations. Such would not be so under the *Mahana* rationale because an earlier ALJ decision could preclude a DIME opinion on causal relatedness, despite the different role of the DIME process in determining MMI and permanent medical impairment. Perhaps, as part of the DIME process, the DIME examiner should be given prior ALJ decisions on causal relatedness and instructed to form opinions within the parameters of the law of the case.

Medical Benefits

g. Respondents are liable for authorized medical treatment that is reasonably necessary to cure and relieve the effects of an industrial injury. Section 8-42-101(1)(a), C.R.S. (2008); *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). To be a compensable benefit, medical care and treatment must be causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's medical treatment after April 19, 2007 is **not** causally related to the compensable

injury of March 16, 2007. It is the ALJ's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether a claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999). Once the DIME was overcome by clear and convincing evidence, the "causal relatedness" of post-MMI medical care after April 19, 2007 is by a preponderance of the evidence. *See Grover v. Industrial Commission, supra.* As found, Claimant failed to prove, by a preponderance of the evidence, that he is entitled to ongoing medical treatment, after April 19, 2007, that is reasonably necessary to cure and relieve the effects of his causally related industrial injuries.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Full Findings of Fact, Conclusions of Law and order, dated January 22, 2008, establish the law of the case with respect to the lack of causal relatedness to the March 16, 2007 compensable event of Claimant's left shoulder condition after April 19, 2007.

B. The Division Independent Medical Examination of Robert Mack, M.D., that Claimant had not reached maximum medical improvement has been overcome by clear and convincing evidence. Claimant reached maximum medical improverment on April 19, 2007.

C. Claimant's request for ongoing medical benefits after April 19, 2007 is hereby denied and dismissed.

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

DATED this_____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 18, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/18/08, Courtroom 3, beginning at 1:42 PM, and ending at 2:39 PM).

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Claimant's counsel, to be submitted electronically within 5 working days, giving Respondents 3 working days within which to file objections, electronically. The proposed decision was filed on December 23, 2008. Respondents indicated they had no objection to the proposed decision on December 29, 2008. After a consideration of the proposal, the ALJ has modified the proposed decision and hereby issues the following decision.

ISSUES

The sole issue to be determined by this decision is whether Claimant's admitted left shoulder (LUE) injury of January 31, 2008, should be converted as to a whole person permanent medical impairment (PPD). At the outset, Claimant does not challenge the four corners of the authorized treating physician's (ATP) opinions, thus, Claimant's burden of proof on the requested conversion is by a preponderance of the evidence.

FINDINGS OF FACT

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

1. Claimant is a delivery driver for AB where he has worked for ten years.

2. This case involves an admitted LUE injury occurring on January 31, 2008, when Claimant was in the course and scope of employment, while stacking beer.

3. Respondents filed a Final Admission of Liability, dated July 18, 2008, admitting for a scheduled impairment of 6% LUE (for a total of $2,959.13 PPD, based on the opinion of Claimant's authorized treating physician (ATP), Lon Noel, M.D. Respondents admitted for a temporary total disability (TTD) benefit rate of $624.35, based on an average weekly wage (AWW) of $936.53.

4. Claimant underwent an MRI (magnetic resonance imaging) arthrogram on March 6, 2008, which demonstrated a partial tear of the supraspinatus tendon with slap lesion. He subsequently underwent surgery with James D. Ferrari, M.D., on April 23, 2008.

5. Claimant's surgery on April 23, 2008, involved multiple procedures including left shoulder arthroscopic subacromial decompression, and a left shoulder arthroscopic debridement of both a superior labral tear and of a partial thickness subscapularis tear.

6. Claimant was eventually placed at maximum medical improvement (MMI) on June 20, 2008, by ATP Dr. Noel. At the time, Claimant was 38 years of age (D.O.B 10/26/1969).

7. At MMI, Dr. Noel, gave the Claimant a 6% LUE impairment rating that Dr. Noel converted to a 4% whole person, pursuant to the mandate of the *AMA Guides to the Evaluation of Permanent Impairment,* 3rd Ed., Rev.

8. Claimant credibly testified, and the ALJ finds, that as a result of his left shoulder injury he has difficulty carrying objects on his left shoulder because of pain he experiences at the site of the surgery on his left shoulder. He also credibly testified, and the ALJ finds, that Claimant's left shoulder pain interferes with both his ability to sleep on his left side, and to lift objects above his head using his shoulder girdle. Additionally, a typical job duty of the Claimant involves carrying kegs of beer into stores on his left shoulder, which he can no longer do because of the admitted, compensable injury. His right shoulder was previously restricted from carrying objects on it.

9. Ronald J. Swarsen, M.D., testified as an expert at hearing. He was of the opinion that the site of Claimant's functional impairment as a result of his January 31, 2008, left shoulder injury was above the arm at the shoulder. Dr. Swarsen's opinion was based on evidence concerning the shoulder structures which were surgically repaired as well as Claimant's testimony concerning the site of functional impairment that he was experiencing.

10. Dr. Swarsen was of the opinion that the Claimant's functional impairment was above the shoulder and not at or below the left arm. Further, Dr. Swarsen noted that the structures that were surgically repaired were above the arm, and part of the shoulder. The ALJ finds that Dr. Swarsen's opinion concerning the site of functional impairment, coupled with the Claimant's testimony concerning functional limitations on top of the left shoulder, credibly support the ATP's conversion to 4% whole person as the appropriate measure of Claimant's PPD.

11. Claimant has proven, by a preponderance of the evidence, that he has suffered an injury which entitles him to a whole person permanent medical impairment for the structures of the shoulder that are above the arm.

CONCLUSIONS OF LAW

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

General

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). 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, both the Claimant's and the testimony of Claimant's expert witness, Dr. Swarsen, met the above tests of credibility.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the entitlement to additional benefits beyond those admitted, including for a conversion from a scheduled award to a whole person award, provided the four corners of the ATP rater's opinions are not challenged. Sections 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 with respect to Dr. Noel's converted rating of 4% whole person.

SHOULDER CONVERSION

c. When an injury results in a permanent medical impairment not set forth on a schedule of disabilities, an employee is entitled to medical impairment benefits paid as a whole person. Section 8-42-107(8)(c), C.R.S. (2008). As found, the site of Claimant's functional impairment is not listed on the schedule.

d. Section 8-42-107(1)(a), C.R.S. (2008), limits medical impairment benefits to those provided in section (2) where the Claimant's injury is one enumerated on the schedule. The schedule of injuries includes the loss of the "**arm at the shoulder"**. The plain meaning of this is "at or below the shoulder." *See* Section 8-42-107(2)(a). The **"shoulder" is not listed in the schedule of im-**

pairments. *See Martinez v. Albertsons*, W.C. No. 4-692-947 [Industrial Claim Appeals Office (ICAO), June 30, 2008]; *Maree v. Jefferson County Sheriff's Department*, W.C. No. 4-260-536 (ICAO, August 6, 1998); *Bolin v. Wacholtz*, W.C. No. 4-240-315 (ICAO, June 11, 1998). As found, the site of Claimant's functional impairment is above the shoulder.

e. Although Section 8-42-107(2)(a), C.R.S. (2008), does not define a "shoulder" injury, the dispositive issue is whether the Claimant has sustained a functional impairment to a portion of the body listed on the schedule of disabilities. *See Strauch v. PSL Swedish Healthcare*, 917 P.2d 366 (Colo. App. 1996). The ALJ is tasked with determining the site of functional impairment, not necessarily the site of the initial harm, in deciding whether the loss is one listed on the schedule of disabilities or not. As found, the site of Claimant's functional impairment is not listed on the schedule of disabilities. It is on top of the Claimant's left shoulder **not** at or below the shoulder.

f. Pain and discomfort which limit a claimant's ability to use a portion of the body can be considered functional impairment for purposes of determining whether an injury is off the schedule. *See Langton v. Rocky Mountain Healthcare Corp.*, 937 P.2d 883 (Colo. App. 1996); *Eidy v. Pioneer Freightways*, W.C. No. 4-291-940 (ICAO, August 4, 1998); *Beck v. Mile Hi Express, Incorporated*, W.C. No. 4-238-483 (ICAO, February 11, 1997). Not only does Claimant experience pain on top of the left shoulder, above the sites of the surgery, the top of his left shoulder is functionally limited from carrying kegs of beer into stores. Claimant suffers pain at the top of his shoulder that limits his ability to perform the function of carrying objects on his shoulder, lifting above the head, and sleeping. Claimant's functional impairment is above the arm at the shoulder, and not on the schedule of impairments. *See Phase II Company v. ICAO*, (Colo. App. No. 97CA2099, September 3, 1998) [NSOP]. As found, the presence of pain, discomfort and loss of function is to the structures beneath the top of his **shoulder**, not the **arm.**

g. There is substantial evidence that Claimant suffered functional impairment beyond, or above, the **arm** at the **shoulder**. City *Market v. ICAO*, 68 P.3d 601 (Colo. App. 2003). Specifically, Claimant suffers functional loss to areas of the **shoulder** joint, both of which are beyond the arm and at the shoulder. Thus, a whole person award is appropriate. See *B v. City of Aurora*, W.C. No. 4-452-408, (ICAO, October 9, 2002).

h. As found, Claimant's left shoulder causes pain and reduced function in structures that are above the shoulder joint. Thus, Claimant's injury should be compensated, based on a whole person because the site of his functional impairment is **off** the schedule. *See Velasquez v. UPS*, W.C. No. 4-573-459 (ICAO April 13, 2006); *Heredia v. Marriot*, W.C. No. 4-508-205 (ICAO, September 17, 2004); *see also Smith v. Neoplan USA Corporation*, W.C. No. 4-421-202 (ICAO, October 1, 2002); *Colton v. Tire World*, W.C. No. 4-449-005 (ICAO, April 11, 2002); *Guillotte v. Pinnacle Glass Company*, W.C. No. 4-443-878

(ICAO, November 20, 2001); *Copp v. City of Colorado Springs*, W.C. No. 4-271-758; 4-337-778 (ICAO, January 24, 2001); *Olson v. Foley's*, W.C. No. 4-326-898 (ICAO, September 12, 2000); *Gonzales v. City and County of Denver*, W.C. No. 4-296-588 (ICAO, September 10, 1998).

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant's left shoulder injury of January 31, 2008, shall be compensated, based on the whole person rating of his authorized treating physician, Lon Noel, M.D.

B. Claimant's whole person impairment of 4% entitles him to compensation based on the formula found at Section 8-42-107 (8), C.R.S. (2008), of $14,385.02 (1.44 age multiplier x 400 x $624.35 (the admitted weekly temporary total disability benefit rate) x 4% whole person).

C. Respondents are entitled to credit for previously paid permanent disability benefits pursuant to the Final Admission filed on July 18, 2008.

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

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

DATED this _____ day of December 2008.

Edwin L. FElter, Jr.,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

No further hearings have been held. On November 25, 2008, the Industrial Claim Appeals Office (ICAO) remanded the above-captioned matter for a redetermination of whether the Division independent Medical Examiner's (DIME), Ranee Shenoi, M.D., opinion had been overcome by clear and convincing evidence, in light of Dr. Shenoi's statement in the original DIME report that Claimant's low back, hip and right leg complaints **were related** to her sacrococcygeal fracture. In her "Follow-Up DIME of October 1, 2007, Dr. Shenoi implicitly modi-

fied this indication of causal relatedness (Claimant's Exhibit 16). The Administrative Law Judge (ALJ), Edwin L. Felter, Jr., therefore, on remand adds to and modifies the previous decision. The remand was referred to the ALJ on December 29, 2008.

Hearing in the above-captioned matter was scheduled before ALJ Felter for July 2, 2008, in Denver, Colorado. The day prior to the scheduled hearing, the parties agreed to submit the matter for decision on briefs and documentary exhibits.

ISSUE ON REMAND

The issue on remand concerns whether or not there is substantial evidence to overcome DIME of Dr. Shenoi, specifically, her ultimate opinion in the Follow-Up DIME of October 1, 2007, that Claimant's lumbar spine and right leg problems lacked causal relatedness to Claimant's work-related sacrococcygeal fracture by virtue of the fact, among other facts, that Dr. Shenoi declined to rate the lumbar spine. Claimant agreed to dismiss her claim for a cervical impairment. Claimant also sought an increase in her average weekly wage (AWW). The parties stipulated that Claimant's AWW is $536.44. The ALJ approved and accepted the stipulation on July 1, 2008. Claimant bears the burden of proof, by clear and convincing evidence.

FINDINGS OF FACT ON REMAND

Based on the evidence presented in the documentary exhibits, the ALJ makes the following Findings of Fact:

1. On May 4, 2006, Claimant sustained alleged injuries to her right hip, lower back, neck and right leg when she tripped and fell at work.

2. On May 5, 2006, Lon Noel, M.D., evaluated the Claimant and diagnosed her with a lumbar and sacral strain. Dr. Noel prescribed physical therapy, Celebrex, Methocarbamol, Cyclobenzaprine and a donut seat.

3. On June 2, 2006, Dr. Noel performed a follow-up evaluation of the Claimant after she continued to complain of right-sided lower back pain, which radiated into her right buttock. Dr. Noel referred Claimant for a lumbar MRI (magnetic resonance imaging).

4. The MRI was completed on June 6, 2006 and it showed degenerative disc disease at L2 through S1 (most prominent at L4-5 and L5-S1), mild bilateral facet arthropathy at L4-5 with minimal central canal and bilateral neural foraminal multi-factorial stenosis at L4-5 of uncertain clinical significance.

5. On June 16, 2006, Dr. Noel performed a supplemental evaluation of the Claimant. Dr. Noel requested an MRI of the sacrum and recommended massage therapy, Ibuprofen, tramadol, Methocarbamol and Cyclobenzaprine.

6. On June 23, 2006, Claimant underwent the sacrum MRI that showed a fracture of the sacrococcygeal area with some adjacent edema. There was no sign of displacement or angulation.

7. On July 7, 2006, Dr. Noel performed a follow-up examination. Claimant continued to complain of pain in the lower back with decreased active range of motion of the lumbosacral spine. Dr. Noel's assessment of Claimant's injury changed to a sacral coccygeal fracture and it did not include a lumbar strain.

8. On August 25, 2006, Claimant was referred to Yusuke Wakeshima, M.D., for evaluation. Dr. Wakeshima noted current complaints of right-sided low back and buttock region pain. On physical examination, he observed tenderness to palpation in several areas including: over the right SI joint region, the L4-5 and L5-S1 facet joint region, and the right coccygeal region. He diagnosed the Claimant with subjective right buttock and low back region pain with clinical findings suggestive of right SI joint dysfunction with coccydynia, MRI demonstrating facture of the sacral-coccygeal area with no angulation or displacement, MRI of the lumbar spine demonstrating **degenerative disc disease** most prominent at L4-5 and L5-S1 and mild bilateral facet arthropathy at L4-5 and multifactorial stenosis at L4-5. Dr. Wakeshima offered the opinion that "the trauma she explained that could possibly cause a sacral-coccygeal fracture certainly would be enough to also irritate the SI joint region." The ALJ finds that Dr. Wakeshima's opinion on the causal relatedness of Claimant's then present back condition to the admitted compensable injury is an opinion concerning a "possibility," which, alone, would not permit the ALJ to determine that the causal relatedness of the present back condition to the admitted injury is more reasonably and probable than not.

9. Usama Ghazi, D.O., performed an SI joint injection and right SI arthrogram on September 15, 2006.

10. On September 28, 2006, Dr. Noel placed Claimant at maximum medical improvement (MMI) with no permanent impairment and no future medical care recommendations. Dr. Noel did not give Claimant a lower back impairment rating even though Claimant complained of continued pain in her lower back.

11. On March 19, 2007, Dr. Shenoi performed a DIME. Dr. Sehoi evaluated the tailbone/buttocks area, back, hips left and right lower extremities and neck. She did not believe that Claimant was at MMI and she recommended additional injections and physical therapy. Dr. Shenoi also did not believe that

Claimant sustained an injury to her lumbar spine. As of the March 19, 2007 DIME, Dr. Shenoi was of the opinion that Claimant's low back, hip and right leg complaints were related to the sacrococcygeal fracture. Dr. Shenoi stated at page 6 of her first report (Claimant's Exhibit 17): "…I believe her low back, hip and right leg complaints are related to the sacrococcygeal fracture." Lter, in the same report, Dr. Shenoi states: "…I do not believe the patient had an injury to her lumbar spine.. rather, the right leg symptoms appear to be related to the bursitis and right sacroiliac dysfunction." Nowhere in the March 19 Report does Dr. Shenoi persuasively relate the bursitis as causally related to the compensable injury.

12. In the Follow-Up DIME of October 1, 2007 (Claimant's Exhibit 16), Dr. Shenoi noted: "Right leg **referred** (emphasis supplied) pain related to sacrococcygeal fracture," and lumbar degenerative disc disease. Later in the report, Dr. Shenoi states: "I believe she [Claimant] has sustained permanent impairment to the sacrococcygeal region as a result of her occupational injury….I do **not** (emphasis supplied) believe there has been a lumbar spine injury…hence, I disagree with Dr. Ghazi in this respect. I believe there is impairment **solely** (emphasis supplied) for the sacrococcygeal fracture and **not** (emphasis supplied) the lumbar spine." Fundamentally, the Follow-Up DIME Report is not inconsistent with the original March 19, 2007 DIME Report. The ALJ finds that Dr. Shenoi has rendered an opinion of no injury, nor permanent disability, to the lumbar spine or right leg –merely referred pain to these bodily parts, which does **not** translate to an injury to these bodily parts. Ultimately, Dr. Shenoi gave the Claimant a 5% whole person rating for the sacrococcygeal fracture, implicitly determining that Claimant had reached MMI on October 1, 2007.

13. On June 8, 2007, Usama Ghazi, M.D., conducted a medical consultation. On review, Dr. Ghazi noted strength in Claimant's lower back as 5/5 from L2-S1 with intact gait and negative bilateral straight leg raise. Dr. Ghazi noted that Claimant did not wish to pursue any further injections. In response, Dr. Ghazi recommended repeat impairment rating and to have Claimant placed at MMI.

14. On June 26, 2007, Dr. Ghazi performed a follow-up examination. He was of the opinion that Claimant should not be placed at MMI until she undergoes a surgical evaluation for her sacral fracture. Dr. Ghazi recommended repeat MRIs to the lumbar spine and sacral prior to the surgical evaluation.

15. On July 11, 2007, Dr. Ghazi stated an impairment rating. Dr. Ghazi noted that Claimant did not wish to seek a surgical evaluation and chose to have her case closed. Upon his physical examination, Dr. Ghazi noted strength and sensation intact from L2-S1. He did note pain over the L4-5 and L5-S1 facet joints. Dr. Ghazi assessed Claimant with a 12% whole person impairment rating (7% to the lumbar spine and 5% for the sacral fracture). Dr. Ghazi noted that he disagreed with Dr. Shenoi that the Claimant should receive a cervical versus

lumbar spine rating. The ALJ finds that this difference of opinion with Dr. Shenoi does not make it highly probable, and free from serious and substantial doubt, that Dr. Shenoi is in error. It is a mere difference of opinion.

16. On July 21, 2007, Dr. Noel performed another follow-up examination. Claimant complained of severe muscle spasms and difficulty walking. Claimant also complained of pain to palpation of the mid to lower sacral and coccygeal areas. Dr. Noel continued his assessment of sacral coccygeal fracture.

17. On August 25, 2007, Dr. Wakeshima examined the Claimant again after continued complaints of low back pain and pain in the buttocks. He was of the opinion that the lower back pain symptoms appeared to be related to the SI joint dysfunction and coccydynia. Dr. Wakeshima recommended diagnostic/ therapeutic right SI joint injection and a right coccygeal injection. On September 15, 2006, the SI joint and right coccygeal injections were performed. Again, Dr. Wakeshima's opinion does not rise to the level of making it highly probable, and free from serious and substantial doubt, that Dr. Shenoi's DIME opinion is in error.

18. On October 1, 2007, Claimant underwent a DIME follow-up examination with Dr. Shenoi. **Dr. Shenoi placed Claimant at MMI as of July 11, 2007 and assigned Claimant a 5% whole person impairment rating.** Dr. Shenoi reiterated that Claimant did not sustain an injury to her lumbar spine. Dr. Shenoi, after reviewing the Level II accreditation guidelines, contacted the OTR at the Division of Workers' Compensation (DOWC) to confirm that a lumbar spine range of motion is not measured for injury to the pelvis region. The Medical Treatment Guidelines place an impairment rating for the pelvis in a separate category from the lumbar spine and do not address range of motion for the lumbar region. The ALJ finds that Dr. Shenoi's opinions are especially credible because she had doubts about the relationship of back ratings and pelvic ratings and she contacted the DOWC to resolve those doubts. Dr. Shenoi specifically disagreed with Dr. Ghazi's recommendations because she believed that the impairment should be solely for the sacrococcygeal fracture and not the lumbar spine. Dr. Ghazi further stated that Claimant did not need any future medical care including surgical intervention. Again, Dr. Ghazi's opinions amount to mere differences of opinion with Dr. Shenoi and do not rise to the level of making it highly probable, and free from serious and substantial doubt, that Dr. Shenoi was in error. At best, any problems with the back and/or right leg amounted to referred pain from the sacrococcygeal fracture.

19. Respondent filed a Final Admission of Liability (FAL), dated October 22, 2007, for 5% whole person, with an MMI date of July 11, 2007, based on the DIME opinions of Dr. Shenoi, who agreed with Dr. Ghazi's MMI date of July 11, 2007. Claimant filed a timely objection thereto and sought to overcome Dr. Shenoi's opinions by clear and convincing evidence. Clearly, the Respondent relied

on Dr. Shenoi's Follow-Up DIME Report of October 1, 2007 in its decision to file an FAL. Claimant may implicitly argue that the first DIME Report of March 19, 2007 controls, thus, Claimant's decision to challenge the FAL and the DIME opinion upon which it was based.

20. Claimant failed to establish that it is highly probable, and free from serious and substantial doubt, that the DIME physician's (Dr. Shenoi's) opinion concerning lack of causal relatedness of Claimant's back problems to the admitted compensable injury of May 4, 2006. Claimant implicitly argues that the admitted injury caused a permanent aggravation of Claimant's degenerative back condition. Dr. Shenoi implicitly disagrees. Therefore, the ALJ finds that Claimant has failed to prove, by clear and convincing evidence, that the DIME physician erred in determining that Claimant's present back condition is not causally related to the admitted injury.

CONCLUSIONS OF LAW ON REMAND

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

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). 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); COLORADO JURY INSTRUCTIONS, 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 ALJ did not observe the Claimant's testimony because the matter was submitted on briefs and documentary exhibits. For this reason, the ALJ makes no credibility determinations concerning the Claimant. To do so, however, would not be germane to the resolution of the issue herein. The ALJ, however, can make a credibility determination concerning DIME physician, Dr. Shenoi. As found, Dr. Shenoi's testimony was consistent throughout, and the fact that she had enough doubts to contact the DOWC on the rating relationship between the back and the pelvis further enhances her credibility. The ALJ finds her opinions, in this regard, more credible than the other medical opinions contained in the documentary exhibits.

b. A **causation** determination by a DIME physician, insofar as it is related to the cause of **permanent** impairment, must be accorded the special deference required by Section 8-42-107 (8) (c), C.R.S. (2008), *i.e.,* the standard of proof to overcome it is "clear and convincing evidence." *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). *See also Esquibel v. Denver Public Schools,* W.C. No. 4-329-119 [Industrial Claim Appeals Office (ICAO), February 11, 1999]. As found, Claimant failed to overcome, by clear and convincing evidence, that Dr. Shenoi's opinion that the problems caused by the back condition were not causally related to the admitted injury. The ALJ infers and finds that inherent in Dr. Shenoi's opinion is the proposition that the Claimant's back problems are not ratable. In effect, this is a determination that there was no permanent aggravation, resulting from the admitted injury. If employment-related activities aggravate, accelerate, or combine with the pre-existing condition to cause a need for medical treatment or produce the disability for which benefits are sought. Section 8-41-301(1)(c), C.R.S. (2008), then there is causal relatedness. *See Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). *Also see* Section 8-41-301(1)(c), C.R.S. (2006); *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Industrial Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). *See Merriman v. Industrial Commission,* 120 Colo. 400, 210 P.2d 448 (1949). As found, Claimant has failed to establish a permanent aggravation of her degenerative back condition, which was caused by the admitted, compensable sacrococcygeal fracture.

c. A written document, concerning identical subject matter, later in time, absent a manifest intent to the contrary, extinguishes and supersedes the earlier document. *See McKay v. Fleming,* 24 Colo. App. 380, 134 P. 159 (1913). As found, Dr. Shenoi's Follow-Up DIME report of October 1, 2007, superseded her first DIME Report of March 19, 2007, as reflected by the Respondent's reliance on the MMI date of July 11, 2007 and the 5% whole person rating. Claimant's implicit argument that the first DIME Report of March 19, 2007, wherein Dr. Shenoi expressed the opinion that Claimant was not at MMI is without merit.

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). The DIME physician's determination of causation related to MMI and or permanent impairment 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. (2008). "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's determinations have been overcome is a factual determination for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, *supra.* As found, Claimant has failed to sustain her burden of proof in this regard.

ORDER ON REMAND

IT IS, THEREFORE, ORDERED THAT:

Claimant having failed to overcome the Division Independent Medical Examination opinions of Ranee Shenoi, M.D., the Final Admission of Liability, dated October 22, 2007, is hereby affirmed and adopted as part of this decision.

DATED this_____day of December 2008

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-726-431

ISSUES

The issues presented for determination at hearing were Respondents attempt to overcome the opinion of the Division IME physician ("DIME") that Claimant was not at maximum medical improvement ("MMI"), and, if successful, the determination of Claimant's permanent impairment; and liability for medical care after MMI.

By agreement of the parties as reflected in an Order date September 11, 2008, the issue of permanent total disability was held in abeyance.

FINDINGS OF FACT

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

1. Claimant suffered an admitted injury in the course of and arising out of her employment, on May 16, 2007. The injury resulted from claimant pressing hard on 'soft brakes' in two motorcoach 'bus' vehicles she was employed to drive for Employer.

2. Claimant was placed at MMI by Dr. Robert Kawasaki, M.D. on October 22, 2007. Dr. Kawasaki reviewed the results of an MRI done on September 5, 2007 and opined that the MRI findings were probably age-related degenerative

changes. Dr. Kawasaki further stated that Claimant's symptoms appeared to be focused to the sacroiliac ("SI") joints. Dr. Kawasaki opined that the underlying degenerative disc and facet changes were age related and not caused by or related to the episodes of pushing on fAy brakes over a two-day period.

3. At the time he placed Claimant at MMI, Dr. Kawasaki assigned a permanent impairment rating of 8% whole person impairment, resulting from sacroiliac joint ["SI"] dysfunction. Dr. Kawasaki's assessment of impairment was based on a 5% impairment for specific disorder, pursuant to Table 53 (II)(B), of the A.M.A. Guides to the Evaluation of Permanent Impairment, 3rd Edition, Revised ["Guides"], combined with 3% for range of motion deficit.

4. The Insurer filed a Final Admission of Liability dated December 21, 2007 in accordance with the opinion of Dr. Kawasaki. Claimant timely objected to the Final Admission and requested a DIME. Dr. John Hughes, M.D. was selected to perform the DIME.

5. Claimant was examined by Dr. Joseph H. Fillmore, M.D. on February 28, 2008. Dr. Fillmore's diagnostic impression was SI joint dysfunction/ irritation, chronic and lumbar spine degenerative disc disease more likely incidental and not related to a specific injury. Dr. Fillmore concluded that because Claimant had benefited from SI joint injections suggested that her problems were from the SI joints and not the degenerative discs. Dr. Fillmore concluded that claimant had reached MMI. Dr. Fillmore assigned a 15% whole person impairment based on 5% impairment for specific disorder pursuant to Table 53(II)(B) of the Guides, combined with 11% for range of motion deficits.

6. Dr. Hughes evaluated claimant on June 19, 2008, and concluded claimant had not then reached MMI. Instead, he recommended additional tests, specifically repeats of EMG/ nerve conduction studies of the lower extremities, and an MRI of the lumbar spine for further evaluation of Claimant's lumbar spine condition. Dr. Hughes questioned whether the lumbar spine condition was actually an occupational condition at all. Dr. Hughes expressed that he was perplexed by Claimant's decline in function evidenced by reduced mobility in the spine and reduced task tolerance. Dr. Hughes agreed with Drs. Fillmore and Kawasaki that the sacroiliac ("SI") joints were the generator of Claimant's pain. Dr. Hughes opined that in case of pure SI joint dysfunction lumbar spine mobility remains normal or near normal. Although he did not consider Claimant to be at MMI Dr. Hughes provided an estimate of Claimant's permanent impairment as 23% of the whole person. Dr. Hughes' estimate of impairment was comprised of an assessment of 7% for specific disorder under Table 53(II)(B) of the Guides, combined with 17% for range of motion deficits.

7. Claimant was seen and evaluated by Dr. Alexander Jacobs, on September 17, 2008. Dr. Jacobs is of the opinion that claimant had reached MMI on October 22, 2007, concurring with Dr. Kawasaki's assessment. Dr. Jacobs

also concluded claimant has a 12% impairment, based on a 5% specific disorder of the spine pursuant to Table 53(II)(B) of the Guides, combined with a 7% range of motion deficit.

8. Dr. Kawasaki again evaluated Claimant on September 29, 2008. Dr. Kawasaki expressed the opinion that the SI joint dysfunction was the source of Claimant's symptoms and that the mechanism of injury was not causative of acceleration of degenerative disc changes or radiculopathy that developed more recently over one year after the date of injury. Dr. Kawasaki referred Claimant for the MRI and electrodiagnostic testing suggested by Dr. Hughes.

9. Dr. Kawasaki saw Claimant for follow-up on October 13, 2008. Dr. Kawasaki reviewed the result of the recent MRI and electrodiagnostic testing noting that the MRI results were unchanged compared to a prior MRI of September 5, 2007 and the electrodiagnostic tests were normal.

10. At hearing, Dr. Hughes acknowledged that he had now had the opportunity to review the medical records from the further evaluations and diagnostic tests performed subsequent to his evaluation of Claimant. Dr. Hughes now expressed the opinion that Claimant was at MMI. Dr. Hughes placed the date of MMI as the date the Claimant was seen by Dr. Fillmore in February 2008.

11. The ALJ finds that Claimant reached MMI as of October 22, 2007 as originally assessed by Dr. Kawasaki. As stated by Dr. Jacobs, the further testing recommended by Dr. Hughes was for evaluation of the cause and causal relationship of a lumbar spine condition separate and distinct from the SI joint dysfunction related to Claimant's admitted injury. Dr. Hughes admitted in his testimony at hearing, and it is found, that the Claimant degenerative disc disease in the lumbar spine was not caused or accelerated by the admitted injury. The ALJ finds that Respondents have overcome Dr. Hughes' opinion on MMI to the extent that Dr. Hughes assessed MMI as of February 2008. The additional diagnostic testing recommended by Dr. Hughes did not identify any further treatment to improve Claimant's SI joint condition as related to her compensable injury. Dr. Hughes was in error to conclude that Claimant was not at MMI for the effects of her compensable injury on the basis that additional diagnostic testing was needed to evaluate a non-occupational condition.

12. At hearing, Dr. Hughes changed his opinion regarding Claimant's permanent impairment. Dr. Hughes testified, and it is found, that Claimant should receive 5% impairment for specific disorders under Table 53 of the Guide instead of the 7% he originally assessed because Claimant's degenerative disc disease did not contribute to her symptoms as related to the compensable injury.

13. With regard to Claimant's range of motion impairment, Dr. Hughes testified that at the time of his examination of Claimant he wondered if he was seeing inordinately reduced mobility of the spine. Dr. Hughes stated that Claimant's range of motion loss was inflated based upon the pathology involved. Al-

though Claimant produced valid range of motion results under the Guides criteria, Dr. Hughes questioned if the results were "biologically plausible". Dr. Hughes testified, and it is found, that Claimant's loss of function is in excess of what would be expected from the pathology seen.

14. Dr. Hughes further testified that while the Claimant's degenerative disc disease has not been proven to contribute to her symptoms, the degenerative changes in the lumbar spine probably contributed measurably to the decreased range of motion in the lumbar spine.

15. Dr. Hughes testified that his range of motion results obtained at the time of his June 2008 examination were accurate. Dr. Hughes also testified that there is variability in range of motion testing due to the waxing and waning of symptoms. Dr. Hughes testified that while he would stand by his measurements of range of motion, he agreed that the range of motion measurements of Dr. Fillmore could be as accurate and valid as his measurements. Dr. Hughes' opinion on Claimant's permanent impairment from loss of range of motion is ambiguous and conflicting. The ALJ resolves this ambiguity and conflict by finding that Dr. Hughes' true opinion of the Claimant's permanent impairment related to the compensable injury is 5% for specific disorders under Table 53 of the Guides and an 11% impairment for loss of range of motion as assessed by Dr. Fillmore for a combined whole person impairment of 15%, also as assessed by Dr. Fillmore.

16. Respondent's filed a Final Admission of Liability dated December 21, 2007. In this Final Admission, Respondent's admitted liability for post-MMI medical treatment. Respondents have not sought to withdraw this admission.

CONCLUSIONS OF LAW

17. 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).

18. 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. 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 respon-

dents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

19. Respondents bear the burden of proof, by clear and convincing evidence to overcome the opinion of the DIME physician that Claimant was not at MMI. §8-42-107(8)(c), C.R.S. The DIME physicians' opinion consists not only of his written report but also any subsequent opinion given including the physicians' testimony at hearing. *Andrade v. Indus. Claim Appeals Office,* 121 P.3d 328 (Colo. App. 2005); *Lambert & Sons, Inc. v. Indus. Claim Appeals Office,* 984 P.2d 656 (Colo. App. 1998). As found, Dr. Hughes testified at hearing that his opinion is now that Claimant is at MMI. Thus, Respondents have met their burden through the further opinion of Dr. Hughes subsequent to his report.

20. Maximum Medical Improvement is defined 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." §8-40-201(11.5), C.R.S.

Claimant's medical condition, *i.e.*, the medical consequence of this injury, is the SI joint dysfunction. That condition became medically stable, and not subject to 'significant improvement by future medical maintenance treatment', on October 22, 2007. While the 'ratings' of impairment differed after that date, no treatment was prescribed, or applied, which altered the SI condition. The repeat MRI and EMG/ nerve conduction testing directed by Dr. Hughes was focused on identifying a different cause, or additional cause or explanation, of claimant's complaints. It was therefore testing for *causation*, rather than for diagnosis or identification of treatment; and the lack of that testing being completed was not inconsistent with claimant having achieved MMI. See: *Brickell v. Overhead Door Co*, W.C. No. 4-586-287 (February 4, 2000); *Hatch v. John H. Harland Company*, W.C. No. 4-368-712, (2000). The burden of proving causation remains with claimant, whether or not the D.I.M.E. physician suggests testing for alternative causation, *Martinez v. Triangle Sheet Metal, Inc.,* W.C.#4-595-741 (ICAO October 8, 2008). As found, the ALJ concludes that Respondents have shown by clear and convincing evidence that Dr. Hughes was in error to conclude that Claimant did not reach MMI as of October 22, 2007.

21. Also as found, Dr. Hughes provided ambiguous and conflicting opinions concerning the extent of Claimant's permanent impairment from the SI

joint condition that is causally related to Claimant's injury. Where a DIME physician offers ambiguous or conflicting opinions concerning impairment the ALJ is to resolve the ambiguity and determine the DIME physicians' true opinion as a matter of fact. *Magnetic Engineering Inc., supra.* In so doing, the ALJ is to consider all of the DIME physicians' written and oral testimony. *Dazzio v. Rice & Rice, Inc.,* W.C. No. 4-660-140 (June 30, 2008). Considering all of Dr. Hughes testimony, the ALJ concludes that Dr. Hughes' ultimate opinion regarding permanent impairment is that Claimant has 15% whole person impairment related to the compensable injury and resulting SI joint dysfunction.

ORDER

It is therefore ordered that:

Respondents shall pay Claimant permanent impairment benefits for 15% whole person impairment commencing October 22, 2007 at the rate of $345.30 per week until paid in full.

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

Respondents are liable for reasonable and necessary medical treatment to relieve and maintain Claimant's condition subsequent to the date of MMI, subject to Respondent's right to challenge the reasonableness and necessity of specific treatment, as well as the cause of the need for any specific treatment proposed or provided;

All matters not determined herein are reserved for future determination.

DATED: December 30, 2008

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ) on December 18, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/18/08, Courtroom 3, beginning at 10:20 AM, and ending at 12:10 PM).

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Respondents, to be submitted electronically, within 5 working days, giving the Claimant 3 working days within which to submit objections, electronically. The proposed decision was filed on December 23, 2008. No timely objections were filed. After a consideration of the proposal, the ALJ has modified it and hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern whether the Claimant is entitled to temporary total disability (TTD) benefits from July 14, 2008 through September 24, 2008; and, Respondents raised the affirmative defense of whether Claimant was responsible for his wage loss due to his termination of employment with the Employer for cause on July 22, 2008. Initially, the Claimant has the burden of proof, by a preponderance of the evidence, of establishing entitlement to TTD benefits. Once satisfied, Respondents have the burden by preponderant evidence of establishing "responsibility for termination," as defined by the Workers' Compensation Act.

FINDINGS OF FACT

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

1. At the commencement of the hearing, the parties agreed to the following stipulations: (1) Claimant sustained a compensable injury to his left shoulder while in the course and scope of employment with the Employer on July 13, 2008; (2) Claimant's average weekly wage (AWW) as of July 13, 2008 was $766.56. Claimant's AWW, effective September 1, 2008, due to his loss of health insurance increased to $1,021.79; (3) the medical treatment Claimant has received since his July 13, 2008 injury through December 18, 2008, has been reasonably necessary and causally related to his industrial injury and it is not in dispute. These stipulations of the parties are hereby made findings of fact. The ALJ further finds that the AWW of $766.56 yields a TTD rate of $511.03 per week, or $73 per day.

2. Claimant injured his left shoulder while working for his Employer on July 13, 2008. Respondents by stipulation admitted the compensability of Claimant's injury.

3. On July 13, 2008, the Employer employed the Claimant as a delivery driver. When Claimant arrived at work on July 13, 2008, following a vacation, he found trash in the truck he was to drive that day. He threw the trash out of the

truck and into the parking lot of the Employer, and left the premises to complete a delivery run.

4. Upon Claimant's return to the Employer's premises, PB, the Distribution Supervisor, met with Claimant and advised him to pick up the trash. Claimant refused B's directive. B then stated to the Claimant that the Claimant needed to pick up the trash or leave the premises. Claimant refused to pick up the trash or leave, stating that he would pick up the trash when he had time. B then suggested the two of them meet with JK, the Plant Supervisor, to discuss the matter further.

5. Claimant, B and K then met to discuss Claimant's refusal to pick up the trash that Claimant had thrown in the parking lot of the Employer. K advised the Claimant to follow B's directive and pick up the trash, and that his failure to do so was insubordination. Claimant then picked up the trash, and deposited it in the windshield washing buck rather than the trashcan. B credibly testified that the windshield-washing bucket was full of windshield washing fluid at the time. Claimant testified that it was summertime and the bucket was empty. Claimant implied that the empty bucket was a reasonable place to deposit trash. A critical credibility determination turns on the credibility of PB versus Claimant's credibility concerning whether the windshield-washing bucket was full of fluid or empty. The ALJ infers and finds that Claimant's version is not credible because the ALJ infers and finds there is still a need to wash windshields in the summertime, or at any other time of the year. For this reason, Claimant's version of events does not "hold water." It is not inherently reasonable. Considering the Claimant's interest in the outcome of this case and B's disinterestedness, and the inherent unreasonableness of Claimant's version of events, the ALJ credits the testimony of B over that of the Claimant in this regard, and finds that there was fluid in the windshield-washing bucket at the time.

6. It is undisputed that Claimant was previously disciplined by the Employer on four occasions for other violations of company policy and rules of conduct, and the ALJ finds that Claimant's prior disciplinary actions show a heightened awareness on the part of the Claimant as to inappropriate behavior that could result in discipline or termination.

7. The ALJ further infers and finds that the Claimant's refusal to pick up the trash when first directed to do so by B was an act of insubordination, and constituted a volitional act in an of itself. Claimant's subsequent act of throwing the trash in a windshield-wiper bucket with fluid in it was an act of defiance that warranted the Claimant's termination from employment based on a volitional act on Claimant's part.

8. The Claimant engaged in a volitional act over which he maintained a certain degree of control by refusing to follow a reasonable directive of his su-

perior, PB, in refusing to pick up trash he threw in the parking lot on July 13, 2008. Claimant also engaged in an additional volitional act, an act of defiance, when he finally did pick up the trash, but deposited it in the windshield washing bucket – a receptacle clearly not designed to hold trash, which was filled with fluid. The act of refusing to pick up the trash and tell his superior that he would pick up the trash when he got around to it is an act of insubordination, or a volitional act over which the Claimant exercised control, that resulted in his termination. Further, Claimant's act of throwing the trash he eventually picked up into the windshield-washing bucket containing fluid is an act of defiance, or volitional act, that further establishes Claimant's termination for cause. As such, Claimant's resulting wage loss after his date of termination is attributable to his termination for cause, which superseded the direct link between the injury and the wage loss.

9. Claimant has proven, by a preponderance of the evidence, that he was TTD from July 14, 2008 through September 24, 2008.

10. Respondents have proven, by a preponderance of the evidence, that Claimant was "responsible for his termination" for cause, effective July 22, 2008, because of a volitional act on his part on July 13, 2008.

11. Claimant was TTD from July 14 through July 21, 2008, both dates inclusive, a total of 8 days, before his termination for cause.

CONCLUSIONS OF LAW

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

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). 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). A critical credibility determination turns of the credibility of PB versus Claimant's credibility on whether the windshield-washing bucket was full of fluid or empty. As found, B's version of events was more credible than Claimant's because B was disinterested in the outcome of this case, and B's version of events was more reasonable and likely than Claimant's version, *i.e.,* that the windshield-wiping bucket was full of fluid at the time Claimant threw the trash into it, which amounted to a capping act of defiance after Claimant's repeated refusals to pick up the trash.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. Sections 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). Also, 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). 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 satisfied his burden with respect to TTD from July 14, 2008 through September 24, 2008. Respondents, however, satisfied their burden of proof with respect to "responsibility for termination," effective July 22, 2008.

c. Section 8-42-103 (1) (b), C.R.S. (2008), provides that where TTD last longer than two weeks, which it has in this case, benefits are recoverable from the day the injured employee leaves work, the day after which was July 14, 2008. Therefore, Claimant is entitled to TTD benefits of $511.03 per week, or $73 per day, from July 14, 2008, through July 21, 2008, both dates inclusive, a total of 8 days, in the aggregate amount of $584.04.

d. Once a claimant establishes entitlement to TTD and/or TPD benefits, it becomes incumbent upon respondents to prove, by a preponderance of the evidence, that the temporarily disabled employee was responsible for his termination of employment. If proven, the resulting wage loss of the injured worker shall not be attributable to the on-the-job injury. Section 8-42-105 (4), and 8-42-103 (1)(g), C.R.S. (2008). *See Anderson v. Longmont Toyota,* 102 P.3d 323 (Colo. 2004). The statutory provisions have been interpreted to mean that "responsibility for termination" must be through a volitional act on the part of the terminated employee. *Colorado Springs Disposal v. Industrial Claim Appeals Office,* 58 P. 3d 1061 (Colo. App. 2002). A claimant should be held responsible for his separation of employment from an employer if he performed some volitional act, or exercised some control over the circumstances of the termination. *Padilla v. Digital Equipment Corp.,* 902 P.2d 414 (Colo. App. 1994), *opinion after remand* 908 P.2d 1185 (Colo. App. 1985). The determination of the fA issue is ordinarily one of fact for resolution by the ALJ. *Id.* As found, Respondents herein have proven that Claimant was responsible for his termination through a volitional act on his part on July 13, 2008, and his termination was effective as of July 23, 2008.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant's July 13, 2008 claim for compensation is compensable.

B. Respondents shall pay the Claimant temporary total disability benefits of $511.03 per week, or $73 per day, from July 14, 2008, through July 21, 2008, both dates inclusive, a total of 8 days, in the aggregate amount of $584.04, which is payable retroactively and forthwith.

C. Claimant's request for temporary total disability benefits from July 22, 2008, through December 18, 2008, is hereby denied and dismissed.

D. Claimant's AWW prior to September 1, 2008 is $766.56, and his AWW following September 1, 2008 is increased to $1,021.79, based on discontinuance of health benefits.

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

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

DATED this _____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-740-891

ISSUES

I. Whether claimant sustained a compensable injury to his neck on April 18, 2006.

II. Whether claimant sustained a compensable occupational disease to his lumbar spine with onset on or about August 22, 2006.

FINDINGS OF FACT

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

1. Claimant began employment with Employer on January 5, 2006 as a delivery driver. On claimant's job application he indicated that he had a prior back injury in 1992 that resulted in 9% permanent impairment. Claimant did not report any permanent work restrictions on his job application or indicate that he would have any difficulty in performing the delivery driver position.

2. Claimant did not have any problems with his back while working for Employer between January 2006 and April 2006. On or about April 3, 2006 claimant called in to work due to an incident lifting a carpet cleaner at his house. Claimant reported to MG, President of Employer, that he had injured his back while lifting the carpet cleaner at home. While conflicting evidence was presented regarding the date of the carpet-cleaning incident, the testimony of MG that claimant did not report difficulties with his back prior to the carpet cleaner incident is credible and persuasive.

3. After the carpet cleaner incident, claimant complained of difficulty with his back. Employer modified the claimant's job duties and hired an assistant, Daniel Benson, to take over any lifting that needed to be performed.

4. Mr. G specifically instructed the claimant in the beginning of April 2006 that if there was any lifting to be done, Daniel was to do it. Mr. G asked the claimant to look for another job, but due to an upswing in business Mr. G determined Employer could utilize the claimant in positions that did not require lifting.

5. Claimant testified at hearing that he was struck in the head by a roof hatch on April 18, 2006. However, inspection of the claimant's daily logs which were accepted into evidence did not show any reference to an injury having occurred on that date or that the claimant was at the location where he alleged the injury occurred on the date in question. Mr. G testified credibly and persuasively that claimant never reported the April 18, 2006 alleged incident to him. The evidence supports a determination that the April 18, 2006 alleged incident with the roof hatch did not occur or, if it did occur, it did not cause disability or the need for medical treatment.

6. Claimant became dissatisfied with his employment relationship with Employer because of a dispute regarding his earnings. Claimant went to Mr. G on or about August 18, 2006 and demanded an increase in salary or he would quit and begin employment with Grandma's Handyman Services, a company owned by the claimant's mother. Termination documents were filed August 24, 2006 with the reason for leaving indicated that claimant "wanted more money."

7. Mr. G testified credibly and persuasively that claimant did not report any work related injury or request medical treatment prior to voluntarily terminat-

ing his employment with Employer. Mike G credibly and persuasively testified that at the time claimant quit his employment, he appeared fine and was not demonstrating any signs or symptoms of back pain.

8. Claimant began work with Grandma's Handyman Services on August 14, 2006 and worked through September 18, 2006.

9. On October 16, 2007 claimant filed a First Report of Injury alleging onset of an occupational disease to his lumbar spine on August 22, 2006. Claimant also filed a First Report of Injury on October 31, 2007 alleging the specific incident to his cervical spine of April 18, 2006. Both claims were filed over one year after claimant left his employment with Employer.

10. The evidence presented supports a determination that claimant had a longstanding history of cervical and lumbar spine issues dating back to an automobile accident in 1978. Claimant has documented pre-existing conditions in both his cervical and lumbar spine including findings of degenerative disc disease. On June 10, 1991 claimant was involved in a prior workers' compensation claim that resulted in a lumbar discectomy. Claimant received additional treatment for his lumbar spine in June 2002 including an MRI in August 2002 that showed degenerative changes at L3-4 and L4-5 as well as clumping of the cauda equina.

11. On November 9, 2006, claimant was treated by his family physician, Dr. Timothy Judd. Dr. Judd's report indicates claimant is "here for evaluation and management of his chronic neck pain." There is no mention in Dr. Judd's report of the April 18, 2006 alleged incident with the roof hatch, nor is there mention of any low back pain complaints.

12. On May 11, 2007, claimant was evaluated by neurosurgeon, Dr. Mark Bryniarski. Claimant was diagnosed with degenerative disc disease in his lumbar spine. Dr. Bryniarski's report provides an opinion that claimant's degenerative disc disease is secondary to the long-term effects from the 1991 injury, secondary to overall degenerative disease of the spine, and secondary to his long-term smoking history.

13. On November 12, 2007 claimant was evaluated by Dr. Jeffrey Wunder in connection with an application for Social Security disability benefits. Dr. Wunder noted inconsistencies in the claimant's presentation and stated that claimant's complaints "could not be taken at face value."

14. On January 11, 2008 claimant was evaluated, at his request, by Dr. Michael Janssen. Dr. Janssen opined that the claimant's current condition of his lumbar spine was an "exacerbation from his occupational-related injury [at Employer] and more likely than not is occupational related." Dr. Janssen provided deposition testimony consistent with this opinion.

15. On April 28, 2008 claimant was evaluated by Dr. Henry Roth, respondents' retained expert, who opined that claimant's cervical and lumbar complaints were not related to any injury or occupational disease sustained at Employer. Dr. Roth opined that degenerative disc disease is a progressive degenerative condition that will advance on its own. Dr. Roth opined that the claimant's current low back complaints are a reflection of the advanced underlying preexisting biological process of lumbar degeneration. Dr. Roth opined that even if the claimant's report of his activities at Employer was taken at face value, the current state of medical literature does not support a relationship between materials handling including the activities of bending, lifting, and twisting and the progression of degenerative disease of the spine. Dr. Roth opined the current condition of the claimant's spine is the product of the natural progression of his underlying degenerative condition and was not caused, aggravated, or accelerated by the claimant's work at Employer.

16. The opinions of Dr. Roth as to causation are more credible and persuasive than the opinions expressed by Dr. Janssen.

17. At hearing, claimant asserted Dr. Roth was biased in favor of respondents and submitted evidence in support of the assertions of bias including an e-mail from Dr. Roth. Claimant had the opportunity to cross-examine Dr. Roth regarding his alleged bias. Claimant attempted to present testimony from Chad Hemmat, Esq., a letter written by Mr. Hemmat, and other documentary evidence in support of the assertion of bias on the part of Dr. Roth. After considering the arguments of the parties, it was determined that the offered evidence was hearsay, cumulative, and/or not relevant and not admitted into evidence. The Judge also declined to allow Mr. Hemmat's testimony on the basis of respondents' objections as the intended testimony related to alleged hearsay statements made by Dr. Roth and was also cumulative. The evidence does not support a finding that Dr. Roth was biased in this particular case or that Dr. Roth's opinions should be rejected due to the allegations of bias.

18. The claimant's testimony is not credible or persuasive. The opinions expressed by Dr. Roth as to causation are credible and persuasive.

19. Claimant's work at Employer did not cause, aggravate, or accelerate the claimant's pre-existing condition in his lumbar spine. Claimant has not met his burden of proof to demonstrate a compensable occupational disease to his lumbar spine. The alleged incident of April 18, 2006 did not cause, aggravate, or accelerate the claimant's pre-existing condition in his cervical spine. Claimant has not met his burden of proof to demonstrate a compensable injury to his cervical spine. To the extent claimant needs medical care to treat conditions of his cervical or lumbar spine, the need for such medical care is not causally related to the claimant's employment activities at Employer.

CONCLUSIONS OF LAW

1. To recover workers' compensation benefits, the claimant must prove he suffered a compensable injury. A compensable injury is one which arises out of and in the course of employment. §8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origin in an employee's work-related functions, and be sufficiently related thereto so as to be considered part of the employee's service to the employer. It is the claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. §8-43-201, C.R.S.; *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, that a fact is more probable than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

2. No benefits flow to the victim of an industrial accident unless the accident results in a compensable "injury." Claimant bears the burden of proving a compensable injury. *See e.g., Smith v. Dept. of Labor,* 494 P.2d 598 (Colo. App. 1972). Inconsistencies in a claimant's account of an injury or his actions thereafter can provide sufficient basis to conclude the claimant has failed to carry his burden of proof. Under the Act, a compensable injury is one which "requires medical treatment or causes a disability." §8-41-301(1)(c) C.R.S. 2005; *See e.g., Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). The determination of whether the claimant's condition is due to the natural progression of the pre-existing condition or an industrial accident is one of fact for resolution by the ALJ. *Industrial Commission v. Riley*, 441 P.2d 3 (Colo. 1968).

3. A claimant sustains an occupational disease when the injury is the incident of the work, or a result of exposure occasioned by the nature of the work, and does not come from a hazard to which the worker would have been equally exposed outside of the employment. Section 8-40-201(14), C.R.S. The claimant had the burden to prove the alleged occupational disease was caused, aggravated or accelerated by the claimant's employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo. App. 1999).

4. The fact that a claimant experiences pain while performing tasks at work does not compel the ALJ to conclude that the pain is the result of an injury or occupational disease sustained while performing the work. This is particularly true where the claimant's pain is the logical and recurrent consequence of some prior industrial injury or pre-existing condition. *F. R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995). An incident which merely elicits pain symptoms caused by a pre-existing condition does not compel a finding that the claimant sustained a compensable aggravation. *Witt v. James J. Keil, Jr.,* W.C. No. 4-225-334 (ICAO April 7, 1998); *Miranda v. Best Western Rio Grande Inn,* W.C. No. 4-663-169 (ICAO April 11, 2007).

5. Claimant failed to sustain his burden of proof to demonstrate by a preponderance of the evidence that his work activities at Employer caused, aggravated, or accelerated the pre-existing condition of the claimant's lumbar spine so as to create an occupational disease. Claimant failed to sustain his burden of proof to demonstrate by a preponderance of the evidence that he sustained a compensable occupational disease to his lumbar spine while employed with the Employer. Claimant's testimony was not credible or persuasive. Testimony presented by Dr. Roth as to causation was credible and persuasive.

6. Claimant failed to sustain his burden of proof to demonstrate by a preponderance of the evidence that he sustained a compensable injury to his cervical spine on April 18, 2006 while employed with the Employer. Claimant failed to demonstrate by a preponderance of the evidence that the alleged April 18, 2006 incident occurred, or even if it did occur, that the incident required medical treatment or caused disability. Claimant failed to prove that the alleged April 18, 2006 incident caused, aggravated, or accelerated the pre-existing condition of claimant's cervical spine. Claimant's testimony was not credible or persuasive. Testimony presented by Dr. Roth as to causation was credible and persuasive.

7. 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).

ORDER

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits under the Workers' Compensation Act is hereby denied and dismissed.

DATED: December 30, 2008

Barbara S. Henk
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-720-435

ISSUES

1. Whether Claimant has overcome by clear and convincing evidence the Division Independent Medical Examination (DIME) physician's determination that her lower back condition was not caused by her employment with Employer.

2. Whether Claimant is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of her industrial injury.

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

4. Whether Claimant is entitled to receive Temporary Total Disability (TTD) benefits from May 1, 2007 until September 6, 2007.

FINDINGS OF FACT

1. Claimant worked for Employer in various production positions from 1979 until May 1, 2007. She performed approximately 10-12 different jobs during the course of her employment.

2. Claimant has suffered an extensive history of lumbar spine problems. She primarily received treatment from Ann T. Colgan, M.D. and Hans C. Coester, M.D.

3. The medical records reveal that Claimant began suffering from documented lower back pain in September 2001. Claimant did not know the cause of her symptoms.

4. Claimant continued to experience lumbar spine pain and visited Dr. Colgan in November 6, 2002. Dr. Colgan recommended a lumbar MRI. The MRI revealed degenerative disc disease at the L5-S1 level.

5. Dr. Colgan also referred Claimant to Dr. Coester for an evaluation. Dr. Coester offered Claimant treatment recommendations that included injections, medications and possible surgery. Claimant declined surgery at the time.

6. Despite ongoing medical care, Claimant's lower back condition continued to deteriorate. On August 2, 2004 Claimant returned to Dr. Coester and reported pain in both legs. An MRI reflected a broad based disc protrusion with severe left-sided L5-S1 foraminal narrowing and moderate to severe right-sided L5-S1 foraminal narrowing. Claimant also had degenerative disc disease at the L4-L5 level. Claimant decided to proceed with surgery.

7. On August 27, 2004 Dr. Coester performed an L5-S1 decompression and fusion on Claimant. The surgery involved the insertion of hardware into Claimant's back. Claimant initially reported an improvement in her condition and Dr. Coester returned her to full duty work for Employer.

8. Claimant again began to experience lower back pain during the summer of 2005. An August 2005 MRI of Claimant's lumbar spine showed surgical changes but did not reflect evidence of any recurrent disc problems. Claimant subsequently underwent a series of epidural steroid injections.

9. In February 2006 Claimant transferred to Employer's 35mm motion picture department. A machine placed a roll of film on a table in front of Claimant. She then slid the roll of film off of the table, carried the roll a couple of steps and placed it on a pallet elevator. The elevator could be adjusted vertically to maintain a stacking height at waist level. Each roll of film weighed approximately 30-35 pounds. Claimant also explained that, approximately seven to eight times each year, employees were required to label and restack pallets.

10. On February 13, 2006 Claimant was involved in a motor vehicle accident. Claimant reported to Dr. Colgan that her back pain was "much worse." X-rays of Claimant's lower back were unremarkable and she was treated with muscle relaxers and non-steroidal anti-inflammatory medications. The medical records reveal that during the summer and fall of 2006 Claimant continued to report lower back pain.

11. On March 5, 2007 Claimant visited Dr. Colgan for an evaluation. Claimant reported continuing lower back pain. Dr. Colgan ordered another lumbar MRI. A March 13, 2007 lumbar MRI revealed postoperative changes at L5-S1 with no significant differences relative to previous MRI's. The MRI also demonstrated a protrusion at L4-L5 that reflected some changes compared to previous MRI's.

12. Claimant testified that on March 5, 2007 she suffered an occupational disease to her lower back as a result of her repetitive lifting activities while working for Employer. Employer referred Claimant to Authorized Treating Physician (ATP) Brian Thompson, M.D. On March 21, 2007 Claimant visited Dr. Thompson for an evaluation. Dr. Thompson noted that Claimant had been transferred to a position as a "T-perf operator." He stated that her position involved frequent lifting and palletizing of 30-pound rolls of film for 10 hours each day. He commented that Claimant had begun to experience increasing lower back pain over the previous five months. After reviewing Claimant's medical history, Dr. Thompson concluded that Claimant had suffered a lower back strain and released her to full duty employment.

13. On April 25, 2007 Claimant again visited Dr. Thompson for an evaluation. He assigned Claimant work restrictions that included only sedentary activities, no lifting and no repetitive bending or lifting.

14. On May 1, 2007 Claimant resigned from Employer. She testified that she ceased employment because her occupational disease prevented her from performing her job duties.

15. After Claimant received additional medical treatment, ATP Dr. Thompson determined that she had reached Maximum Medical Improvement (MMI) on September 13, 2007. He assigned Claimant a 20% whole person impairment rating for her March 5, 2007 occupational disease. Respondent subsequently filed a Final Admission of Liability (FAL) consistent with Dr. Thompson's 20% whole person impairment rating.

16. Claimant timely objected to the FAL and sought a DIME. Robert Kawasaki, M.D. performed the DIME on February 27, 2008. Dr. Kawasaki reviewed Claimant's complete medical history and performed a physical examination of Claimant that included range of motion measurements. Based on his review of Claimant's medical history, Dr. Kawasaki stated "it appears that [Claimant] has had a continuum of low back pain, the initial disc protrusion at L5-S1, and degenerative disc changes at L4-5 and L3-4." He explained that there had been no significant change in Claimant's "symptomatology over the course of many years." Because there had been no "appreciable change" during March 2007, Dr. Kawasaki opined that Claimant did not suffer a work-related injury.

17. After reviewing Claimant's case and performing a causation analysis, Dr. Kawasaki explained that Claimant's chronic pain was not caused or substantially altered by her work activities for Employer. He commented:

> It is medically probable [Claimant's] symptoms would be similar with or without the stated work activities. Based on the extensive work up that was repetitive as far as x-rays of the hip and lumbar spine, MRI's and more recent diagnostic interventional procedures, it appears [Claimant's] main pain generator may be due to hardware from her prior fusion. There is also epidural and perineural fibrosis related to the prior surgeries.
>
> With the above-identified pain generation, which would be specifically related to postoperative changes and sequelae from the surgery, it is within medical probability that the need for treatment including potentially removing the hardware would not be related to [Claimant's] reported work activities. Work activities would result in a temporary aggravation of the ongoing chronic pain syndrome. Chronic pain syndrome is a result of nonspecific degeneration of [Claimant's] lumbar spine resulting in the 08/04 surgery with failed back syndrome postoperatively.

Dr. Kawasaki thus concluded that Claimant's back condition was not caused by her work activities for Employer. He noted that Claimant reached MMI on March 21, 2007 and did not suffer any permanent impairment.

18. On April 2, 2008 Claimant underwent surgery to remove the hardware in her lumbar spine.

19. On August 4, 2008 Greg Reichhardt, M.D. performed an independent medical examination on Claimant. Dr. Reichhardt reviewed all of Claimant's medical records. He agreed with Dr. Kawasaki that, to a reasonable degree of medical probability, Claimant's lower back condition was not caused by her work activities. He noted that Claimant had significant ongoing back complaints after her 2004 fusion surgery. Dr. Reichhardt also stated that Claimant's February 13, 2006 motor vehicle accident aggravated and may have contributed to her condition. Dr. Reichhardt also agreed with Dr. Kawasaki that Claimant's chronic lower back problems preexisted her reported work injury and that there was no substantial change in her status as a result of her work activities. He thus determined that Claimant did not suffer any impairment as a result of her work activities for Employer.

20. On October 13, 2008 Claimant underwent an independent medical examination with David Yamamoto, M.D. Dr. Yamamoto noted that Claimant had a long history of lumbar pain and suffered from degenerative disc disease. Nevertheless, he concluded that the proximate cause of Claimant's lower back symptoms was her change in job duties during February 2006. He commented that Claimant had been "doing relatively well" and was able to perform her regular job duties after her lumbar fusion in 2004. Dr. Yamamoto also stated that he disagreed with the conclusions of Dr. Kawasaki and Dr. Reichhardt that Claimant's lower back condition was not related to her job duties for Employer. He nevertheless determined that Claimant had reached MMI and assigned her an 18% whole person impairment rating.

21. On November 11, 2008 the parties conducted the evidentiary deposition of ATP Dr. Thompson. Dr. Thompson stated that he disagreed with Dr. Kawasaki because there are many factors that can aggravate chronic lower back pain. He explained that Claimant's condition was substantially altered by her work activities. Dr. Thompson thus disagreed with Dr. Kawasaki's causation determination.

22. Although Dr. Thompson determined that Claimant's lower back condition was caused by her employment activities, he acknowledged that he did not review medical records that existed prior to Claimant's occupational disease claim. He specifically commented that he did not review Claimant's medical records that preceded and followed her fusion surgery. Because Dr. Thompson's opinion was based in part on the temporal proximity of Claimant's occupational disease claim, he agreed that a review of prior medical records could change his causation determination. Dr. Thompson also acknowledged that Dr. Kawasaki offered a reasonable opinion and that Claimant may have suffered a temporary aggravation of her condition. He also conceded that his determination merely constituted a difference of opinion with Dr. Kawasaki.

23. Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Kawasaki's causation determination was incorrect. The medical records reveal that Claimant has suffered an extensive history of lower back problems that began in 2001. She underwent lumbar fusion surgery on August 27, 2004 and continued to suffer from chronic, intermittent back pain. Claimant was also involved in a February 13, 2006 motor vehicle accident that exacerbated her lower back condition and required additional medical treatment. Dr. Kawasaki persuasively determined that Claimant's chronic pain was not caused or substantially altered by her work activities for Employer. He commented that Claimant's work activities caused a temporary aggravation of her ongoing chronic pain syndrome. Dr. Kawasaki also noted that Claimant's chronic pain was caused by "nonspecific degeneration of the patient's lumbar spine resulting in the 08/04 surgery with failed back syndrome postoperatively." Dr. Kawasaki thus concluded that Claimant's back condition was not related to her work activities for Employer. Claimant thus reached MMI on March 21, 2007 and did not suffer any permanent impairment. Moreover, Dr. Reichhardt agreed with Dr. Kawasaki that Claimant's chronic low back problems preexisted her reported work injury and that there was no substantial change in her physical condition as a result of her employment duties. He thus also determined that Claimant did not suffer any impairment as a result of her work activities for Employer.

24. Dr. Yamamoto and ATP Dr. Thompson disagreed with Dr. Kawasaki's causation determination. Dr. Yamamoto acknowledged that Claimant had suffered from a long history of lumbar pain and degenerative disc disease but concluded that the proximate cause of Claimant's lower back symptoms was her change in job duties during February 2006. Dr. Thompson testified that he disagreed with Dr. Kawasaki's causation determination but acknowledged that he did not review medical records predating Claimant's occupational disease claim. He specifically commented that he did not review Claimant's medical records that preceded and followed her fusion surgery. Dr. Thompson conceded that Dr. Kawasaki offered a reasonable opinion and that his determination merely constituted a difference of opinion with Dr. Kawasaki. The opinions of doctors Yamamoto and Thompson do not constitute unmistakable evidence establishing that Dr. Kawasaki's causation determination was incorrect. Their opinions merely constitute a difference of opinion regarding the cause of Claimant's lower back problems.

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 worker's 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 worker's 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 worker's 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 (2005).

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); *see In Re Backes,* W.C. No. 4-677-535 (ICAP, Sept. 22, 2008) (stating that, a "DIME physician's determination that an impairment is or is not caused by the industrial injury is also subject to the clear and convincing evidence standard"). "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. As found, Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Kawasaki's causation determination was incorrect. The medical records reveal that Claimant has suffered an extensive history of lower back problems that began in 2001. She underwent lumbar fusion surgery on August 27, 2004 and continued to suffer from chronic, intermittent back pain. Claimant was also involved in a February 13, 2006 motor vehicle accident that exacerbated her lower back condition and required additional medical treatment. Dr. Kawasaki persuasively determined that Claimant's chronic pain was not caused or substantially altered by her work activities for

Employer. He commented that Claimant's work activities caused a temporary aggravation of her ongoing chronic pain syndrome. Dr. Kawasaki also noted that Claimant's chronic pain was caused by "nonspecific degeneration of the patient's lumbar spine resulting in the 08/04 surgery with failed back syndrome postoperatively." Dr. Kawasaki thus concluded that Claimant's back condition was not related to her work activities for Employer. Claimant thus reached MMI on March 21, 2007 and did not suffer any permanent impairment. Moreover, Dr. Reichhardt agreed with Dr. Kawasaki that Claimant's chronic low back problems preexisted her reported work injury and that there was no substantial change in her physical condition as a result of her employment duties. He thus also determined that Claimant did not suffer any impairment as a result of her work activities for Employer.

6. As found, Dr. Yamamoto and ATP Dr. Thompson disagreed with Dr. Kawasaki's causation determination. Dr. Yamamoto acknowledged that Claimant had suffered from a long history of lumbar pain and degenerative disc disease but concluded that the proximate cause of Claimant's lower back symptoms was her change in job duties during February 2006. Dr. Thompson testified that he disagreed with Dr. Kawasaki's causation determination but acknowledged that he did not review medical records predating Claimant's occupational disease claim. He specifically commented that he did not review Claimant's medical records that preceded and followed her fusion surgery. Dr. Thompson conceded that Dr. Kawasaki offered a reasonable opinion and that his determination merely constituted a difference of opinion with Dr. Kawasaki. The opinions of doctors Yamamoto and Thompson do not constitute unmistakable evidence establishing that Dr. Kawasaki's causation determination was incorrect. Their opinions merely constitute a difference of opinion regarding the cause of Claimant's lower back problems.

ORDER

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

1. Claimant has failed to overcome Dr. Kawasaki's DIME determination that her lower back condition was not caused by her work activities for Employer.

2. Because Claimant's lower back condition was not caused by her employment activities, she is not entitled to receive medical benefits or TTD benefits.

3. All issues not resolved in this Order are reserved for future determination.

DATED: December 30, 2008.

Peter J. Cannici
Administrative Law Judge